Title Page with ALL Author Contact Information

Guiding Principles for Implementing Stepped Care in Mental Health: Alignment on the Bigger Picture

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Abstract

Stepped care models are a mental healthcare delivery framework in which a continuum of support allows selection of a range of interventions to match a client's evolving needs and preferences. Currently in use in multiple settings worldwide, stepped care has the potential to provide a needed advance for the development of comprehensive mental health systems. However, definitions of stepped care lack consistency, resulting in differing interpretations reflected in variable implementation, ultimately limiting its replicability, utility and potential for impact. To help foster greater alignment in research and practice, we propose a set of principles for stepped care which can provide guidance on how to bridge multiple mental health services together, reduce fragmentation, and respond to the full breadth of mental health needs along a continuum of care in diverse settings. We hope that articulating these principles will foster discussion and spur mental health stakeholders to translate them into actionable standards.

Introduction

Stepped care (SC) models are an emerging framework for the development of comprehensive mental health systems and are currently in use in dozens of settings worldwide (Berger et al., 2020). Broadly, SC involves constructing a continuum of support integrating a variety of interventions that can be selected to match a client's evolving needs and preferences. This approach is particularly valuable given that there are few evidence-based frameworks for mental health system design that address the realities of high fragmentation, poor service coordination, and a large treatment gap. Despite such promise, current evidence has demonstrated that research- and practice-based definitions of SC have lacked consistency – resulting in varying interpretations and priorities.

This creates an urgent need to identify both core elements of SC as well as keys to its implementation. Accordingly, critiques of SC have called for establishing consensus on operational details with respect to the application of such models (e.g. specific services to include, the set number of "steps" required, etc.) (Berger et al., 2020; Firth et al., 2014). While conceptual alignment is certainly required in order for SC to be more effectively applied in practice, in our opinion these well-intentioned critiques may be misdirected. Here, we instead argue that future efforts should not be organized around the specific operationalization of SC. This would not allow sufficient flexibility for local adaptation and would, in turn, shepherd the development of rigid rather than responsive systems. Instead, consensus in SC should first be generated at the broader level of guiding principles that can, in turn, inform and direct local decision-making in implementing SC. To that end, in this manuscript we provide a background and

review on stepped care models and propose a set of principles that could both underpin SC and provide guidance on how to deliver SC's promise: to bridge multiple mental health services together, reduce fragmentation, and respond to the full breadth of mental health needs along a continuum of care in diverse settings. These proposed guiding principles are intended, first and foremost, to engage the mental health community in dialogue around the core elements, and ultimately to spark greater discussion regarding alignment on SC in research and practice.

The guiding principles we propose are grounded in four years of collaborative inquiry that we have undertaken as a Stepped Care Models Working Group supported by Frayme, a Canadian knowledge translation network aiming to "transform youth mental health and substance use systems in order to ensure that youth receive the right care at the right time from the right provider …" (Frayme, 2022). Working Group members are clinicians, researchers, and health systems leaders committed to systematic inquiry and reflective practice on SC models. In collaboration with partners in Canada and the US, we have completed a series of knowledge synthesis, environmental scans, and stakeholder engagements on the topic of SC in youth mental health (YMH).

Background

Fragmented mental health service delivery is a critical issue globally, leading to complex and tortuous pathways to care in addition to the noted lack of much-needed services (MacDonald et al., 2018; World Health Organization, 2022a). It is estimated that 1 in every 8 people live with a mental disorder (World Health Organization, 2022a), and more than 700,000 people die from suicide each year (World Health Organization, 2021). Tragically, while the burden of mental health problems is significant, access to timely and appropriate services is limited due to a combination of lack of political commitment, limited financial and human resources, and incomplete data (World Health Organization, 2022b). For example, 71% of people with psychosis do not receive mental health services (World Health Organization, 2022b). Even in high-income countries such as Canada and the United States, it has been demonstrated that only 43.8% and 56.4% of individuals respectively with mental health concerns will receive the care they need (Statistics Canada, 2019; Mental Health America, 2019). When discussing this treatment gap, many have noted issues specific to the poor arrangement of mental health services including confusing pathways to care, improper transitions between siloed systems, discoordinated services, and long waitlists as fundamental issues limiting access to support (Berger et al., 2020; Iyer et al., 2019; MacDonald et al., 2019).

