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Topic brief: Levels of care

Knowledge Institute
on Child and Youth Mental Health and Addictions

Acknowledgements

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Introduction

This document provides an overview of quality standards and the results of a scoping search on levels of care, including the scope, timelines, target audiences, and proposed topic areas for this quality standard. It is important to note that the topic brief is not a quality standard; it is a foundational document to support scoping and driving conversations about what a quality standard should look like. More specifically, this document:

1. Provides Quality Standard Advisory Committee (QSAC) members with background information for discussions and decisions.
2. Identifies individuals and organizations to engage in the development and adoption of the quality standards.

As the topic brief is a foundational document, the information presented here will inevitably change as we continue scoping the literature, discuss with topic experts, and begin drafting the quality standard.

Background

The Knowledge Institute on Child and Youth Mental Health and Addictions (the Knowledge Institute) has invested in the development of provincial quality standards for the child and youth mental health and addictions (CYMHA) sector. Throughout 2018 and 2019, we developed two quality standards (Quality Standard for Youth Engagement and Quality Standard for Family Engagement) and, in 2020, a quality guideline (Quality Guideline for Virtual Walk-In Services). Since then, we have been leading the development of a suite of resources while providing coaching to help agencies implement these standards.

In 2021, our Strategic Advisory Council, along with the Lead Agency Consortium, and representatives from Ontario Health and the Ministry of Health unanimously agreed that the Knowledge Institute would continue to lead the development of quality standards to inform the delivery of care in our sector. In 2022, we published our standard development process, which will be further refined as we continue developing standards over time (Knowledge Institute, 2022). To learn more about our quality standards work, please see the quality standards page on our website.

What are quality standards?

A quality standard is a resource pertaining to a specific topic, which consists of 5 to 15 quality statements that describe what the highest quality looks like, based on the best available evidence and expert consultation (Health Quality Ontario, 2017). These statements are aspirational, concise, measurable, realistic, and accessible. They come together to form a unified standard that includes best practices, as well as indicators to demonstrate the progress and impact of each statement. Standards are essential to a system that is driven by accountability and continuous improvement.

Many quality standards are rules-based — the quality statements outline specific practices and processes to be implemented across all settings and expect specific outcomes (Schantl & Wagenhofer, 2021). However, rules-based standards can be challenging to implement, as they are not always inclusive of the specific needs of diverse communities. In contrast, principles-based standards are made up of quality statements that are defined by a general concept, and the individuals or community implementing them must use their judgement to apply the principle to their context (Schantl & Wagenhofer, 2021). Principles-based standards provide flexibility and allow for a person or community-centred approach.

Ontario's communities are diverse in strengths, needs and challenges. A uniform approach is not appropriate or effective in bringing system-level initiatives to life and improving child and youth mental health and addictions care. We recognize the importance of flexible quality standards that can be tailored across diverse communities. That is why we are developing our quality standard using principle-based statements, with special attention to implementation and evaluation considerations. This will ensure that communities can use the standard as a guidepost and tailor the quality statements to specific community context, needs and values that already exist.

Timelines

Phase	Activities
Selecting topic August 2022 - February 2023	• Hold topic selection activities with key partners. • Select a topic for next quality standard. • Announce topic selected for next quality standard.
Scoping March 2023 - August 2023	• Establish Quality Standard Advisory Committee (QSAC). • Prepare topic brief, case for improvement, indicator framework, implementation framework and needs assessment, and knowledge mobilization plan.
QSAC consultations October 2023 - April 2024	• QSAC members participate in meetings and contribute to deliberations and feedback around key topic areas, quality statements and indicators, public feedback and modifications, implementation, and knowledge mobilization.
Drafting October 2023 - August 2024	• Draft the standard. • Revise the standard. • Finalize the standard.
Mobilizing September 2024	• Publish the standard. • Disseminate the standard according to communications and knowledge mobilization plans.
Maintaining September 2024 and onward	• Review the standard for continued relevance and necessary updates.

Why is this quality standard needed?

What are levels of care?

Mental health and addictions (including behavioural addictions) systems have long recognized that everyone has their own set of strengths and challenges — meaning they need different types of care at varying levels of intensity. Over the years, different models of care, such as integrated care models and continuum of care models, were designed to bring together community-based mental health and addictions agencies with related sectors (education, primary care, child welfare and youth justice) and provide clients with the right care, at the right time and in the right place (Child Health BC, 2022; Mental Health Commission of Canada, 2012; Mental Health Commission of Canada, 2016; Ontario Ministry of Health, 2020; Rush & Saini, 2016; School and Community System of Care Collaborative, 2022). Although different, these models share the goal of improving access to care, building capacity among young people, families, agencies, and communities, and supporting seamless transitions between care within the child and youth mental health and addictions system and into the adult system (Shaligram et al., 2022).

In Ontario, initiatives to develop and implement different models of care have been driven to address key priorities and challenges in the sector. Mental health and addictions care for children and young people in Ontario is in high demand due to increasing prevalence and complexity (Chiu et al., 2020; Comeau et al., 2019; Knowledge Institute, 2023). This was exacerbated by the COVID-19 pandemic, with many children and young people in Canada experiencing worsening mental health concerns (Cost et al., 2022; Radomski et al., 2022). Additionally, young people and their family members face many barriers to care, including long wait lists (Children's Mental Health Ontario, 2020), and a lack of availability to care that best fits their needs and readiness (Chan et al., 2023). Agencies are struggling to match the needs of their communities as they grapple with challenges hiring and retaining staff (Children's Mental Health Ontario, 2022).

