
Characteristics, Interventions, and Integrated Care Mechanisms of Effective Stepped Care Models: A Systematic Review

Session 6J, 26th International Conference on Integrated Care (ICIC26), Birmingham, UK
14 April 2026

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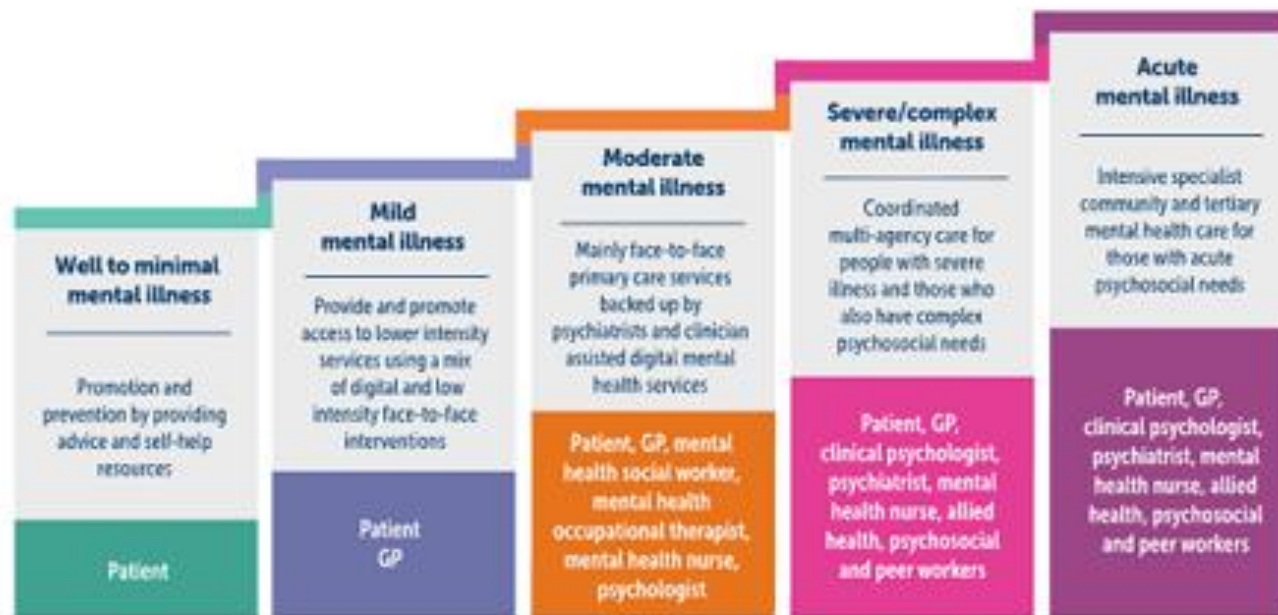
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Background

- Mental health conditions are growing globally
- Serious barriers exist in accessing mental health care. Care is fragmented, ever more expensive, and patients face treatment delays due to the lack of available care
- Stepped care has been advocated to improve accessibility, coordination and outcomes
- Large gaps remain in understanding how stepped care can be adapted in different contexts, for a range of population cohorts, and to support real-world implementation
- This review sought to identify the core components and mechanisms influencing the effectiveness of stepped care models for adults with mental health conditions

Stepped Care Models in Mental Health



Caption Fig 1. Schematic summary of the five levels of the National PHN Guidance for Initial Assessment and Referral for Mental (PHN Murray, 2025)

- Stepped care models (SCM) provide stratified, patient-centred treatment that adapts dynamically to ongoing clinical assessment.
- By systematically matching intervention intensity to individual needs—beginning with the least intensive yet effective options—these models aim to maximise resource efficiency, reduce wait times, and optimise care and outcomes

Stepped Care Model Types

Model Types	Description
Progressive	The clients usually allocated to begin with at the lowest level of care within the model structural hierarchy and progress to the next after step completion based on a progress assessment.
Stratified	The client is allocated to a step of care within the model structural hierarchy according to his health needs based on an initial assessment of the intensity of their needs.
Sequential	The client is allocated to a step of care within the model structural hierarchy according to his health needs based on an initial assessment of suitable therapy type (psychological, pharmacological) or modality (CBT or interpersonal therapy).
Adaptative	The client can switch between steps or add treatments from different steps usually within sequential stepped care structures.
Collaborative	The client is allocated to a case manager or more complex interdisciplinary team that can select, coordinates or provide different interventions according to level of needs.

