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

Introduction

Stepped care (SC) models are an emerging framework for the development of comprehensive mental health systems. Broadly, SC involves incorporating a variety of interventions across a continuum of support that can be matched to a client's needs and preferences. This approach is much needed, particularly in Canada, where there are few evidence-based guidelines for mental health system design that address high fragmentation, poor service coordination, and a large treatment gap. However, in recent research and practice, definitions of SC have lacked consistency – resulting in varying interpretations and priorities reflected in its implementation. Accordingly, recent critiques of SC call for establishing a consensus on operational details with respect to implementation of such models (e.g. specific services to include, the set number of "steps" required) (Berger et al., 2020; Firth et al., 2014).

While we agree that conceptual alignment is required in order for SC to be effectively applied in practice, it is our opinion that these critiques are misdirected. Additional clarity should not be regarding the specific operationalization of SC, as this would not shepherd the development of cohesive systems or sufficiently allow for local adaptation. Instead, consensus should first be at the broader level of guiding principles that can in turn inform and direct local decision-making.

To this end, we propose a set of principles for SC 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. These proposed guiding principles are intended, first and foremost, to spark greater discussion toward alignment on SC in research and practice. Our hope is that articulating these principles will spur mental health stakeholders to translate them into actionable standards.

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 national 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 in Canada" (Frayme, 2022). As Working Group members, we 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), including a scoping review and systematic assessment of SC interventions for YMH (Berger et al., 2020) and a focus group study with youth, families, and service providers examining their perspectives on SC (Saxton et al, manuscript in preparation). Members of this group have also developed a practical evaluation tool kit to promote structured, high quality, and utilization-focussed evaluations of SC implementations (Snow et al., 2022).

Background

Fragmented mental health service delivery is a critical issue in Canada, leading to complex and tortuous pathways to care and a lack of much-needed services (MacDonald et al., 2018). It has been estimated that 17.8% of Canadians are affected by mental health and/or substance use disorders (Statistics Canada,

2018), and 11.8% of Canadians aged 15 and over report that they have contemplated suicide in their lifetime (Public Health Agency of Canada, 2020). Yet, while the burden of mental health problems is significant, multiple studies estimate that only 56% of Canadians with mental health concerns will receive timely and appropriate care (Statistics Canada, 2018). 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, a lack of service coordination, and long waitlists as fundamental issues limiting access to support (Berger et al., 2020; Iyer et al., 2019).

Importantly, some mental health needs are more likely to be met than others in the current Canadian mental health system. 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, 2018). This speaks to a potential over-reliance on psychiatric medical services in Canada to respond to mental health challenges, and a failure to ensure equivalent access to complementary health supports (i.e. talk therapy, psychoeducation).

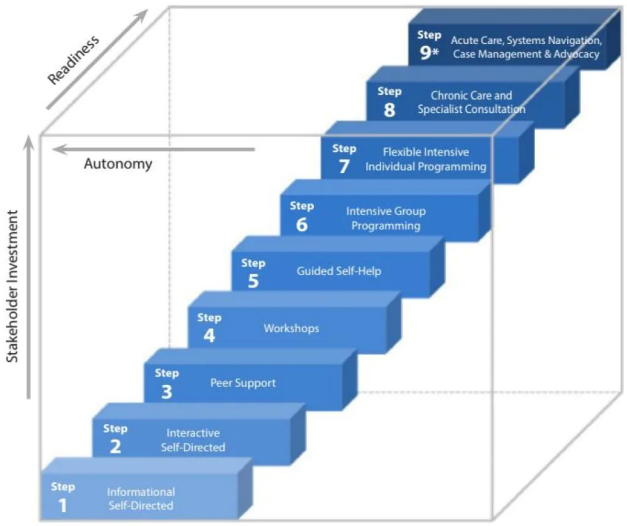
Emerging best practices demonstrate that mental health challenges are experienced along a spectrum of needs and severity; as such, mental health supports and services should be offered across the entire continuum of care (Keyes, 2013). Despite this, traditional psychiatric practice prioritizes categorical diagnoses, and with it the provision of relatively high-intensity clinical care which is only needed for a subset of the population seeking support (Cornish et al., 2017). This approach to service provision enables access only to those with discrete mental disorders, thereby rationing the provision of evidence-based treatments (Shah, 2019). Notably, a much larger group of Canadians experience sub-threshold levels of mental distress with associated impairment; despite not meeting the most stringent criteria for access to care, they still need and would benefit from receiving mental health services (Shah, 2015).

