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IMPLEMENTING A STEPPED CARE MODEL: A CASE STUDY OF TWO COLLEGE COUNSELING CENTERS

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ABSTRACT

The demand for mental health counseling services has surged, but the capacity of college counseling centers to meet this demand has not kept pace. The effects of COVID-19 have exacerbated this already fragile system of care. College students are enrolling in college with increased levels of anxiety, depression, disordered eating, suicidal ideation, and substance use. College counseling center staff are facing burnout. The waitlist to receive mental health services is at critical capacity. This multi-site case study was designed to foster an understanding of two college counseling centers' implementation of the stepped care approach as a mental health service delivery model. By interviewing seven college counselors at two universities and reviewing public and internal documents, this study developed an in-depth exploration of the cases. As a result of this study, there is an increased understanding of how the stepped care model has been conceptualized at each university. Results from this study indicated that implementing the stepped care approach will decrease the waitlist time for students to receive mental health services, decrease counseling staff burnout, and provide limited mental health resources efficiently and effectively.

Karen Card

Dr. Karen Card, Ph.D., Committee Chair

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Table of Contents

List of Tables

CHAPTER 1

Introduction

The request for campus counseling services has surged, yet the capacity to provide these services has not kept pace (Center for Collegiate Mental Health [CCMH], 2021; Reilly, 2018). Over 60% of college students met the criteria for one or more mental health problems, a nearly 50% increase since 2013 (Lipson et al., 2022). Anxiety, depression, and suicidal ideation among college students were at the highest rates ever reported in the Health Minds National Collegiate Mental Health Study (Lipson et al., 2022; Rosenbaum & Webb, 2023). The COVID-19 pandemic accelerated this already alarming trend as students struggled with social isolation, the trauma of losing loved ones, and the disruption of emotional and developmental growth (Booker et al., 2022; Murthy, 2023).

Utilizing the traditional counseling model, a one-size-fits-all approach to psychotherapy delivered through an individual 50-minute session, university counseling centers might not be able to meet the mental health concerns of students who face symptoms such as anxiety, depression, suicidality, substance use, and disordered eating (Cohen et al., 2021; Haaga, 2000). Inadequate access to mental health care had the potential to affect students negatively, the counseling center staff, and the entire institution (Reilly, 2018). In a study of collegiate mental health services, college counseling directors reported that 88% of their students did not receive timely care, 75% reported the inability to offer weekly appointments, 73% reported staff worked over-time, and 35% reported utilizing a waitlist for students seeking services; therefore, creating a need for a solution to address these mental health needs (Cornish et al., 2017; Mughal et al., 2023). The promise of the stepped care model as a heuristic approach potentially addressed these collegiate mental health concerns (Sobell & Sobell, 2000).

Stepped care was a self-correcting service delivery system based on a medical model that first offered the least restrictive services to meet mental health needs (Bower & Gilbody, 2005). It is estimated that 40% of university college counseling centers implemented some version of the stepped care mental health service delivery model to provide students with mental health resources (Association for University and College Counseling Center Directors [AUCCCD], 2022; Kognito, 2020). Cornish et al., (2017) described stepped care as: "A model for rationally distributing limited mental health resources to maximize the effectiveness of services based on the needs of the students" (p. 428). The stepped care framework was developed to offer the lowest level of intensity as determined through an initial screening process between the student and the mental health provider (Bower & Gilbody, 2005; Davison, 2000; Richards et al., 2012).

Placement in the stepped care model was not linear, and treatment could be self-corrected by stepping mental health services either up or down, depending on the student's mental health needs and goals (Bower & Gilbody, 2005; Firth et al., 2014). University counseling centers utilizing the stepped care model have developed some variation of the following steps: (a) self-guided/self-directed resources; (b) peer supports; (c) psycho-educational workshops; (d) group therapy; (e) short-term solution-focused individual counseling; (f) long-term individual counseling; and (g) acute/crisis care (Cornish et al., 2017). Each university had the agency to create the model that best suits its campus needs and available resources.

Purpose of Study

This study aimed to explore two universities in the United States that shifted counseling services from a traditional model to a stepped care model to meet students' mental health needs. The specific case study style used within this research was a multiple case study, which involved interviews with counseling staff and reviewing documents and artifacts. As a result of this study,

an increased understanding was gained of the strengths and limitations experienced at two universities that implemented the stepped care model. Additional considerations were discovered to benefit other universities interested in shifting to the stepped care model. Throughout this study, I sought to understand the catalyst that prompted universities to implement a stepped care model, its strengths and limitations, and its perceived effectiveness.

Research Questions

The following research questions guided this study:

1. What institutional reasons justified the shift in practice to a stepped care model?
2. What are the perceived strengths and limitations of integrating a stepped care model?
3. To what extent does the college counseling center staff perceive the effectiveness of a university stepped care model to meet students' mental health needs?

Significance of the Study

The mental health problems of college students were rising, with symptoms of depression, anxiety, and suicidality intensifying (Bourdon et al., 2020; Xiao et al., 2017). Over the last two decades, while the number of college students seeking counseling services increased, the number of counseling staff did not increase, and, therefore, was unable to meet the demands (CCMH, 2021). Based on the current model of providing traditional counseling services, lengthy wait times that limited access to mental health care resulted in students suffering additional distress (Kognito, 2020). Furthermore, this distress might negatively impact academic performance, retention, and future employment possibilities, resulting in universities needing to create solutions to this problem (Abrams, 2020; Rosenbaum & Webb, 2023; Williams & Reetz, 2020; Xiao et al., 2017). Results from this study could potentially aid universities seeking an alternative model for providing mental health services that benefit the students, counseling staff, and campus community.

Definition of Terms

The following list of terms defined the scope of this study:

Guiding Principles of Stepped Care: Individuals should have timely access to psychological services, individuals require different levels of care, and finding the right level of care is a fluid process (CCMH, 2019; Mughal et al., 2023).

Recovery-Oriented Model: A philosophy that assumes every individual, regardless of mental health status, possesses internal strengths and capacities for well-being (Cornish, 2020).

Stepped Care Model: A flexible mental health model that provided a holistic menu of services and distributed these resources effectively, efficiently, and personalized for each student needing mental health support (Bailey et al., 2022; Davison, 2000; Haaga, 2000; Kognito, 2020; Mughal et al., 2023; Sobell & Sobell, 2000).

Traditional Mental Health Model: A one-size-fits-all approach to psychotherapy delivered through an individual 50-minute session (Cohen, et al., 2021).

Limitations and Delimitations

1. This study was limited to two universities implementing stepped care models to meet the mental health needs of college students.
2. This study was limited to the extent to which the participants and their universities incorporated the stepped care approach into their counseling centers.
3. The study participants only included college counseling center staff who experienced working with both traditional and stepped care models.
4. The participants in the study were limited to college counseling staff and did not include students.
5. The study was limited to the extent of the participants' buy-in to the stepped care approach.

6. The data collected was based on the extent to which the university staff studied shared data.

Organization of the Study

This study consisted of five chapters. Chapter one provided the introduction, purpose of the study, research questions, significance of the study, definitions of terms used throughout the study, limitations, and delimitations of the study. Chapter two reviewed the literature and discussed the theoretical framework. Chapter three discussed the methodology used to collect data for the study. Chapter four reported the findings. Chapter five concluded with a case report, recommendations, and concludes the study.

Summary

The mental health needs of college students increased significantly, especially after the COVID-19 pandemic. The traditional model for offering mental health services did not allow the timely access to care that students require, nor has it allowed counseling center staff to relieve the heavy burden placed upon them. This study sought to explore the perceived effectiveness of shifting to a stepped care model as an alternative to the traditional model for mental health. This research might assist universities in exploring and understanding the effectiveness of integrating the stepped care model into their counseling centers.

Chapter 2

Review of Related Literature

This literature review aimed to identify the currently available resources on the implementation and program review of collegiate stepped care mental health models. Additional literature supplemented the significance and need for the study. The literature review relied upon several resources and academic institutions. This literature was accessed through the I.D. Weeks Library at the University of South Dakota and the Briggs Library at South Dakota State University. Digital databases of Academic Search Primer, EBSCO, JSTOR, and ProQuest, aided in accessing relevant literature. Further, the interlibrary loan system provided access to materials not readily available at physical library locations. This chapter begins by discussing the theoretical framework.

Theoretical Framework

In 2019, the World Health Organization (WHO) published a report on the principles of a recovery-oriented framework. Individuals would undoubtedly experience episodes of poor mental health and crises; however, within the recovery model, individuals had the innate ability to use personalized strengths to change their attitudes, problem-solve, and develop skills to rebound from setbacks and live a meaningful life (Badu et al., 2023; Leamy et al., 2011; WHO, 2019). While an individual's symptoms and diagnoses were recognized within the recovery model, the focus was on supporting them to reclaim control over their lives, identify strengths, explore new growth areas, and exercise autonomy to pursue relationships, work, and spirituality (WHO, 2019).

Specifically, the recovery-oriented model emphasized the following external and internal components: connectedness, hope, identity, meaning in life, and empowerment (Badu et al., 2023; WHO, 2019). Connectedness was grounded in supportive relationships with friends,

family, peers, partners, and health professionals and is a critical element of the recovery model (WHO, 2019). Hope for the future and the belief that circumstances could change were central components of recovery grounded in an individual's self-esteem, spirituality, and quality of life (WHO, 2019). Without hope and belief, individuals might find it impossible to continue the path of recovery. Exploring one's identity within the recovery model allowed individuals to conceptualize their experiences living with mental health issues and provide support as individuals redefine their sense of self (Badu et al., 2023; WHO, 2019). Another central component of recovery was supporting individuals to find meaning and purpose in life (Badu et al., 2023; WHO, 2019). Finally, within the recovery-oriented model, individuals needed empowerment to take control and make decisions for their personal care and treatment.

Mental Health Trends in College Counseling

Over the last three decades, college students' mental health significantly declined (Abrams, 2022; Booker et al., 2022; Field, 2022; Iarovici, 2014; Lipson et al., 2019; Xiao, 2017). Unfortunately, the COVID-19 pandemic accelerated this already concerning trend (Booker et al., 2022). Beginning in March 2020, the effects were devastating across all ages, races, and genders (Williams & Reetz, 2020). Students suffered the traumatic death of family members, navigated social isolation, and experienced disrupted daily life functioning (Booker et al., 2022). The lingering effects of the post-COVID world added another layer to the mental health issues already faced by students. Williams and Reetz (2020) inferred that mental health concerns of college students reach far beyond just "stress," and increased issues of depression, anxiety, suicidal ideation, eating disorders, substance use, trauma, and other psychiatric issues would flood college counseling centers. In 2021, the Healthy Minds Network surveyed approximately 104,000 students from 102 colleges and universities (Healthy Minds, 2021). This survey reported that 76% of college students aged 18-25 indicated they needed support for emotional and mental

health issues, while 24% of students aged 26+ indicated the same need (Healthy Minds, 2021). While the need for counseling services increased, a discrepancy existed, as reported by nearly 400 counseling center directors surveyed in 2022 by the Association for University and College Counseling Center Directors (AUCCCD), whereby only 12% of college students reported utilizing campus mental health services.