Research Aim

Identify the key components of effective stepped care models for adults with mental health conditions across various settings, including core features, interventions, and supportive mechanisms. Specifically, it sought to

1. Delineate key model characteristics and configurations;
2. Map therapeutic and coordination interventions across stepped care levels;
3. Identify mechanisms facilitating implementation, integration, and stakeholder engagement;
and
4. Appraise evaluation metrics for model effectiveness.

Methodology

A systematic review methodology was employed to identify published articles and grey literature

Eligible studies focused on adults aged 18–64 with diagnosed or subsyndromal mental health disorders, also including care provided for those presenting with co-occurring physical or comorbid conditions.

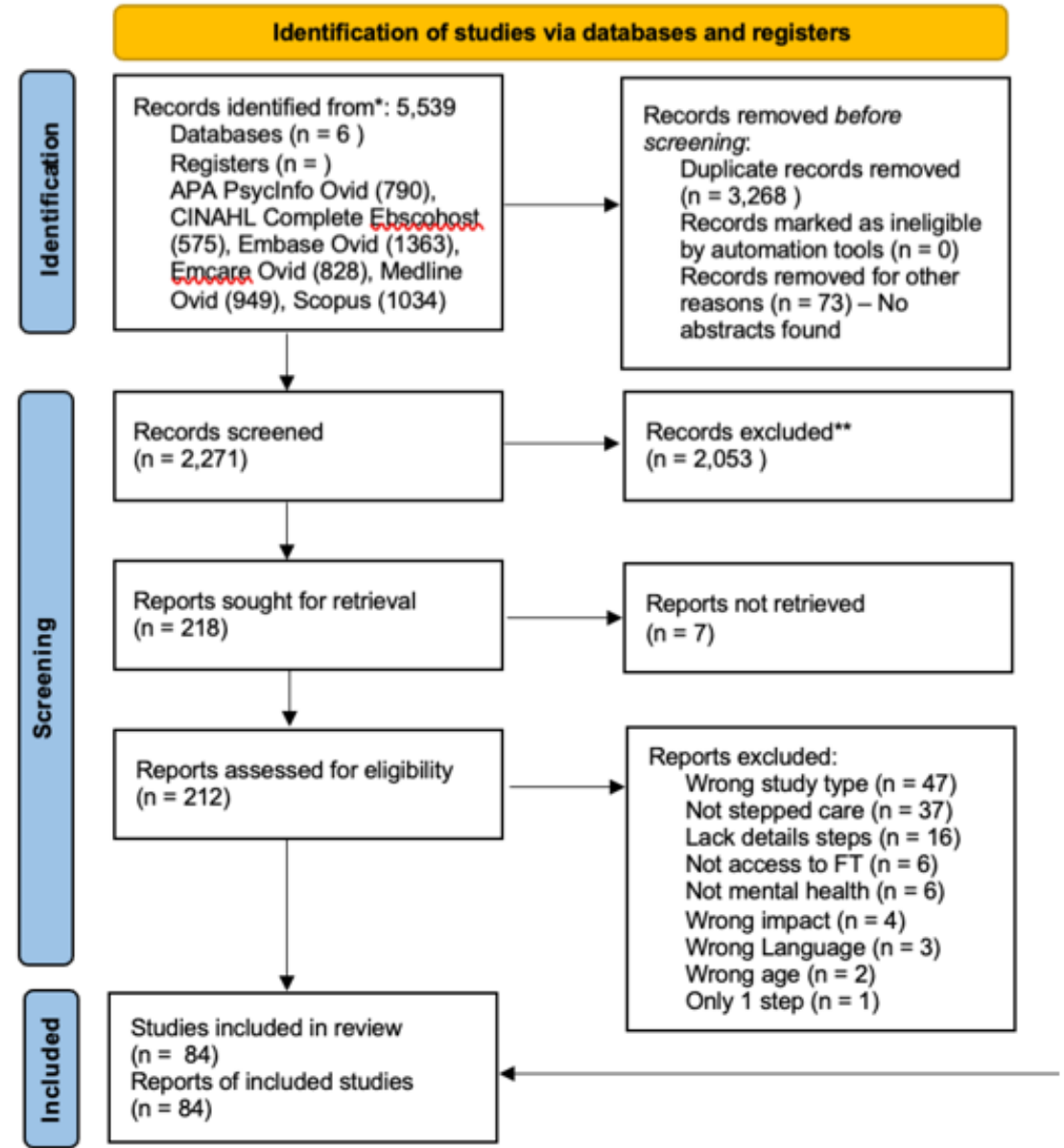
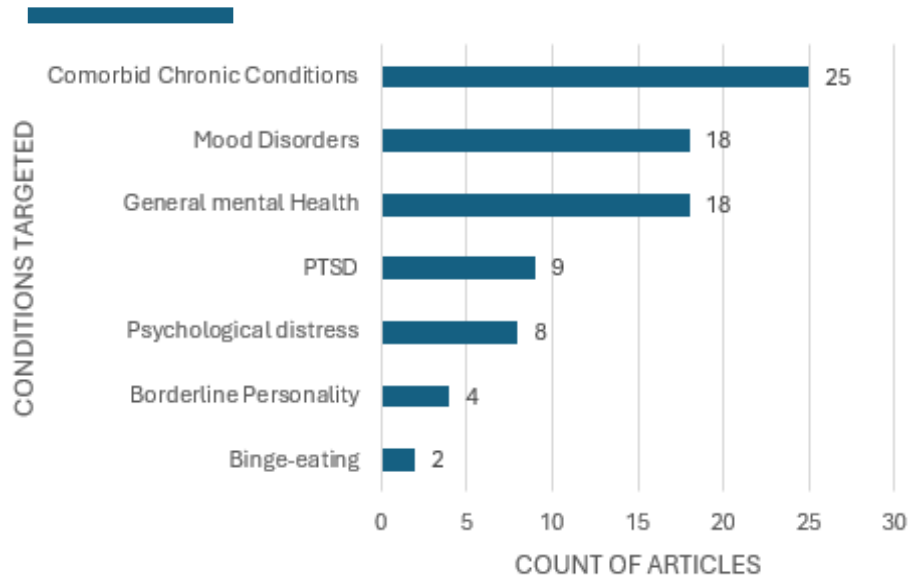
Only studies in which stepped care was a central, explicitly described model for mental health care services were included.