Models of care (see the section below, "Relevant and related models of care") to address these challenges and transform health systems have a long history. Relevant to this brief are continuum of care models, which originated in the United Kingdom and were designed to transform the healthcare system to meet the diverse needs of clients being served (Rush, 2010). Continuum of care models include a variety of types of care across different settings that reflect the diagnoses, severity of problems, and other criteria of the targeted clients. Principles of continuum of care models inspired other models of care, including stepped care models. Stepped care models are also known as matched care, appropriate care, and tiers of support models. However, we refer to stepped care as a levels of care model.[1]

Broadly, levels of care models organize care from least to most intensive, and match clients to the most appropriate level of care based on their unique, individual needs (Berger et al., 2022; Body Brave, n.d.; Centre for Innovation in Campus Mental Health, 2019) with the intention to match young people to the least-resource intensive intervention first (Centre for Innovation in Campus Mental Health, 2019; Cornish et al., 2017). Matching clients to a level of care is largely agency- and practitioner-dependent. The client's well-being, suicidality, psychosis, and mental health and addictions concerns are assessed through validated measures (e.g., HEADS-ED; Cappelli et al., 2012) or informal assessments at intake, depending on where they are receiving care (Berger et al., 2022). In some cases, preferences of the young person or client and their readiness for care are also considered (Berger et al., 2022 Bridge the Gapp, n.d.).

1 We recognize that the term "stepped care" may hold negative connotations for young people and family members. Currently, we are using the term "Levels of care: Matching the right care to a young person's needs."

Relevant and related models of care

Continuum of care

- Model of care that includes a spectrum of types and settings of care that reflect the concerns and severity of symptoms of clients.
- Principles of continuum of care models have inspired similar models, including levels of care. While both models include a spectrum of care that reflects the needs of the clients being served, levels of care include an additional component that matches and allows for movement.

Levels of care

- Models of care that are organized by least to most intensive and matches clients to the most appropriate level of care. Clients can move up and down the levels as their needs shift over time.
- Levels of care models have been used alongside integrated care models. Levels of care models provide a framework for matching and moving clients in an integrated care model (Halsall et al., 2018).

Integrated care

- Model of care that address needs across many life domains, including mental health, substance use health and addictions, education, housing and physical health (Foundry, 2023; Halsall et al., 2018; Halsall et al., 2019).

There is not one single approach to levels of care models (Mughal et al., 2022), but there are shared components to most models that are described and used in the CYMHA sector (Berger et al., 2022; Cornish et al., 2017). Core components of levels of care models include identifying and mapping:

- Types and intensity of care (e.g., self-help resources, peer support, workshops, one-on-one therapy, crisis, and acute supports, etc.).
- Criteria to match clients to a level of care.
- Access points into care.
- Movement between levels of care based on their needs.

Some levels of care models use a stepped or progressive approach, where clients start at the lowest level of intensity of care and if symptoms persist, they increase to the next level of care. Other models use a staged or stratified approach, where clients' needs are assessed and matched to the level of intensity of care that is most appropriate (Berger et al., 2022; Boyd et al., 2019; Wolf et al., 2022).

There are important considerations when developing levels of care models for child and youth mental health and addictions care (Berger et al., 2022; Mental Health Commission of Canada, 2016). Specifically:

- Embedding health equity and social determinants of health.
- Providing developmentally appropriate care for specific age groups.
- Integrating family members and community resources in the model.

What is the current state?

To inform our work, we reviewed published academic and grey literature and found limited information on levels of care models in child and youth mental health and addictions (Berger et al., 2022; Shah et al., 2021). In addition, there is a "lack of implementation of evidence-based interventions across multiple real-world settings and jurisdictions" (Henderson et al., 2017, p. 2). As a result, we took additional steps and hosted consultations with researchers, clinician scientists, system leaders, agency leaders, service providers, young people, and family members. These discussions helped our team learn from the individuals who are studying, using, implementing, and accessing levels of care models. They informed what we know about levels of care and how these models are used in communities, and provided perspective on gaps, needs and important considerations.

Through our review of the literature and consultations, we learned that levels of care models are gaining popularity in the CYMHA sector and are being used in different settings across communities in Ontario, including elementary and post-secondary education and primary care. Levels of care models are a cost-effective (Australian Government Department of Health, 2019; Berger et al., 2022; Body Brave, n.d.; Boyd et al., 2019) and promising approach to achieving key priorities in the sector, such as:

- Improving access to and satisfaction with care (Child and Youth Mental Health Lead Agency Consortium, 2021; Cornish et al., 2017).
- Enhancing continuity of care (Tobon et al., 2015).
- Advancing health equity and holistic care that address social determinants of health (Foundry, 2023; Mental Health Commission of Canada, 2016).
- Ensuring timely access to care (Centre for Innovation in Campus Mental Health, 2019; Munter, 2023; Wolf et al., 2022), including specialized and intensive services (Cheese, 2023; Children's Mental Health Ontario, n.d.; Child and Youth Mental Health Lead Agency Consortium, 2021).

Emerging evidence indicates that levels of care models have the potential to both decrease wait times for care and increase the capacity to serve more clients, leading to higher levels of client satisfaction with the care provided[2] (Mental Health Commission of Canada, 2020a; Mental Health Commission of Canada et al., 2023).

Despite the systemic burdens facing our sector, including long wait times and an increased demand for care, levels of care are a promising approach to meet the mental health, substance use health, and addictions needs of children and young people. While levels of care models are gaining popularity and being implemented in our sector, there are notable gaps and challenges.

What are the challenges with levels of care?

Through our literature review and consultations, we learned that levels of care models are being used for different reasons and in different ways without clear principles to drive a cohesive vision of a youth-centred, community-specific care. The lack of consistency of levels of care models are influenced by a lack of:

- Clear guidance on creating levels of care models that are youth-centred, community-specific and bring together agencies using a common language to provide a complete continuum of care that can match care to a young person's needs.
- Evidence available that addresses the efficacy of levels of care models such as accessibility of care, accuracy of matching young people to appropriate care, satisfaction with care received, and achievement of intended clinical outcomes.
- Implementation supports and evaluation of processes and outcomes to ensure that levels of care models are being implemented with fidelity and achieving their intended results.