This gap in treatment is especially notable because there are many additional mental health services that could meet a variety of needs across a spectrum of intervention intensity. In reality, these are currently provided in a variety of community, nonprofit, private, digital, and workplace settings across Canada (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, collaborative care transitions between acute and/or specialist mental health care and all of these necessary and varied services. Most importantly, it 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 system problems, SC models have recently emerged as a framework for creating a comprehensive system of mental health service delivery. The primary 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 in the context of a system of care (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 commentary, but one model, known as "Stepped Care 2.0", is pictured (right) to provide an example. In Stepped Care 2.0, options include a range of formal and informal services, traditional and innovative e-mental health services, a variety of mediums (e.g., web-based, in person), and health promotion services which foster individual and community protective factors.

In many implementations of SC, including Stepped Care 2.0, higher-intensity treatments such as therapy or inpatient treatments are available for those who need them; their delivery is integrated with additional support services as part of a comprehensive system. In this way, SC is not simply about the breadth or diversity of services provided, but the arrangement of services, the transitions between them, and the efficient facilitation of guiding clients to the service or intervention that best meets their needs both in moments of distress and throughout their recovery. In a SC model, it is also recommended that there be methods to ensure both clients and service providers can make informed decisions about accessing the most appropriate care among the services provided, 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 care (right), SC is described as a system of delivering care so that the most effective yet least resource-intensive treatment is delivered first. Here, it is described that 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).

Focus of the Intervention	Nature of the Intervention
Step 4:Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
Step 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychological interventions, psychological interventions, medication and referral for further assessment and interventions
Step 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

Similarly, in O'Donohue and Draper's (2011) account of SC delivery systems, services are organized in a hierarchy of intensity, and that increased intensity is linked to increase in financial cost. Here, the 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 (p.2). Notably, 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 (p.2). In this way, resource efficiency is at the heart of some interpretations of SC.

Of course, prioritizing financial savings can be interpreted as 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, the priorities and values driving decisions related to matching services with individuals should always be client-centered. By advancing a principle-focussed definition of SC, the intention is to recenter its discussion and implementation on common core values and shield against potentially misaligned interpretations that may deprioritize client readiness, need, and empowered choice.

The Need for a Principle-Based Definition

Many have recognized that significant gaps remain in the implementation details of SC (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 implementing the model, the mechanisms related to triaging clients and facilitating connections between services, and the degree to which a SC model can be tailored to different environments. This has resulted in substantial variability in both conceptualizations of SC and its implementation. 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 described. This led the authors to conclude that there is an urgent need for a consensus position on the definition, implementation, and outcome measures required to strengthen the implementation and scientific assessment of SC models (Berger et al., 2020). In an additional 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 the clinical benefits of the model (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 there is substantial variability in the implementation of SC models, and that this variability limits 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 set, inflexible series of interventions. Identifying operational details such as the specific services to be implemented is indeed important to operationalizing SC, however these details will understandably vary in different contexts and environments in response to diverse needs and realities. We propose that alignment should instead be on guiding principles that will help to inform local decisions regarding the development of comprehensive mental health systems in line with SC. Re-centering the discussion and implementation of SC models on common values such as client readiness and client

choice-determined service is an articulation of core principles, which work to inform and direct decision-making while preserving operational flexibility. This has several additional benefits.

First, clear principles can serve to orient SC implementation around the broader goal of creating a cohesive system. Seeking clarity on 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 and, in fact, risks additional fragmentation as new services are implemented in an already cluttered and disorganized system. In contrast, an articulation of principles refocuses implementation on system integration, the development of clear pathways, and a common vision for holistic system design.