Inclusion and Exclusion Criteria

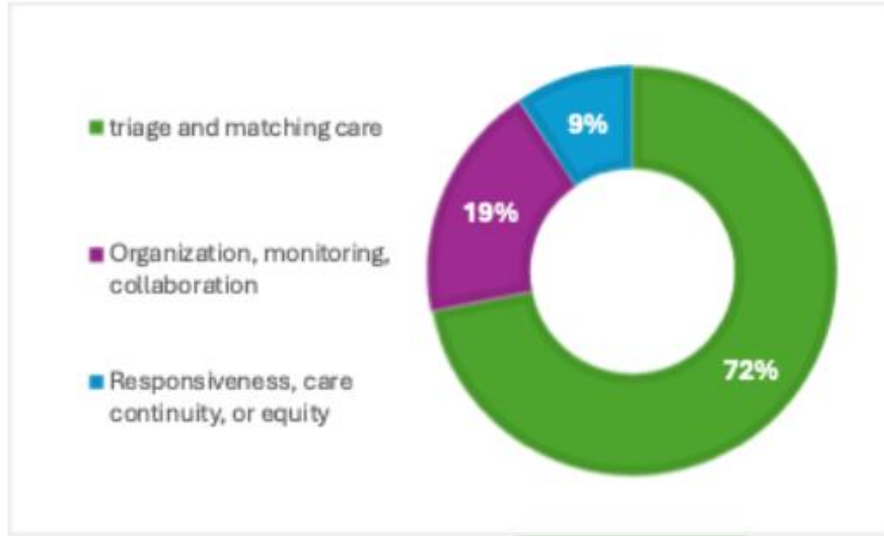
PICO	Inclusion Criteria	Exclusion criteria
Population	18 to 64 years (> 50 % sample) and individuals with mental health disorders- subsyndromal presentations, or seeking to improve their mental health, with or without comorbid conditions.	> 18 years <u>or</u> <65 and individuals without a mental health condition or not looking to improve their mental health.
Intervention	SCM explicitly described as such with a minimum of 2 treatment steps with different intensity levels.	Not stepped care, single-level, or no details regarding steps or steps or their integration.
Comparison	Traditional, previous care, no comparison, alternative interventions or waiting lists.	Not applicable – not comparative studies included.
Outcomes	Outcomes directly related to the SCM studied.	Outcomes not-directly related to <u>the SCM</u> .
Study Type	Original primary studies that had participants in real world settings, or secondary analyses studies using regression analyses or predictive modelling.	Studies without participants in real world settings or secondary analyses studies not using regression analyses or predictive modelling.
Other	Published between 2015 to 2025 in English, Spanish or French	Published before 2015 or in English, Spanish or French

Results

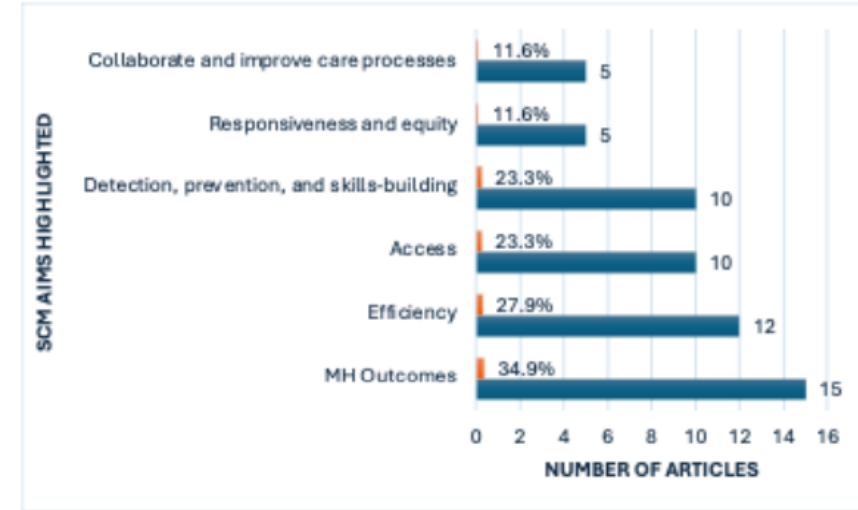
- 84 included articles for review
- Evaluation method
 - 60 quantitative or which 37 RCTs
 - 17 qualitative
 - 7 mixed methods
- Context and setting
 - 82% developed countries
 - 44% in primary & community care
 - 30% hospital based
 - 19% telehealth