2 Mental Health Commission of Canada and colleagues (2023) reported that the "average wait time for counselling services decreased by 79% between 2020 and 2022, with the median wait time of 19 days reduced to 4 days" (p. 15). Most people were satisfied with the care, including the overall experience (73%), location (78%) and hours of availability (72%).

As a result, descriptions of levels of care models are inconsistent and present implementation gaps (Mughal et al., 2022). For example, levels of care models have been described at the service-level (i.e., levels of intensity in a program), at the agency-level (i.e., levels of care offered within an agency), and at the community-level (i.e., levels of care offered across agencies and sectors within a community). We heard that the availability of a complete continuum of care (i.e., a variety of care by type and intensity are available across settings) at the system-level was confused with a levels of care approach. While optimal level of care models include a complete continuum of care, levels of care models take a step further by clearly mapping the continuum by intensity, and strategically matching clients to the most appropriate level of care using specific criteria (Centre for Innovation in Campus Mental Health, n.d.).

Through the literature and in our consultations, we found notable gaps and criticisms in the way levels of care models are structured and implemented, especially for children and young people. These include:

- Lacking a complete continuum of care.
- Insufficient collaboration and partnerships.
- Challenges addressing concurrent disorders.
- Difficulty matching to appropriate care.
- Difficulty achieving structure vs. rigidity.
- Challenges addressing social determinants of health.
- Obstacles to providing developmentally appropriate care.

Appendix A. Notable gaps and challenges describes these challenges and details the important considerations for addressing them.

What is an ideal vision for levels of care?

Levels of care models are a promising approach to transforming care in communities. Our review of the literature and consultations has identified opportunities to improve the consistency and quality of levels of care models in the sector through the development of a quality standard.

To guide the development of our quality standard, we look to a shared vision of what a levels of care approach should embody. What we heard was that children, young people and family members should be able to enter a levels of care model through any door (Sheikhan et al., 2023), and move through the levels to match their needs as they shift over time (Tobon et al., 2015).

There is a demand to create levels of care models that are youth-centred, community-specific, and actively involve family members (Haskell et al., 2016; Mood Disorders Society of Canada, n.d.). These models should also:

- Provide care that is individualized, holistic, and culturally responsive (Algonquin College, n.d.; Haskell et al., 2016).
- Reflect shifting priorities, needs and strengths throughout developmental stages. For example, among infants and children, there is a greater emphasis on building capacity among caregivers; promoting healthy attachment, autonomy, social-emotional development; and early identification through coordinating with infant-specific settings, such as with service providers in primary care, daycare, and education (Kulkarni et al., 2019). In comparison, among transition-aged young people, the focus is on peer relationships, collaborative care planning and support for transitions into the adult mental health and addictions system.
- Remain responsive and flexible, as children and young people benefit from models of care that allow them to receive support that is tailored to their needs, as their needs shift over time (Mental Health Commission of Canada, 2016). For example, young people may benefit when they can receive support in two levels of care simultaneously (e.g., continuing engagement in peer support groups while also receiving one-on-one therapy; Shah et al., 2021).
- Engage young people and family members to co-develop and consult on levels of care models that are relevant and impactful (Centre for Innovation in Campus Mental Health, 2019; Doery et al., 2023; Health Standards of Canada, 2021; Ontario Centre of Excellence for Child and Youth Mental Health, 2021a, 2021b; Shah et al., 2021).
- Create a menu of services through effective collaboration and coordination between community agencies (Edwards et al., 2022; Kulkarni et al., 2019; Shah et al., 2021), including health promotion and informal supports to bolster well-being (Rush, 2010) as well as for children and young people with less severe mental health, substance use health and addictions care needs (Fischer et al., 2016; Turuba et al., 2022).
- Foster a shared understanding of needs and care with consideration of the preference of young people (Berger et al., 2022; Bridge the Gapp, n.d.; Mood Disorders Society of Canada, n.d.), to help overcome stigma and improve access (Sheikhan et al., 2023).

There are also opportunities to foreground levels of care approaches that advance equity, diversity, inclusion and access to care. These models would:

- Support collaboration and partnerships between agencies and sectors to create a system that addresses social determinants of health. In our scoping research, factors including family income, food and housing security, education and racial identity were most often cited (Duncan et al., 2020).
- Create more accessible spaces for care and meet young people where they are at in the community. This is particularly important in rural communities, where there are greater geography-related barriers (Chan et al., 2023; Duncan et al., 2020).
- Build partnerships with local community organizations that represent equity-deserving communities to improve access to care (Mental Health Commission of Canada, 2018).
- Provide culturally responsive and identity affirming mental health and substance use health and addictions care, including community-specific health promotion activities and informal supports (Doery et al., 2023; Heid et al., 2022).

Case for improvement

Ontario's child and youth mental health and addictions agencies are creating and implementing levels of care models to address systemic burdens (e.g., increasing demand for care, long wait times) and improve access to high-quality care that aligns with the unique needs of children and young people in their respective communities. Despite a consistent vision of a levels of care model, the implementation across the province varies in approach and purpose. Introducing a quality standard on levels of care models will establish guiding principles to ensure that foundational elements of levels of care models are adapted to the local context of communities which will facilitate consistent application and adherence, leading to optimal outcomes.

Purpose and proposed topic areas

The purpose of this quality standard is not to define a specific model of levels of care. We recognize that a one-size-fits-all approach does not work to meet the diverse needs of Ontario's communities. The quality standard will identify specific topic areas (or themes) that represent the most important considerations for creating a cohesive levels of care model. It will be accompanied by specific principles-based statements related to each topic area. These statements define an optimal, high-quality levels of care approach tailored to community needs and values.

Topic areas and quality statements will be defined in consultation with the Quality Standard Advisory Committee (QSAC); however, we have identified some preliminary topic areas for consideration based on recurring themes in our search of the literature and consultations.

