Shaping Care, Shaping Us: A Systemic Analysis of Mental Health Service Models and Professional Identity in Canada

by

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Dedication

To my constant and beloved wife, Stefani, of 26 years, with gratitude for grounding me in the truth that all good work emerges in a life, not in isolation.

Abstract

This capstone critically examines the ideological, structural, and ethical forces shaping access to contemporary mental health care, with particular attention to the expansion of stepped and stratified care, digital platforms, and metrics-driven governance shaped by neoliberal policy environments. Drawing on global health history, international research, and critical policy analysis, the project traces how mental health systems have shifted from the principles of Comprehensive Primary Health Care toward Selective Primary Health Care, replacing universal, needs-based, and publicly accountable models with efficiency-driven frameworks that often constrain equitable access. Central to this analysis is the counsellor's role: the paper considers how professional choices about practice settings, modalities, collaboration, and whose work is recognized may contribute to hierarchies, fragmentation, elitism, and privatization drift towards a two-tier system, and how counsellors might choose differently to foster more inclusive and equitable care. The capstone highlights tensions between evidence-based standardization and foundational public health values of equity, universality, participation, and client-centered care, illustrating how counsellors can actively navigate these pressures to create meaningful change. It also acknowledges that public–private partnerships (P3s) increasingly form the backdrop for contemporary mental health modalities, inviting reflection on how counsellors ethically navigate the tensions these structures produce. By reframing stepped care within a values-driven, access-oriented framework, the project argues for aligning system design with ethical commitments and for strengthening the profession's role in advancing equitable, community-centered practice.

Keywords: mental health care systems, neoliberalism, comprehensive primary health care, stepped care, access, equity, counsellor practice

Table of Contents

Abstract 3

Chapter 1: Introduction 7

- Purpose Statement 9
- Contribution to the Field 10
- Reflectivity and Positionality Statement 11
- Theoretical/Conceptual Framework 13
- Definition of Terms 15

Chapter 2: Literature Review 18

- Overview 18
- Mapping the Canadian Mental Health Service Landscape 19
  - Publicly Funded Services 19
  - Privately Funded Services 20
  - Public-Private Partnerships (P3s) 21
- Canada's National Health Insurance Framework 24
- Origins and Conceptual Logic of Stratified and Stepped Care 28
  - Staging and Stepped Care 28
  - Biomarkers and Stratified Care 29
- Stratified and Stepped Models in Action 30
  - Stratified Care Models 30
  - Stepped Care Models 34
- Artificial Intelligence and Digital Technologies in Mental Health 41
- Integration of AI in Digital Health Systems 41

Prevalence of AI and Digital Systems in Stepped Care 43
AI and Digitized Stepped Care for Adults 43
AI and Digitized Stepped Care for Children and Youth 46
WHO-Led Digital and AI-Supported Stepped Care Interventions....48
Limitations of Stepped Care....49
Public-Private Partnerships and Digital Innovation 50
Principles for Digital Health Governance in Stepped Care....52
Origins and Principles of Primary Health Care....54
Neoliberalism 55
Neoliberalism Influence in Health care Policy and Funding Arrangements 57
Parallels in Stepped Care and Neoliberalism 58
Evidence-Based Therapy: “Gold Standard” or Neoliberal Subterfuge? 61
Questioning the Motivations and Rationale for EBT 61
Methodological and Structural Biases in EBT 62
Rebuilding Health care on Foundational Values....64
Competing Value Systems in Health care Delivery 64
Philosophical Worldviews: Cnidus vs. Cos 64
Re-Aligning Stepped Care with the Principles of Health 65
Recovery-Based Model of Stepped Care 67
Task Shifting and Task Sharing in Stepped Care....71
Conclusion....75
Chapter 3: Discussion....77
Situating the Research Question 77
Ethics....85

Applications 91

Chapter 4: Conclusion 97

References 100

Chapter 1: Introduction

As a counsellor or intern, have you noticed that some clients (or even yourself) may benefit from counselling but are discouraged from accessing services because symptoms do not meet the criteria for publicly funded programs? This is the reality for many Canadians navigating a mental health care system designed primarily for crisis intervention. Public funding in Canada tends to prioritize individuals with moderate to severe mental illness or substance use disorders, leaving those with less acute, but still significant, mental health concerns to either pay out-of-pocket or forgo care entirely.

In 2018, an estimated 2.3 million Canadians experienced mental health concerns that went partially or completely untreated (Statistics Canada, 2019). Among those seeking counselling or psychological support for interpersonal concerns, 34% were unable to access services. More broadly, only about half of Canadians who sought counselling or therapy for any reason reported that their needs were fully met (Statistics Canada, 2019). While financial barriers, uncertainty about where to seek care, and long wait times continue to shape access, pharmacological interventions remain comparatively available, with approximately 85% of those requiring medication reporting that their needs were met (Canadian Institute for Health Information, 2017). Untreated anxiety and depression also carry significant social and economic costs, contributing an estimated $49.6 billion annually in lost workplace productivity (Mental Health Commission of Canada, 2017), while stigma continues to discourage help-seeking and reinforce delayed intervention (Mohr et al., 2010). These patterns point not only to a service gap, but to a system organized around particular assumptions about risk, efficiency, and evidence.

These circumstances are often framed as evidence of a need for more accessible and preventative models of care, typically contextualized as a funding issue. This project takes the

position that they are also shaped by political priorities, professional hierarchies, and deeply embedded assumptions about whose knowledge matters and which forms of care are valued within publicly funded systems.

These same dynamics are reflected in the organization of counselling work and professional pathways. Counsellor training and practice in Canada are increasingly situated within private, fee-for-service (FFS) contexts, while publicly funded systems remain oriented toward short-term, diagnosis-driven, and crisis-focused interventions (Canada Medical Association [CMA], 2024; Klimkowski et al., 2024). As a result, professional identities are often formed within systems that normalize scarcity, fragmentation, and credential-based authority, even as the profession espouses commitments to equity, access, and social justice. This misalignment between public need, system design, and professional socialization raises important questions about how mental health systems shape not only care delivery, but also the values, aspirations, and ethical positioning of those who work within them.

This project critically examines the historical, political, and professional forces that have shaped contemporary mental health care in Canada. It situates stepped care, stratified care, recovery-oriented models, and task sharing within broader debates about access, evidence, professional power, and system sustainability. In doing so, it approaches these models not simply as technical interventions, but as expressions of deeper ideological commitments and systemic tensions that have evolved across decades of global and national reform. Combined, these analyses highlight how contemporary service models both respond to and reproduce the structural conditions that shape mental health care in Canada.

This capstone is guided by the following research question: How have historical, political, and professional forces shaped publicly funded mental health service models in

Canada, and how might counsellors respond to the ethical and systemic tensions embedded within these structures from a justice-oriented perspective?

Purpose Statement

This paper was written because the Canadian mental health system does more than deliver care; it also actively shapes professional identity, authority, and hierarchy, often in ways that go unnoticed. From this perspective, professional prestige, control, and definitions of legitimate evidence are not neutral, they are produced through funding structures, policy decisions, and service models that privilege certain forms of knowledge and practice. Although counsellors and interns frequently articulate commitments to equity, access, and social justice, their choices of practice setting, modality, and engagement can unintentionally reproduce inequities. Participation in private practice models, credential-driven hierarchies, or protocol-bound interventions may reinforce systems that elevate particular professionals and populations while rendering others less visible. This orientation frames the central concern of the project: counsellors are not outside the systems they critique, and their everyday decisions contribute to the broader landscape of access, authority, and care.

This paper highlights that counsellors and interns are not merely passive recipients of these structures; they actively participate in and reproduce the system. The ways they practice, the research they choose to conduct, and the settings they enter collectively shape the mental health landscape. For instance, community-based workers and community mental health workers, who likely deliver the majority of primary mental health care, are rarely represented in research or in policy discourse. Their absence from the literature reinforces professional hierarchies and marginalizes the experiences of the people and communities they serve. This

raises a critical reflective question: if counsellors help reproduce the systems they work within, what forms of power, choice, and responsibility do they hold to support clients more equitably?

This paper traces how scarcity, authority, and systemic norms shape both professional identity and care delivery, and invites the field to reflect critically on the power practitioners hold. This analysis extends the central inquiry of the project by examining where buy-in to neoliberal, capitalist logics occurs, and how everyday practice choices reproduce or challenge these structures. By encouraging counsellors and interns to consider their role in shaping a more just, accessible, and equitable system, this paper illuminates the subtle ways professional identity, privilege, and systemic inequity intersect, and asks whether change is possible when practitioners first acknowledge their own complicity in sustaining the system.

Contribution to the Field

This study is significant because it challenges the field to pause and reflect on the foundations of mental health care itself. It asks practitioners to reflect on the core values and principles that originally guided care - equity, access, justice, and accountability - and to consider how far current systems and practices have drifted from those commitments. By examining the often-invisible work of community mental health workers and the people receiving care, this paper exposes gaps that the dominant literature has overlooked. It shows that much of what sustains the system - who delivers services, how they are compensated, and the relationships that hold care together - is largely absent from research, leaving whole segments of primary care invisible. This perspective deepens the project's central inquiry by highlighting how counsellors and the counselling field might use their influence to better support clients within these systemic constraints.

In making these dynamics visible, this study also illuminates how the system appears fragmented: not because care itself is inherently disjointed, but because the dominant analytic lens has been narrowed, made selective, and shaped by professional hierarchies. By challenging the field to look more broadly at the landscapes of care in Canada, this paper creates space for thinking about how the system could be more connected, responsive, and equitable. This orientation also sets the stage for the Applications section in Chapter 3, which considers how counsellors and interns might translate critical reflection into concrete practices that support clients more effectively within these systemic constraints. It positions professional reflection as a form of intervention: when counsellors and interns critically examine their own practice, their choices, and their complicity in reinforcing systemic inequities, they gain the power to reshape the system from within. In this way, the study not only maps what is happening but opens a conversation about what could be possible, a more just and sustainable mental health system grounded in the lived realities of those delivering and receiving care, rather than solely in narrowly defined measures of evidence or efficiency.

