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Utilizing the Stepped Care Model to Empower University Students with Learning Disabilities

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Abstract

Students with learning disabilities (LD) face a number of challenges in postsecondary education settings. This manuscript explores the issue and sheds light on the importance of self-advocacy for academic success. The stepped care model is suggested as an approach to assist college students with LD in developing these skills and obtaining services. A brief case example from one of the authors' work is shared to illustrate the use of SCM with a student with LD.

Keywords: stepped care model, learning disabilities, self-advocacy

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Even under the best circumstances, the transition to postsecondary education can be a significant challenge and one of the most dramatic changes of a young adult's life (Bardi, Koone, Mewaldt, & O'Connor, 2011). Many first-year students find it difficult to adapt, with roughly 30% choosing not to enroll at an institution of higher learning the following year (National Student Clearinghouse Research Center, 2015). For a variety of reasons, the challenge of adjusting to and eventually completing college is even more difficult for students with learning disabilities (LD). In fact, only 41% of students with LD ultimately obtain a college degree as compared to 52% of those without LD (DuPaul, Pinho, Pollack, Gormley, & Laracy, 2017).

Many factors are important to the success of students with LD during the transition to postsecondary education (Yssel et al., 2016), including foundational academic skills and personal dispositions such as independence, resilience, and problem solving (Eckes, 2005; Shifrer, Callahan, & Muller, 2013). Under ideal circumstances, students would develop these attributes during their K-12 education and be fully prepared for college, but unfortunately this is frequently not the case (Eckes, 2005; Shifrer, Callahan, & Muller, 2013). The reality is that many students with LD begin their postsecondary journey with little understanding of their disabilities, the impact of LD on learning, or how to access disability services on campus (Brinckerhoff, Shaw, & McGuire, 1993; Burley, 2010).

This article begins with an exploration of the challenges faced by college students with LD and the importance of self-advocacy skills in attaining success. We then introduce the stepped care model (SCM) and demonstrate via a brief case example how the counseling center

at one university is utilizing this approach to build self-advocacy skills in students with LD by empowering them with choice throughout the counseling process and equipping them with the skills needed to locate and advocate for necessary educational services.

Higher Education with a Learning Disability

The term LD has been defined as, "… a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are intrinsic to the individual, presumed to be due to central nervous system dysfunction, and may occur across the lifespan" (National Joint Committee on Learning Disabilities, 2016). Students with LD face a variety of challenges in higher education, all of which contribute to the alarming completion statistics cited above. In addition to specific difficulties with academic skills such as word reading, processing speed, semantic processing, and working memory (Bowden et al., 2008; Trainin & Swanson, 2005), students with LD have also been found at risk for greater academic procrastination (Hen & Goroshit, 2014), higher academic stress (Heiman, 2006), lower levels of academic and social melding in the college environment (DaDeppo, 2009), and struggles with time management, attending to academic assignments, and communicating their needs to instructors (Smith, English, & Vasek, 2002).

While previous research has found that academic accommodations targeted at the challenges above are associated with improved grades (Troiano, Liefeld, & Trachtenberg, 2010) and degree completion rates (Mamiseishvili & Koch, 2010), it is estimated that only one-third of postsecondary students with a diagnosed LD actually receive accommodations (McGregor, 2016). There are many reasons for this, but the complex and highly individualized choices involved with disclosing one's disability, seeking out services on campus, and utilizing

accommodations are likely key contributors (Denhart, 2008). Previous studies on the subject have found that many issues factor heavily in these decisions, including perceived stigma, knowledge of one's disability, and the availability of quality transition services (Denhart, 2008; Lightner, Kipps-Vaughan, Schulte, & Trice, 2012). Additional research has found that while some students with LD intentionally forego or postpone disability services due to a highly scheduled freshmen year, a general feeling that things are going well, and/or a desire to forge an identity free of disability (Lightner et al. 2012), others do make the decision to seek out services but find themselves unable to secure them due to difficulties navigating campus, forming relationships with students and staff, locating the disability support services office (Brinckerhoff et al., 1993), and/or obtaining updated documentation of their disability (Denhart, 2008).

Whatever the reason, it is clear that university students who receive accommodations are more likely to overcome the challenges associated with LD and find academic success, but that the responsibility for seeking out and advocating for these services ultimately falls on each individual student, many of whom are facing a tumultuous transition to college without the self-awareness, resilience, and self-advocacy skills necessary to meet the challenge.