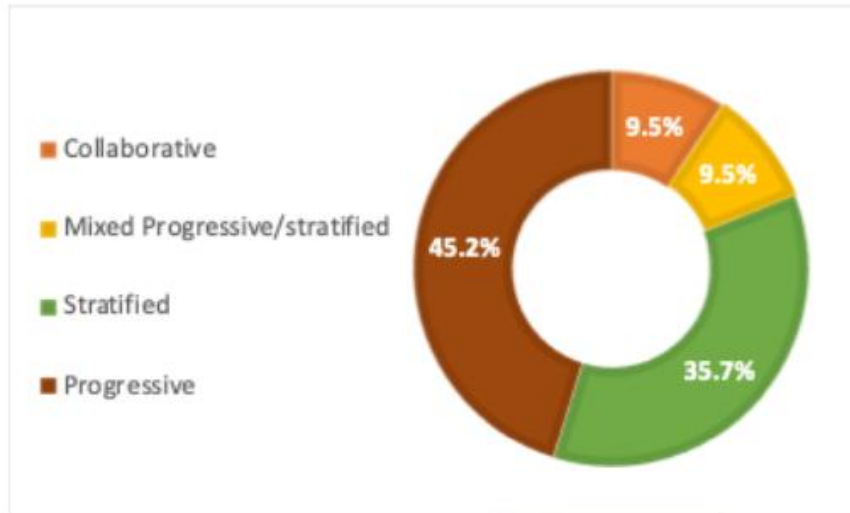
Stepped Care Models Conceptualisations



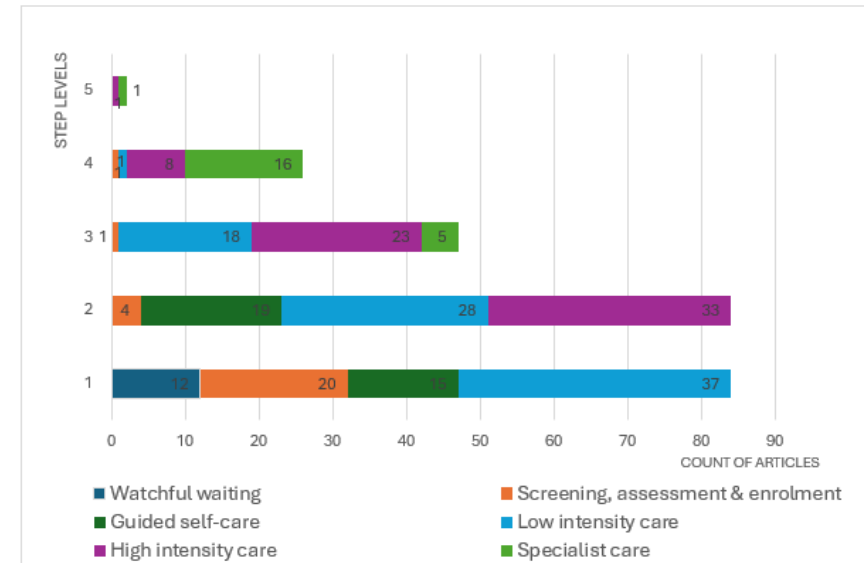
Rationale of Stepped Care Models



SCM Structural Types



Core components of the stepped care models by level of care (n=84)



Interventions and Steps

	STEP 1 Watchful Waiting	STEP 2 Screening, Assessment & Enrolment	STEP 3 Guided Self-Care	STEP 4 Low Intensity Care	STEP 5 High Intensity Care	STEP 6 Specialist Care
Prevalence	12/84 studies.	26/84 studies [1]	34/84 studies	All 84 studies.	65/84 studies.	22/84 studies
Purpose	To monitor people potentially at risk of depression or anxiety	To identify patients that might benefit from stepped care, assess their level of need and enrol them in services.	To support people with self-guided information and tools to self-manage their stress or anxiety or improve their levels of wellbeing.	To directly provide accessible, structured and time-limited treatment to maintain symptoms and/or ability to cope. Used when a patient's condition worsened or did not improve in Step 3, or as step-down from Step 5	To directly provide accessible, structured and time-limited treatment to reduce mental health needs and support recovery. Includes patients whose condition worsened or did not improve during Step 4 [2]	To directly provide ongoing specialist care, including to those whose condition worsened or did not improve during Step 5 [3]
Target	Patients with low-risk conditions	Patients identified at-risk of, or with probable mental health problems	Patients assessed with sub-threshold depression or low to moderate needs	Patients assessed with low to moderate mental health needs	Patients assessed with moderate to severe mental health needs	Patients assessed with severe or very severe mental health needs
Description of typical interventions	Patients at risk of mood disorder or distress are monitored over time. This often under the care of a nurse or GP in primary care settings, or for patients presenting with co-morbid conditions such as cancer and diabetes.	Patients identified, or self-referring, with a probable mental health issue are screened using standard tools. Eligible clients are offered stepped care support. Education and awareness raising of mental health and its treatment is provided.	Patients gain self-directed access to information libraries, self-help guides (such as computerized CBT), and self-directed courses using various written and web-based formats. Direct support from a mental health professional is usually not provided.	Patients are supported by a mix of guided self-help tools, group/peer support, and behavioral activation exercises, both face-to-face and on-line. Often delivered by trained staff without formal mental health qualifications using a manualized approach.	Patients gain intensive provision of personal and individualized support, incorporating CBT and other psychotherapies. Usually led by qualified mental health professionals (e.g. mental health nurses, psychologists).	Psychiatrists and other specialist mental health professionals provide ongoing care and support.