Reflectivity and Positionality Statement

As a Registered Social Worker, I am guided by a deep belief in the welfare state and the foundational ideal of publicly funded health care. I hold that social policy should lead economic policy, not the reverse. My professional background includes more than twenty-five years working in the non-profit sector delivering community-based mental health services for clients who meet the criteria for publicly funded services, and also in community-based health centers in the public sector at Vancouver Coastal Health. This long-term experience as a community mental health worker also shapes my standpoint and biases, particularly my sensitivity to what is invisible in research and policy. These experiences provide a sustained view of the structural and

ethical challenges that shape access to mental health support, particularly for individuals whose needs fall below the thresholds required for publicly funded services. They reinforce a commitment to relationship-based, publicly accountable models of care and to the principle that early, preventative support should be available to all Canadians.

My trajectory has also shown how systemic forces shape the developmental experiences of emerging practitioners. When seeking internship placements, I was confronted with the limited options available within the current system. Public health authority placements were largely oriented toward medication management and narrowly defined evidence-based interventions such as cognitive behavioral therapy (CBT) or interpersonal psychotherapy (IPT). These approaches are situated within risk focused, diagnosis driven paradigms that prioritize procedural compliance and measurable outcomes over relational or contextual forms of care. Although these interventions can support clinical skill development, they also reflect the system's preference for efficiency, standardization, and quantifiable results.

In contrast, private practice internships offered broader exposure to relational and client driven approaches, but often lacked the structural supports necessary for developmental learning. Business imperatives, minimal and tightly constrained supervisory engagement, and fragmented pedagogical structures revealed how market-based models can subordinate intern development to profitability and individual entrepreneurship. This tension between evidence driven public systems and market driven private systems mirrors the broader themes explored in this capstone, including the influence of neoliberal logics, scarcity, and professional hierarchies on both care delivery and professional identity.

These observations illustrate how counsellors and interns, through everyday decisions and practice norms, participate in creating and sustaining the very constraints and barriers that

shape access, authority, and equity within mental health systems. My own experience navigating internship options made visible the systemic forces that determine what kinds of practice are supported, what forms of knowledge are legitimized, and how emerging practitioners are socialized into the profession.

This capstone is shaped by a standpoint that integrates professional experience policy analysis, and a commitment to equity in mental health systems. By examining the historical, political, and professional forces that structure contemporary service models, this paper aims to understand how these systems influence both care delivery and practitioner identity, and how acknowledging embeddedness within these structures is a necessary step toward imagining more just, accessible, and community-grounded mental health care.

Theoretical/Conceptual Framework

This capstone project employs a critical narrative literature review grounded in Mullaly's (1997) structural social work, systems theory, and critical feminist perspectives. These frameworks are well suited to examining how issues of access, inequity, and professional practice are shaped by broader social, political, and economic structures. Rather than focusing on individual experience or phenomenological meaning-making, this methodology emphasizes the analysis of power, ideology, and institutional arrangements that organize mental health service delivery in Canada. Systems theory provides a lens for understanding how policies, funding structures, professional hierarchies, and service models interact to produce patterns of access and exclusion. Structural social work offers a critical framework for interrogating how neoliberal policy logics, risk-based triage, and credential hierarchies shape both public mental health systems and the professional identities of those who work within them. This perspective is directly relevant to the counselling field because counselling in Canada is not a single profession

but a function carried out by a wide range of practitioners including social workers, nurses, community mental health workers, and counsellors who are all shaped by the same structural forces. Critical feminist theory further supports the analysis by foregrounding the principle that the personal is political, highlighting how individual professional choices are embedded within and influenced by larger ideological and structural forces.

The critical narrative literature review integrates empirical research, policy documents, theoretical scholarship, and historical analyses to trace the evolution of stepped care, stratified care, community mental health work, and public mental health policy in Canada. Selection criteria prioritized literature that illuminates the structural, ideological, and historical forces shaping access to care and the organization of the mental health workforce. Reflexivity is incorporated through a positionality statement that situates the researcher within the systems under examination. This standpoint is not treated as data, but as a lens that clarifies how professional experience informs the interpretation of structural dynamics and policy debates.

This methodological approach allows for a systems-level critique of Canadian mental health service delivery and explicitly supports analysis of how historical, political, and professional forces shape both care delivery and practitioner identity, in line with the reflective inquiry guiding this capstone. It also provides a foundation for examining how systemic logics, such as neoliberalism, risk orientation, and credential hierarchies, influence both the organization of services and the professional identities of those who work within them. To ground this analysis, the following section clarifies key terms and concepts that structure the discussion throughout the capstone.

Definition of Terms

Capitation

A physician payment model in which providers receive a fixed amount per patient, regardless of the number of services delivered, emphasizing population-based care and continuity (Vu et al., 2021).

Community Health Workers (CHW)

Frontline, non-specialist health workers who are trusted members of the communities they serve. They provide basic health education, support, navigation, and psychosocial assistance, and often act as a bridge between communities and formal health systems (Barnet et al., 2018).

Evidence-based Therapy

Refers to psychological treatments that have been systematically tested using research designs, typically randomized controlled trials, and shown to produce measurable benefits for specific conditions or populations. EBTs rely on standardized protocols, manualized interventions, and outcome measures to demonstrate effectiveness. In policy and service planning, EBTs are often positioned as the "gold standard," shaping funding decisions, training requirements, and models of care (Lee & Hunsley, 2015; Shedler, 2018).

Fee-for-Service (FFS)

A physician payment model in which providers are reimbursed for each service delivered, creating incentives for volume-based care (Allin et al., 2020; Marchildon et al., 2020).

Neoliberalism

A political and economic ideology that prioritizes market competition, privatization, individual responsibility, and reduced state involvement in social services. In health care,

neoliberalism often manifests through efficiency metrics, cost-containment, outsourcing, and the framing of health as an individual responsibility rather than a collective right (Rutar, 2023).

Practice-based Evidence

Refers to knowledge generated from real-world clinical practice rather than controlled research environments. It emphasizes outcomes observed in routine care, clinician expertise, client preferences, and contextual factors such as culture, community, and service setting. PBE challenges the assumption that research-generated evidence automatically translates into effectiveness in everyday practice, arguing instead for iterative learning from what actually works for diverse clients in diverse contexts (Cornish, 2020, 2024).

Public-Private Partnerships (P3s)

A cooperative arrangement between public and private sector entities aimed at delivering a public service or infrastructure. In the context of mental health, P3s may involve private organizations delivering services that are publicly funded, often under government oversight. These partnerships can support service delivery models that blend public funding with private operational capacity (Reynolds, 2018).

Recovery Model of Stepped Care

A model of stepped care organizes services around client choice, autonomy, and strengths rather than risk, diagnosis, or professional control. It emphasizes flexible access, multiple entry points, and the ability for clients to move freely among supports based on readiness and preference (Cornish, 2020, 2024).

Risk Paradigm

A risk paradigm refers to a framework in which mental health services are organized around assessing, predicting, and managing risk - typically risk of harm, severity, or deficit. This

paradigm often leads to triage systems, conditional access, and clinician-driven decision-making (Cornish, 2020, 2024).

Stepped Care Model

Stepped care is a system of organizing mental health services in which clients receive the least intensive intervention likely to be effective, with the option to "step up" to more intensive support as needed. It emphasizes early access, efficiency, and clinical appropriateness, and can be used to expand publicly funded care without compromising quality (Arns et al., 2023).

Stratified Care

Individuals are matched to the appropriate level of care from the outset based on their specific needs and severity of conditions (Arns et al., 2023).

Transdiagnostic Care

Focuses on underlying processes such as emotion regulation or avoidance, that cut across diagnostic categories. It allows providers to use a single, flexible intervention for a range of mental health presentations (Ó hAnrachtaigh et al., 2024).

Chapter 2: Literature Review

Overview

Mental health care in Canada exists within a fragmented and evolving ecosystem shaped by layered funding models, jurisdictional divides, and shifting paradigms of care. Understanding how reform might take root requires more than mapping services; it requires examining the political, historical, and professional forces that structure access, authority, and practice. This chapter traces the architecture of Canada's mental health system while also interrogating the logics that sustain it: risk-based triage, diagnosis-bound evidence hierarchies, and credential-driven models of expertise. These dynamics directly inform the research question by revealing the structural conditions that shape how counsellors and interns practice, and by clarifying the systemic constraints within which any meaningful reform must occur.

We examine the rise of stratified and stepped care, the global history of task shifting and task sharing, and the recovery-oriented, practice-based approaches that challenge traditional assumptions about who delivers care and how. Drawing on international research and the foundational commitments of Alma-Ata and Astana (Sanders et al., 2023; World Health Organization, 1978), this chapter situates Canada's system within a broader movement toward community-grounded, transdiagnostic, and client-directed models of care. These international frameworks are directly relevant to the Canadian counselling field because they shape the policy directions, service models, and professional expectations that counsellors and interns now practice within. This analysis connects to the research question by identifying alternative models that expand who can deliver counselling and how, and it anticipates the Applications section in Chapter 3, where these ideas are translated into concrete possibilities for practice within the Canadian counselling context.

Ultimately, it offers a synthesis: a panoramic view of the current landscape and a scaffold for imagining a more equitable, integrated, and culturally responsive mental health system. The next section begins by outlining how public, private, including mixed and overlapping arrangements, shape access to care in Canada. Understanding these arrangements is essential to the research question because they determine where counsellors and interns actually practice, what forms of counselling are supported or constrained, and how systemic inequities show up in everyday clinical work, which Chapter 3 addresses directly.