Client-centric

- Levels of care models are youth-centric and reflect the needs, readiness, and realities of young people with mental health and substance use health and addictions needs.
- Care planning fosters a shared understanding of needs and care between young people, family members, and service providers (Fisher et al., 2022) through informed choice and consent of the young person.
- Family support is integrated in care planning.
- Levels of care models are community-specific (Thunderbird Partnership Foundation et al., 2011), responding to community needs, while coordinating and leveraging existing resources and strengths.

Empowering and equitable

- Considerations for equity and social determinants of health are embedded throughout levels of care models (Mental Health Commission of Canada, 2018; Rush, 2010).
- Based on socioecological models of health, care for young people is considered in the context of their individual strengths and needs, family and peer relationships, community environments, and social climate (Bronfenbrenner, 1977).

- In levels of care models, care is:
  - Individualized (Bridge the Gapp, n.d.).
  - Holistic (Fisher et al., 2022; Marchand et al., 2022).
  - Strengths-based.
  - Free of stigma (Marchand et al., 2022; Sheikhan et al., 2023).
  - Trauma-informed.
  - Recovery-oriented.
  - Focused on harm reduction.

Co-developed

- Young people, family members (Shah et al., 2021), and community partners are key co-developers of a levels of care model (Ontario Centre of Excellence for Child and Youth Mental Health, 2021a, 2021b).

Multifaceted

- Levels of care are supported by a complete continuum of care (Australian Government Department of Health, 2019), including lower levels of health promotion and informal supports (Rush, 2010; Sheikhan et al., 2023; Thunderbird Partnership Foundation et al., 2011), and higher-level crisis supports (PHN South Western Sydney, n.d.). Informal supports include non-clinical social activities, as well as education and mental health literacy.
- Levels of care models are responsive to the needs, strengths and challenges of children and young people across developmental stages. Care should be evidence-informed, developmentally appropriate and circumstance-informed.
- A continuum of care includes care that is culturally responsive and identity affirming.
- There is sector capacity to address concurrent mental health, substance use health, and addictions needs (Knowledge Institute, 2023; Mental Health Commission of Canada, 2018) in a levels of care model.

Flexible and responsive

- Levels of care models prioritize health promotion and early intervention.
- Across levels of care, there are clear and agreed upon assessments and matching criteria to match young people consistently and accurately to the most appropriate level of care.
- There are roles and processes to support continuity of care; relationships are maintained, and information is shared across levels of care.

- There are clear processes and time points to reassess needs and appropriate care.
- There is flexibility in levels of care models that allows children and young people to access care that best fits their needs (e.g., use supports in more than one level of care such as peer support and one-on-one therapy if it is beneficial).

Rooted in community collaboration and partnerships

- There are strong relationships and partnerships between agencies (including across sectors) in communities (PHN South Western Sydney, n.d.) to create comprehensive and cohesive levels of care models and strengthen continuity of care (Mughal et al., 2022).

Timely and accessible

- Children, young people, and family members receive care in a timely fashion.
- Children, young people, and family members receive support while waiting for care.
- In levels of care models, there is a lower threshold for accessing care (Shah et al., 2021).

Continuously improving

- Levels of care models are continuously evaluated to identify gaps and challenges and leverage strengths and unique opportunities to enhance care.
- Quality standard goals and progress indicators are accessible to and developed in collaboration with community partners (Health Standard of Canada, 2021).

Proposed scope and targeted audience

One quality standard will be developed to address levels of care models in community-based child and youth mental health and addictions agencies. This quality standard will focus on infants, children and young people ages 0-25 years old. The primary audience for this standard are system- and agency-leaders and service providers. This standard should also be accessible and relevant to children, young people, and their family members. Although mental health and substance use health and addictions care should be inclusive of other settings (e.g., education and primary care), the target setting for this standard is community-based child and youth mental health and addictions agencies. This standard is not explicitly developed for use by those in allied sectors, but it can support community-based agencies to foster partnerships with agencies in related sectors to provide an optimal levels of care model in their communities.

Table 2. Proposed inclusion and exclusion of the quality standard

	Proposed inclusion	**Proposed exclusion**
Criteria	• Topic: Levels of care for concurrent mental health, substance use health and addictions. • Age: Children and young people ages 0-25. • Setting: Ontario's community-based child and youth mental health and addictions agencies. • Audience: Professionals, including clinicians, researchers, system- and agency-leaders, service providers and policymakers; children, young people, and their family members.	• Settings outside of Ontario's community-based child and youth mental health and addictions agencies.

Important considerations

Using, mobilizing, and evaluating the quality standard is as important as the quality standard itself. This standard will be supported by strong, comprehensive implementation, knowledge mobilization, evaluation processes and resources so it can be applied to new or existing practices.

Performance indicators

Drafting quality statements involves identifying accompanying performance indicators that are measurable, appropriate, and feasible. Performance indicators help agencies and communities evaluate if a quality statement has been properly implemented and if it's effective in improving care. The Knowledge Institute is preparing an indicators framework which will outline data that can be collected to measure improvements related to each of the quality statements that make up the standard (Knowledge Institute, 2022).

Implementation and evaluation

At the beginning of the standard development process, the Knowledge Institute developed a high-level plan that identifies feasible implementation and evaluation activities to accompany the quality standard. This plan is rooted in the principles of implementation science and performance measurement. As we develop the implementation and evaluation resources, we will consider the importance of policy, leadership, performance measurement, research, knowledge mobilization (Rush, 2010), community engagement/partnership (Shah et al., 2021), and sustainable continuous improvement (Mental Health Commission of Canada et al., 2023; Rush, 2010; Shah et al., 2021).

Knowledge mobilization

Part of the standard development process includes mobilizing the quality standard, which includes publishing and sharing it based on communications and knowledge mobilization plans. The knowledge mobilization plan introduces and promotes awareness of the new quality standard in the sector. Key aspects of this plan are the creation of supplementary resources and the encouragement of partners and QSAC members to champion the standard.