Importantly, some mental health needs are more likely than others to be met depending on the structure and function of the mental health system itself. For example, in 2018, 85% of Canadians who required medication reported having their needs fully met, but only 50% of Canadians who sought counseling or therapy reported the same (Statistics Canada, 2019). This speaks to a potential over-reliance on medical services as a response to mental health challenges, and a failure to ensure equivalent access to complementary health supports (i.e. talk therapy, psychoeducation). This is consistent with emerging best practices demonstrating that mental health challenges are experienced along a spectrum of needs and severity – meaning that the corresponding supports and services should be obtainable across the entire continuum of care (Keyes, 2013). Despite this, traditional psychiatric practice in multiple countries prioritizes categorical diagnoses, and with it the provision of relatively high-intensity clinical care which is then restricted to a subset of the population seeking support (Cornish et al., 2017). This approach to service provision enables access only to those with discrete (diagnosed) mental disorders, thereby rationing the availability of evidence-informed treatments (Shah, 2019; Shah, 2015). Notably, a much larger group of individuals experience sub-threshold (compared with threshold) levels of mental distress with some degree of impairment (Roberts et al., 2015); despite not meeting criteria for access to care, they still need and would benefit from receiving mental health services (Shah, 2015).

Fortunately, complementary services are currently provided in a range of community, nonprofit, private, digital, and workplace settings that do not rely on specialist diagnosis and gatekeeping (MacDonald et al., 2018). In the absence of well-integrated, cohesive systems for delivering mental health services, mechanisms are not currently in place to enable swift entry into services via multiple portals, or facilitate collaborative care transitions between acute and/or specialist mental health care and all of these necessary and varied services. This creates great challenges for clients who have limited access to information about services and their benefits, little to no opportunity to efficiently navigate between services if their needs change or if they desire different approaches, and have to endure wait times that can prolong and potentially worsen distress.

Stepped Care Models

As a potential solution to these challenges, multiple iterations of SC models have emerged as a framework for creating a comprehensive system of mental health service delivery. In this context, which includes countries such as Canada, Australia, the U.K. and others, the overarching goal of SC is to guide the organization and integration of

multiple mental health services along a continuum of support, such that the appropriate intensity of interventions can be provided in response to varying and evolving individual needs (Cornish, 2020; Berger, et al. 2020; Firth, 2014). In SC, services are ideally arranged so that a) less intensive or invasive interventions can be provided in a low-barrier fashion to individuals with less acute needs and/or those who may not desire or be ready to engage with more intensive or high-commitment interventions; while b) all services are integrated such that clients can be "stepped" up or down based on their individual needs and preferences (Cornish, 2020).

Many different interpretations of SC models exist. Describing each is outside the scope of this paper, but one model, known as "Stepped Care 2.0", is depicted as an example (Figure 1). In Stepped Care 2.0, options include a range of formal and informal services, traditional and innovative e-mental health services, a variety of portals (e.g., web-based, in person), and health promotion services which foster individual and community protective factors.

In many implementations of full SC models, including Stepped Care 2.0, higher-intensity treatments such as therapy or inpatient treatments are also available for those who need them, integrated with additional support services as part of a comprehensive system. In this way, the SC heuristic is not simply about the breadth or diversity of services provided, but instead about the arrangement of services, the transitions between them, and efficiently facilitating the process of guiding clients to the service or intervention that best meets their needs at any given point in their recovery process. SC models also embrace other best-practices, such as recommending methods to ensure that both clients and service providers can make informed decisions about accessing the most appropriate forms of care possible, as well as creating functional connections between services for continuity and referral (Cornish, 2020; Cross & Hickie, 2017).