Mapping the Canadian Mental Health Service Landscape

Publicly Funded Services

Canada's health care system operates under a national health insurance (NHI) model, in which approximately 70% of total health expenditures are publicly funded through taxation (Canadian Medical Association [CMA], 2024). The federal government transfers funds to provinces and territories via the Canada Health Transfer (CHT), allowing each jurisdiction to determine its own modes of service delivery. While funding is centralized through the CHT, the actual delivery of services varies widely between provinces and territories due to local priorities and administrative discretion. However, the designation of whether a particular service qualifies as publicly funded remains highly discretionary and varies by province and territory (Marchildon et al., 2020). Mental health services are inconsistently covered under the Canada Health Act (CHA), R.S.C., 1985, c. C-6, which limits public billing to specific professionals in specific settings. On average, provinces and territories allocate just 6.3% of their total health budgets to mental health, which is well below international benchmarks (Lowe et al., 2024).

In addition to the CHT, the federal government maintains direct responsibility for mental health services for specific populations, including Veterans, First Nations, and Inuit (Marchildon,

2020; Veterans Affairs Canada, 2025). These services are administered outside the CHA through dedicated programs such as Veterans Affairs Canada (VAC) and Indigenous Services Canada's Non-Insured Health Benefits (NIHB) program (Lowe et al., 2024). These federally funded services reflect fiduciary and treaty obligations and are not subject to provincial discretion. These funding structures are central to the research question because they determine which counselling services are publicly accessible, which practitioners are recognized or excluded under public funding rules, and how counsellors and interns navigate the systemic constraints that shape everyday practice.

Privately Funded Services

The remaining 30% of health expenditures are covered by private sources, including employer-sponsored insurance benefits (12%), out-of-pocket payments (15%), and other non-governmental contributions (CMA, 2024). This funding split has produced a two-tiered system in mental health care, where counselling and psychotherapy are often excluded from public coverage, and are accessed through private insurance or direct payment (Flood et al., 2020; Marchildon et al., 2020). This two-tiered arrangement can exacerbate inequities, particularly for those with mild to moderate mental health needs who cannot afford private care. Psychologists, counsellors, social workers, and psychotherapists generally cannot bill directly to the publicly funded system unless employed within publicly funded hospitals or government programs (Esmail, 2023). As a result, individuals with mild to moderate mental health concerns are often redirected to limited community supports or the private sector, creating inequitable access to early intervention and relational care (Bartram, 2019; Lowe et al., 2024). These dynamics connect directly to the research question because they reveal how the structure of private funding shapes who can access counselling, how counsellors position their work within a two-tiered

system, and how interns and emerging practitioners learn to navigate the market-driven realities that influence everyday practice.

Public-Private Partnerships (P3s)

Public-private partnerships (P3s) have become a key mechanism for funding and constructing health-care infrastructure, particularly large-scale hospital and facility projects (Auditor General of British Columbia, 2013; Reynolds, 2018). Under P3 models, provincial governments contract non-profit organizations, community agencies, and private clinics to deliver publicly accessible care (Canadian Council for Public-Private Partnerships [CCPPP], 2025). Poschmann (2003) characterizes P3s as arrangements in which private financial resources are mobilized to achieve public objectives, yet he notes that they draw criticism from both sides of the political spectrum: those on the left view them as a step toward privatization, while free-market advocates argue that they reflect excessive government involvement through corporate channels. Hurl et al. (2022) argue that the formation of P3s is not neutral. These partnerships are actively shaped by elite networks of consultants, financiers, legal experts, and public officials, which together form what they call the "P3 enabling field." This constellation of actors legitimizes P3s as the preferred model for infrastructure delivery while sidelining democratic accountability and public-interest alternatives. The authors further contend that this field depoliticizes infrastructure decisions, concentrates power, and reinforces procurement practices that privilege large, well-connected entities.

Hally (2008) observes that, due to their politically contentious nature, governments often adopt less provocative terminology when implementing P3s. In Ontario, for instance, they are referred to as Alternative Financing and Procurement (AFP) while in Nova Scotia they are labeled Strategic Infrastructure Partnerships. By 2005, Ontario had used the AFP framework to

fund nine hospitals (Benzie, 2005), and in 2010, it was applied to the development site for the Centre for Addiction and Mental Health (CAMH) (Infrastructure Ontario, 2010). In British Columbia (BC), these arrangements were initially called Partnerships BC (Reynolds, 2018) and were later named Infrastructure BC (Infrastructure BC, 2025). Between 2003 and 2016, BC entered into 17 long-term P3 agreements to deliver major infrastructure projects, including hospitals, roads, and facilities in sectors such as transit, education, and corrections, with a total value of $18.2 billion (Reynolds, 2018). Infrastructure BC is still actively engaged in P3s, and their involvement in health care not only appears to be growing, but are increasingly shaping the future of health care delivery across the province (Infrastructure BC, 2025). In fiscal year 2024/25, they supported or advanced multiple health care projects, including major hospital redevelopments (Burnaby, Richmond, Dawson Creek), new cancer centres (Kamloops, BC Cancer Centre), and planning for future facilities such as the Surrey Memorial Hospital Tower and University Hospital of Northern BC. Compared to previous years, this reflects a broader and more sustained role in health care infrastructure, not only in procurement but also in business planning and advisory services.

Critiques of P3s caution against assuming neutrality or efficiency. Reynolds (2018), in his review of 17 P3 infrastructure projects in BC, found that many resulted in higher long-term costs, reduced public oversight, and limited transparency. He argues that the complexity of P3 contracts often obscures true financial risk and can constrain public flexibility over time. Dove et al. (2025) found that P3s can fragment accountability and make governance less transparent, making it harder for patients to understand decision-making or advocate for their needs. Hurl et al. (2022) show that P3s do not emerge in isolation; they are actively sustained by enabling fields, or networks of public and private actors, legal frameworks, and institutional reforms, that

have normalized P3s as a dominant model of service delivery. Ontario, in particular, has served as a national center for P3 diffusion, shaped by elite brokerage and policy infrastructure that bind these actors together (Hurl et al., 2022).

Boardman et al. (2016) offer a policy-oriented analysis of P3s, identifying both theoretical strengths and empirical weaknesses. On the pro side, they note that P3s can transfer construction and delivery risks to the private sector, align incentives across sectors, and potentially improve lifecycle cost efficiency. However, they also highlight significant drawbacks: higher financing costs compared to public borrowing, opaque value-for-money assessments, limited competition, and high transaction costs. They caution that P3s are often pursued for political expediency or off-book accounting benefits rather than genuine efficiency.

Beyond service expansion, P3s may also serve as platforms for innovation. Liu et al. (2023) argue that well-designed P3s can foster adaptive infrastructure and delivery models by leveraging cross-sector collaboration. In mental health, this could mean integrating digital tools, flexible staffing models, or culturally responsive programming more rapidly than traditional public systems allow. These innovations have become increasingly relevant as Canadian jurisdictions explore stratified and stepped care, both of which depend on tiered access pathways, rapid triage, and scalable service delivery.

Taken together, Canada's public, private, and P3 funding structures reveal a system that is layered, fragmented, and often inequitable in its delivery of mental health services. Yet funding alone does not determine access. The architecture of Canada's national health insurance framework, particularly the selective definitions embedded in the CHA, plays a critical role in shaping who receives care, under what conditions, and through which providers (CMA, 2024). These structural boundaries are not merely bureaucratic. They directly shape the feasibility and

impact of reform models such as stratified and stepped care, which aim to match service intensity with client need and reallocate resources more efficiently. The following section examines how the CHA governs access and how its constraints set the stage for both the promise and the limitations of stratified and stepped care.

Canada's National Health Insurance Framework

The CHA guarantees universal access to medically necessary care, but its selective definition of "medically necessary" has produced structural gaps in mental health coverage (Flood et al., 2020). Physicians and psychiatrists are covered under provincial insurance plans and may operate in public institutions or private clinics, billing the public system for eligible services (Marchildon et al., 2020). However, psychiatrists primarily treat severe mental illness and focus on diagnosis and medication management, while general practitioners who are often the first point of contact may lack training or capacity to provide sustained mental health support (Moroz et al., 2020). This material connects directly to the research question because the organization of medically necessary services determines which forms of counselling are publicly supported, how practitioners are positioned within the system, and how counsellors and interns must navigate the diagnostic and medicalized pathways that shape clients' access to care.

Wener and Woodgate (2017) found that many physicians feel unprepared to manage complex mental health presentations, often preferring to consult with specialists or refer patients to psychiatry. This tendency is compounded by Canada's FFS model, which rewards high patient turnover and brief visits, undermining early intervention and continuity (Allin et al., 2020; Wener & Woodgate, 2017). Swanson et al. (2022) add further evidence to this critique, showing that shorter primary care appointments are associated with increased emergency department (ED) visits and hospitalizations, suggesting that insufficient time for assessment may lead to

unresolved issues and escalation. Increasingly, patients who are not getting their mental health needs met are showing up at EDs (Lavergne et al., 2022). This pattern reflects broader system pressures: national assessments of ED overcrowding highlight that EDs often absorb the consequences of limited access to timely primary and community-based care, with mental health presentations forming part of this wider strain (Mason et al., 2023). Providers themselves identify these same structural barriers such as limited availability of timely outpatient services, fragmented pathways, and rigid eligibility criteria, as key reasons why people "fall through the cracks" and ultimately present in crisis (Wang et al., 2024). Vu (2021) reinforces this pattern, demonstrating that physicians who shifted from blended FFS to a blended capitation model saw a 6.2% reduction in psychiatric hospitalizations and a 4.7% decrease in the number of patients hospitalized. These findings suggest that remuneration models directly shape the quality and continuity of mental health care delivered in primary settings. Meanwhile, federally administered programs such as VAC and NIHB operate independently of provincial systems, offering tailored services to Veterans and Indigenous clients (Marchildon, 2020; Veterans Affairs Canada, 2025). However, coordination between federal and provincial systems remains limited, contributing to fragmentation and uneven access across jurisdictions.