Self-Advocacy Skills and Students with LD

Previous literature has defined self-advocacy broadly as public recognition of the resilience of people with LD (Goodley, 2005) or a knowledge of self, knowledge of rights, and leadership (Test, Fowler, & Wood, 2005). Others offer specific knowledge and skills that comprise self-advocacy, such as self-determination and the abilities to make independent decisions and express one's needs (Phillips, 1990). Self-determination has been further defined as a dispositional characteristic indicated by behaviors that are based on autonomy, self-regulation, self-realization, and psychological empowerment (Farmer, Allsopp, & Ferron, 2015).

Combining the definitions above, self-advocacy might be thought of as the expression of one's needs made possible by knowledge of self, the ability to make independent decisions, and an empowered psychological state. Unfortunately, many students with LD find themselves entering postsecondary education without these skills (Eckes, 2005; van Ingen et al., 2015).

While no student's journey is the same, a number of factors impacting this generation of students with LD are likely to contribute to underdeveloped self-advocacy skills. One such factor is the trend of over-involved parents sometimes dubbed "helicopter parenting" (Padilla-Walker & Nelson, 2012). A lingering issue in K-12 schools for years, helicopter parenting has become a growing concern among postsecondary education administrators (Schiffrin & Liss, 2017) as increasing numbers of parents exert an unhealthy degree of influence in their children's lives -- even going so far as to text their children's professors to solve class-related problems (Schiffrin et al., 2014). While a full exploration of helicopter parenting is beyond the scope of this article, it is important to note the links between this phenomenon and a delay in the development of many skills and dispositions considered important for postsecondary success among students with LD, including self-advocacy (van Ingen et al., 2015), feelings of competence and self-determination (Schiffrin et al., 2014), and independent decision-making with regard to setting goals for accomplishing tasks (Hong et al, 2015).

Another factor that may contribute to underdeveloped self-advocacy skills among college students with LD is the structure of special education services in K-12 public schools. While the most recent reauthorization of the Individuals with Disabilities Education Act (IDEA; 2012) was an improvement, the roles of adults (i.e., teachers, school counselors or psychologists, parents, etc.) continue to be emphasized throughout the typical special education process while students are frequently marginalized and therefore leaving high school unaware of the details of the

services they received (Smith, English & Vasek, 2002). For example, a study of students with LD attending new student orientation at Boston University revealed that while approximately half the group remembered having an IEP in high school, only a small number knew its purpose and even fewer even knew what the acronym IEP even represented (Brinckerhoff et al., 1994).

Many students with LD enter higher education without the self-advocacy skills critical for success (Eckes, 2005; van Ingen et al., 2015). Whether the result of over-involved parents, a high degree of management by adults during the K-12 years, or some other factor, the fact remains that many of these students need help, encouragement, and training to find success.

The Stepped Care Model

Originally created in the United Kingdom for use in primary healthcare settings (Cornish et al., 2017), the stepped care model (SCM) is now commonly used by general practitioners in many parts of the world (Bower & Gilbody, 2005). Mental health and addictions treatment providers began adopting the approach in the late 1990s and early 2000s as a way to standardize procedures in order to improve efficiency, lower costs, and eliminate personal inconvenience for the client and counselor (Bower & Gilbody, 2005). Over the years, SCM has been slowly incorporated into growing numbers of mental health settings, particularly those in which rapid access to services is needed and efficiency is paramount (O'Donohue & Draper, 2011).

Whether in a primary healthcare or mental health counseling setting, SCM operates in much the same fashion. As illustrated by figure 1, available interventions are grouped according to factors such as intensity, duration, and cost. Each resulting group is considered a "step" in SCM, which is oftentimes presented as a pyramid of care with low-cost, short-duration methods at the base of the pyramid (representing the bulk of services offered) and more intense, less frequently utilized methods near the top. Preference is given to interventions that are less

restrictive and still likely to achieve clinically significant results, with the most intensive treatments typically being reserved for those who do not benefit from short duration, frontline treatment in its many forms. That said, as illustrated by figure 2, the steps do not need to be implemented in a specific order. After an initial intake, patients and clinicians work together to choose the best treatment modality from among all available interventions, keeping in mind that another hallmark of SCM is that it is meant to be self-correcting, with the results of treatment guiding subsequent decisions about interventions (e.g., modality, length, etc.) as both patients and clinicians monitor progress and discuss modifications when desired outcomes are not being achieved (Bower & Gilbody, 2005). In a mental health setting, this means that while psychoeducation, short-term groups, and brief therapy would typically be utilized before extended individual therapy, every treatment option is on the table for clients and counselors to discuss and mutually agree to implement as appropriate.