Importantly, however, there are varied interpretations of SC reflected in the literature, and the rationale for designing mental health systems in this way can reflect differing and conflicting priorities. In an additional example of SC for depression (Figure 2), SC is described as a system of delivering care so that the most effective yet least resource-intensive treatment is offered first. Here, the aim of SC is to "enhance efficiency by providing low-intensity treatments to a proportion of depressed patients in the first instance, before providing higher intensity treatment to those who do not improve with the first step" (Richards et al., 2012).

Similarly, in O'Donohue and Draper's (2011) account of SC delivery systems, services are organized according to a hierarchy of intensity, but increased intensity is linked to increases in financial cost. Their emphasis is on offering clients lower intensity (i.e. lower cost) services first, and allowing them to move up to higher intensity

services if their problems persist. Notably, these authors also emphasize the role of shared decision making between patients and providers, but with the expressed purpose of seeking to minimize costs while maximizing benefits. In this way, resource efficiency is at the heart of some interpretations of SC.

Of course, prioritizing financial savings can be interpreted as potentially resource-withholding, particularly by clients. It can also imply a hierarchy of services with respect to their quality or rigor, even though that may not be the case. While there is no way to avoid the fact that some interventions or services in a SC model may be more or less evidence-informed and/or resource intensive than others for clients, providers, and systems, this articulation of SC explicitly privileges the perspective of managing scarce resources rather than prioritizing client-centered needs. In contrast, advancing a principles-focused definition of SC can center discussions and implementation around common core values and client needs, thereby shielding against potentially misaligned interpretations that may deprioritize client readiness and empowered choice.

The Need for a Principles-Based Definition

Given inconsistencies in the principles and values underpinning SC models, it is perhaps unsurprising that there is substantial variability in its implementation (Firth et al., 2014; Richards et al., 2012; Berger et al., 2020). For example, there is no current consensus on the ideal number or types of services to be provided when operationalizing SC, how to triage clients and facilitate connections between services, and the degree to which a SC model can be tailored to different environments. Indeed, in a recent review of SC interventions for mental health and substance use service delivery to youth and young adults, significant differences were found in almost every aspect of the SC models identified. This led authors to conclude that a consensus position on the definition, implementation, and outcome measures was required to strengthen the implementation and scientific assessment of SC models (Berger et al., 2020). In a previous review of SC models in the treatment of depression in adults, similar variation in implementation was found and it was recommended that further research to specify and investigate the "active ingredients" of SC be conducted to clarify its clinical benefits (Firth et al., 2014). Without agreement on the number of services to be included, the types of services provided, and the definition of what exactly it means to implement SC in practice, there is concern that the replicability, clinical impact, and evidence base for SC will remain limited.

While it is true that variability in implementation of SC models restricts the utility, replicability, generalizability, and assessment of SC in practice, it is our view that the dominant focus of existing critiques is misdirected: fundamentally, SC is not (and should not be treated as) a static, inflexible series of interventions. Identifying details such as the specific services to be implemented is indeed important to operationalizing SC, but these details will understandably vary in different system contexts and environments in response to diverse needs and realities. We now instead propose that alignment should be on guiding principles that can help to inform local decisions regarding the development of comprehensive mental health systems that employ a SC-based approach. Re-centering the discussion and implementation of SC models on common values such as client readiness and client choice are articulations of core principles, which work to inform and direct decision-making while preserving the operational flexibility needed to create locally responsive mental health systems.

Such a perspective has several additional benefits. First, organizing principles can serve to orient SC implementation around the fundamental goal of creating a cohesive system. A reliance on over-defining operational details, such as a set number of services or the inclusion of specific interventions (or intervention packages), does not in itself create a system of care if it is not grounded in striving toward this broader intention; indeed, it risks additional fragmentation if new services are implemented in an already cluttered and disorganized system and if no efforts are prioritized for their integration. For example, if SC were to be defined by the inclusion of both peer support and psychiatric services, it is possible that these services would consequently be built in discrete silos. In contrast, an articulation of goal-based principles, such as the desire to build a connected system, states a direction under which these operational decisions can be made and guides local decisions related to individual service design. This would encourage system planners to focus on building clear pathways and methods for integration that otherwise might not be apparently necessary.