Canadian national data indicate that unmet mental health needs are concentrated among specific groups, including young women, Black and other racialized communities such as South Asian, Chinese, Filipino, and other visible minority groups, as well as Indigenous peoples and individuals without a regular primary care provider, all of whom face disproportionate barriers to timely and appropriate care (Stephenson, 2023). This study is methodologically robust because it draws on Statistics Canada's nationally representative survey data, which uses probability sampling, standardized instruments, and rigorous quality controls to ensure population-level

validity. The large sample size and stratified design strengthen the reliability of subgroup estimates, including those related to racialized and Indigenous populations. A limitation is that the data are self-reported and cross-sectional, which prevents conclusions about whether one factor causes another; however, the consistency of these findings with other national and international surveys supports their credibility. Overall, the study's transparent methodology, national scope, and statistical weighting procedures provide a strong foundation for trusting the validity and reliability of its results.

These structural limitations of selective coverage under the CHA and fragmented jurisdictional responsibilities have created persistent gaps in mental health service delivery (Canadian Mental Health Association, 2018), while remuneration models such as FFS continue to disincentivize continuity in mental health care (Vu et al., 2021). While selective coverage was originally designed to ensure universal access to core medical services and protect Canadians from catastrophic health costs, this same design has left counselling and other relational supports outside the publicly funded framework. Individuals with mild to moderate distress often fall through the cracks, while those with complex needs encounter fragmented care pathways (Bartram, 2019; Moroz et al., 2020).

Bartram (2019) conducted a quantitative analysis using nationally representative data from the Canadian Community Health Survey (CCHS), examining income-based inequities in access to mental health services across Canada. The study's strengths include its large sample size, population-level scope, and use of standardized survey measures, which enhance the reliability of its estimates and allow for meaningful comparisons across demographic groups. A limitation is that the CCHS relies on self-reported data and cannot establish causality, though its methodological transparency and alignment with other national datasets strengthen confidence in

the findings. Overall, the study's rigorous statistical approach and national representativeness make its conclusions about inequitable access both valid and highly relevant to understanding who falls through the cracks in Canada's mental health system.

Moroz et al. (2020) conducted a narrative review of Canadian mental health service barriers and cost-effective solutions, synthesizing evidence from peer-reviewed studies, policy reports, and national data sources. As a qualitative synthesis, its strength lies in integrating diverse forms of evidence to identify system-level patterns, including gaps in early intervention and the fragmentation of care for individuals with complex needs. A limitation is that narrative reviews are subject to selection bias and do not follow the strict protocols of systematic reviews; however, the authors draw on well-established Canadian data sources and clearly describe their analytic focus, supporting the credibility of their conclusions. The study's value lies in its ability to contextualize individual barriers within broader structural dynamics, making its findings both reliable and directly relevant to understanding the systemic pathways that shape access to care. Each study contributes a distinct layer of understanding, as Bartram (2019) quantifies inequitable access across the population, while Moroz et al. (2020) provides a descriptive analysis to explain the structural mechanisms behind those patterns, together strengthening the case that these gaps are systemic rather than incidental.

In response to these challenges, stratified and stepped care models have emerged as frameworks for organizing services more efficiently and equitably (Canadian Mental Health Association, 2018; Jamieson et al., 2024; Vancouver Coastal Health Research Institute & Centre for Clinical Epidemiology and Evaluation, 2021). These models are important to the research question because they directly shape how counsellors and interns navigate access pathways,

service eligibility, and the distribution of mental health supports. The following section explores their conceptual foundations, clinical logic, and relevance to the Canadian context.

Origins and Conceptual Logic of Stratified and Stepped Care

Staging and Stepped Care

In their conceptual and theoretical review, Scott and Henry (2017) hypothesized that the roots of stepped care can be traced to clinical staging models developed in general medicine during the early twentieth century. These models, originally applied in oncology and infectious diseases, later informed chronic disease frameworks by emphasizing prevention, early detection, and stage-specific intervention. Scott and Henry (2017) were critical of diagnostic categories citing that such symptoms failed to capture the fluid nature of mental illness. Instead, they proposed a transdiagnostic staging model for psychiatry, particularly for youth aged 15–25, where early symptoms often overlap and evolve across multiple disorders. Building on this conceptual foundation, Wade et al. (2025, p. 1) define a transdiagnostic *process* as "a mechanism that is present across different disorders and is either a risk or a maintaining factor for the disorder." Their research on youth experiencing eating disorders, depression, and anxiety found that targeting these shared processes such as emotion regulation and cognitive control can improve early intervention outcomes, even before a formal diagnosis is reached.

Scott and Henry (2017) further argued that clinical staging enables earlier, more tailored interventions, and may help prevent progression to more severe illness; they linked stage-specific care to stepped care, suggesting that organizing services by stage and need could improve outcomes and system efficiency. This aligns with current definitions of stepped care, which emphasize beginning with the least intensive intervention likely to be effective, with the option to "step up" if needed (Boyd et al., 2019; Hronis, 2025). Wade et al. (2025) similarly emphasized

early intervention, though their focus was on transdiagnostic processes, or mechanisms present across multiple disorders that act as risk or maintaining factors. While they did not explicitly link their framework to stepped care, their findings support the idea that targeting shared processes early can enhance treatment responsiveness and reduce chronicity. Their conclusions are supported by a quantitative design that used validated psychological measures and established statistical procedures to identify these transdiagnostic mechanisms, a strength that enhances the reliability of their results despite limitations such as self-report data and the cross-sectional nature of the study.

Conversely, de Filippis et al. (2024) operationalize a disorder-specific approach by applying a six-stage model to schizophrenia spectrum disorders. Their framework, grounded in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association, 2022) and the International Classification of Diseases, 11th Revision (ICD-11; World Health Organization, 2019), reinforces the categorical logic that Scott and Henry (2017) explicitly critiqued. The study demonstrated that staging can sharpen diagnostic precision within a single disorder, highlighting its clinical utility for identifying risk and functional decline but also, exemplifying the rigidity and diagnostic siloing that Scott and Henry sought to move beyond.

Biomarkers and Stratified Care

While stepped care organizes treatment by stage and evolving need, stratified care shifts the logic toward prediction by matching patients to optimal interventions from the outset (Arns et al., 2023). Rather than beginning with low-intensity care for all, Arns et al. (2023) argue that stratified care uses predictive indicators to assign the most appropriate treatment immediately. Biomarker-informed psychiatry represents a biologically driven form of this model, using

physiological data to guide treatment selection and personalize care from the start. Arns et al. (2023) describe electroencephalography (EEG)-based biomarkers, such as frontal alpha asymmetry and alpha peak frequency, that stratify patients into subgroups likely to respond to specific treatments, improving remission rates compared with traditional trial-and-error approaches. In contrast, Drysdale et al. (2017) proposed functional magnetic resonance imaging (fMRI)-derived "biotypes" of depression to predict response to a single modality transcranial magnetic stimulation (TMS). While innovative, Drysdale's predictive precision model lacks the service-delivery flexibility inherent in stratified stepped care, which guides not only what treatment to provide but also when and at what intensity.

Stratified and Stepped Models in Action

Stratified Care Models

Although stratified care is not yet a standardized component of Canadian mental health policy, its operational logic is increasingly visible in select service settings and planning frameworks. Within BC, the Vancouver Coastal Health Authority's Psychiatric Emergency Assessment & Triage (PEAT) service exemplifies stratified assessment in action: individuals presenting with mental health and substance use concerns are triaged based on acuity, complexity, and service eligibility, allowing for targeted referrals to appropriate care levels (Vancouver Coastal Health [VCH], 2025). This illustrates a key strength of stratified care, which is its capacity to direct individuals to the level of service that aligns with their assessed acuity and complexity. These stratified processes are largely embedded within publicly funded hospital and regional health authority services, which positions them within the universal system rather than the private counselling sector. This trend is echoed in the emergency department (ED). For example, Lavergne et al. (2022) use administrative data from BC to show that EDs are frequently

used as entry points due to gaps in community-based services, with repeated visits suggesting poor continuity and fragmented triage. In contrast, Williams et al. (2024) drew from a national survey data to highlight perceived barriers to care, emphasizing that over half of respondents faced access challenges particularly for conditions like post-traumatic stress disorder (PTSD) and depression. They found patients often turned to EDs not because they were appropriate, but because other services were inaccessible. Mason et al. (2023) further note that ED overcrowding is a documented systems-level issue and the triage systems designed to manage patient flow are themselves fragmented. Chua et al. (2025) found that paramedics, ED, and community services often operate with inconsistent protocols and limited integration, resulting in repeated assessments, poor continuity, and inappropriate referrals. In this context, individuals with mental health concerns may be triaged based on immediate risk rather than long-term need, reinforcing a cycle of acute stabilization without sustained support. This is important to the research question because these triage patterns determine how clients enter counselling, what needs remain unmet, and how counsellors and interns must navigate fragmented pathways in their practice.

Tertiary Mental Health & Substance Use Services further illustrate stratified care in practice, offering intensive treatment to individuals with serious and persistent mental illnesses who have not responded to acute hospital interventions (VCH, 2025b). These services may be delivered in hospital or outpatient settings, including specialized programs affiliated with academic institutions such as UBC Psychiatry. Community-based Adult Mental Health Teams also operate under stratified care logic, providing specialized services to individuals with complex psychiatric conditions such as schizophrenia, bipolar disorder, and major depression, contingent on diagnostic severity and treatment history (VCH, 2025a). These programs reflect the predictive logic of stratified care, in which individuals are matched to specialized

interventions based on assessed clinical complexity (Arns et al., 2023). These examples illustrate a core strength of stratified care, which is its ability to direct individuals to the level of service that best matches their acuity and complexity, supporting more efficient use of specialized resources when the broader system is functioning as intended.

Limitations of Stratified Care. In hospital and community-based mental health settings, it is a normative practice to match symptom severity and complexity with high-intensity interventions (Boyd et al., 2019). However, the literature offers limited evidence that this approach consistently improves outcomes. Rost et al. (2023) note that despite extensive efforts to identify predictive indicators of treatment response in major depressive disorder, no biomarkers or empirical tests have proven reliable for clinical decision-making. As a result, treatment allocation continues to rely on symptom questionnaires and broad clinical guidelines, which may oversimplify recovery and fail to account for individual variability.