Notes: [1] Screening, assessment and enrolment were activities prevalent in all studies but not formally included in the design of most programs, where the first step was to a treatment level. This step was often used to stratify patients by levels of need and was sometimes repeated as a follow-up after low- or high-intensity care. [2] Some programs developed additional high-intensity steps for those identified as needing ongoing support (e.g. Stoop et al, 2015). [3] No studies indicated a step-down process for patients with severe needs when in recovery.

Outcomes_ 1

Clinical and provider experiences

- Reported in 22/84 studies
- 17/22 were qualitative studies
 - 7/17 reported high levels of client acceptability and satisfaction, specifically access to, and engagement with, low-intensity care and guided self-care support where therapeutic value welcomes
 - 8/17 reported 'mixed' outcomes, with negative aspects on the ability access and navigate stepped care models, and the need for better trained staff, more personalized and culturally responsive care
- 5/22 were RCTs,
 - 2/5 reported 'no difference'
 - 3/5 reported a 'positive' difference, but not statistically significant

System effectiveness

- Reported in 15/84 studies
- 13/15 economic evaluations, 12 of which embedded in an RCT
 - 11/15 reported significant positive impact on costs for stepped care vs care as usual, of which 7/11 reported significant cost savings
 - 2/15 found negative results, potentially attributed to treating clients in higher-intensity cohorts

Outcomes_ 2

Clinical and functional outcomes

- Reported in 47/84 studies
- Range of methods:
 - 26 RCTs, 16 quantitative studies of various designs. 5 qualitative
- Range of measurement tools:
 - 30 different PROMs tools – PHQ9, HAD & HRQoL most common
- Wide range of client groups:
 - Anxiety/depression (n=10), cancer (n=10), general mental health (n=7), psychological distress/panic (n=5), comorbid conditions (n=4), PTSD (n=3), other (n=8)
- Selected outcomes from RCTs:
 - 12/26 RCTs examining depression symptoms had a positive impact versus care as usual, of which 9/12 statistically significant
 - 6/7 RCTs examining stress and anxiety outperformed care as usual, with 4/6 statistically significant
- Selected outcomes from other studies:
 - 10/21 studies on depression symptoms of which 6/10 reported improvements and 4/10 no change
 - 9/21 studies on anxiety of which 5/9 reported improvements and 4/9 no change
 - 10/21 studies on quality of life of which 7/10 reported positive outcomes, but 3/10 did not
 - All 4 comorbidity studies described positive outcomes, such as concern with pain and reduced fear of cancer and cancer fatigue