Second, a principles-focused definition allows for adaptability; something much needed as no two health systems or communities look alike. Defining SC as an overly prescriptive set of services will restrain the ability of community leaders and practitioners to make choices that align with community needs and values or to evolve in response to emerging evidence over time. For example, were SC to be defined by the inclusion of set services with pre-determined quality metrics and clinical frameworks, communities would not be able to adapt to local conceptions of health and wellness or linguistic and spiritual differences. Further, if SC were to be defined by pre-determined workforces (psychiatrists) or service settings (i.e. hospitals), health system planners without these

elements would not be able to leverage local resources such as community centers or public health nurses in order to build a contextually appropriate system of care. In order for a SC model to effectively allow for adaptation to evolving and locally-specific needs, SC principles need to act as heuristics that guide decision making rather than as a structured intervention set with rigid operational ingredients.

Finally, a principles-focused definition allows for implementation and iteration to be client-centric. In order to create a responsive mental health service delivery model, the focus must be on identifying the varied needs within a population and gaps in existing services, and subsequently addressing these needs in a manner that optimizes care and accessibility. This is true for decisions related to the specific interventions to be provided, as well as decisions related to designing the full system itself (i.e. pathways, access points, etc). In this way, in order to be client-centric and responsive to client needs, a system cannot be predetermined. In order to ensure this stays consistent within understandings of SC, client-centeredness must therefore be a defining principle and understood as central to SC implementation.

Proposed Principles

We argue that SC should not be defined by a set number, ladder, or type of interventions. We propose instead that SC be conceived of as a flexible healthcare delivery model for creating a comprehensive mental health service system that can meet diverse needs in a variety of contexts, guided by common principles. To generate discussion, we suggest five guiding principles that we consider core to successful implementation of SC models. These principles are intended to provide sufficient direction to guide the application of SC to create mental health systems in various settings, while not dictating specific components (i.e. service type, number of services, service provider type) of mental health service delivery that should be community-adaptive and context driven. They are also designed to organize implementation of SC chiefly around client choice – ensuring that the right service is able to be provided to meet each individual clients' needs, goals, and priorities.

1. **Provide a breadth of mental health services along a continuum of care, including a range of different intensities;**

   No singular type of mental health service, intervention or therapy can meet the needs of an entire population. In a comprehensive mental health system, it is essential to provide a breadth of options (across a range of

intensities) along a continuum of care that together meet varying needs. Intensity, in this frame, does not refer to the severity of a mental health symptom or disorder. Instead, it refers to the level of engagement required from both a clinician and a client, the level of commitment required from both parties, the invasiveness of intervention (i.e. expert direction with reduced client autonomy, introduction of medications and/or hospitalizations), and relative risk/benefit ratios. Lower intensity services require less engagement and include services such as psychoeducational resources, coping skills development, and self-directed recovery. Higher intensity services require greater engagement on behalf of both the clinician and the client and include services such as multi-session psychotherapy, psychopharmacology and/or inpatient specialist services. Typically, comprehensive SC models include supports such as psychoeducational resources, self guided tools, peer support, psychotherapy, and specialist services, which together represent a range of intensities along a continuum of care. However, the exact services at each intensity level should reflect context and community, enabling the services incorporated to vary in response to different cultures, environments, resources, priorities, and varied client needs.

2. **Implement methods to ensure clients can make informed decisions about their care, based on their readiness, goals, and priorities;**

   It is necessary to implement multiple mental health services at a range of differing intensities to effectively meet needs. In conjunction with this and given the orientation of SC models, it is crucial to strengthen mental health literacy and implement processes that support self-awareness of needs and inform clients of their options. The services a client participates in for their own recovery must be decided on by the client to the best of their ability and with support as needed, as well as informed by their own readiness to invest time and resources, the goals they wish to achieve, and the priorities they value and articulate. As such, the integration of methods to assess needs, facilitate self-awareness, inform clients of their options, clearly communicate the details of services provided, and support client choice are crucial in a SC model.