This process also depends heavily on clinician judgment, leaving room for human error, bias, and inconsistency. Bradford et al. (2024) found that diagnostic errors in mental health are common, under-recognized, and often stem from cognitive bias, incomplete information, and system-level failures. Smith et al. (2020) similarly found that therapist-rated severity and complexity were only weakly correlated with standardized symptom scores, and that case complexity such as comorbidities, social stressors, and chronicity did not consistently predict treatment outcomes. No single measure, whether clinical judgment, complexity, or symptom severity, emerged as a reliable standalone predictor of recovery. Jamieson et al. (2024) evaluated four predictive modelling approaches (e.g. logistic regression, decision trees, random forests, and gradient boosting machines) for their effectiveness in stratified care delivery within community services. Gradient boosting machines demonstrated the highest predictive accuracy in matching

patients to appropriate treatment intensity at intake. While this supports stratified care as a method for individualized treatment allocation, the study did not examine long-term outcomes, equity across diverse populations, or client experiences with algorithm-driven decisions. These limitations are inferred from the study's focus on intake precision and operational efficiency rather than therapeutic engagement or ethical responsiveness.

Across these studies, several methodological similarities strengthen the validity and reliability of their findings. All three draw on systematic, transparent analytic procedures: Bradford et al. (2024) through a structured review of diagnostic-error research, Smith et al. (2020) through correlational analyses using validated symptom measures, and Jamieson et al. (2024) through comparative modelling using clearly specified algorithms and performance metrics. Each study uses established assessment tools or standardized criteria, which enhances measurement reliability and reduces the risk of idiosyncratic interpretation. Importantly, despite their different designs (review, observational analysis, and predictive modelling), they converge on the same conclusion: neither clinician judgment, symptom severity, nor algorithmic prediction reliably identifies who will benefit from more intensive treatment. This cross-study convergence increases confidence in the overall critique by demonstrating that the limitations of stratified care are not artifacts of a single method but appear consistently across diverse research approaches. By making these methodological strengths and constraints explicit, the reader is better equipped to evaluate the credibility of the evidence and to understand how systemic and cognitive biases shape treatment allocation within stratified care frameworks.

Delgadillo et al. (2022) found that when clinical decision tools (e.g. predictive algorithms) were used stratified care led to faster symptom reduction and lower dropout rates compared to stepped care, particularly for clients with moderate depression. However, those with

comorbidities or socioeconomic disadvantage benefited less. This suggests that complexity may require flexibility, not just intensity. Collectively, these studies challenge the assumption that higher symptom severity or complexity automatically warrants more intensive treatment, and they cast doubt on the reliability of predictive matching at intake.

Finally, stratified care has been criticized for creating delays in treatment due to long waitlist times (Boyd et al., 2019), and for leaving individuals with mild to moderate symptoms without support. When combined, these findings suggest that while stratified care may enhance clinical precision for certain diagnostic groups, it leaves notable gaps in equity, responsiveness, and early access. These limitations highlight why stepped care may be better positioned to support broad population-level mental health needs in a publicly funded system.

Stepped Care Models

Early Implementations: Manuals, In-Person Therapy, and Telehealth. Unlike stratified care, which uses predictive tools or clinical judgment to assign individuals to the appropriate level of care at intake, and typically matches symptom severity and complexity with high intensity interventions (Boyd et al., 2019), stepped care begins with the least intensive intervention likely to be effective, with the option to step up if needed. Boyd et al. (2019) note a central difference between the two models is the locus of decision-making. In stratified care, clinicians determine treatment intensity at intake, whereas in stepped care, patients guide the process based on their experience and evolving needs. Olsson et al. (2025) further explain that stepped care incorporates stratification when clinical judgment or algorithmic triage assigns higher-intensity services based on symptom persistence or complexity. In practice, stepped care frequently drifts toward stratified care, especially when clinicians reassess and reallocate clients. This distinction is directly relevant to the research question because the way treatment intensity

is determined shapes how counsellors and interns engage with clients, how much autonomy clients retain in navigating care, and how practitioners must adapt their work within systems that either empower or constrain client-led progression through services.

Stepped care has continued to evolve since its early 2000s inception, when there were no internet components and delivery was entirely face-to-face. Richards and Suckling (2009) demonstrated in UK primary care that low-intensity options such as guided self-help (manuals, workbooks), psychoeducational groups, and brief telephone support could function as first-step interventions. Progress was monitored using standardized outcome measures like the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7) (Kronke et al., 2001; Spitzer et al., 2006); if symptoms did not improve, patients were stepped up to higher-intensity CBT.

Scaling Up: IAPT and the Role of Supervision. By 2012, Richards et al. (2012) showed how these principles were scaled through the Improving Access to Psychological Therapies (IAPT) program. Low-intensity supports expanded to include structured self-help and telephone CBT, which increased reach without requiring face-to-face appointments. A cornerstone of IAPT was supervision for Psychological Wellbeing Practitioners (PWPs), newly trained staff who delivered guided self-help and telephone CBT. Regular case management supervision ensured safety, protocol fidelity, and caseload support.

However, Richards et al. (2012) found highly inconsistent implementation across IAPT sites. Some operated like stratified care, others adapted to local constraints, and overall fidelity was poor: fewer than 10% of patients were stepped up, up to 34% of referrals were never assessed, and 30% dropped out before completing treatment. Allocation varied depending on the assessor, and routine outcome monitoring, essential for adaptive escalation, was often absent.

These findings raised concerns about stepped care's vulnerability to workforce pressures and operational drift, which refers to the gradual shift away from the model's intended design when real-world constraints lead services to function differently than planned.

Improvements on IAPT. In their meta-analysis of IAPT's first decade of service, Wakefield et al. (2021) found that routine outcome monitoring had become a core feature of the program. Standardized measures such as the PHQ-9, GAD-7, and Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002) were implemented across all services to support feedback-informed care, national performance reporting, and large-scale evaluation. This infrastructure enabled benchmarking and transparency, and has generated over 7.5 million referral records, with approximately 4.9 million patients receiving psychological treatment. While they noted that structural consistency has increased, fidelity to stepped care principles still varies especially in complex presentations (e.g., depression with PTSD, substance use, characterological traits, housing instability, or financial disadvantage). Notably, such cases tend to fare poorly in low-intensity care, with higher drop-out rates and poorer outcomes, reinforcing the need for early identification and appropriate allocation. Across the board, drop-out rates remain inconsistently reported. Wakefield et al. (2021) also noted that relapse after low-intensity treatment is common, and recommend booster sessions, mindfulness-based relapse prevention, and telephone-delivered support as scalable solutions.

Whereas Richards et al. (2012) highlighted the absence of routine outcome data and feedback mechanisms, Wakefield et al. (2021) emphasize IAPT's open-access national reporting, practice research networks, and the scientific potential of its outcome infrastructure. The review itself is a product of this system-wide evolution. While IAPT remains one of the most extensively scaled stepped care programs globally, its protocol-driven structure and clinician-led

triage reflect a more stratified orientation. Clients are often assigned care levels based on intake assessments rather than self-directed choice, and digital integration though present is not foundational to the model.

Similar fidelity concerns have been documented in Norway, where national guidelines assign mild problems to community services, moderate problems to specialist care, and complex or severe problems to shared responsibility. In a cross-sectional study of 4,061 outpatients, Lindberg et al. (2024) found substantial overlap (80-99%) in symptoms, impairment, and health status across service levels, with only modest associations between actual severity and the care level received. Allocation was influenced not only by impairment but by demographic factors such as younger age, male gender, better health, and being partnered. These findings indicate that stepped care allocation is inconsistently applied, shaped more by organizational routines and demographic biases than by systematic feedback or client choice. Like IAPT, the Norwegian model functions largely as a clinician-and guideline-driven system, underscoring a broader limitation of traditional implementations and highlighting the need for progressive models that prioritize readiness and choice. In contrast to these more clinician-driven national systems, Canadian innovations in stepped care, beginning in campus mental health, shifted the emphasis toward readiness, flexibility, and client choice.

Canadian Adaptations - Campus Mental Health. In Canada, Peter Cornish began adapting the UK's stepped care principles in the late 2000s, initially designing a campus mental health framework at Memorial University to address rising student demand and persistent waitlists (Cornish et al., 2017). This adaptation emerged in response to growing recognition that university counselling centers could no longer sustain the traditional model of individualized weekly 50-minute sessions. It was designed to remediate system pressures identified in research

showing that treatment delays had increased by 88%, triage had shifted toward crisis intervention, and 35% of students were placed on waitlists for care that primarily prioritized those in acute distress (Cornish et al., 2017). Salient concerns were that in-person therapy are costly, are not accessible for students whose preferred means of interacting is online, and misaligned with students' preference for short-term, expedient support rather than long-term therapy. Another feature was that students needing help were often pre-contemplative, with readiness levels around 20%, and therefore required a flexible system that allowed them to gradually warm up to therapy by exploring different treatment options (Cornish et al., 2017).

These early efforts laid the groundwork for Stepped Care 2.0 (SC2.0), first articulated in Cornish et al. (2017) and later codified in Cornish (2020). The model emphasized online service delivery, expanded community-based supports, and introduced more steps than the traditional four offered in UK programs. It was later scaled provincially and nationally, but its roots are firmly in the postsecondary context. Although early publications focused on model development rather than measured impact, documented outcomes emerged through a provincial rollout led by the Mental Health Commission of Canada (MHCC) in Newfoundland and Labrador, which emphasized recovery-orientation, client choice, and integration of digital supports, and reported significant reductions in wait times and improved system responsiveness (MHCC, 2019). More recently, Niagara College's Health, Wellness and Accessibility Services (HWAS) launched the development of a Student Mental Health and Well-Being Framework, aligning with the National Standard for Mental Health and Well-Being for Post-Secondary Students and embedding supports across campus life (Niagara College, 2022).