SCM is relatively new to college counseling centers. In fact, it is our belief that as few as 10 centers in the United States and Canada have adopted this approach -- which is surprising given that SCM has a great deal of utility in settings such as these (with notoriously long waitlists and typically inadequate staffing and budgets), because the model is designed to guide clinicians to the least restrictive and shortest duration treatment that creates clinically significant outcomes (Oosterbaan et al., 2013; van der Aa et al., 2015). In that way, SCM is meant to facilitate more efficient, efficacious, and cost-effective approaches to treatment, thereby freeing up staff to see a greater number of clients over time -- an obvious benefit in settings such as college counseling centers.

SCM and Self-Advocacy

We believe that the use of SCM in a university counseling setting empowers students to make choices about their treatment, thereby contributing to the development of self-advocacy skills that are useful in other settings, and that this phenomenon is especially true for students with LD. To illustrate this point, we will provide a brief explanation of the general structure of SCM, followed by a case example from one of the authors' work with a client with LD.

SCM begins with an intake session, the first ten to twenty minutes of which is devoted to the client speaking freely about their concerns. As appropriate, the counselor will ask questions to obtain enough clinically relevant information to present appropriate treatment options. When enough information has been gathered, the counselor will present various treatment options or "steps" in the center's SCM that match the appropriate level of care for the client's concern. As noted above, these do not always include further counseling sessions. In fact, less restrictive psychoeducational approaches in the form of movies, apps, and reading materials are frequently suggested. At this point, the client and counselor embark on a client-centered collaboration to decide which treatment modality is the most appropriate fit. While the counselor will educate the client about various options as requested, highlighting the potential pros and cons of various choices, the counselor simply facilitates the process. The primary focus during treatment selection is on the client's use of critical thinking skills to evaluate each option and select and advocate for the one that will (1) be most appropriate for their stage of change; (2) fit their personality, temperament, and developmental stage; and (3) help them grow and meet their personal treatment goals with maximum buy-in.

When ready, the client will build an argument for why they prefer a particular approach. The counselor will then offer to answer any questions the client has and provide feedback on their choice of treatment. If the counselor disagrees, reasons will be provided, and the client will

be gently encouraged to further analyze their decision given this new information. This is another point at which clients are given the opportunity to build their self-advocacy skills in a safe environment. Ultimately, they will be allowed to make the final decision assuming it is safe and clinically appropriate (e.g., an actively suicidal client will not be allowed to completely refuse treatment), but they are consistently challenged to explain why they have made that choice and what potential benefits and pitfalls they foresee. When a final choice is made, the counselor will explain that the treatment plan will be monitored by both parties and can be adjusted at any time. The counselor will note that SCM works best when clients take ownership and advocate for their personal care, and that it is therefore critical for clients to reflect on their progress, participate fully in the process, argue for change when needed, and demonstrate the self-agency needed to experience optimal treatment outcomes.

In our opinion, SCM creates a unique, developmentally appropriate opportunity for university students to begin learning the skills associated with self-advocacy and self-determination. We believe this is particularly true for students with LD who, for all the reasons noted above, oftentimes do not come to college with the will or skills needed to seek out and secure the services they might need in order to succeed. A counselor using SCM creates the conditions for students to practice these skills via critical thinking, building an argument, and ultimately advocating for their preferred method of care in a safe, secure, and non-judgmental setting like a counseling center, all the while receiving encouragement and feedback from a non-judgmental supporter.

Case Example

To further highlight how SCM works in a university counseling center with a student with LD, the following case example is presented. Consider Eric (pseudonym), an 18-year-old

male, cisgender, White, first-year student who voluntarily sought services at a university counseling center during his first semester. Eric's presenting concerns were mild depression and significant anxiety related to academics and the adjustment to college. Specifically, he was struggling to keep up with the work in his writing class, which is a core general education requirement. During the thirty-minute assessment, it became clear that Eric was having a hard time with reading comprehension and retention. The counselor inquired about Eric's educational background, including any history of LD (since it often manifests as reading issues), and Eric shared prior diagnoses of dyslexia and ADHD. He further stated that he was aware he could receive academic accommodations but had not sought them out because he did not know where the office of Disability Support Services (DSS) was located, did not want to be seen as intellectually inferior, and could not imagine how accommodations would help.