Proposed QSAC composition

The Quality Standards Advisory Committee (QSAC) acts as a topic-specific advisory committee to provide input and feedback on the Knowledge Institute's quality standard on levels of care throughout one cycle of the standard development process (The Knowledge Institute, 2022).

The primary objective of this QSAC is to provide input and feedback on the Knowledge Institute's quality standard on levels of care. They also provide feedback on accompanying indicators, implementation supports and knowledge mobilization efforts. QSAC members will also act as champions of the final standard in their communities and promote its uptake and implementation.

The committee will be made of 20-25 members, including two co-chairs, who are experts in their fields and represent diverse perspectives. Committee members will represent a spectrum of professions that study, implement, plan, provide services in and receive care in levels of care models. This includes clinician scientists, researchers, system and agency-leaders, service providers, young people and family members with lived or living experience. Young people and family members in the QSAC will be supported by Engagement Allies. A specific engagement process based on our Quality Standard for Youth Engagement and Quality Standard for Family Engagement will be carried out throughout the development of this standard.

We strive to create a QSAC that is representative of Ontario's diversity, including across geographic regions (e.g., Central, Western, Eastern and Northern Ontario, as well as Toronto); racial identities; sexual orientations and gender identities.

Proposed deliverables

- Quality Standard on Levels of Care
- Indicator framework
- Implementation resources
- Resources specific to young people and family members
- Knowledge mobilization planning
- Evaluation resources

References

Addictions and Mental Health Ontario. (2020). Snapshot: Recommendations for Ontario's mental health and addiction strategy.

Algonquin College. (n.d.). Pathways to care.

Australian Government Department of Health. (2019). PHN mental health flexible funding pool programme guidance: Stepped care.

Badesha, K., Wilde, S., & Dawson, D. L. (2023). Mental health mobile application self-help for adolescents exhibiting psychological distress: A single case experimental design. *Psychology and Psychotherapy: Theory, Research and Practice, 96*, 223– 248.

Berger, M., Fernando, S., Churchill, A. M., Cornish, P., Henderson, J., Shah, J., Tee, K., & Salmon, A. (2022). Scoping review of stepped care interventions for mental health and substance use service delivery to youth and young adults. *Early Intervention in Psychiatry, 16*(4), 327– 341.

Body Brave. (n.d.). Eating disorders and stepped care.

Boyd, L., Baker, E., & Reilly, J. (2019). Impact of a progressive stepped care approach in an improving access to psychological therapies service: An observational study. *PloS ONE, 14*(4): e0214715.

Bridge the Gapp. (n.d.). Stepped care in Newfoundland and Labrador.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*(7), 513.

Cappelli, M., Gray, C., Zemek, R., Cloutier, P., Kennedy, A., Glennie, E., Doucet, G., & Lyons, J. S. (2012). The HEADS-ED: A rapid mental health screening tool for pediatric patients in the emergency department. *Pediatrics, 130*(2), e321–e327.

Centre for Innovation in Campus Mental Health. (2019). Stepped care for post-secondary campuses toolkit: A promising model to improve access to mental health care on campus.

Centre for Innovation in Campus Mental Health. (n.d.). Stepped care approach.

Chan, S., Markoulakis, R., & Levitt, A. (2023). Predictors of barriers to accessing youth mental health and/or addiction care. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 32*(1), 27–37.

Cheese, T. (2023). Kids could have shorter wait times for autism diagnoses in Ontario, study suggests. CBC Toronto.

Child Health BC. (n.d.). Tiers of service.

Children's Mental Health Ontario. (2020). Kids can't wait: 2020 report on wait lists and wait times for child and youth mental health care in Ontario.

Children's Mental Health Ontario. (2022). Addressing urgent workforce challenges in child and youth mental health.

Children's Mental Health Ontario. (n.d.). Ontario's child and youth mental health agencies.

Chiu, M., Gatov, E., Fung, K., Kurdyak, P., & Guttmann, A. (2020). Deconstructing the rise in mental health-related ED visits among children and youth in Ontario, Canada. *Health Affairs, 39*(10).

Comeau, J., Georgiades, K., Duncan, L., Wang, L., Boyle, M. H., & 2014 Ontario Child Health Study Team. (2019). Changes in the prevalence of child and youth mental disorders and perceived need for professional help between 1983 and 2014: Evidence from the Ontario Child Health Study. *Canadian Journal of Psychiatry, 64*(4), 256–264.

Cornish, P. A., Berry, G., Benton, S., Barros-Gomes, P., Johnson, D., Ginsburg, R., Whelan, B., Fawcett, E., & Romano, V. (2017). Meeting the mental health needs of today's college student: Reinventing services through Stepped Care 2.0. *Psychological Services, 14*(4), 428–442.

Cost, K. T., Crosbie, J., Anagnostou, E., Birken, C. S., Charach, A., Monga, S., Kelley, E., Nicolson, R., Maguire, J. L., Burton, C. L., Schachar, R. J., Arnold, P. D., & Korczak, D. (2022). Mostly worse, occasionally better: Impact of COVID-19 pandemic on the mental health of Canadian children and adolescents. *European Child & Adolescent Psychiatry, 31*, 671–68.

Doery, E., Satyen, L., Paradies, Y., & Toumbourou, J. W. (2023). The relationship between cultural engagement and psychological well-being among Indigenous adolescents: A systematic review. *Journal of Cross-Cultural Psychology, 54*(1), 90–113.

Duncan, L., Georgiades, K., Reid, G. J., Comeau, J., Birch, S., Wang, L., & Boyle, M. H. (2020). Area-level variation in children's unmet need for community-based mental health services: Findings from the 2014 Ontario Child Health Study. *Administration and Policy in Mental Health and Mental Health Services Research, 47*, 665–679.

Edwards, J., Wang, L., Duncan, L., Comeau, J., Anderson, K. K., & Georgiades, K. (2022). Characterizing mental health related service contacts in children and youth: A linkage study of health survey and administrative data. *Child and Adolescent Psychiatry and Mental Health, 16*(48).

Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and facilitators to accessing mental healthcare in Canada for Black youth: A scoping review. *Adolescent Research Review, 5*, 115–136.

Fischer, B., Kurdyak, P., Goldner, E., Tyndall, M., & Rehm, J. (2016). Treatment of prescription opioid disorders in Canada: Looking at the 'other epidemic'?. *Substance Abuse Treatment, Prevention, and Policy, 11*(12).

Fisher, A., Rochesson, S. E. D., Mills, K. & Marel, C. (2022). Guiding principles for managing co-occurring alcohol/other drug and mental health conditions: A scoping review. *International Journal of Mental Health and Addiction*.

Foundry. (2023). Transforming access to care: Foundry's integrated youth services model.

Grant, S., Pederson, E. R., Hunter, S. B., Khodyakov, D., & Griffin, B. A. (2020). Prioritizing needs and outcomes for adolescent substance use treatment planning: An online modified-Delphi process. *Journal of Addiction Medicine, 14*(4), 83-88.

Halsall, T, Manion, I., & Henderson, J. (2018). Examining integrated youth services using the bioecological model: Alignments and opportunities. *International Journal of Integrated Care, 18*(4), 1–12.

Halsall, T., Manion, I., Iyer, S. N., Mathias, S., Purcell, R., & Henderson, J. (2019). Trends in mental health system transformation: Integrating youth services within the Canadian context. *Healthcare Management Forum, 32*(2), 51–55.

Haskell, R., Graham, K., Bernards, S., Flynn, A., & Wells, S. (2016). Service user and family member perspectives on services for mental health, substance use/addiction, and violence: A qualitative study of their goals, experiences and recommendations. *International Journal of Mental Health Systems, 19*(9), 1-14.

Health Quality Ontario. (2017). Quality standards: Process and methods guide.

Health Standard of Canada. (2021). Integrated people-centred health systems.

Heid, O., Khalid, M., Smith, H., Kim, K., Smith, S., Wekerle, C., The Six Nations Youth Mental Wellness Committee, Bomberry, T., Hill, L. D., General, D. A., Green, T. J., Harris, C., Jacobs, B., Jacobs, N., Kim, K., Looking Horse, M., Martin-Hill, D., McQueen, K. C. D., Miller, T. F... Wekerle, C. (2022). Indigenous youth and resilience in Canada and the USA: A scoping review. *Adversity and Resilience Science, 3*, 113–147.

Henderson J. L., Cheung, A., Cleverley, K., Chaim, G., Moretti, M. E., de Oliveira, C., Hawke, L. D., Willan, A. R., O'Brien, D., Heffernan, O., Herzog, T., Courey, L., McDonald, H., Grant, E., & Szatmari. (2017). Integrated collaborative care teams to enhance service delivery to youth with mental health and substance use challenges: Protocol for a pragmatic randomised controlled trial. *BMJ Open, 7*, e014080.

Knowledge Institute on Child and Youth Mental Health and Addictions. (2022). Standard development process - Brief.

Knowledge Institute on Child and Youth Mental Health and Addictions. (2023). Priorities in substance use and addictions services for young people in Ontario.

Kulkarni, C., Khambati, N., Sundar, P., Kelly, L., Summers, N. & Short, K. (2019). Beyond building blocks: Investing in the lifelong mental health of Ontario's three- to six-year-olds. Ontario Centre of Excellence for Child and Youth Mental Health.

Kurzawa, J., Lucente, G., Danseco, E. & Sundar, P. (2021). We journey together: How Ontario's child and youth mental health agencies are addressing racial equity [Final Report]. Knowledge Institute on Child and Youth Mental Health and Addictions.

Marchand, K., Fogarty, O., Pellatt, K. M., Vig, K., Melnychuk, J., Katan, C., Khan, F., Turuba, R., Kongnetiman, L., Tallon, C., Fairbank, J., Mathias, S., & Barbic, S. (2022). "We need to build a better bridge": Findings from a multi-site qualitative analysis of opportunities for improving opioid treatment services for youth. *Harm Reduction Journal, 19*(37).

Markoulakis, R., Cader, H., Chan, S., Kodeeswaran, S., Addison, T., Walsh, C., Cheung, A., Charles, J., Sur, D., Scarpitti, M., Willis, D., & Levitt, A. (2023). Transitions in mental health and addiction care for youth and their families: a scoping review of needs, barriers, and facilitators. *BMC Health Services Research, 23*, 470.

Mental Health Commission of Canada, Stepped Care Solutions, & Government of Northwest Territories. (2023). Partnering together for person-and-family centric care: The Northwest Territories Stepped Care 2.0 final report.

Mental Health Commission of Canada. (2012). Changing directions, changing lives.

Mental Health Commission of Canada. (2016). The mental health strategy for Canada: A youth perspective.

Mental Health Commission of Canada. (2018). Expanding access to psychotherapy: Mapping lessons learned from Australia and the United Kingdom to the Canadian context.

Mental Health Commission of Canada. (2020a). Clients and providers get behind Stepped Care 2.0.

Mental Health Commission of Canada. (2020b). Early childhood mental health: "What we heard" — Report summary.

Mood Disorders Society of Canada. (n.d.). What's happening in the youth mental healthcare system? The stepped care approach.

Mughal, S., Salmon, A., Churchill, A., Tee, K., Jaouich, A., & Shah, J. (2022). Guiding principles for implementing stepped care in mental health: Aligning on the bigger picture. PsyArXiv Preprints.

Munter, A. (2023). Munter: Pediatric innovations just might save public health care. *Ottawa Citizen*.

Ontario Centre of Excellence for Child and Youth Mental Health. (2021a). Quality standard for family engagement.

Ontario Centre of Excellence for Child and Youth Mental Health. (2021b). Quality standard for youth engagement.

Ontario Ministry of Health. (2020). Roadmap to wellness: A plan to build Ontario's mental health and addictions system.

PHN South Western Sydney. (n.d.). What is stepped care for mental health?