Similar patterns emerge across North American campuses, where high demand and limited capacity pushed counselling centers to adapt their service models. University counselling

centers frequently supplemented individual therapy with workshops and group formats, a practice documented across Canadian campuses (UBC Counselling Services, n.d.; University of Lethbridge Counselling Services, 2025; University of Manitoba Student Counselling Centre, 2025; University of Toronto Mississauga Health & Counselling Centre, 2025.) While some centers added online self-help or apps, the model itself was not defined by internet delivery.

North American Campus Contexts. Bailey et al. (2022) focused on college students aged 17-25 in university counselling centers in North America. Bailey's study was a program evaluation rather than a randomized trial, and it examined how centers adapted service delivery under high demand. Students presented with a wide range of concerns, including depressive and anxiety symptoms, but the study did not impose strict diagnostic exclusion criteria; the emphasis was on service utilization and systemic strain rather than diagnosis-specific outcomes. Initially, centers relied on a triage system to assess urgency and attempted to maintain the "gold standard" of weekly 50-minute psychotherapy sessions. However, this format quickly proved untenable as demand outpaced staff capacity. Long waitlists led to larger caseloads and more severe symptom presentations, making weekly sessions unsustainable. In response, the centers adapted a stepped care framework, introducing lower-intensity options to students on a waitlist (i.e., workshops, groups, self-help tools, psychoeducation, and online supports) and attenuated session frequency for ongoing clients. Bailey et al. (2022) emphasized that reduced frequency was driven by capacity constraints rather than clinical evidence that fewer sessions were therapeutically superior, and their study highlighted that these reductions typically took the form of session caps and lower-intensity in-person formats rather than digital-first care.

Wolitzky-Taylor et al. (2025) expanded this trajectory through the STAND program, a scalable digital system combining universal screening, algorithm-guided triage, and step-

matched interventions for adults 18-25 years. STAND blends Artificial Intelligence (AI)-enabled monitoring with human support, offering a model for how digital pathways can be integrated within post-secondary settings at scale. Implementation began with universal online screening for anxiety, depression, and suicidality, after which participants were triaged into different levels of care depending on symptom severity. Those with minimal symptoms were directed to wellness resources, individuals with mild to moderate symptoms received digital CBT modules supported by trained coaches, and those with severe or persistent symptoms were referred to licensed clinicians for telehealth care. Continuous digital monitoring allowed participants to be stepped up or down in intensity as needed, ensuring flexibility and efficient use of clinical resources. The study reported significant reductions in anxiety and depression symptoms across stepped-care levels, high engagement with digital CBT, and strong feasibility and acceptability indicators, demonstrating that the model produced measurable clinical and implementation outcomes. The program was later expanded to partner campuses such as East Los Angeles College, demonstrating its potential as a replicable, end-to-end stepped-care model for higher education settings.

While Bailey et al. (2022) illustrates how stepped care has been used to manage strain within youth-serving postsecondary systems, the broader evidence base for stepped-care models is concentrated in adult populations (Berger et al., 2020). This includes both adult-centered digital platforms and system-level stepped-care studies. The shift from campus-based youth care to adult digital stepped care highlights how the model has been developed and evaluated most extensively outside of youth settings.

Artificial Intelligence and Digital Technologies in Mental Health

Integration of AI in Digital Health Systems

Artificial intelligence (AI), first formally recognized in 1956, has become deeply embedded in institutional infrastructures across education, health care, government, and security sectors (Thakkar et al., 2024). In health care, AI was first predominantly applied to diagnosing and treating diseases (Rajkomar et al., 2018), but its integration with electronic health records (EHRs) and digital platforms has since expanded its role to structuring, exchanging, and applying health data in clinical decision making. Standards such as Fast Healthcare Interoperability Resources (FHIR; Graham et al., 2019) support the consistent formatting and movement of data across systems, while application programming interfaces (APIs; Gordon et al., 2020) act as connectors that allow software platforms to communicate, share information, and coordinate services.

Within this global context of AI expansion, Canada has emerged as a leading force, ranking among the top nations for academic output, with a leading research H-Index and the highest per-capita AI publications in the G7, according to Accenture and the Canadian Institute for Advanced Research (CIFAR, 2020). This leadership was consolidated through the launch of the Pan-Canadian AI Strategy, a federally funded initiative that invested $125 million over five years, administered by CIFAR. The strategy established three major hubs: Montreal Institute for Learning Algorithms (MILA; Montreal Institute for Learning Algorithms, 2025), the Alberta Machine Intelligence Institute (AMII; Alberta Machine Intelligence Institute, 2025) in Edmonton, and the Vector Institute (Vector Institute, n.d.) in Toronto, creating a national infrastructure for AI research and application.

Canada's prominence in AI is closely tied to the contributions of three pioneers often called the "godfathers of AI." Geoffrey Hinton of the University of Toronto advanced deep belief networks and backpropagation methods that became foundational for analyzing brain imaging data and classifying psychiatric disorders (Hinton et al., 2006; Vieira et al., 2017). Yoshua Bengio of Université de Montréal, co-founder of MILA, has driven innovations in representation learning and generative models, now applied to neuroscience and mental health research, including predictive modeling of psychiatric trajectories (Bengio et al., 2013; Shatte et al., 2019). Yann LeCun, currently at NYU and Meta but long collaborating with Canadian researchers, helped develop convolutional neural networks (CNNs; LeCun et al., 1989), which underpin affective computing and image-based diagnostic tools increasingly used in early detection of psychiatric and behavioral health conditions (Lei et al., 2022; Nirigina et al., 2024). Collectively, their breakthroughs established the technical infrastructure that enables AI to be integrated into mental health care, from neural imaging to predictive psychiatry, reinforcing Canada's global role in digital innovation.

The innovations led by Canadian researchers demonstrate that AI is not just present in health care: it is being actively shaped and driven by Canadian expertise. From neural imaging to predictive psychiatry, these technologies have created the foundation for AI-enabled mental health interventions. Digital mental health solutions are spreading rapidly across the globe, transforming the way care is delivered. One of the clearest examples is the rise of adult-focused digital platforms within stepped-care frameworks. These platforms leverage AI to provide scalable, personalized interventions, and research increasingly suggests that many adults find them as effective, or in some cases more accessible, than traditional in-person therapy (Cornish, 2020; Jeong et al., 2025; Mak et al., 2023). Canadian polling data show that adults are

increasingly turning to AI-enabled mental health tools, with usage highest among younger and racialized Canadians (Mental Health Research Canada, 2024).

Prevalence of AI and Digital Systems in Stepped Care

Stepped care has become one of the most widely adopted models for structuring mental health service delivery, and digital systems now play a central role in its global expansion (Compri et al., 2025; Mediavilla et al., 2022, 2024). Across diverse settings and populations, countries and international bodies are integrating online platforms, app-based interventions, AI mediated tools, and digitally delivered psychological programs into stepped care pathways (Igelström et al., 2020; Jagayat et al., 2024; Jeong et al., 2025; Mak et al., 2023; Mediavilla et al., 2022). These systems are not marginal supplements to traditional care, but increasingly constitute the first point of contact for adults experiencing mild to moderate psychological distress (Horwitz et al., 2024). Importantly, the World Health Organization (WHO) has also developed and evaluated its own stepped care intervention model (Compri et al., 2025; Mediavilla et al., 2022, 2024) demonstrating that stepped care is now embedded not only in national innovation strategies but also within global mental health infrastructures. The following examples illustrate the prevalence of digital and AI supported stepped care interventions across multiple countries and contexts.

AI and Digitized Stepped Care for Adults

Hong Kong. Mak et al. (2023) examined the development of TourHeart+, a web-based stratified stepped care platform designed to promote mental wellbeing in adults. Although internet access in Hong Kong is high (92%), uptake of digital mental health tools has historically been low due to preference for face-to-face counselling, stigma, and the high cost of private care. Using qualitative interviews (n=28) and empathy mapping, the designers identified that adults

with mild symptoms often relied on willpower and self-reliance, while adults with more severe symptoms described hopelessness and a desire for anonymous support. Barriers across groups included stigma, lack of motivation, and difficulty maintaining self-care habits. In response, TourHeart+ incorporated culturally responsive features focused on patience, hope, self-knowledge, and habit scaffolding. Its design was driven directly by user readiness rather than clinician-based triage, making it a strong example of stratified stepped care aligned with local cultural context (Mak et al., 2023). Initial testing showed that users were able to navigate the platform easily and viewed it as helpful for supporting their own wellbeing. Participants also reported that the platform felt relevant to their needs, and the iterative design process led to clearer content and more personalized features. Although the study did not measure clinical outcomes, these early indicators suggest that a digitally delivered stratified stepped-care model can be both feasible and acceptable when shaped through user-centered design.

Europe. Across Spain, Belgium, Portugal, France, Italy, and the Netherlands, Mediavilla et al. (2022, 2024) evaluated the efficacy and cost effectiveness of a two-step stepped care model for health care workers with mild to moderate distress during the COVID pandemic. Step 1 consisted of online Acceptance and Commitment Therapy (ACT) modules and mindfulness exercises over five weeks, supported by telephone guidance. Step 2 used the WHO interventions Doing What Matters and Problem Management Plus for individuals requiring higher-intensity care. Participants valued confidentiality, flexibility, and accessibility, although common barriers included digital literacy, limited time, stigma, and unequal access to technology. Organizational leadership and a workplace culture of care were critical factors that supported successful implementation (Mediavilla et al., 2022, 2024).

Canada. In Canada, Jagayat et al. (2024) examined a stepped care model delivered entirely through internet-based CBT (iCBT) using the Online Psychotherapy Tool or Platform (OPTT) among 58 adults diagnosed with major depressive disorder. Participants either received iCBT only (Step 0) or progressed through a structured sequence in which intensity escalated based on symptom monitoring and engagement. Steps ranged from asynchronous therapist messages (Step 1), to weekly phone calls (Step 2), weekly video sessions (Step 3), and psychiatric consultation with optional medication management (Step 4). Stepping decisions were determined using PHQ 9 scores, homework completion, and goal tracking, demonstrating how digital stepped care can maintain clinical safety while expanding access and scalability.