3. **Use validated tools to assess the benefits of care provided, so that both service providers and service users can engage in collaborative treatment planning;**

A goal of a comprehensive mental health system should be continual improvement, and measurement based care is central to identifying gaps, making data-based decisions, and continually taking action to meet the needs of a population. In addition, in a system with multiple different services of varying intensities, it is essential that measures to guide treatment selection are based on determinations of intensity of need. This, along with regular implementation of methods to assess the appropriateness of individual services provided, as well as methods to measure outcomes over time, achieves two purposes: at the individual level, it can monitor progress, inform shared decision-making around service use, and assess the benefit of specific interventions or services. At the service level, it can assess gaps within the mental health system (i.e. unmet needs, underrepresented groups) and guide the development of new or adapted services or approaches.

4. **Integrate services with each other to form a cohesive system, with functioning connections for continuity and referral;**

Implementing multiple different services at varying levels of intensity does not, on its own, create a mental health system. Services cannot be implemented in silos; it is essential that methods to integrate services, create seamless transitions, reduce overlap, and remove redundant transitions in care be incorporated into building a cohesive system that can meet the diverse needs of a community. It is also crucial that individual services be planned and implemented with consideration to their role within a broader continuum (i.e. the needs they fill, the gaps they leave behind). For example, if there are exclusionary criteria in place for one service offering, it is essential that services for those who do not meet these criteria are also implemented to reduce unmet need. Alternatively, if some services are only available on a fee-for-service basis (e.g. structured psychotherapy) while other services are publicly funded, actions to integrate the provision of these services and equalize their accessibility should be prioritized. In this way, the system to be developed in line with SC is greater than the sum of its individual parts. This broad view of services, how they fit together, and how they respond to the needs of a population is fundamental to implementing SC in practice.

5. **Ensure community-responsive adaptation with flexible definitions of services, providers, and access points, guided by community need and expertise;**

Decisions around which services to be included in a model, the expertise and technologies required for delivery, and the methods through which services are accessed should be flexible and responsive to the local community. Efforts to continually listen to diverse community expertise, measure success, align with community priorities, and course-correct in the event that services are misaligned should be continually incorporated in the design, implementation, and evaluation of individual services and the full system. No two communities have the same mental health needs, and efforts to listen to and respond to the needs and priorities of diverse populations are paramount to implementing SC in practice.

Conclusion

As clients continue to experience high fragmentation, poor service coordination, and limited accessibility of needed mental health supports, it is critical that models such as SC are developed and standardized to better arrange previously disorganized mental health systems. The five principles outlined here are intended to spark further discussion on the topic of SC implementation, and more work to derive consensus on the guiding principles of implementing SC is essential. Of course, although principles play an essential role by rooting implementation in common values and priorities, principles alone are insufficient to ensure evidence-based implementation of SC and to, more broadly, improve mental health systems. Other frameworks, such as the well-recognized LOCUS (American Association of Community Psychiatrists, 2016) which supports person-centered, clinical decision-making across a breadth of available services, exist to achieve this same outcome. Notably, the LOCUS is aligned around similar principles to the five proposed here. The fact that these models have been built upon similar guiding principles strengthens their credibility and validity; emphasizing the importance of each of these 5 elements to effective mental health systems and service delivery. With greater conceptual clarity, SC could interface with established tools such as the LOCUS to guide the integration of multiple, discrete services together into cohesive systems in diverse community settings.

Subsequent efforts to build on these principles and further refine minimum standards for their implementation will be crucial to fully guide the development of comprehensive SC systems on the ground. Defining SC with rigor and consistency offers an opportunity to set a standard for responsive, community-driven mental health systems and to fill a gap not yet fully addressed by other mental health service standards or approaches.

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Figure 1

The Stepped Care 2.0 model of stepped care. With permission from Stepped Care Solutions.