Radomski, A., Cloutier, P., Gardner, W., Pajer, K., Sheridan, N., Sundar, P., & Cappelli, M. (2022). Planning for the mental health surge: The self-reported mental health impact of COVID-19 on young people and their needs and preferences for future services. *Canadian Journal of Community Mental Health, 41*(1), 46-61.

Rush, B. & Saini, B. (2016). Review of coordinated/centralized access mechanisms: Evidence, current state, and implications. Report submitted to the Ontario Ministry of Health and Long-Term Care.

Rush, B. (2010). Tiered frameworks for planning substance use service delivery systems: Origins and key principles. *Nordic Studies on Alcohol and Drugs, 27*(6), 617-636.

Schantl, S. F., & Wagenhofer, A. (2021). Principles-based versus rules-based accounting standards: A relevance-enforceability tradeoff. Columbia University.

School and Community System of Care Collaborative. (2022). Right time, right care: Strengthening Ontario's mental health and addictions system of care for children and young people.

Settipani, C. A., Hawke, L. D., Virdo, G., Yorke, E., Mehra, K., & Henderson, J. (2018). Social determinants of health among youth seeking substance use and mental health treatment. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 27*(4), 213–221.

Shah, J., Salmon, A., Churchill, A., & Tee, K. (2021). Stepped care, an emerging service model in youth mental health [PowerPoint Presentation]. Frayme.

Shaligram, D., Skokauskas, N., Aragones, E., Azeem, M. W., Bala, A., Bernstein, B., Cama, S., Canessa, L., Silva, F. D., Engelhard, C., Garrido, G., Guerrero, A. P. S., Hunt, J., Jadhav, M., Martin, S. L., Miliauskas, C., Nalugya, J., Nazeer, A., Ong, S. H., ... Leventhal, B. (2022). International perspective on integrated care models in child and adult mental health. *International Review of Psychiatry, 34*(2), 101-117.

Sheikhan, N. Y., Henderson, J. L., Halsall, T., Daley, M., Brownell, S., Shah, J., Iyer, S. N., & Hawke, L. D. (2023). Stigma as a barrier to early intervention among youth seeking mental health services in Ontario, Canada: A qualitative study. *BMC Health Services Research, 23*(86).

The Child and Youth Mental Health Lead Agency Consortium. (2021). Better together: Strengthening the Ontario mental health and addictions system for children, youth and their families.

Thunderbird Partnership Foundation, Assembly of First Nations, & Indigenous Services Canada. (2011). Honouring our strengths: A renewed framework to address substance use issues among First Nations People in Canada. Health Canada.

Tobon, J. I., Reid, G. J., & Brown, J. B. (2015). Continuity of care in children's mental health: Parent, youth and provider perspectives. *Community Mental Health Journal, 51*, 921-930.

Turuba, R., Amarasekera, A., Howard, A. M., Brockmann, V., Tallon, C., Irving, S., Mathias, S., Henderson, J., Marchand, K., & Barbic, S. (2022). A qualitative study exploring how young people perceive and experience substance use services in British Columbia, Canada. *Substance Abuse Treatment, Prevention, and Policy, 17*(43).

Wolf, R.T., Puggaard, L.B., Pedersen, M.M.A., Pagsberg, A. K., Silverman, W. K., Correll, C. U., Plessen, K. J., Neumer, S.-P., Gyrd-Hansen, D., Thastum, M., Bilenberg, N., Thomsen, P. H., & Jeppesen, P. (2022). Systematic identification and stratification of help-seeking school-aged youth with mental health problems: a novel approach to stage-based stepped-care. *European Child & Adolescent Psychiatry, 31*, 781–793.

Appendix A. Notable gaps and challenges

Through the literature and in our consultations, we found notable gaps and criticisms in the way levels of care models are structured and implemented, especially for children and young people. These include:

- Lacking a complete continuum of care.
- Insufficient collaboration and partnerships.
- Challenges addressing concurrent disorders.
- Difficulty matching to appropriate care.
- Difficulty achieving structure vs. rigidity.
- Challenges addressing social determinants of health.
- Obstacles to providing developmentally appropriate care.

Lacking a complete continuum of care

Levels of care models rely on having a complete continuum of care ranging from low-intensity care, such as self-help resources and peer support groups, to high-intensity care, including acute and crisis interventions. All of these care options are also considered to be of equal value (Thunderbird Partnership Foundation et al, 2011). From our literature review and consultations, we heard that the inclusion of universal health promotion and informal supports at the lower levels of intensity are missing from current levels of care models. On the other end of the continuum, children and young people face barriers accessing high-intensity levels of care, including acute crisis care and live-in treatment. Agencies providing live-in treatment often have long wait lists, are sparsely located across vast geographic regions, and require transportation to receive care. The availability and accessibility of varying intensities of care across different settings are important to meet children, young people, and their families where they are at, in their communities and in their readiness for care.

However, not all communities have the resources and capacity to create a system that provides a complete continuum of care. This is particularly a challenge in Northern, rural, and remote communities, where there are fewer agencies and resources (Duncan et al., 2020; Mental Health Commission of Canada, 2018).

Insufficient collaboration and partnerships

Levels of care models are most effective and efficient when the care types, their intensities, and the pathways to accessing care are mapped across other community-based agencies and agencies in related sectors, including education and primary care. Mapping and coordinating care require agencies and sectors to work together and coordinate their efforts (Cornish et al., 2017; Edwards et al., 2022; School and Community System of Care Collaborative, 2022). From our consultations and review of the literature, we identified challenges to establishing relationships and partnerships, including:

- Siloed systems that are fragmented along funding, mandate, and policy lines (Knowledge Institute, 2023; Sheikhan et al., 2023).
- A lack of common definitions of services and understanding of roles across agencies and sectors (Rush, 2010).
- Minimal awareness of other programs and services in the community, which can impede relationship-building and coordination of services.