Demand for Counseling

Over the last 20 years, requests for college counseling services surged, but the capacity to provide the services has yet to keep pace (Reilly, 2018; Xiao et al., 2017). Unfortunately, based on the traditional counseling model that typically offered individual 50-minute counseling sessions, college counseling centers could not provide mental health services to all students seeking care (Bailey et al., 2022; CCMH, 2021). The demand for mental health services increased by approximately 30–40% between Fall 2009 and Spring 2015; notably, this was contrasted with only a 5% growth in institutional enrollment during the same period (CCMH, 2021; Reilly, 2018,). The lack of access to mental health care resulted in critical outcomes such as less improvement in students' mental health symptoms along with large caseloads, burnout, and fatigue faced by the counseling center staff (Brown, 2020; Lipson et al., 2015).

Presenting Concerns and Complexity of Cases

Before the COVID-19 pandemic, Xiao et al. (2017) reported that college students enrolling in post-secondary education and receiving mental health services presented with complicated and intricately complex psychological problems. Reilly (2018) reported severe depression and suicidal ideation as examples of these complex problems. Furthermore, according to Carrasco (2021), mental and emotional exhaustion increased due to the pandemic. Consequently, these psychological concerns, coupled with inadequate staffing, shortage of resources, and declining funding, resulted in college counseling centers inability to meet these

mental health needs, further increasing a systemic crisis and weak infrastructure (Xiao et al., 2017). While not an exhaustive inventory, a list of mental health concerns facing college students is provided below in Table 1.

Table 1

Mental Health Concerns of College Students

Academic concerns	Grief	Sexual orientation
Anxiety	Disordered eating	Gender identity
Depression	Sexual assault	Family concerns
Suicidal ideation	Developmental concerns	Complex trauma
Non-suicidal self-harm	Medication use and compliance	General stress
Substance use	Relationship issues	Learning differences
Loneliness and isolation	Sleep hygiene and insomnia	Attention Deficit/ Hyperactivity Disorder (ADHD)

Note: Table created by this researcher with information from Xiao, H., Carney, D.M., Youn, S.J., Janis, R.A., Castonguay, L.G., Hayes, J.A., & Locke, B.D. (2017). Are we in crisis? National mental health and treatment trends in college counseling centers. *Psychological Services, 14*(4), 407-415. https://doi.org/10.1037/ser0000130

Resource Challenges

The demand for college counseling services escalated while the number of counseling staff increased slowly (Abrams, 2020; Bailey et al., 2022; Brown, 2020; Reilly, 2018). Additionally, there was a societal mindset shift in removing the stigma associated with mental health services, allowing college students to seek university counseling services at increased rates (Bourdon et al., 2020). College students' experience receiving mental health counseling helped to break down any personal stigma associated with receiving mental health support (Pompeo-Fargnoli, 2022).

Notably, hiring staff counseling positions at college counseling centers did not match the increased number of students seeking counseling services, resulting in high caseloads (Rosenbaum & Webb, 2023). According to the CCMH annual report (2021), the average counselor-to-student ratio was 1:120, while some colleges averaged a dangerously high 1:300 counselor-to-student ratio. This high caseload did not allow counselors the time, emotional investment, or ability to provide timely, quality care to students with acute needs such as suicidality (Reilly, 2018; Rosenbaum & Webb, 2023). Beyond this, another outcome of high caseloads, according to Abrams (2020), was placing students on a lengthy waitlist or inadvertently losing students in the system of care.

Concerns Over Traditional College Mental Health Models

College students' mental health problems increased ubiquitously across college campuses (Lipson et al., 2015; Reilly, 2018; Xiao, 2017). There was evidence that a traditional one-size-fits-all model that only offered a individual 50-minute session did not meet the needs of all students and was the most resource-intensive counseling modality (Bailey et al., 2022; Haaga, 2000). Due to the increased demand for counseling services, Field (2022) reported that college counseling centers utilized multiple methods to meet students' needs. Examples of these methods included referring to outside providers and telehealth resources, attempting to hire additional counseling staff, implementing wait lists, imposing a limit on the number of sessions available per student, and seeing students monthly (Field, 2022).

Stepped Care Approach: Increasing Access, Effectiveness and Efficiency

Throughout the last decade, considerable progress was made in removing the stigma of receiving mental health services, resulting in individuals being more comfortable and motivated to seek services (Pompeo-Fargnoli, 2022). As a result, campus counseling centers faced increased demand and reduced resources to meet students' mental health needs (Carrasco, 2021).

Universities were pushing campus counseling centers to make mental health services more accessible while reducing wait times and wait lists (Brown, 2020). One service delivery method, the stepped care model, aimed to increase access to care while using resources effectively and efficiently (Bailey et al., 2022; Borsari et al., 2007; Boyd et al., 2019; Cornish et al., 2017; Haaga, 2000).

According to Haaga (2000), there were numerous modalities for treating mental health concerns, making it difficult to get the correct treatment matched at the right time to the individual seeking help, supporting the belief that not all students need the same levels of services. Additionally, Davison (2000) posited that the stepped care model for treating mental health concerns was based on a do-more-with-less approach. Through their work with the stepped care model, Sobell & Sobell (2000) supported this belief by recognizing three underlying tenets: (a) mental health services should be tailored to the individual; (b) mental health treatment should be research-based; and (c) mental health treatment should utilize the least intensive and least restrictive resources possible.

According to a 2022 report by the AUCCCD, approximately 42% of campus counseling centers utilized the stepped care model, offering a wide range of service options. While the stepped care model approach provided a general framework for care, each university could create its unique version based on local resources and populations (Richards et al., 2012). Specifically, when operating the stepped care model, campus counselors could determine the appropriate resources for their students, including individual therapy or a referral to another campus department, among various options (Davison, 2000).

The stepped care model was created as an arching recovery framework where symptom severity was not the impetus for treatment placement; instead, it allowed multiple pathways to recovery (Mughal et al., 2022). Recovery-oriented care was focused on an individual's

experiences and journey toward wellness (Badu et al., 2023). For example, individuals with severe symptoms might be highly motivated and have a high-functioning ability to guide their care path (Cornish, 2020). Alternately, an individual with less severe symptoms might be less capable and require a higher-intensity collaboration with a therapist (Richards, 2012).

The stepped care model was built on the foundation of person-centric-ness and was designed to promote individual preference and prioritize the client's decision-making power and autonomy (Davison, 2000; Richards, 2012; Sobell & Sobell, 2000). Within the recovery framework, help-seeking individuals wanted to be involved in determining their care and asked about their thoughts on problem-solving rather than being told or prescribed how to proceed and heal (Badu et al., 2023). Instead of relying on screeners and assessments, mental health professionals worked best by asking individuals to identify their goals and beginning steps (Badu et al., 2023).

The number of steps in the stepped care model varied anywhere between two and nine, with each college and university determining its own needs; however, the steps contained some version of the following: self-guided resources, consultation service, individual brief therapy, group therapy, acute and crisis care (Bailey et al., 2022; Cornish, 2020). The steps incorporated both the autonomy and advocacy of the help-seeker from high to low and the intensity of services received from high to low (Mughal et al., 2023).

Critiques of the Stepped Care Model

There were some challenges with the stepped care model, Lyon (2023) stated that one challenge presented with the stepped care model was grounded in the fact that there was not one ubiquitous model; instead, each university or facility could develop and create a model that best fits their client's needs. Therefore, the effectiveness and success of the model were difficult to measure (Lyon, 2023). Additional challenges with the stepped care approach lie in the fact that

individuals with severe mental health illnesses might be unable to determine or provide consent to receive mental health care (Davison, 2000). Rosenberg et al., (2020) further stated that the stepped care model, by design, may unintentionally offer fragmented mental health services.

According to their meta-analysis of databases containing stepped care information related to treatment and prevention measures, Ho et al., (2016) reported that individuals seeking treatment through the stepped care model had higher attrition rates than traditional support models; the authors suggested that individuals may have lost motivation and interest within this model. Furthermore, Ho et al. (2016) cautioned that the stepped care model should be evaluated holistically rather than assessing each step as an independent unit. Lastly, Espie (2009) asserted that a further limitation of the stepped care model was its broad and nonspecific approach to mental health needs. Nevertheless, learning how to navigate the stepped care model could help mitigate challenges.

Navigating the Stepped Care Model

The stepped care framework as a system of delivering care was organic; it was not staged nor predetermined and was not a one-size-fits-all model (Cornish, 2020). Each time an individualsought mental health support, one would enter the model on the step that best fits one's needs at that specific time (O'Donohue & Draper, 2011). Based upon the counselor's clinical judgment and recommendation, screening tools and assessments were not ubiquitous for placement in the stepped care model (Borsari & Tevyaw, 2005; Sobell & Sobell, 2000).

Through a collaborative process, the counselor and the client would determine the direction and placement on the stepped care model (Sobell & Sobell, 2000). Throughout much of the history of psychology, psychotherapy or one-on-one counseling was considered the "gold standard treatment" by therapists and clients (Cohen et al., 2021). However, within the stepped care approach framework, the "gold standard treatment" was based entirely on the client's

readiness to receive mental health services and not on which step the client began (Borsari et al., 2012; Cohen et al., 2021; Davison, 2000; Sobell & Sobell, 2000).

Summary

Due to the increased demand for mental health services, college counseling centers faced a long waitlist of students requesting counseling. The waitlist, the increased acuity of problems, and the demand for counseling resulted in increased counselor burnout and unsustainable practices. This case study highlighted the potential solution of implementing the stepped care model to meet the mental health needs of students while also benefiting the entire campus community.

Chapter 3

Methodology

This multiple case study aimed to explore the shift in practice from a traditional model of offering college mental health services to a stepped care approach. A traditional counseling model consisted of a one-size-fits-all approach to psychotherapy delivered through an individual 50-minute session (Cohen et al., 2021). The stepped care approach was a flexible model for delivering mental health services via a holistic menu of services and resources distributed effectively, efficiently, and personalized for each student needing mental health support (Kognito, 2020).