Sweden. Igelström et al. (2020) conducted a qualitative study as part of the U CARE AdultCan trial, which evaluated an internet-based stepped care program for cancer patients experiencing anxiety or depression. The first step consisted of psychoeducational resources and self-help modules, with individuals who continued to experience distress offered iCBT. Participants reported that the digital format improved flexibility and allowed them to better integrate mental health support with cancer treatment. However, they also identified challenges including technical issues, emotional fatigue, and a desire for increased human connection. The authors recommended improvements in usability, personalization, support options, and emotional sensitivity, emphasizing the need for iterative refinement to ensure equity and effectiveness (Igelström et al., 2020).

Korea. In Korea, Jeong et al. (2025) evaluated Mindling, a 10-week schema informed digital intervention delivered through a web and mobile platform. Although not designed as a formal stepped care model, the authors explicitly situate the intervention within stepped care principles, arguing that digital schema informed programs can serve as scalable, low intensity

entry points that can be escalated to more comprehensive treatment when needed. The program demonstrated high completion rates and increased help seeking. Participants frequently cited anonymity, affordability, and self-paced learning as motivators, particularly within a cultural landscape in which stigma and self-reliance shape mental health behaviour.

AI and Digitized Stepped Care for Children and Youth

Sweden. In Sweden, between 20 and 30% of children and youth experience at least one anxiety-related condition, yet many remain untreated because of long waitlists and limited community resources (Olsson et al., 2025). To address this gap, Olsson et al. (2025) conducted a randomized pilot trial comparing a stratified care model with a stepped-care approach. In the stratified model, children aged 8 to 17 were assigned directly to either iCBT or in-person CBT-based on clinical indicators. In the stepped-care model, all participants began with iCBT and were stepped up to in-person CBT only if improvement was insufficient.

Feasibility challenges were largely therapist-centred, reflecting time and resource strain, whereas acceptability was judged through satisfaction, completion rates, and adverse events. Although the study was not powered to detect differences in efficacy, both models were considered safe and acceptable, with early indications that stratified care might produce stronger clinical response. Because most participants were referred through Child and Adolescent Mental Health Services rather than voluntarily seeking treatment, satisfaction with iCBT was lower than in previous studies. Even so, this pilot demonstrates how stepped and stratified models can be integrated into real-world youth services to expand access while revealing how therapist-driven feasibility criteria differ from recovery-oriented frameworks that centre client readiness, choice, and effort.

India. In contrast to Olsson et al. (2025), whose trial used a traditional stepped-care progression from lower to higher intensity, Hronis (2025) draws on Cornish's description of Stepped Care 2.0 as a flexible progressive model designed to accommodate varying levels of readiness and preference while maintaining efficiency (Cornish, 2020). This lens is particularly useful when examining emerging youth adaptations in India, where developmental context, stigma, and family systems significantly shape engagement. India faces extensive unmet youth mental health needs: approximately 11 million children under five have developmental disabilities, and 17% of youth aged 10 to 19 experience mental health conditions, yet fewer than 1% receive treatment (Nisarga et al., 2024). Public insurance coverage remains limited, with the national survey data showing that only 37% of the population had any form of health coverage in 2017 to 2018 (Ghia & Rambhad, 2023).

Nisarga et al. (2024) caution that progressive stepped-care models cannot be transplanted directly into India's context. Families often act as health gatekeepers, so youth-centred models based on readiness and choice must integrate family engagement from the outset. This makes a blended approach combining stepped-care sequencing with stratified assignment, more feasible in practice. Gellatly et al. (2024) further note that many evidence-based treatments reflect cultural bias, as they were developed primarily through North American randomized controlled trials with predominantly White participants. When applied uncritically in racialized or resource-constrained contexts, these models risk reproducing access barriers rather than reducing them.

Stigma also functions differently in India. Raghavan et al. (2023) report that stigma tends to be experienced at the family or community level rather than solely as an internalized belief. Sehgal et al. (2025) found that among Indian youth, social stigma (41.7%) far outweighed self-stigma (11.2%), and many young people rarely discussed mental health with family. They were

more likely to seek support from friends. Gellatly et al. (2024) observed that some adolescents dismissed counselling as “foolish” or unnecessary, indicating that sensitization activities at Step 0 may be essential to normalize counselling and clarify its purpose.

Sehgal et al. (2025) also show how digital tools can support progressive stepped care. In their survey of 278 youth, 41.7% feared negative reactions to therapy, yet 77% of those who used chatbots found them helpful. Adolescents strongly preferred text-based communication for its privacy and flexibility, and smartphone access was high at 87%. However, they reported that many digital tools lacked cultural relevance. Examples, metaphors, and coping strategies were mismatched with Indian lived experiences, and tools rarely integrated local languages or India-based support systems. Participants valued chatbots that offered warmth, affirmation, and culturally grounded encouragement rather than impersonal clinical responses.

Altogether, these findings underscore that progressive stepped-care approaches for youth must be adapted to developmental stage, cultural context, and family systems. They also illustrate that digital tools can support readiness, privacy, and incremental engagement when they are culturally attuned and integrated into local service pathways.

WHO-Led Digital and AI-Supported Stepped Care Interventions

The World Health Organization (WHO) has developed several scalable psychological interventions (e.g., Doing What Matters, Problem Management Plus), clinical guidelines such as mhGAP, and implementation manuals that are increasingly being incorporated into stepped-care programmes internationally (Compri et al., 2025; Purgato et al., 2023; World Health Organization, 2024). In a multinational study involving migrants experiencing psychological distress, Compri et al. (2025) evaluated the combined use of Doing What Matters, a low-intensity WHO-guided self-help program, followed by Problem Management Plus, a higher-

intensity WHO intervention delivered digitally or remotely when symptoms persisted. This approach demonstrates how WHO interventions are being adapted into structured stepped-care pathways across cultural settings.

Similarly, the RESPOND health care worker trials implemented a stepped-care programme using WHO-developed interventions across several European countries (Mediavilla et al., 2022). Health care workers first received online ACT-based modules and WHO's Doing What Matters as Step 1, with those who continued to experience distress stepped up to Problem Management Plus delivered through video-based sessions (Mediavilla et al., 2022; 2023). Together, these trials illustrate how WHO interventions are being integrated into international stepped-care programmes, highlighting the scalability of digital and task-shared approaches within global mental health systems.

Limitations of Stepped Care

Stepped care, while promising in theory, has struggled in practice. In BC, provincial stepped-care guidance for depression and anxiety is built almost entirely around a narrow suite of evidence-based protocols, primarily iCBT, CBT, and IPT, delivered in standardized formats and sequenced through algorithmic triage (Vancouver Coastal Health Research Institute & Centre for Clinical Epidemiology and Evaluation, 2021). Too often, implementation drifts toward stratified care, where clinicians or algorithmic triage classify patients at intake and determine treatment intensity, resulting in unnecessarily long waitlists to be assessed by a specialist for people with low-intensity needs (Cornish et al., 2024). This reliance on professional judgment re-centers decision-making in the hands of experts and leaves clients outside collaborative processes, undermining the original intent of stepped care as a flexible, client-guided model. Stepped systems also create fragmentation and allocation errors, since decisions about who assesses, how

steps are defined, and what counts as sufficient response vary widely across services (Berger et al., 2022; Lindberg et al., 2024; Mughal et al., 2023).

Large-scale programs like IAPT revealed inconsistent fidelity, high dropout rates, poor outcomes for complex cases, and relapse after low-intensity treatment. Allocation is frequently shaped by organizational routines or demographic biases rather than client choice, and user preference is rarely incorporated meaningfully. Scholars have challenged the assumption that greater severity always requires high-intensity treatment, noting that this logic perpetuates over-medicalization (Boyd et al., 2019; Cornish, 2020, 2024). Moreover, when stepped care is tethered to cost-savings, it risks becoming a rationing tool rather than a recovery pathway (Mughal et al., 2023). In short, the model's limitations lie in its fragmentation, clinician-driven orientation, neglect of client autonomy, and vulnerability to neoliberal efficiency metrics (Cornish, 2020, 2024). When translated into digital formats, the model often privileges scalability and efficiency over cultural relevance, relational depth, and developmental fit (Gellatly et al., 2024; Nisarga et al., 2024; Sehgal et al., 2025). As a result, digital tools risk reproducing inequities through access barriers, stigma, and cultural mismatch, while reinforcing rigid, protocol-based escalation.

Public-Private Partnerships and Digital Innovation

Digitizing stepped care has become fertile ground for the rise of P3s. The internet now serves as a medium through which ideas about P3s are disseminated, shaping public opinion and persuading stakeholders of their relevance. For instance, Dr. Daniel Edgcumbe, Vice President of Medical & Regulatory Affairs and Country Medical Director at Roche Canada (Hoffmann-La Roche Limited, 2025), has argued that P3s are not optional but essential for addressing systemic challenges in Canadian health care. He highlights persistent gaps, including too few providers,

rising burnout, heavy caseloads, limited-service availability, and inequities related to socioeconomic status and ethnicity, suggesting that coordinated partnerships can help address these challenges (Hoffmann-La Roche Limited, 2025). According to Edgcumbe, solutions lie in aligning the efforts of public agencies, clinical institutions, corporate partners, and academic sectors, allowing them to jointly confront system-wide strains, improve service quality, foster innovation, and bolster economic resilience. Similar to how Graham et al. (2019) describes FHIR standards connecting disparate systems, Edgcumbe frames P3s as the connective tissue that enables coordination across sectors.

Transform Health (2022), an NGO-led global coalition of more than 200 organizations, argues that equitable digital health requires coordinated investment across governments, donors, and private partners. In its *Closing the Digital Divide* report (2022), the coalition cites the WHO's goal of achieving universal health coverage (UHC) by 2030, framing digital innovation as a critical pathway toward that target. Transform Health underscores that public funding alone cannot realize this pathway and calls for coordinated multi-sector investment, including public-private collaboration, to mobilize additional financing, technical expertise, and infrastructure. Within the Transform Health model (2022), governments and civil society retain responsibility for equity, regulation, and accountability, while private partners contribute innovation and resources. This framework implies that principles, values, and ethics must form the foundation upon which operational systems are built, rather than being retrofitted after digital systems and infrastructure are already decided.