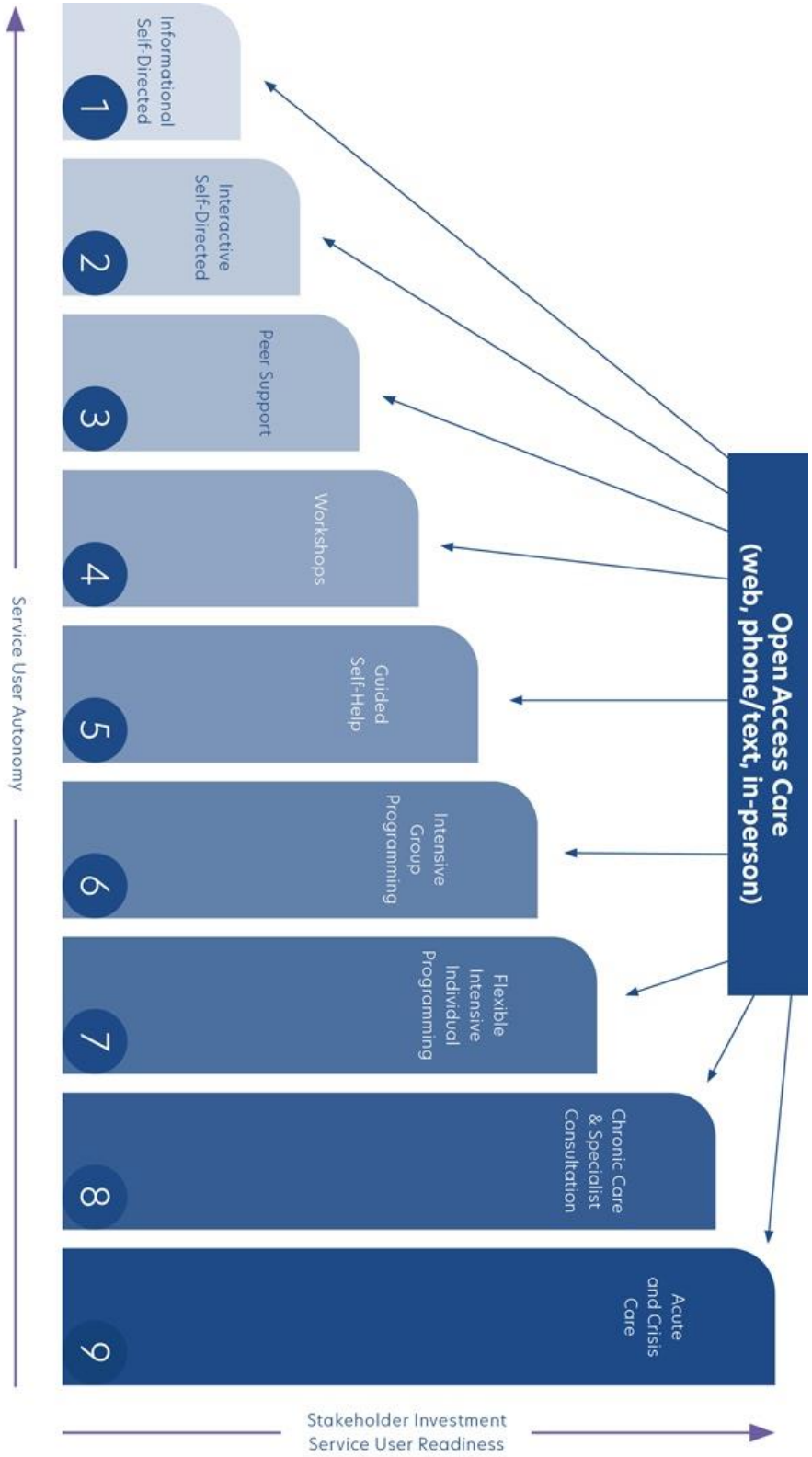
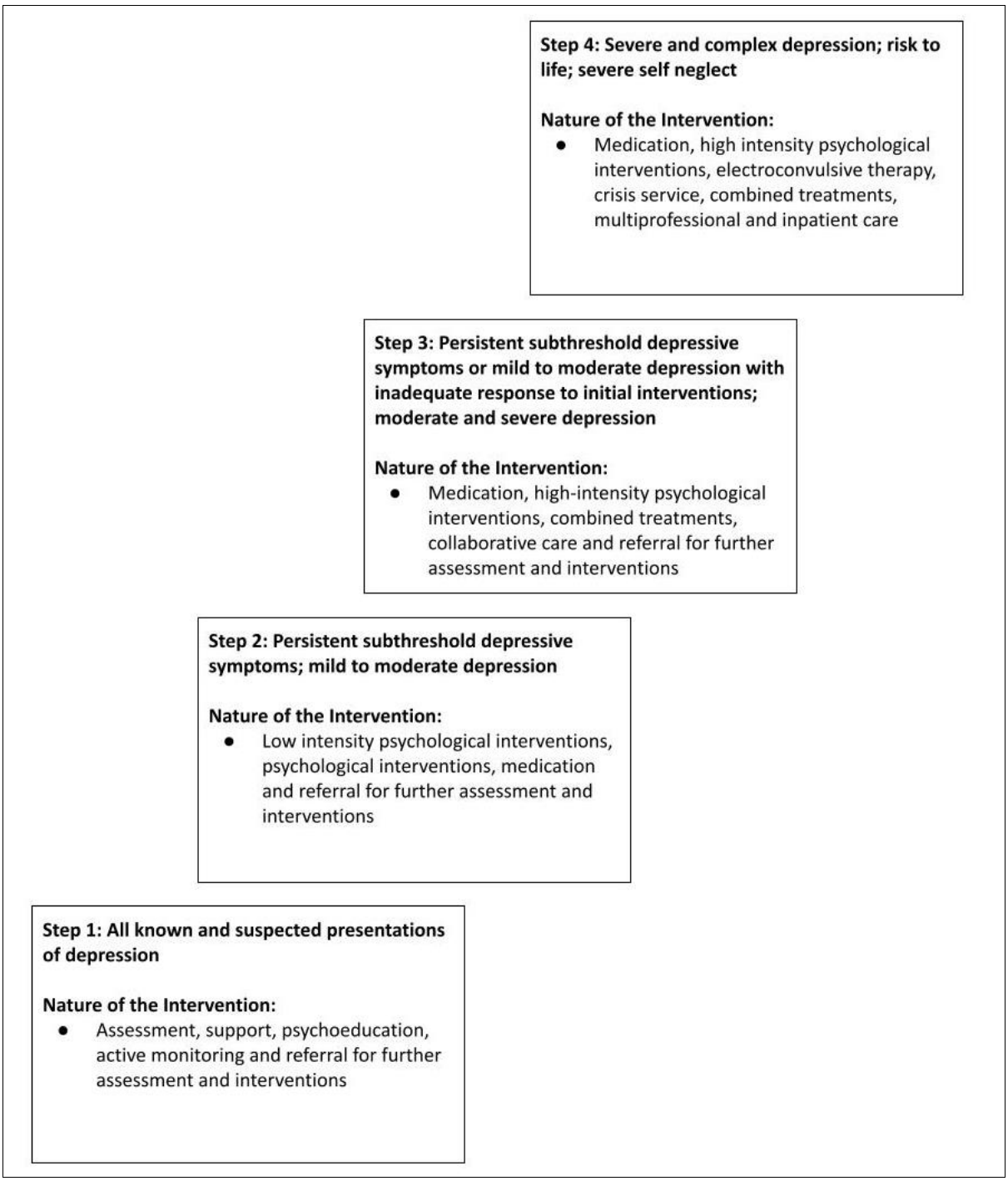


Figure 2

The NICE depression guideline model of stepped care (Richards et al., 2012)



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Conflicts of Interest

A. Churchill and A. Jaouich are both employed with Stepped Care Solutions. Stepped Care Solutions is a not-for-profit mental health system consultancy group and is the developer of the Stepped Care 2.0 model.