At this point, the counselor educated Eric about SCM and the array of treatment options available, including long and short-term individual counseling, groups, and informal check-ins. As explained in the section above, the counselor first emphasized Eric's role as a self-advocate who will determine the course of treatment with the support of the counselor, and then explained that in SCM the client holds the power of self-determination and can adjust the treatment plan as necessary. Eric stated that he liked the flexibility of the approach and the feeling of empowerment associated with customizing his treatment. After about 20-minutes spent exploring various paths forward, the counselor encouraged Eric to build his case for a particular option, which he did by selecting short-term individual counseling to address his depression and anxiety, as well as to explore the possibility of engaging with DSS. The counselor agreed that this path seemed appropriate and commended Eric for advocating for the level of care he felt was necessary, despite other options being presented. The counselor closed the session by explaining

that SCM works best when the client monitors his own progress and advocates for change as needed, so the treatment plan could be modified at any point.

Shortly after, Eric and the counselor met again to begin working on mindfulness CBT skills, which is the counselor's preferred approach to addressing anxiety and depression. The counselor also used motivational interviewing techniques to build rapport, express empathy, and explore Eric's ambivalence towards seeking assistance from DSS. With Eric's permission, the counselor also provided extensive psychoeducation on dyslexia and ADHD, including information about the types of accommodations that might be available through DSS. The counselor frequently asked Eric to reflect on his progress and to consider whether the treatment was moving him closer to his goals. Eric consistently indicated that it was, and he was able to give examples of change but also articulate a case for why subsequent sessions were needed -- a mark of the self-advocacy skills he seemed to be developing slowly.

Eric's treatment ultimately consisted of three 30-minute sessions and a final 15-minute check-in. He reported a significant reduction in depression and anxiety symptoms, a feeling of being more adjusted to college, and confidence that he would be academically successful. Furthermore, he overcame his ambivalence and made the choice to engage DSS, where he was provided with a variety of possible accommodations. Working together with DSS staff in ways that were very similar to his work with the counselor under SCM, Eric was able to advocate for the accommodations he felt were most appropriate, including extended time on exams and written assignments.

Implications for Practice

SCM seems to be a promising approach to helping college students with LD develop basic self-advocacy skills and obtain access to the help and services they need. Rooted in the

beliefs that clients should take the lead in driving their own care and the least restrictive options should be used to obtain clinically significant outcomes, SCM seems to make sense in settings such as college counseling centers in which efficiency and speed are important considerations, and in which students need every opportunity to practice self-advocacy skills in a safe environment.

Anyone can learn to provide care under the umbrella of SCM, although it is most helpful when entire practices make the commitment to do so as a team. SCM is not a manualized treatment, but rather an approach to organizing and providing services in the most efficient manner possible. Clinicians remain free to treat clients using whatever methods and theoretical approaches seem most appropriate after considering the center's staffing levels and available interventions alongside each client's presenting concerns and preferred treatment modality. That said, SCM is comprised of standardized procedures that must be learned and practiced over time in order to be employed successfully. Foundational knowledge is typically provided by experts in the field during full-day workshops that include training on the core components of the model including steps available at the clinician's site, theory behind SCM, case examples, and ethical considerations. Video vignettes and demonstrations by the trainers are also typically employed to show how the model is applied in practice. Following these trainings, clinicians new to SCM might also participate in regular coaching sessions with their senior colleagues if the model is already established at their place of employment. Weekly individual and group supervision by a senior clinician or "SCM coordinator" can help fine-tune a beginner's knowledge of the system. Once basic mastery has been demonstrated, adjunctive trainings can be provided on best practices around implementing the model with specific clientele (such as students with LD) or to

take a deep-dive into therapeutic techniques that are useful in the model such as motivational interviewing and solution focused brief therapy.

While SCM may provide a useful structure for organizing services, it is probably not the best approach in all situations. One potential critique of SCM in university clinics is that it may not be helpful to those with more severe psychopathology, especially in settings that overemphasize brief interventions or limit the degree to which clinicians may offer treatments such as intensive ongoing therapy. Again, there is no "one size fits all" approach within SCM. While short-duration, less-restrictive interventions are often tried first, the model allows for quick modifications to modality as outcomes are monitored and the counselor and client agree that a new approach might be needed. SCM is only meant to funnel clients into the appropriate level of care rather than restrict options or prevent clients from accessing costly interventions. In that way, SCM also has utility for clients who may require longer-term care (Oosterbaan et al., 2013), but may be unable to seek it outside the university for financial reasons or a desire to prevent family from discovering that they have sought help. If the clinician and client agree that open-ended individual therapy is the most appropriate treatment choice at that time, nothing within SCM would prevent that intervention from being implemented.