Second, a principles-focused definition allows for adaptability. Defining SC as an overly prescriptive set of services will not sufficiently allow for community leaders and practitioners to make choices that align with community needs and values or to evolve in response to emerging evidence over time. In order for a SC model to effectively guide the development of a coordinated system of care, SC principles need to act as heuristics that guide decision making and allow for adaptation to evolving and community-specific needs, rather than as a structured intervention set with rigid operational ingredients.

Finally, a principle-focussed definition allows for implementation and iteration to be client-driven. 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 adapting to fill these gaps to optimize care and accessibility. This is true for decisions related to the services to be provided, as well as decisions related to designing the full system itself (i.e. pathways, access points). In order to ensure this stays consistent within understandings of SC, client-centeredness must be a defining principle and understood as central to SC implementation.

Proposed Principles

We argue, then, 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 healthcare delivery model for creating a comprehensive mental health system that can meet diverse mental health needs in a variety of contexts, guided by common principles. To generate discussion, we suggest five guiding principles that we propose are core to successful implementation of SC models. These principles are intended to provide sufficient direction to guide the implementation of SC models 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. These also are intended to center implementation of SC chiefly around client choice; ensuring 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 or therapy can meet the needs of a population. In a comprehensive mental health system, it is essential that a breadth of options along a continuum of care are provided that meet varying needs at a range of intensities. Intensity, in this way, 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, and the depth of intervention (i.e. expert direction with reduced client autonomy, introduction

of medications and/or hospitalizations). In this way, lower intensity services require lower engagement and include services such as psychoeducational resources, coping skills development, and self-directed recovery. Higher intensity services require higher engagement on behalf of both the clinician and the client and include services such as multi-session psychotherapy and/or inpatient specialist services. Typically, 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. The exact services at each intensity should reflect context and community and therefore the services to be incorporated can and should 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, but in doing so, there is potential to create an overwhelming number of options for clients. In a SC model, it is crucial to strengthen mental health literacy of the population and implement processes that support self awareness of needs and help 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 express. As such, methods to 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. **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 can not be implemented in silos; it is essential that methods to integrate services, create seamless transitions, reduce overlap, and remove redundant handovers be incorporated into building a cohesive system that can meet the diverse needs of a community population. It is also crucial that individual services be planned and implemented with consideration to their role within a broader system (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. Or, 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 parts. This broad view of services, how they fit together, and how they, together, respond to the needs of a population is fundamental to implementing SC in practice.

4. **Use validated tools to assess the benefits of care provided, so that both service providers and service users can track outcomes;**

   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 and access

points, it is essential that measures to assess the appropriateness of individual services provided are regularly implemented, as well as methods to measure outcomes over time. Fundamentally, this is to assess the benefit of specific interventions or services, monitor progress, and to inform shared decision making around service use, as well as to assess gaps within the full mental health system (i.e. unmet needs) and guide the development of new or adapted services or approaches.

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

   Decisions around the services to be included, the expertise 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 Canadians continue to experience high fragmentation, poor service coordination, and limited accessibility of needed mental health supports, it is critical that mental health system design frameworks such as SC are conceptualized beyond the siloed implementation of discrete services. There is existing evidence on individual interventions and guidance on their implementation; what is lacking is broad, evidence-based frameworks for bringing multiple services together and building cohesive systems. SC has the potential to respond to many challenges currently facing mental health systems, but the lack of agreement and variance in discussions and iterations of the model is limiting its replicability, potential for clinical impact, and strength of its evidence base.

The five principles outlined here are intended to spark further discussion on this topic, and more work to derive consensus on the guiding principles of implementing SC is essential. It should be noted that principles alone are insufficient to ensure consistent, evidence-based SC implementation. Principles play an important role by aligning implementation in common values and priorities, but subsequent efforts to build on these principles and further refine minimum standards for their implementation are crucial to fully guide the development of comprehensive SC systems on the ground. Defining SC with rigour and consistency offers an opportunity to set a standard for responsive, community-driven mental health systems across the country and to fill a crucial need not yet met by other mental health service standards or approaches.

Citations

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