These challenges inhibit seamless movement between levels of care and care settings, which can be burdensome to children, young people and their family members.

Challenges addressing concurrent disorders

Children and young people with concurrent mental health, substance use health, and addictions needs are particularly vulnerable and can have complex needs. Through our recent needs assessment of substance use health and addictions care for children and young people in Ontario, we learned that mental health, substance use health, and addictions care are siloed, leaving children and young people to move between mental health settings and substance use health and addictions settings without receiving the concurrent care that they need. Additionally, feedback revealed a lack of concurrent mental health, substance use health and addictions services (Chan et al., 2023; Knowledge Institute, 2023), including lower-level intensity of care for individuals with substance use disorders (Fischer et al., 2016). Levels of care models have been recommended to ensure the system is using resources more efficiently to provide the most appropriate care to individuals with substance use health and addictions needs (Addictions and Mental Health Ontario, 2020; Fischer et al., 2016).

Difficulty matching to appropriate care

Matching children and young people to the appropriate level of care is an essential component to levels of care models. In our review of the literature and consultations, we identified:

- A lack of consensus between clinicians, researchers, and young people and family members on what is most appropriate to consider when matching a young person to the level of care that best fits their needs (Grant et al., 2020). Several factors have been suggested to match a young person to a specific level of care: mental health diagnosis, severity of symptoms, assessing risk of suicidality, harm to self and to others, and risk of psychosis (Berger et al., 2022; Grant et al., 2020).
- A lack of culturally responsive assessments that capture the strengths and needs of young people from equity deserving communities.
- Inconsistencies in considering the preferences and opinions of young people, and a lack of collaboration between them and their service providers which can lead to tension and disagreements between everyone involved.
- Organizational challenges, including buy-in from service providers who may feel burdened finding a balance between assessments that are comprehensive, but also brief and do not impede relationship building with their clients.

Without guiding principles, matching criteria and processes vary considerably and are not always youth centred.

Difficulty achieving structure vs. rigidity

Developing a well-structured levels of care model supports coordination and navigation of services for system planners, agency leaders, service providers, young people and family members (Mughal et al., 2022). To this end, levels of care models often define the different levels of services that are available, who is responsible for providing services, and the clients who may be best served in each level of care (Berger et al., 2022). However, there's concern among system leaders and clients that levels of care models can become rigid and can fail to accurately represent the experiences of individuals with mental health (Mughal et al., 2022) and substance use health concerns. In some instances, levels of care models can be so operationalized that it can feel exclusionary. Although stepped care models are often visualized as "steps", this imagery does not always resonate with family members (Shah et al., 2021), as well as system and

agency leaders. Levels of care model should most importantly reflect the strengths and needs of children, young people and their families; overly rigid models can unnecessarily exclude children and young people from the care that they need.

Challenges addressing social determinants of health

Different factors in the lives of children and young people can impact their health and well-being, as well as their access and engagement in care for mental health, substance use health and addictions concerns (Settipani et al., 2018). When young people and families struggle with housing, money, and access to food, it's difficult for them to stay healthy while they face additional barriers to care (e.g., costs of services, transportation, technology equity). Findings indicate that many young people seeking care for mental health and substance use disorders experience at least one problem with social determinants of health and these experiences negatively impact their ability to engage in care. Financial problems are particularly prevalent and are related to other problems with social determinants of health, including food and housing security (Settipani et al., 2018). These concerns need to be addressed in order to support children, young people and their families to be fully engaged in their care and have the best outcomes. In a levels of care model, communities can address social determinants of health through partnerships across agencies and sectors.

Young people from equity deserving communities, including Black, Indigenous and 2SLGBTQIA+ communities, experience additional barriers of care, such as stigma and microaggressions (Edwards et al., 2022; Fante-Coleman & Jackson-Best, 2020; Sheikhan et al., 2023). Agencies recognize the importance of culturally responsive and identity affirming care through organizational practices that promote health equity. However, there are areas of improvement in Ontario's CYMHA sector to implement organizational practices, including a lack of:

- Culturally responsive and identity affirming care that is anti-racist and culturally safe.
- Co-development of services with equity-deserving communities.
- Collection and analysis of health equity data (Kurzawa et al., 2021).

Current mental health and addictions care doesn't always account for social determinants of health and systemic oppression of children and

young people from equity-deserving communities. As a result, access to and outcomes of care are not equitable. This has implications for levels of care models, which are driven and comprised of the organizational culture, practices and services already available in communities.

Obstacles to providing developmentally appropriate care

Developmentally appropriate considerations are important when creating and implementing levels of care models, including how young people can access support (e.g., chat, phone, or in-person; Badesha et al., 2023; Berger et al., 2022; Cornish et al., 2017). While children and young people across developmental stages face similar challenges in accessing care (physically and financially) and all could benefit from more coordinated access to care, they also experience their own unique challenges.

Considerations for infants and children under the age of six are often neglected or misunderstood among families, service providers and communities (Mental Health Commission of Canada, 2020b). Literature and consultations provided minimal evidence related to the inclusion of care for infants and children. In comparison, concerns among transition-aged youth are more well known but are still complex and a challenge for the sector. Mental health and addictions services for transition-aged young people often transfer them to the adult system when they reach a certain age, regardless of their developmental readiness (Markoulakis et al., 2023). The transition from the youth to the adult system can be challenging and disjointed. The involvement of families drastically diminishes as the young person is expected to become completely independent.

These challenges are further compounded by a lack of literature on youth-specific models of levels of care. Existing literature varies across geographic locations, settings, types of interventions, and mental health and addictions concerns being addressed, making it difficult to make comparisons and draw conclusions for future directions (Berger et al., 2022). The structure and implementation of levels of care need to be guided by developmental considerations so that children and young people can access the right care and thrive in their communities.

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cymhaon

695 Industrial Avenue, Ottawa, Ontario K1G 0Z1

– 1 613 737 2297

– 1 613 738 4894

EN – cymha.ca

FR – smdej.ca