All this said, some conditions do present a challenge within SCM, including delusions, hallucinations, paranoia, and other psychotic disorders that make it difficult for clients to monitor their progress and make choices about their care. In the same way, clients who are unable to use logic, are not oriented to reality, or are consistently under the influence of drugs or alcohol may find it difficult to benefit from SCM. While ongoing care and case management could be considered as high-level steps of the model and an option for treatment as explained above, there are ultimately situations in which a student is not clinically appropriate for a university

counseling center until they are stabilized in a hospital setting or receive other outside treatment, such as in cases of active psychosis.

While a strength of SCM is that it can create opportunities for clients to make choices about their care, ultimately empowering them to develop self-agency, such an approach may not be the best choice with all clients. For example, students from collectivist cultures may not value individualism and instead prefer making decisions in concert with friends and family. A culturally competent clinician will be aware of this dynamic and allow the client time to consult their support network and get back to the clinician before deciding on a plan of action. Additionally, international students with LD for whom English is a second language may struggle with understanding the core concepts of SCM as well as the idea of self-advocacy -- especially if they were also raised in a collectivist culture. The clinician may have to slow the process a bit and take care in explaining the concepts in simple terms that increase client understanding. Aside from understanding SCM, the very foundations of personal counseling and the sharing of intimate information may need to be explained in a way that translates into the native culture of the student. This could be especially true for those who hail from regions of the world in which mental health services are stigmatized or rarely utilized.

Conclusion

Professional counselors work with many marginalized populations, including students with LD in higher education settings. While there is no perfect approach to assisting these students, we offer SCM as one option to consider. As demonstrated by the case example from one of the authors' work with a student with LD in a university setting, SCM can assist counselors in keeping the focus of treatment on the progress of clients towards their stated goals in the least restrictive and most empowering manner possible. By emphasizing psychoeducation, self-monitoring, and client choice, SCM naturally fosters self-advocacy and self-awareness skills

that are critical for success in postsecondary education and can be applied in settings outside the counseling office. Furthermore, as a structure for providing services rather than a theoretical orientation, SCM lends itself well to a number of counseling approaches. While research is needed on the efficacy of SCM in a variety of counseling settings including college and university clinics, we hope readers will consider SCM as a vehicle for empowering clients and teaching self-advocacy, especially among students with LD in university settings.

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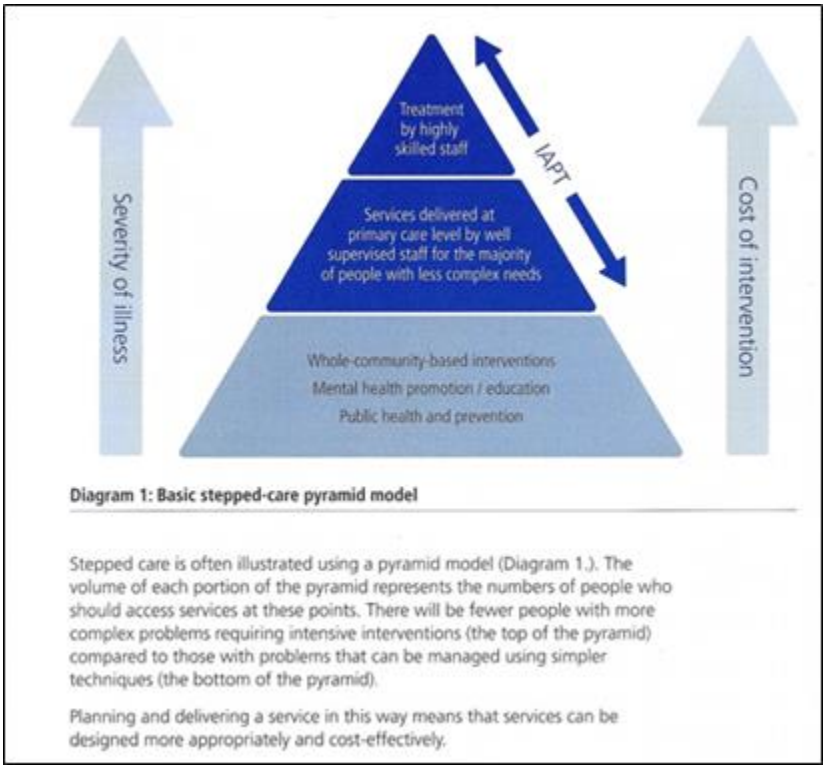
Figure 1.



(Step 2/3 and Stepped care model, 2018)

Figure 2.

(Stepped Care Counseling, 2018)