The researcher conducted a multiple case study of two universities that implemented a stepped care model to explore the reasons for the change and the perceived effectiveness of the model. The case studies of these two universities involved interviews via Zoom with college counseling center clinicians, along with reviewing documents/artifacts. This design aimed to answer three research questions.

Research Questions

To gain an understanding of the catalyst for shifting counseling practice and perceived outcomes, the following research questions guided this study:

1. What institutional reasons justified the shift in practice to a stepped care model?
2. What are the perceived strengths and limitations of integrating a stepped care model?
3. To what extent does the college counseling center staff perceive the effectiveness of a university stepped care model to meet students' mental health needs?

Research Design

According to Creswell and Poth (2018), the term research design referred to the complete scope of the research process, from formulating the purpose of the study to writing the narrative and data collection and analysis. Additionally, Yin (2018) defined the research design components as consisting of five elements: (a) the case study's questions; (b) propositions; (c) cases (or unit of analysis); (d) logic linking data to the propositions; and (e) criteria to interpret the findings. The case study's questions, the first element of case design, asked "what" questions of the counseling center clinicians. The second element of case design, propositions, explored the perceptions and experiences of the clinicians. The third element, the case, was bound to two universities that implemented the stepped care model. The logic linking data to the propositions, the fourth element of case design, included a synthesis of the two universities and included key findings from the semi-structured participant interviews. The fifth element of case design, the criteria to interpret the findings, was acquired through coding the interviews and enumerating the responses.

Case Study

A case study was chosen for this research as it was focused on understanding a specific element within a particular, bounded system (Rudestam & Newton, 2015; Stake, 1995). Yin (2018) further suggested that case studies were an ideal methodology within a practice-oriented field such as counseling, where the goal was to acquire a holistic understanding of a phenomenon. Additional evidence for why a case study was an appropriate methodology for this research was that it elicited a deep dive into a particular phenomenon or event in a real-life context (Creswell & Poth, 2018; Crowe et al., 2011; Yin, 2018).

Stake (1995) posited that case study methodology was chosen because of its specificity, not generalizability. An additional defining feature of a case study was its interpretative nature,

whereby the researcher was placed in the field to gather and record evidence to thoroughly understand the case being studied (Stake, 1995). Within case study research, the researcher described and analyzed a specific case study bounded by specific places and retrieved multiple sources of evidence (Creswell & Poth, 2018; Yin, 2018).

Additionally, a case study was appropriate for this research because it met several of the characteristics needed for a qualitative study, as determined by Creswell and Poth (2018). These characteristics included collecting data in the field where the issue was being studied, gathering information by talking to people, utilizing the researcher as the vital instrument to examine the multiple sources of data through interviews and documents, and finally, implementing an inductive process to understand and interpret the data (Creswell & Poth, 2018). Throughout this qualitative process, the researcher holistically interpreted each institution's stepped care model based on the various data sources collected.

For this case study, the researcher chose purposeful sampling to identify two appropriate universities for this research, with the intended outcome of exploring various perspectives, strengths, limitations, and perceived effectiveness of implementing a stepped care model. Purposeful sampling was a strategy for intentionally selecting sites to provide the best information for the researcher (Creswell & Poth, 2018). The protocol for this case study is summarized in Table 2.

Table 2

Case Study Protocol

Section A. Overview of the Case Study	Purpose	To explore how two universities created a campus paradigm shift by implementing a stepped care model for supporting students' mental health needs
	Research Questions	What institutional reasons justified the shift in practice to a stepped care model? What are the perceived strengths and limitations of integrating a stepped care model? To what extent does the college counseling center staff perceive the effectiveness of a university stepped care model to meet students' mental health needs?
	Framework	Recovery-oriented model
	Role of the Protocol	This serves as an agenda for the line of inquiry
Section B. Data Collection Procedures	Researcher	Stephanie Johnson-Kane
	Data Collection Plan	Interviews with counseling center directors and staff. Analysis of related documents and artifacts were triangulated, including website reviews, informed consents, yearly reports, scope of services, and resource guides
	Preparation Prior to Fieldwork	IRB approval, create a timeline for interviews, create a list of open-ended questions for semi-structured interviews, access documents
Section C. Protocol Questions	Participant Interview Questions	See Appendix C for interview questions
Section D. Tentative Outline for the Case Study Report	Audience	Higher education faculty, staff, and administrators
	Concepts	Catalyst for change, strengths and limitations of the stepped care model, perceived effectiveness
	Recommendations	Recommendations for future research

Background and Role of the Researcher

At the inception of this study, I served as a student care coordinator in a counseling center within a university that, for multiple years, had 200+ students waitlisted for counseling services. In this traditional counseling model, a staff of seven counselors, each with a caseload of 55–60 students, could only provide approximately 420 students with mental health services. The university's enrollment was approximately 11,500 students, allowing nearly 4% of the student body access to counseling.

The traditional counseling model did not give students timely access to mental health care at this institution. Additional impacts of the lengthy waitlist included counselor burnout and compassion fatigue, which resulted in half of the staff resigning. The traditional counseling model was no longer sustainable, and the need to find an alternative counseling model was imminent.

The concept of the stepped care model was introduced to our counseling center staff in January 2023 by the assistant director of counseling. As the student care coordinator, I was tasked with researching this model and determining if it was viable to provide students better access to care while supporting the well-being of the counselors. After in-depth staff and campus partner conversations deliberating the possible positive and negative outcomes, in July 2023, our counseling center adopted the stepped care model. Throughout my research, I attempted to bracket my personal experience implementing the stepped care model to enhance the trustworthiness of this case study.

My educational background included graduate work in student affairs and school counseling. As a professional working in K–12 education and post-secondary systems, my career included various aspects of counseling, providing support, working within my community of care, and triaging services for students of all ages. No matter what position title I held within the

various institutions, my bias as a researcher is rooted in the belief that mental health access is a fundamental human right.

Cases

According to Yin (2018), the participants of a study should be chosen because of their direct involvement with an identified phenomenon, which in this research is the stepped care model. This case study reviewed two institutions chosen through purposeful sampling: Great Plains University (GPU) and Southern State University (SSU) (both pseudonyms). These universities and participants were selected because they best informed the researcher about implementing a stepped care model for mental health in their campus counseling centers (Creswell & Poth, 2018).

The participants from GPU and SSU held various positions, including those of director of student health and counseling, staff therapists, and psychologists. Through purposeful sampling, the researcher intentionally selected one individual at each institution to interview with the additional participants selected through snowball sampling. The participants were selected because they had experience working with both the traditional model and the stepped care model approach.

Data Collection

According to Yin (2018), because no data source provided a greater value than any other, using as many data sources as possible is recommended to achieve triangulation. Data triangulation occurred by collecting multiple data sources, including interviews, documents, and a review of artifacts. Specific documents included each institution's scope of services, informed consent, screening forms, annual reports, marketing materials, training manuals, resource guides,

and website reviews. Before collecting any data for this study, approval was gained from the institutional review board (IRB) to conduct interviews and access documentation and physical artifacts.

The GPU and SSU counseling center staff were contacted via email and asked to participate in a semi-structured interview via Zoom. The interviews were recorded, stored on a password-protected computer, and deleted after research completion. The participants were identified in July 2023, and the in-depth interviews were completed by September 2023. The email sent to the research participants requesting participation and institutional documents related to implementing the stepped care model at their respective universities can be found in Appendix A.

Interview Process

According to Yin (2018), interviews were instrumental in case studies because they allowed the researcher to examine elements of the phenomenon from the interviewee's perspective. Stake (1995) further supported this sentiment by stating, "The interview is the main road to multiple realities" (p. 64). The semi-structured interview format was selected because it allowed the researcher and the interviewee to have an in-depth and guided conversation about the phenomenon studied.

Semi-structured Zoom interviews were initially conducted with the two counseling center directors. Then, snowball sampling was applied, leading to interviews with two counseling staff at GPU and three at SSU, all willing to offer additional stepped care model information. The Zoom interviews were scheduled for 60 minutes, and the interview questions were offered to the participants before the interviews. Each participant was assigned a pseudonym to protect one's identity. These interviews offered information about the catalyst for shifting to a stepped care model, the stages of implementation, the strengths and limitations, and the perceived

effectiveness of the stepped care model. After the interviews, member checking was utilized by sharing the transcripts and themes with the participants to ensure validity and credibility. The documentation forms related to the interview procedures and protocols were listed in the following appendices: (a) participant invitation (Appendix A); (b) the consent form (Appendix B); and (c) the interview questions for the counseling center directors and staff (Appendix C).

This researcher followed several of the recommendations offered by Creswell and Poth (2018) for conducting interviews. The first approach followed was using open-ended questions that focused on understanding the central phenomenon asked through the research questions. The second strategy implemented was collecting data through Zoom recordings, which were formatted to provide transcripts automatically. Each participant who agreed to be interviewed was asked to complete a consent form approved by the IRB. Finally, to be an effective interviewer, this researcher followed procedures to elicit good responses from the participants, including being conscientious of the time, offering a kind and courteous demeanor, practicing active listening skills, and letting the participants know that they could stop the interview at any time.

Documents

In addition to the information gained through participant interviews, the documents collected and analyzed included institutional profiles, informed consent, counseling scope of services, annual reports, training manuals, resource guides, and marketing materials. Yin (2018) reported that documents were integral to data collection because they provided verifiable information such as names, spellings, and job position titles that might have been mentioned in interviews. The researcher made inferences from the documents to better understand the implementation and practices of the stepped care approach at both universities.

Data Analysis

Stake (1995) stated that analyzing data required an artful way to make sense of and interpret the data. According to Creswell & Poth (2018), the central steps to analyzing qualitative data included organizing the data, an initial read-through, coding, developing themes, and establishing an interpretation of the data. Additionally, Yin (2018) suggested that the five techniques for analyzing data included: (a) pattern matching; (b) explanation building; (c) time-series analysis; (d) logic models; and (e) cross-case synthesis. Because the research herein centered on examining stepped care models at two institutions, Yin's (2018) cross-case technique was the method utilized. According to Yin (2018), the cross-case technique involved a comprehensive approach to data analysis that incorporated the synthesis of cases to detect patterns. Additionally, to maintain a holistic point of view, Yin (2018) suggested thinking "upward conceptually" rather than drilling down into individual variables to determine patterns.

After the interviews were conducted and the data was transcribed, I reviewed the transcriptions to familiarize myself with the content. The second reading of the transcripts allowed me to identify commonalities and variances between the two universities. These concepts were highlighted in the transcripts and then transferred to a codebook. Creswell and Poth (2018) purported that codebooks manage themes and connect relationships between ideas. Further, trustworthiness was considered throughout the development of this study.