Key Barriers and Facilitators to the Implementation of Stepped Care

Barriers	Facilitators
<p>Patient level</p> <ul style="list-style-type: none"> - Demanding requirements and content of stepped care support - Too short an intervention timeframe - Perceived restriction of access to specialist care and to one-to-one care support - Physical and cognitive barriers to use of telephone and internet-based models - Cost of care / reimbursement - Stigma / fear of judgement - Medication concerns - Transportation - Mistrust / lack of awareness - Language barriers <p>Professional level</p> <ul style="list-style-type: none"> - Staff burden - Difficulties in fitting stepped care into existing workflows, including new referral processes and bureaucracy - Lack of awareness and low motivation of non-mental health clinicians (e.g. GPs) to participate - Inability to see clear benefits - Lack of readiness for change - Lack of cultural awareness <p>System-level</p> <ul style="list-style-type: none"> - Limited resource capacity and staffing - Restrictions in access to therapy provision, especially in rural areas - Lack of trained personnel and/or appropriately trained nurses and health workers - Insufficient training in the stepped care model organisational processes 	<p>Patient level</p> <ul style="list-style-type: none"> - Regular feedback on progress to support gaining control over treatment - Appealing content – well-structured and easily accessible - Opportunity for self-directed care - Ease of access / well-coordinated processes - Personalized rather than generic - Trusted relationships / relational continuity - Confidentiality - Supportive environment <p>Professional level</p> <ul style="list-style-type: none"> - Investment in professional and organizational preparedness for change - Dialogue with patients to explain the process of care using personal calls and open communication - GPs and other professional staff with a special interest in depression / understanding of mental health issues <p>System-level</p> <ul style="list-style-type: none"> - Manualized guidance to support lower cost health workers / non-mental health professionals effectively deliver care - Availability of training and professional development programs - Engagement with community to consult and/or use codesign approaches - Investment in staff resources and capabilities

Implementation issues

- Only 4/84 studies reported using a framework to develop a theory of change (TOC) to guide the development of their stepped care model (NPT, RE_AIM, CFIR, EPIS)
- *Collaborative co-design* was observed as a facilitating factor in just 12/84 studies
- *Evidence-based stepped care* was explicitly identified in just 13/84 studies, primarily for mood disorders
 - English NHS' Improving Access to Psychological Therapies (IAPT)
 - WHO's Doing What Matters in Times of Stress (DWM) and Problem Management Plus (PM+)
- Studies using TOC reported high levels of acceptability, use and appropriateness

Overall Impact _ A Question of Equity

- Stepped Care Models in this review demonstrated promise in alleviating symptoms of anxiety, depression, psychological distress and PTSD
- Outcomes usually matched or excelled care as usual, but were most effective for people with low-to-moderate needs and less adaptable to complex and high-needs populations
- Considerable limitations exist concerning responsiveness, client engagement and equity
- 'Effective' stepped care models were driven by resource and capacity concerns, rather than an effort to improve the equity of access to psychological therapies
- Clients with higher levels of need were typically 'screened out', as were clients with socio-economic vulnerabilities _ potentially perpetuating the 'inverse care law' where those populations with the greatest mental health need receive the least access

Implications for Policy and Practice

- There is no 'one model'. Standardization of SCMs must be balanced with flexibility and personalization.
- The drive for cost-efficiencies should not come at the expense of discrimination against vulnerable groups.
- Complex clients facing trauma and socio-economic disadvantage, as well as high-intensity users should be included given the likelihood of benefit
- Increased co-production with clients is needed to ensure design and delivery aligns with end-user needs and priorities.
- Proponents of SCMs need to realize that mental health recovery is not a linear process. Attention to the wider psycho-social causes of mental health and wellbeing is required.



Suggestions for Future Research

- Evaluations are challenged in drawing precise conclusions on the impact of SCMs. The variability and limitations to current research, and research quality, requires attention to:
 - Framing SCMs as complex interventions to provide specific, transparent reporting on contextual, intervention and implementation variables following guidelines for complex interventions
 - Documenting stepped care intervention process to understand how they interact within the context of their delivery
 - Expanding outcome measurement beyond symptom reduction to include client empowerment and engagement, recovery, and reductions in inequalities

Conclusions

1. SCMs in mental health demonstrate the capacity for positive outcomes across varied design and context
2. Adaptive, context-driven, delivery is a likely determinant of effectiveness
3. There is a need to balance cost containment with improving access to psychological therapy
4. Inequalities in access to care to vulnerable populations and high-intensity users needs to be addressed
5. Standardization must be balanced with flexibility and personalization
6. Meaningful co-production with end-users is required to enhance the relevance and potential impacts of SCMs
7. Future research should embrace complexity and prioritize rigorous reporting