Trustworthiness

Trustworthiness in qualitative research allowed the reader to interpret the researcher's work and have confidence in what was reported (Stahl & King, 2020). Establishing trustworthiness in qualitative research was imperative and could be achieved by incorporating specific measures (Shenton, 2004; Stahl & King, 2020). Utilizing Lincoln and Guba's (1985) seminal overview for establishing trustworthiness, the following constructs (credibility,

transferability, dependability, and confirmability) were addressed in this research to ensure the study was grounded in its worth.

Credibility

Credibility (internal validity) was one of the most important constructs in establishing trustworthiness (Lincoln & Guba, 1985). The establishment of credibility was founded on several principles. The first principle was grounded in creating solid qualitative research methods (Shenton, 2004). The second principle employed was the use of triangulation. Triangulation involved using interviews as a method to collect qualitative data. This three-pronged triangulation approach ensured the data's validity (Shenton, 2004). The third principle to establish credibility involved the researcher encouraging participants to be frank and honest and offering the opportunity to withdraw from the study at any time (Shenton, 2004). Soliciting participant feedback to review the case write-up and colleagues to offer varying perspectives and challenge the data and research design was another way to maintain credibility (Shenton, 2004).

Transferability

The concept of transferability could be complicated because qualitative research does not aim to be replicated (Stahl & King, 2020). For Merriam (1998), transferability, or external validity, existed if the findings of a study could apply to other studies. As in the case of qualitative work, the results must be understood within the context in which the study was carried out. To allow transferability to the reader of this study, the researcher established boundaries for the study and transparency within the data collection and analysis by providing a thick description of each case (Shenton, 2004).

Dependability

Reliability also represented the dependability (reliability) construct, which occurred when a study could be repeated within the same context and the same results emerge (Shenton, 2004).

If, within the research design, the same context, methods, participants, and detailed processes are implemented, the study is grounded in reliability and dependability (Shenton, 2004). This researcher invited peers to participate in the analysis process to establish dependability and provided a detailed description of the research methods.

Confirmability

According to Lincoln and Guba (1985), confirmability was achieved when credibility, transferability, and dependability were well-developed. The researcher attempted to achieve confirmability, or getting as close to objective reality as possible, by bracketing the beliefs and inevitable biases in a reflexive journal (Lincoln & Guba, 1985; Shenton, 2004). Triangulation was a method to elevate the construct of confirmability and researcher objectivity (Shenton, 2004). This researcher relied upon the triangulation of interviews and document analysis to construct confirmability in the research.

Assumptions

The researcher maintained the following assumptions throughout this study:

1. The participants interviewed might have a different philosophical belief about counseling services than what is involved in the stepped care model.
2. The participants were honest about their experience implementing the stepped care model.
3. The participants' experience with counseling at the collegiate level might affect their perceptions of the efficacy of the stepped care model.

Ethical Considerations

Several ethical considerations guided this study. First, I participated in the Collaborative IRB Training Initiative (CITI) program's human subjects research core training. Second, I applied for and obtained approval from the University of South Dakota's Institutional Review

Board (IRB). Third, a copy of the informed consent (Appendix B) was obtained from each participant. The informed consent provided detailed information regarding the purpose of the study, associated risks from participating in the study, potential benefits, confidentiality measures, and contact information for the researchers. Fourth, additional ethical measures included the researcher protecting the participants' privacy by assigning pseudonyms, deleting recordings after the research was completed, and maintaining the transcripts on a password-protected computer. Lastly, the researcher utilized a reflexive journal to achieve objectivity throughout the study and used triangulation to establish credibility.

Summary

This case study aimed to explore how two universities shifted counseling services from a traditional model to a stepped-care model. The role and background of the researcher were described, along with detailed information about the participants. Data collection involved participant interviews and a review of documents to add depth to the qualitative research. The data analysis method, trustworthiness measures, assumptions, and ethical considerations were included in this chapter. The results of this case study are shared in chapter four, while chapter five includes key findings and recommendations for institutions interested in adopting a stepped care model.

Chapter 4

Results

Introduction

This case study aimed to explore two universities in the United States that shifted the counseling service scope of practice from a traditional model to a stepped care model to meet students' mental health needs. For each institution, I present a demographic description of the institution and the context of each case within the stepped care model. Key findings emerged through the analysis of participant interviews, documents, and artifact analysis. Three overarching research questions guided this study:

1. What institutional reasons justified the shift in practice to a stepped care model?
2. What are the perceived strengths and limitations of integrating a stepped care model?
3. To what extent does the college counseling center staff perceive the effectiveness of a university stepped care model to meet students' mental health needs?

Context of the Cases

Each institution was analyzed as a single case study before comparing the two cases. The case description of each institution emerged through interviews with counseling staff conducted via Zoom and through a review of document and artifact analysis. The context of each case is provided through demographic information. The list of individual participants is in Appendix D. The institutions chosen for this study, GPU and SSU, are public institutions located in the Midwest and the Southern regions of the United States, respectively, and both have implemented a stepped care model after following a traditional model for delivering counseling services.

Findings Great Plains University

GPU was a public university in a Midwestern city located approximately 85 miles southwest of a regional metropolitan area. A population of around 104,000 residents surrounded the GPU campus. The student enrollment at GPU comprised 14,500 students, including more than 1,300 international students from more than 90 countries. More than 1,600 faculty and staff, including nearly 700 teaching faculty, brought their talents to GPU, with nearly 90% of the full-time instructional faculty having terminal degrees. GPU's Carnegie Classification fell under the Master's Colleges & Universities: Larger Programs.

GPU offered more than 130 undergraduate programs of study, including 13 pre-professional programs, and more than 80 graduate programs, including master's, specialist, and doctoral programs. Five academic colleges offer these programs: allied health and nursing, business, education, humanities and social science, science, engineering, and technology.

Three participants from GPU's counseling center were interviewed for this study. The primary contact at GPU recommended participants to the researcher who had experience with the traditional counseling model before implementing the stepped care model, and the interviews were conducted during the Fall 2023 semester. All three participants served in a dual capacity as licensed, practicing psychologists and as faculty members. Two participants were employed at the GPU Counseling Center, while one individual, formerly employed at GPU, was now employed in private practice.

Document Analysis

During the interviews with the participants, I asked if there were any documents related to the GPU stepped care model that they would be willing to share with me. The documents I received included public records available on the GPU website. Additional internal documents I

received included the counseling center guide, campus resource guide, student care plan, and the orientation manual designed for new counseling staff.

According to the counseling center guide, the mission of GPU's counseling center, as written in its scope of services, was to offer confidential and short-term counseling services at no charge to students enrolled at GPU. In addition to the scope of services, the counseling center guide provided the following overview of the stepped care model utilization: The first step in utilizing the GPU stepped care model began with a same-day screening appointment with a counselor. Each counselor was assigned a specific day and time that they were scheduled to conduct screenings. GPU students were informed that the screening process may take 60–90 minutes, and students were seen on a first-come, first-serve basis. The required screening paperwork included informed consent, a brief mental health assessment, and presenting concerns (reason for seeking services). Once the required paperwork was completed, the student met with the screening counselor for approximately 20–30 minutes to discuss the reason for seeking counseling services. After screening, the student and counselor collaborate to determine the resources that best fit the student's mental health needs. Students were empowered to utilize these resources and were informed to return to the counseling center if additional help was needed.

Interviews

Meeting Demand for Mental Health Services: The Catalyst for Change

During the Spring 2019 semester, GPU's counseling center staff reported that the impetus for implementing the stepped care model began with staff conversations surrounding the 200-student waitlist for mental health services. Dr. Kayla, GPU Assistant Professor/Psychologist, shared:

> Yeah, it really started from, you know, the conversations around we are too busy, we're carrying huge wait lists. It was 2019, maybe, if I'm remembering correctly, and we had a waitlist of over 200 students, and it was just obscene. There was just no way we could see everybody. It felt really, I know I personally had a reaction to the idea of like we have their paperwork, they've come in and then we send them away and never potentially see them, right? Or we call and offer an intake a couple weeks out. And by that time they're concern has been, you know, addressed or they're at a much worse place and they just didn't have the interventions in a timely way. And for me, that idea of having people wait outside of the door while we already had information, did not feel great.

Dr. Madeline, GPU Counseling Center professor and staff psychologist, supported Dr. Kayla's sentiment by stating:

> So we came together as a staff, and we're looking for ways to meet students needs without adding to our waitlist, because the waitlist for individual counseling was significant. And we could definitely use more staff, as probably every counseling center, but we knew that funding and the ability to provide more staff was not coming our way.

Before the implementation of the stepped care model, GPU's counseling center protocol was to have students come in and complete the paperwork and send them on their way until there was an opening. When asked if any other factors contributed to the shift to the stepped care model, Dr. Kayla continued that there was pressure from the vice president of student affairs and other institutional leaders to meet the demands of students needing access to mental health services. She stated:

> It was kind of like looking at that pressure and then also pressure from our VP and the institution itself to be like how are we, you know, we can only hire so many people and that's not seeming to, like, change the system, right?

After several conversations among the GPU counseling staff and university leadership, it was determined that finding a solution to providing accessible mental health care was a top priority. Dr. Lara, former GPU staff psychologist and Counseling Center colleague of Dr. Kayla, reiterated:

> A lot of conversations were about every semester having a wait list… Administration or other departments really struggle with us having a waitlist, and then they get upset. We only have so many people and so much time, and all of these things. Waitlists were like pretty much every semester a given by end of September, early October, at the latest sort of thing, even if we had a lot of trainees. And then I think the other, the other thing that was happening was there was a history of a 10 session limit. But somewhere over the course of that happening it was, everybody gets 10 sessions. Students were getting this message from advisors and new student orientation, all these different places, that go get your free counseling sessions at the counseling center. I think that also overloaded the system over time because everybody was getting this message. Well, I should go no matter if the problem was too big or too small, you know, and that is true. Then we'd have these students who really didn't need 10 sessions of individual therapy, and then you have some people who definitely did, but they couldn't get in.

Dr. Lara led the way in researching multiple universities that shifted mental health services from a traditional counseling model to a short-term model and stated:

> I did a lot of research and talked to other directors and stuff like that when we were looking into different models. We wrote a lot of policies and procedures to really try to tackle the hypotheticals for training new faculty or trainees and have a document that says, here's what we do and how we do it. A couple of other directors that I talked to, and they were like, yeah, like, it takes probably at least three years to even know what you're

doing. And then probably like five to know if it is working.

The long waitlist and other internal personnel changes catalyzed the GPU Counseling Center into implementing the stepped care model. From the initial conversations to implementation, Dr. Lara shared, "We had constant conversations, we had a lot of meetings in the spring semester to kind of implement it in the fall 2019. To be honest with you, it's like sometimes that felt like I was dragging people along." Dr. Madeline summarized the collective outlook of the GPU counseling center staff to implement the stepped care model was focused on the idea that:

> We just gotta [*sic*] give it a try. And we'll, you know, if it fails, it fails. We can always go back. If it works, it'll [*sic*] work, or if it gives us a new idea for modification, we go forward.

Perceived Strengths and Limitations of the Stepped Care Model

Strengths. Dr. Lara stated that once the stepped-care model was rolled out at GPU, the university community embraced the change, including faculty, staff, and students. While the GPU counseling staff was nervous about introducing the changes, Dr. Kayla further iterated by stating that the message "students will be seen on the same day that they walk into the counseling center" was energizing. Dr. Kayla reported:

> Students can talk about what is bringing them through these doors. It can be hard to walk through the doors of the counseling center and admit that you are struggling with mental health issues. These issues impact school, work, and home. To walk in and get the energy up to do that and then be sent away for a couple of weeks is not centering on the needs of our students. So, same-day walk-in mental health screenings have helped everyone on campus feel better about referring to us. This has shifted our reputation on campus.

An additional strength of the stepped care model, according to Dr. Lara, was that the

stepped care model lies in the fact that it is not a one-size-fits-all model, and not everybody required the most intensive sessions. With stepped care, students have multiple resources to address their concerns and meet their needs. Dr. Lara continued to elaborate on these strengths of the stepped care model:

> The variety and range of services and resources that it provides and pulling together all of the resources. We had some groups, so, our group options expanded, and the themes expanded. But then also we brought in workshops like coping skills workshops from [university]. They have these protocol based workshops that I asked if we could use. And so it was a matter of expanding. It's like the variety and the range of different sort of services that can be offered.

According to Dr. Madeline, an additional strength of the stepped care model is the overall population of students who are served:

> I think we do target another population of students that maybe we weren't seeing before, students who weren't really interested or have a large stigma about counseling. And now they can go into a three-session workshop that's really structured, and you know, it just meets a different need.

Finally, the variability and fluidity provided by the various steps on the stepped care model proved to be a strength of this approach. Dr. Lara shared:

> It's a not a one-size-fits-all type of thing, the counseling center, right? But we learned, yeah, not everybody needs individual counseling for 10 sessions, you know. A lot of people come in and they need a campus, a different campus office, or they need short term. They need more coping skills, that sort of thing. Not everybody needs the most intensive sessions, and that really, people, you know, can kind of get their needs met, get their wellness needs met, and get their concerns addressed.

Limitations. Dr. Lara reported that one limitation of stepped care can be balancing autonomy with resources for the individual client. She explained:

> Because there's so much variety with the resources, it can be hard to know what's going to be the right one for us. There's maybe too many options. Maybe we're trying to offer too many things, and then we're not. If we're not following kind of the spirit of the model which is least intensive resource used first and then step up.

It was also about utilizing time more effectively and doing more with less. Individual counseling is the most time-intensive resource. Another limitation of the stepped care model was identifying the best resources for a student based on a 20–30 minute initial screening appointment. Dr. Kayla said, "It can sometimes feel like a little fast and a little wrong. But this can be modified with a rescreening in the future or after learning more about the students."

An additional limitation of the stepped care model is that it was not taught in graduate preparation programs for counselors, in fact, according to Dr. Lara, for some GPU therapists, it proved to be a:

> Big philosophical shift of what university counselors do in higher ed [*sic*] and for those counselors who wanted to do kind of like a private practice sort of thing were frustratedwith the stepped care model because it was not what they went to school for and how they learned to practice therapy.

Furthermore, there has been a learning curve to educate students, faculty, and staff that the gold standard for treatment was not, in fact, a 50-minute counseling session. Dr. Madeline shared how, at times, the counselors may question the stepped care model. Dr Madeline continued, "One of our new counselors talked a little bit about like feeling like they were disappointing a student because they thought that they were going to go to individual counseling and group counseling just makes so much more sense."

Stepped Care Best Practices

When asked about the stepped care best practices that GPU follows to provide efficient and effective services, Dr. Kayla stated

> It's meeting the students where they're at. Trying to be person-centered. The goal is instilling some hope. Wanting to support students without becoming overly handholdy [*sic*] or you know, like this idea of we can trust for students to also be able to problem solve and to kind of pursue what they need without telling them what they need. Asking the students "What do you need?" and "How can we empower you?" and not creating like some dependence, like encouraging that autonomy.

Another best practice that came out of implementing the stepped care model at GPU was the creation of a policy manual that outlined this new vision of delivering services (Policy & Procedure Guide, 2021). Specifically, Dr. Kayla stated aspects of the policy manual included:

> Respecting individual providers and different theoretic orientations and approaches to the work. But we did sort of say, like, how do we make sure that we are not over prescribing services or under prescribing them or just settling on individual as the default.

While Dr. Lara added the creation of the stepped care policy manual allowed the GPU counseling center to share:

> Here are our goals: We want people to get in quick, as quick as possible. We want them to have an individualized plan that's not a one-size-fits-all. And that we wanted to properly use the resources or recommendations, whether that's outside referrals, whether that's campus referral, whether that's within our center. But like having a variety, having a range of services that can fit those individualized needs.

Dr. Kayla shared that an additional stepped care model best practice included the involvement of campus partners in creating the stepped care model. She stated that the GPU

counseling center had previously established relationships with other campus departments, including financial aid, athletics, multicultural center, and the student health clinic, among other departments. Additionally, Dr. Lara indicated that the stepped care model information was shared with the campus community by hosting multiple information sessions across campus, orientation sessions, and tabling events for students, faculty, and staff. She stated, "We're having talks in bigger meetings and just trying to over-communicate in a lot of different ways." Finally, Dr. Lara offered that the GPU campus administration shared the stepped care model approach in departmental and academic meetings to help inform campus partners. Specifically, she stated that, "Our VP of student affairs was, like, on board with it from the beginning."

The final stepped care model best practice shared by Dr. Kayla was the creation of care cards that were developed and given to each student after the screening session. She stated:

> We made these care plan cards for our students and then we have all these QR codes on them this year that identify a specific department or resource that might help students reach their mental health goals.

Dr. Kayla also shared that the care cards are given to GPU faculty and staff to encourage students to utilize the counseling center services:

> We give them out all over campus to folks because here's a little bit about what to expect. Here's a QR code to our website so you can learn more. So that is like the information that I give out all over the place.

Findings Southern State University

SSU was a public university with multiple branch campuses in a Southern state. The student enrollment across SSU's five campuses was nearly 19,000 students. SSU offered over 100 associate and bachelor's degrees, 13 master's degrees, and a doctoral degree. SSU had over 600 students involved in the ROTC program and was strongly affiliated with the military. SSU's

Carnegie Classification was listed as a Basic Master's College and University. SSU offered more than 140 associate, bachelor's, and graduate-level programs with focus areas in business, education, health, humanities, STEM, and social sciences.

Four individuals associated with SSU's counseling center were interviewed for this study. The primary contact at SSU recommended the other three participants to the researcher, and the interviews were conducted via Zoom during the Fall 2023 semester. The participants, the Director of Counseling, an Associate Director of Counseling, and two staff counselors, worked at separate campuses within the SSU system.

Document Analysis

During the interviews with the participants, I asked if there were any documents related to the SSU stepped care model that they would be willing to share with me. The documents I received included public records available on the GPU website. Additional internal documents I received included the informed consent, stepped care model infographic, student handbook, student care cards, screening form, and the yearly report.

The mission of SSU's counseling center was the same at all five campuses, as written in its informed consent: "To be a personalized and relevant mental health service to each individual student. The type of services you are eligible to receive will be determined after the initial care planning meeting with one of our mental health professionals" (Informed Consent, 2023). SSU's counseling center provides counseling services to enrolled or matriculated students at no charge.

The stepped care model infographic (n.d.) illustrated that the first step to utilizing the SSU stepped care model began with an initial contact and a brief assessment with a counselor. Counselors were scheduled to conduct screenings at various times throughout the week. The initial required paperwork included an extensive informed consent for treatment. Once the required paperwork was completed, the student would meet with the screening counselor to

discuss the reason for seeking counseling services.

Interviews

Meeting Demand for Mental Health Services: The Catalyst for Change

When asked about the catalyst for change, Dr. Samuel, SSU Director of Counseling, stated:

> We experienced a problem over a five-year period. Our demand for counseling went up 40%, and that's kind of a 1-2 punch because not only did the demand go up 40%, but the acuity of the things that we're dealing with, the number of people presenting as suicidal, the number of people self-injuring, you know, all those crisis things that we manage started to become a bigger portion of our day. And then the year before stepped care, it literally accounted for over 33% of our day was managing crises. So that resulted in losing lots of good clinicians because they were getting burnt out. Along with the increased demand, the acuity of the presenting concerns, ranging from suicidal ideation to self-injuring behaviors, increased.

Dr. Samuel continued:

> That led us to trying to figure out, how do we make this sustainable? Because not only for us, but for the students. We had a three-week wait time. If you're not in a life-threatening crisis, then it'll be three weeks. And so we're meeting students at our time of availability and not at their time of need. And that didn't feel good at all. That's not why we, you know, got into the helping professions.

Dr. Samuel further mentioned that the university administration strongly suggested the SSU counseling center focus on solving this problem. In fact, Dr. Samuel stated, "There was lots of pressure from administration." Dr. Katie, Associate director of counseling, supported this perspective by stating:

> That led to you can't do everything for everybody anymore. The clinicians were getting burnt out and they were leaving. And you know, when a clinical staff gets burnt out, mistakes are made, and that leads to a board complaint, and your license can be taken away. They didn't tell us what to do, but we started researching ways to make our services more efficient.

Simone, a SSU staff therapist added her perspective about why the SSU university administration was nudging the counseling center to find a solution to the mental health needs on campus:

> The higher ups, realizing that everyone's responsible for students' mental health, not just our office. Like you can't just say, "Oh that person's crying, and shove them into the office and get them some help." They figured that there was a lot of underutilization of resources on campus. There's a lot of things that contributed to students' mental health that they weren't accessing.

Additionally, Dr. Samuel commented that on a statewide level, the government realized that counseling centers were struggling and directed Federal COVID funding toward implementing a mental health initiative. Dr. Samuel stated that this governmental aid resulted in, "A mental health initiative where they gave 12 million dollars split between 26 [institutions]." Dr. Samuel continued stating that most of this funding was spent on a contract to provide online therapy options for students available 24/7. According to Dr. Samuel, this funding is "wonderfully utilized" and provided the option for students to receive online telepsychiatry via phone or video conferencing and has successfully allowed students to remain in school.

The final impetus that nudged SSU to initiate the stepped care model resulted from a recommendation by Dr. Davis, Director of the National Mental Health Institute (a pseudonym). Dr. Samuel recounted a conversation with Dr. Davis:

> Brought up this idea about like what you are doing is not sustainable and I think we all knew that. I'm a little bit of an old-fashioned, you know, old dog, not wanting to change, not wanting to do something new. But at that point, like we were exhausted. And like I said, we were burnt out. We were losing good therapists. We were having trouble hiring people. And so we started looking at what can we do that's sustainable? And Dr. Davis suggested we look into the stepped care model.

Perceived Strengths and Limitations of the Stepped Care Model

Strengths. Because the stepped care model was a fluid model built on variations and levels of care, Dr. Samuel said the ability to refer students with long-term needs to outside community or private practices was significant. He stated, "Making these outside referrals was like just draining the water down to where we could breathe." Additionally, Dr. Samuel stated that referring these students to therapists in the community or private practice allowed the SSU counseling center therapists to, "Focus on more college-type problems that we could really have an affect on ameliorating in a few sessions." Dr. Samuel shared:

> There was a study that at the same time that I read that 80% of the people that are in therapy are not at a state of change, a state of change where they are ready to change. That's the difference between working with somebody and feeling like, Wow! That was a great session, like so much happened. They're really working. I see the changes. And having the same session again and again with some people. They're just not at a place to change. We had to incorporate that like we're gonna [*sic*] respond differently to these clients. By not keeping these people locked into weekly counseling appointments, more time is available for students seeking services and who are willing to change.

Creating a scope of practice was another strength of implementing the stepped care model. Dr. Katie iterated:

> You need a scope of practice. Every program, every institution, every agency. You need to know the boundaries of what you're doing. You need that scope of practice to say, this is what we can do, and this is what we can't do. It not only protects the institution, but it protects the clinicians as well.

The scope of practice is included in the informed consent. Students must read it before receiving mental health services. In this scope, SSU clearly defined the type of students, presenting concerns that can be served in the counseling center and those issues that were not serviceable. SSU also made the scope of practice available on its website for public viewing.

The SSU counseling center staff spent one year collaborating with other departments and directors to craft the plan to implement the stepped care model. Before this year-long process, Dr. Katie stated that most of these departments were siloed yet experiencing similar problems of not fully utilizing resources on campus. Regarding the campus silos, Dr. Katie added:

> We brought in some key players and sat around the table and just pounded it out. And we worked on the stepped card model from idea to implementation for about a year. Until we sat around the table with other directors, we had no idea how much other departments were doing related to mental health and supporting students. It was incredible to see how much SSU was doing, but we didn't know the other was doing it.

SSU staff therapist, Simone recalled her perspective from that collaborative meeting where departments were conversing about campus mental health needs:

> There's a lot of things that contributed to students' mental health that they weren't accessing. And so that's kind of how it started with this awareness. We were informing the administration like, "Hey, we can't keep up with these numbers as they are, we definitely need to have some other resources to help students." That's kind of like where I feel like it started with that acknowledgement. And then, of course, you had to get

information from all these departments on what can you provide students before we knew what the steps needed to be. We needed to see what we had.

According to Dr. Katie, an additional, yet unintended strength of the SSU stepped care model came as a surprise. The dean of students and the behavioral intervention team adopted the stepped-care model to respond to student issues, strengthening partnerships by giving everyone a framework with a common language. Dr. Katie stated, "It has given us this unified presence. It really has us looking like we are a unified university. We are not siloed. We have one voice as a university."

Lastly, Andi, SSU Associate director of counseling, shared that group therapy was another strength of the stepped care model. Andi stated:

> I love the fact that we're doing group therapy now on campus. I just started an anxiety group, and that's been great because I have been able to refer many students to that, and they have followed through with it. So I'm super excited and I love group. I think it's fantastic. It's an amazing tool. I'm glad that it's a referral source for me and the students.

Dr. Katie supported the impact of group therapy by stating, "The students are more lonely than they've ever been, and after Covid, people are very disconnected. So it's good to have a place where you can go and connect with people face-to-face." Dr. Katie continued as it allowed a handful of students to come together in a safe space with a shared concern. Group therapy enabled students to connect with others face-to-face to provide peer support and validation to help begin effective change. One of the many benefits of offering group therapy was the limitless number of topics that could tie the group members together.

Limitations. The SSU counseling center staff discovered one limitation to the stepped care model: students' belief that they were not receiving "counseling" because they were not scheduled for a traditional 50-minute individual session. Dr. Samuel shared:

> Therapy is dose dependent, right? Everybody's you know, always said that like the more you get, the better you do and we're feeling like we're doing good. But we feel like sometimes we're finishing before we'd like to. Students leaving saying "I'm not getting counseling." Well, yes you are. There's just different modalities, right, of counseling. That's one of the things we did is like we, we're trying to explain to them like counseling can be 30 minutes for walk in. If it's a 30 minute issue, it's a 30 minute issue. But we're clear like, you can come back anytime. And other people are "No, I want my weekly session." And then we're gonna [*sic*], you know, we have to have a little bit of a delicate conversation about what we can do and at that point, they need to be going off campus and paying for it. You know, which is not a fun conversation, but it's again to make the system sustainable.

However, once students matriculated through the educational system, every new class would become accustomed to the scope of services offered through the stepped care model. Dr. Samuel explained, "We must re-educate the students and encourage them to try the stepped care model. We are here to love and help them, but there is a limit to what we can do."

While group therapy as part of the stepped care model had many benefits and was a strength of the stepped care model, it also presented limitations. Not all therapists had the experience, training, or comfort level required to conduct groups. An additional limitation of the stepped care model at SSU was rooted in some therapists feeling they could not establish long-term therapeutic relationships with their clients. Dr. Katie shared:

> We started training our clinicians on brief therapy and I did a lot of training on group therapy. And in grad school they don't teach enough of the brief therapies and group therapy. But I think one of the things that offset that need for the deeper connection that you get a lot of times with the long term therapy was all set with how deep group can go.

Additionally, because the stepped care model was not taught in graduate-level counseling programs, some SSU therapists questioned if they were providing appropriate counseling services. Andi addressed this learning curve by stating:

> I would say that I'm finally getting into the swing of using the stepped care model. It doesn't come intuitively to me. It kind of felt like we were just giving them resources then sending them on their way and saying, "Hey, try these out and if these don't work for you, then give me a call. We'll make another appointment. We'll see what other resources we can find for you."

Evaluating and assessing the stepped care model was another limitation the SSU counseling center encountered. Dr. Katie reported:

> I wish we did better at this but we do some things. We have client satisfaction surveys at the end. We do group surveys. We do workshop surveys. Like we are surveyed out. Which is why I think we could do better because everything in higher ed [*sic*] is very data driven. We also have Counseling Center Assessment of Psychological Symptoms (CCAPS). We were hesitant to have them do another thing, but they do it before every session. Not groups, but every session. And it literally is like 60 seconds for them to complete. We compare that data with nationwide data to see how we're doing.

Stepped Care Best Practices

When asked about the development of SSU's best practices, Dr. Katie stated, "My first thought is stepped care is best practice. That as a whole it is quickly viewed as best practice." She continued by explaining an intentional best practice is the SSU counseling center prioritizing the updating of it's website with current stepped care model information. Dr. Katie mentioned:

> I think best practice would be to maintain that website to reflect and make sure that everybody is still up-to date. And use the website to create a common vernacular to

describe the stepped care model, its steps, and resources.

nother SSU internal best practice developed from stepped care was scheduling weekly time for intentional case consultation between therapists. This practice allows SSU's counseling center staff to receive validation and/or accountability as they share caseloads, outcomes, and placement or referrals related to the stepped care model. This case consultation has helped create a healthy work environment for the counselors to receive assistance from their colleagues when they are stuck with a particular client, have medication management questions, or needed time to brainstorm ideas. When asked about stepped care best practices, Simone mentioned:

> I guess the biggest one we do is that we definitely consult each other very regularly. We have built in case conferencing, but then, even beyond that, we always walk into each other's office and say, like, "Hey, like this is what's going on." And it's really validating sometimes to get told, "That definitely sounds like someone who needs to be referred for higher level care. And then kind of like brainstorm what that would look like, rather than kind of feeling like, "Oh, this is hard."

Sharing the "why" behind moving to the stepped care model and educating the stakeholders, including students, parents, staff, faculty, and the surrounding community, was vital to the success of the stepped care model. Dr. Samuel stated:

> We did a dog and pony show, right. We took it to staff meetings. We took it to division meetings. We took it to faculty meetings. We even have an internal professional development day where we present to each other and the whole, you know, faculty and staff come together and we presented it there. We talked to the student newspaper. We talked to the student government where I went and presented on the model and answered questions. And I think that really helped them understand.

Another best practice was concentrated in the SSU counseling center's tabling efforts to

advertise the stepped care model to the campus community. They also offered multiple outreach opportunities to get the word out about stepped care. Dr. Katie stated:

> I don't think we've ever done as many outreaches as this past year. We are getting out of our offices and doing more preventative things. One of our peer health educators came up with this idea. We have a spinny [*sic*] wheel, and so the student can come over. They spin the wheel and the color they land on is something. We have cards of the colors, there's six different colors and it has questions on there, so they can ask the counselor the question. But then we also ask the student the question, and it gets us talking. But we also have coffee, cookies, donuts, and then we have all different kinds of swag. Little journals, little charges, webcam privacy covers.

Assertions

According to Stake (1995), assertions or conclusions were the takeaways and lessons learned by the researcher; these are presented in Table 3. These lessons comprised the researcher's experience and understanding from interacting with the research (Creswell & Poth, 2018). The assertions described in Table 3 below, followed by a narrative description, are based on my unique experience and understanding as a researcher (Creswell & Poth, 2018).

Table 3

Comparison of Stepped Care Models

Italicized items are common between GPU and SSU.

	Great Plains University (GPU)	Southern State University (SSU)
Meeting Demand for Mental Health Services: The Catalyst for Change	**Waitlist for counseling services* **Counselor burnout* **One size fits all model for offering mental health services* Need for accessible mental health services	**Waitlist for counseling services* **Counselor burnout* **One size fits all model for offering mental health services* Increased demand for counseling services Increased acuity of presenting concerns Sustainable mental health model
Perceived Strengths of the Stepped Care Model	**Elimination of a waitlist for counseling services* **Model is fluid, and services can be stepped up or down depending on students' needs* **Group therapy* Same-day screenings	**Elimination of a waitlist for counseling services* **Living, breathing, and fluid model* **Group therapy* Creating a scope of practice Stepped care model adopted by the Dean of Students and Behavioral Intervention Team
Perceived Limitations of the Stepped Care Model	**Stepped care model is not taught in graduate school* Balancing autonomy with available resources Short initial screenings	**Stepped care model is not taught in graduate school* Students' belief that they were not receiving counseling because they were not scheduled for weekly individual appointments Counselor's comfortability leading group therapy Evaluating stepped care

While both GPU and SSU have implemented a stepped care model to deliver mental health services to students, there were several areas of similarity along with areas of difference. Three common catalysts prompted GPU and SSU to search for a new mental health model: a waitlist for counseling services, counselor burnout, and a one-size-fits-all approach. These reasons created a critical and unsustainable environment within each counseling center. The catalyst for seeking change unique to GPU included making services more accessible to students.

At SSU, the unique catalysts for change were related to the increased demand for counseling services and increased acuity of presenting concerns and exploring a sustainable model.

Both GPU and SSU counseling centers perceived a strength of the stepped care approach as a fluid, living, breathing model that allowed them to step mental health services up or down to meet students' needs. A shared additional strength of stepped care was the inclusion of group therapy to provide a safe space for validating and working through common topics for students. GPU and SSU found strength in the fact that the stepped care model was not based on a one-size-fits-all approach and offered services based on students' unique needs. GPU discovered strength in offering same-day screenings to students. For SSU, the strengths of the stepped care model were found in creating a scope of practice and the campus-wide adoption of the model.

The counseling staff at GPU and SSU cited a limitation of implementing the stepped care model approach because it was not taught in graduate school; instead, the counselors learned on the job how to navigate the stepped care system while meeting with students. At GPU, additional limitations include balancing the students' autonomy for receiving mental health services with the availability of resources. GPU counseling staff perceived the short screening times as a limitation when finding the right outcome for the students. The perceived limitations that the SSU counseling staff found in the stepped care were related to the students' belief that they were not receiving counseling because they were not scheduled for weekly individual appointments, the counseling staff's comfortability leading group therapy, and a final limitation was evaluating the stepped care model.

Within the two universities that implemented the stepped care model, it was evident that this model could eliminate the waitlist for receiving mental health services, support the well-being of the counseling staff, and provide individualized mental health services and resources for the students. University counseling centers looking for an alternative model to meet the increased

demand for counseling services might consider the stepped care model as a solution.

Summary

Chapter four presented the findings of this case study. Through interviews with the study's participants, the stepped care model allowed the counseling resources to be offered most efficiently and effectively. Theme one, meeting demand for mental health services: the catalyst for change, shared how the waitlist for counseling was the impetus for seeking a new way to offer mental health services. In theme two, perceived strengths and limitations of the stepped care model, both GPU and SSU offered the positive outcomes and challenges that resulted from implementing the stepped care model. The perceived strengths included creating a fluid model offering students individualized mental health services. In contrast, the limitations included therapists' lack of experience working with the stepped care model, as it is not taught in graduate school programs, and finding an effective way to evaluate it. Finally, in theme three, stepped care best practices offered daily walk-in appointments for students to receive mental health services at GPU and SSU, and strong collaborative partnerships with other campus departments existed. Chapter five provides a case report to engage the stakeholders directly involved with college counseling centers.

Chapter 5

Stepped Care Model Case Report: Shifting College Counseling Practice

For college counseling centers that find their current counseling practices unsustainable, inefficient, and inaccessible, the stepped care model might be a model to consider. This report includes the catalyst for change, key findings, and recommendations for colleges intending to shift college mental health services. The report format is intended to engage the stakeholders directly involved with college counseling centers.

> *"That led us to trying to figure out, how do we make this sustainable? Not only for us, but the students…we were meeting students at our time of availability and not at their time of need. And that didn't feel good at all."*
>
> Dr. Samuel, Director of Counseling

Introduction

Over 60% of college students met the criteria for one or more mental health problems, a nearly 50% increase since 2013 (Lipson et al., 2022). Anxiety, depression, and suicidal ideation among college students were at the highest rates ever reported in the Healthy Minds National Collegiate Mental Health Survey (Lipson et al., 2022). Since 2013, college students reported a 135% increase in depression, a 110% increase in anxiety, eating disorders have increased by 96%, and suicidal ideation has increased by 64%, leading to an increased demand for campus counseling services and support (Lipson et al., 2022; Mental Health Commission of Canada, 2019). The COVID-19 pandemic accelerated this already alarming trend as students struggled with social isolation, the trauma of losing loved ones, and the disruption of emotional and developmental growth (Booker et al., 2022; Murthy, 2023).

The request for counseling services surged, but the capacity to provide these services has not kept pace (CCMH, 2021; Reilly, 2018; Xiao et al., 2017). Utilizing the traditional counseling model, university counseling centers might not be able to meet the mental health concerns of students who faced symptoms such as anxiety, depression, suicidality, substance use, and disordered eating. According to a study by Lipson et al., (2015), lack of access to mental health care resulted in critical outcomes for the students, the counseling center staff, and the entire institution. In a 2017 study of collegiate mental health services, Cornish et al. (2017) indicated

that 88% of counseling center directors reported that their students did not receive timely care, 75% reported they were unable to offer weekly appointments, 73% reported their staff worked over-time, and 35% reported utilizing a waitlist for students seeking services. Shifting mental health services from a traditional model to a stepped care model allowed two universities studied by the researcher to create a sustainable scope of practice to offer mental health care to students, as evidenced by eliminating a waitlist at both institutions and offering same-day mental health services.

Researcher

I am the assistant director of a college counseling center at a public land-grant university in the Midwest. In the Fall 2023 semester, this university shifted its counseling scope of practice to a stepped care model. The study on integrating a stepped care model for college mental health was to partially fulfill a requirement in my doctoral program in Adult and Higher Education.

Background and Methods

This dual-site case study analyzed how two institutions shifted counseling practice from a traditional counseling model into a stepped care model, the perceived strengths and limitations of this model, and the model's effectiveness in meeting students' mental health needs. A traditional counseling model is a one-size-fits-all approach to psychotherapy delivered through an individual 50-minute session (Cohen, et al., 2021; Cornish, 2020). The stepped care model was a flexible mental health model that provided a holistic menu of services and distributed these resources effectively, efficiently, and personalized for each student needing mental health support (Cornish, 2020; Kognito, 2020). Multiple data sources were collected from both universities, including participant interviews and document analysis, to provide a holistic view of this counseling model shift. The interview questions sought to understand the perceptions of counseling center staff directly involved in shifting from a traditional college counseling practice to a stepped care model.

Participants & Data Sources

Seven semi-structured interviews were conducted via Zoom between both case study sites with counseling center staff who provided mental health services within the stepped care model. The

45–60 minute interviews were conducted in fall of 2023. Data sources, including participant interviews, documents, and artifacts, were analyzed, and included in the study.

Key Findings

Key Finding 1: A Catalyst for Change

Throughout the seven interviews, it was unanimous that inaccessible mental health care, mainly in the form of a lengthy waitlist, was the catalyst that prompted the college counseling center staff to find a solution to this problem. One participant reported that the demand for counseling services increased by 40%, along with an increased acuity of concerns. The solution they discovered was the stepped care model. Not only did the consequences of maintaining a lengthy waitlist affect the student's ability to access mental health care, but it also negatively impacted the well-being of counselors. Due to the long waitlist, both college counseling centers experienced significant staff turnover and burnout.

> *"We had a waitlist of over 200 students, and it was just obscene. There was just no way we could see everybody. By the time we could see a waitlisted student, the odds were good that they were at a much worse place."*
>
> Dr. Kayla, Psychologist & Assistant Professor

Recommendation 1: The mental well-being of college students is the responsibility of the entire university system, not just the college counseling center. Therefore, implementing the stepped care model should fall on the shoulders of key university stakeholders, not just the counseling staff. Ideally, in addition to the counseling staff, these stakeholders include representatives from the Dean of Students office, student affairs leadership, academic affairs leadership, student government, and athletics. The shift to the stepped care model might be a significant philosophical shift for counselors, so training opportunities should be offered for counseling staff to become comfortable working with the stepped care approach. The stepped care model is not a one-size-fits-all approach, and each university should carefully consider how the model will work and how it can be implemented on its campus. Considerable research on what the stepped care model is and is not should be fundamental to the process. Visiting other campuses that have implemented the stepped care model is recommended.

Key Finding 2: Perceived Strengths and Limitations of the Stepped Care Model

> *"It can be hard to walk through the doors of the counseling center and admit that you are struggling with mental health issues…so same-day walk-in mental health screenings have helped everyone on campus feel better about referring to us. This has shifted our reputation on campus."*
>
> Dr. Kayla, Psychologist & Assistant Professor

Through a screening intake process, the counselor and student are allowed space to collaborate on the next best step for the student. According to this study's participants, a great strength of the stepped care model is that it matches the student's individual needs with an intentional response. All campus resources are used effectively and efficiently as each student is matched with an appropriate mental health service. The stepped care model is fluid and built on variations and levels of care. It is not a one-size-fits-all approach. Creating a scope of services to establish boundaries for care lends itself to establishing a sustainable practice.

Perceived limitations based on the participant's experience with the stepped care model include finding ways to evaluate and assess the effectiveness. Another limitation is that the stepped care model is not taught in graduate school programs, so counselors often feel underprepared to work within this short-term model. There is a learning curve and professional development to understand brief therapy. Additionally, some students feel they are not receiving "counseling" because they are not referred to a weekly 50-minute individual therapy session.

Recommendation 2: Finding ways to evaluate and assess the perceived effectiveness of the stepped care model will help support the credibility and validity of the model. Focus on educating students and other key stakeholders on the stepped care model and its effectiveness. If there is a graduate-level counseling program on your campus, collaborate with the faculty to make presentations about the benefit of practicing short-term therapy to the students in the program.

Key Finding 3: Stepped Care Best Practices

As a service offered through the university, the counseling center cannot operate like a private practice in the community sector. It is impossible to provide a one-stop shop for all the comprehensive psychological needs of students. The scope of practice begins with an initial screening. Then, through a collaborative process, the counseling center clinician and the student will determine which step of the stepped care model will best meet the student's needs. The short-term services are intended for presenting concerns that can be addressed quickly and of limited acuity that fit within the scope of practice for most college counseling centers. Short-term services assist students in managing their primary presenting concerns in the most efficient way possible for desired outcomes and are tailored to meet each student's needs best. The presenting concerns most appropriate for the counseling center are issues generally resolved within a semester. Clinicians and students will engage in a check-in process to assess progress and fit for continued services.

"What is the primary concern that brings you in today?"

"What are you hoping to get out of coming in today?"

Questions asked by the therapist to help tailor a recommended action plan for students to follow when they leave their counseling appointment.

Recommendation 3: Develop a short screening intake or assessment for the initial interaction between the student and the counseling center. Create a scope of services that clearly outlines the services the counseling center provides and does not provide. Advertise the scope of counseling services to provide transparency and clarity for students, parents, faculty, and staff. Provide the students with a care card or recommended action plan stating the next steps. This could include a date and time for a short-term counseling appointment, a referral to a campus resource, a community counseling referral, guided self-help resources, etc. Schedule weekly case consultation opportunities for counseling staff to share caseloads, outcomes, and referrals. Involve campus partners so they are informed and educated about the stepped care model and how it works. Additionally, host tabling events and informational sessions across campus so students and campus staff receive information about stepped care and have opportunities to ask questions.

Directions for Future Research

The case studies explored two universities that shifted counseling center practices from a traditional model to a stepped care model due to inaccessibility and other deficits. Directions for future research could include focusing on students' perceptions and experience with the stepped care model by utilizing qualitative interviews and focus groups. An additional opportunity for research could consist of a longitudinal study that follows students who utilize the stepped-care counseling services throughout their time at the university and tracks their academic performance, retention, and graduation rates. Finally, a potential opportunity could be to research the perceived effectiveness of the stepped care model by collecting 360-degree survey information from campus partners, including faculty, staff, students, parents, and counseling center staff.

Conclusion

Due to the increased demand for mental health services, college counseling centers faced a long waitlist of students requesting counseling. The waitlist, along with the increased acuity of problems and demand for counseling, has resulted in increased burnout of counselors and an unsustainable practice. This case study highlighted the potential solutions of implementing the stepped care model to meet the mental health needs of students, while also benefiting the entire campus community.

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Appendix A

Invite to Participate in Research

Date:

Dear :

You are invited to participate in a research study, which is in partial fulfillment of the completion of my doctoral studies in Adult and Higher Education. The study aims to examine the integration of a stepped care model for mental health in college counseling centers.

We invite you to be in this study because of your affiliation with the stepped care model at [university].

If you agree to participate, you will be asked to participate in an interview to discuss your experience with the stepped care model. Interviews will be conducted via Zoom and recorded to create transcripts for analysis. The recording will be deleted after the creation of the transcript. Interviews will take approximately one hour, with the possibility of additional requests for interview sessions as questions arise. Participants may also be asked to provide access to institutional resources related to the stepped care model, for example, policies, training materials, procedures, etc. In writing up the details of the study, we will do so in such a way that you cannot be identified.

The information you provide will be kept confidential; however, the University of South Dakota Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records about this research.

Your participation in this research study is entirely voluntary. If you decide not to be in this study, you may stop participating at any time. There are no known risks from being in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn because of this study.

If you have any questions, concerns, or complaints now or later, you may contact me at the number below. If you have any questions about your rights as a human subject, complaints, concerns, or wish to talk to someone independent of the research, contact the Office for Human Subjects Protections at 605-658-3743.

If you are willing to participate in the study, please reply to this email, and we will coordinate an interview time that is convenient for your schedule. I greatly thank you for your time.

Stephanie Johnson-Kane
Student Health Clinic and Counseling Center
South Dakota State University
605-366-0923

Appendix B

Informed Consent Form for Interview

UNIVERSITY OF SOUTH DAKOTA
Institutional Review Board

Informed Consent Statement

Title of Project:	Implementing a Stepped Care Model: A Case Study of Two College Counseling Centers
Principal Investigator:	Dr. Karen Card, Delzell Education Center, Vermillion, SD 57069 (605) 658-6621 karen.card@usd.edu
Student Investigator:	Stephanie Johnson-Kane, Delzell Education Center, Vermillion, SD 57069 (605) 366-0923 stephanie.danielsen@coyotes.usd.edu

Invitation to be part of a Research Study

You are invited to participate in a research study. To participate, you must be affiliated with the stepped care model for mental health. Taking part in this research project is voluntary. Please read this entire form and ask questions before deciding whether to participate in this research project.

What is the study about, and why are we doing it?

The purpose of this qualitative study is to examine the integration of the stepped care model in college counseling centers. About nine people will take part in this research.

What will happen if you take part in this study?

Potential participants will be sent email invitations asking for their participation. Once the participants have been identified and agree to participate, each will be asked to complete a 45-60 minute interview conducted via Zoom. The interview will begin by reviewing informed consent and allowing the participant to ask any questions they may have. You may also need to provide

follow-up or clarifying information via email. Each interview will be recorded and transcribed to remove identifying information with the recording being destroyed. Finally, participants will be asked to review the transcript of their interview as a form of validation to ensure accuracy. If follow-up Zoom calls are necessary for clarification purposes, they will be scheduled and kept to no more than 10 minutes.

What risks might result from being in this study?

There are no risks in participating in this research beyond those experienced in everyday life. You may stop at any time or choose not to answer a question.

How could you benefit from this study?

You might benefit from this study through exposure to ideas developed during the interviews about the stepped care model. Further, this research will provide a better understanding for universities to integrate a stepped care model for mental health.

How will we protect your information?

The records of this study will be kept confidential to the extent permitted by law. Any report published with the results of this study will remain confidential and will be disclosed only with your permission or as required by law. To protect your privacy, we will not include any information that could identify you. We will protect the confidentiality of the research data by asking you to use a pseudonym during the recording of the interviews, removing any identifying names in the interview transcripts, deleting the interview recordings after the creation of the transcript, and storing the transcript on a protected computer for three years after which it will be deleted. Other people may need to see the information we collect about you. These people work for the University of South Dakota and other agencies as required by law or allowed by federal regulations.

Your Participation in this Study is Voluntary

It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

Contact Information for the Study Team and Questions about the Research

The researchers conducting this study are Stephanie Johnson-Kane and Dr. Karen Card. You may ask any questions you have now. If you have questions, concerns, or complaints about the research, please contact Stephanie Johnson-Kane at (605) 366-0923 or Dr. Karen Card at (605) 658-6621 during the day.

If you have questions regarding your rights as a research subject, you may contact The University of South Dakota- Office of Human Subjects Protection at (605) 658-3743. You may also call this number with problems, complaints, or concerns about the research. Please call this number if you cannot reach the research staff or wish to talk with an informed individual independent of the research team.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. Keep a copy of this document for your records. If you have questions about the study later, you can contact the study team using the information above.

Appendix C

Participant Interview Questions

Study Title: Implementing A Stepped Care Model: A Case Study of Two College Counseling Centers

Researcher: Stephanie Johnson-Kane, Doctoral Candidate | stephanie.danielsen@coyotes.usd.edu
605-366-0923

Thank you for taking the time to meet with me today. My dissertation study examines how institutions implemented a stepped care model for mental health within the college counseling centers. Your experience with this model will help me understand the implementation process and the model's strengths and limitations.

To help validate the data, I will record our discussion to create a transcript of our interview. I will share the transcript with you after it is completed so that you can confirm that your ideas came across correctly.

Background gathering

A. Can you talk about your current role and how long you have been at your institution?

B. How are you affiliated with the stepped care model?

1. How long has your institution (department) been involved with the stepped care model for mental health?
2. Was there a particular event that kickstarted the initiative?
3. How did your institution implement a stepped care model?
4. What are the perceived strengths of the stepped care model? Limitations?
5. What barriers did your institution (department) overcome while implementing the stepped care model?

6. What step care model best practices or guiding principles does your university (department) follow?
7. What policies or procedures were developed to guide the stepped care model?
8. How does your institution (department) involve campus partners in the stepped care model?
9. To what extent do you perceive the integration of the stepped care model met your student's mental health needs?
10. What tools do you use to evaluate the effectiveness of the stepped care model?

Appendix D

Participants, Data Sources, & Collection Method

Institution	Participant	Data Source	Collection Method
GPU	Dr. Kayla • Assistant Professor/Counselor	Audio transcripts and archival documents	Interviews, public website, and documents shared by GPU participants
	Dr. Madeline • Professor/Training Coordinator/Counselor		
	Dr. Lara • Assistant Professor/Counselor (former)		
SSU	Dr. Samuel • Director of Counseling	Audio transcripts and archival documents	Interviews, public website, and documents shared by SSU participants
	Dr. Katie • Associate Director of Counseling		
	Simone • Staff Counselor		
	Andi • Associate Director of Counseling		

Appendix E

Verbal Consent Script for Informed Consent

I am a University of South Dakota student conducting a research study to explore the integration of the stepped care model into college counseling centers. Your participation in this study is entirely voluntary. This means that you do not have to participate unless you want to.

The purpose of this research study is to understand the reason for changing models, strengths and limitations of the stepped care model, and the perceived effectiveness. You will be asked to complete this interview about your role and experiences as a clinician practitioner providing counseling services in the stepped care model. This should take about 45-60 minutes. You may choose to skip any questions that you prefer not to answer. I will also review documents specific to your campus regarding the stepped care model. These documents may include the university website, marketing materials, and internal documents that you are comfortable providing for my review.

All the information I receive from your interview, including your name, university, and other identifying information, will be confidential. Pseudonyms will be used. I will not identify you or use any information that would make it possible for you to be identified in the dissertation or any presentations about this study. All data will be kept on a password-protected computer.

The only risk to you might be if your identity were ever revealed. I will not even record your name with your responses, so this cannot occur. There are no other expected risks for participating in this research study. The benefit of participating is through exposure to ideas developed during the interviews about the stepped care model.

Do you have any questions?

If you have questions, concerns, or complaints about this research project, do not hesitate to contact Dr. Card or me. Our contact information is provided on the informed consent form for you. All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject, you may contact, anonymously if you wish, the Office of Human Subjects Protection at (605) 677-6184.

Do you agree with me using your quotes in the research using a pseudonym?

Do you agree to be recorded during the interview?

Do I have your permission to begin asking you interview questions?

Appendix F

Document Analysis

What was the purpose of the document?

Who created the document?

When was the document created or date of last revision?

Who is the intended audience for the document?