Evidence from digital health initiatives reinforces this trend. Ganapathy et al. (2021) describe how P3-based telemedicine and digital health programs have been promoted as efficient solutions for expanding access, particularly in resource-constrained settings. Yet their analysis

also reveals recurring governance challenges: uneven oversight, fragmented accountability, and risks of widening inequities when private partners drive technological adoption faster than regulatory frameworks can adapt. Their findings illustrate how digital innovation, when embedded in P3 structures, can simultaneously accelerate service delivery and reproduce systemic vulnerabilities. This duality mirrors the tensions emerging in digitized stepped-care models, where technological expansion is often celebrated while questions of equity, public accountability, and long-term sustainability remain unresolved.

Principles for Digital Health Governance in Stepped Care

As digital systems, AI-driven triage, and P3s reshape the architecture of stepped care, it becomes increasingly important to clarify what should guide these transformations. Arguably, operational systems cannot dictate values; rather, ethical principles must form the foundation upon which digital infrastructures are built. Holly et al. (2023) argues that digital health transformation and P3 involvement are already happening, so governance must catch up to ensure equity and rights are protected. The WHO has echoed this emphasis, welcoming Transform Health's *Closing the Digital Divide* report as a timely resource to advance its Global Strategy on Digital Health (2020–2025) (Transform Health, 2022). Holly et al. (2023) then propose a structured framework of principles for the creation of health data governance garnered through the elicitation of stakeholder feedback from public sector institutions, global agencies, civilians, young constituencies, academia, digital regional health networks, and the private sector stakeholders.

Holly et al. (2023) provide eight health data governance principles, consisting of three overarching objectives that are designed to complement and reinforce one another: protect people, promote health value, and prioritise equity. Under *protect people*, the principles

emphasize safeguarding individuals and communities, building trust in data systems, and ensuring data security. They include protections against exploitation, discrimination, and bias, alongside requirements for informed and collective consent, transparent processes, and robust technical safeguards across the data lifecycle. Under *promote health value*, the principles focus on enhancing health systems, facilitating data sharing and interoperability, and promoting innovation using health data. These objectives stress strengthening resilience, empowering frontline workers, establishing common standards, and applying governance responsibly to emerging technologies. Finally, under *prioritize equity*, the principle aims to ensure that the benefits of health data are distributed fairly and that data rights and ownership are clearly codified. It embeds equity into governance, ensures representation of marginalized groups, mitigates bias, and operationalizes rights through participatory mechanisms such as health data trusts and cooperatives. Collectively, these eight principles provide a comprehensive framework for health data governance that safeguards against harm, maximizes public value, and embeds justice and equity at every level.

At a broader scale, global governance frameworks emphasize equity, human rights, and inclusion by ensuring that marginalized groups, women, and youth are represented in data-governance decisions; transparency through clear rules on how health data is collected, stored, and used; accountability via oversight, audits, and redress mechanisms; participation through civil-society and community involvement; rights protection for privacy, consent, and safeguards against discrimination; and global alignment that encourages countries to adopt unified approaches, building on the WHO's push for a global health-data governance framework (Transform Health, 2022). Although framed as an ethical and participatory governance framework, Holly et al.'s (2023) principles are shaped within a context of global public-private

partnership (GPPP) collaboration, highlighting the potential for tension between equity objectives and the structural imperatives of neoliberal P3s (Sanders et al., 2023).

Origins and Principles of Primary Health Care

The WHO has consistently acted as a broker of principled action in global health, negotiating consensus among governments and civil society and shepherding values into formal commitments. Its pivotal presence was especially clear in the mid-20th century, when the WHO convened and guided international debates that crystallized into the foundational principles of primary health care (PHC). Sanders et al. (2023) describe how PHC emerged from a series of international conferences in the mid-1960s, where scholars and health planners developed community-based, rural-first health systems and shaped early policy recommendations and academic models. These ideas were further refined in WHO and UNICEF publications and culminated in the 1978 Alma-Ata Declaration, which established a global commitment to universal PHC and formally recognized health as a human right (Sanders et al., 2023; World Health Organization, 1978).

The concept of PHC was later expanded to include “comprehensive” primary health care (CPHC), describing health measures that encompass promotion, prevention, treatment, and rehabilitation, while addressing social determinants of health for entire populations, not just individuals or communities (Sanders et al., 2023). These commitments to a global vision of health care were concretized in five principles: equitable access based on need rather than privilege; comprehensive care including prevention, promotion, treatment, and rehabilitation; intersectoral collaboration to address social determinants of health; active community and individual participation fostering self-reliance; and the use of appropriate, cost-effective, locally suitable technology (Sanders et al., 2023). This historical grounding is directly relevant to the

research question because these PHC principles establish the equity-oriented, population-level foundations that continue to shape how mental health services are organized in Canada, influencing the conditions under which counsellors and interns practice and the expectations placed on them within publicly funded systems. These historical commitments demonstrate that principled, ethical frameworks have long underpinned health system design, providing a model for how modern digital and P3 initiatives must also be guided by clear values and equity-driven governance. However, the values embedded in CPHC did not remain uncontested, and the decades that followed saw the rise of neoliberal reforms that fundamentally reshaped global health governance.

Neoliberalism

The Emergence of Neoliberalism as a Dominant Governing Ideology

Emerging in the 1980s, neoliberalism positioned itself as the cure for inflation, advancing policies that dismantled regulatory safeguards, opened industries to market competition, and sold off public enterprises to private interests (Barnoff et al., 2017). Neoliberalism is often introduced as an evolution of earlier liberal traditions, yet it marks a significant departure from classical or reform liberalism. Classical liberalism of the 18th and 19th centuries emphasized individual liberty, equal opportunity, mixed economies combining free markets with government regulation, targeted state intervention to mitigate the harms of capitalism, commitment to pluralism, and the rule of law (Mullaly, 1997). Neoliberalism, by contrast, advances the premise that social and economic progress is best achieved through the expansion of market mechanisms, the reduction of state authority, and the increased role of private-sector actors in public service delivery (Rutar, 2023).

Across social policy, public administration, and critical health studies, scholars consistently describe neoliberalism as the dominant governing paradigm in many Western democracies from the 1980s onward (Clarke, 2004; Harvey, 2005; Navarro, 2007). This paradigm has shaped health care restructuring (Sakellariou & Rotarou, 2017), privatization and outsourcing (Armstrong & Armstrong, 2023; Hurl et al., 2022), P3 expansion (Harvey, 2005), digital governance (Jobberns & Guihot, 2024; Zamani & Rousaki, 2024), and widespread shifts toward performance management and user-responsibilization (Brown, 2015). As Sanders et al. (2023) explain, neoliberal policy reforms sought to "liberalize" markets by reducing regulation, expanding privatization, and curtailing public-sector authority, prioritizing economic expansion over social protection.

In practice, this approach has often privileged national growth metrics over the rights and needs of marginalized populations, particularly communities experiencing poverty or structural disadvantage. Zeira (2022) demonstrates that these reforms have contributed to rising rates of mental illness and emotional distress, with evidence showing that populations in neoliberal capitalist nations experience significantly higher levels of psychological suffering compared to welfare-oriented states. The dismantling of social protections, coupled with economic insecurity and precarious employment, has intensified poverty and widened inequities, disproportionately affecting minority populations. These structural conditions not only exacerbate distress but also correlate with declining life expectancy and "deaths of despair," underscoring how neoliberal economic policies translate directly into adverse mental health outcomes (Zeira, 2022).

Sanders et al. (2023) argues that neoliberal actors, including the Rockefeller Foundation, played a key role in dismantling the WHO-championed CPHC in favor of a Selective Primary Health Care (SPHC) model. This shift undermined the foundational principles of societal and

economic advancement, cross-sector collaboration, and community engagement in the design, implementation, and oversight of PHC. SPHC represented a move from a multidimensional view of health encompassing mental, physical, and social well-being to a narrow biomedical, disease-focused approach; from community and individual agency in health matters to professional, top-down control; from addressing systemic determinants of health to prioritizing medical and technical interventions; from multidisciplinary, collaborative teams to single medical professionals; and from multisectoral collaboration to primarily medical interventions (Sanders et al., 2023).

Arguably, these systemic and operational changes reflected a broader ideological shift in values. Where CPHC emphasized holistic health, well-being, and equity, SPHC prioritized efficiency, disease-targeting, and reductionist approaches (Sanders et al., 2023). Empowerment, participation, and self-determination gave way to professional authority and centralized decision-making. Social justice, equity, and attention to social determinants of health were replaced by a focus on technical effectiveness and measurable outcomes. Collaboration and inclusivity were narrowed to specialization and hierarchy, and systems thinking and intersectoral equity were reduced to narrow interventions with an emphasis on cost-effectiveness (Sanders et al., 2023).

Neoliberalism Influence in Health care Policy and Funding Arrangements

Under neoliberal influence, health care increasingly became structured as a business: interventions were costed, packaged, and justified through economic efficiency rather than social justice or holistic well-being. As Sanders et al. (2023) observes, the World Bank's *Investing in Health* report and the WHO's subsequent Commission on Macroeconomics and Health institutionalized market principles and cost-effectiveness analysis, privileging interventions that were most easily measured. In doing so, they reframed health systems as sites of investment and

return rather than rights-based social infrastructure dividing the populace into those with access and those without. The trickle-down effect can be seen in current health care themes felt in Canada and internationally: cutbacks in publicly funded health care, rollbacks of public funding, and the expansion of FFS (CMA, 2024; Marchildon et al. 2020; Sanders et al., 2023).

Strumberg and Taher (2025) highlight how payment systems carry both intended and unintended consequences. FFS models incentivize service volume and prioritize diseases that can be cured, but often fragment care and overlook broader dimensions of patient well-being. In contrast, outcomes-based payments encourage holistic care yet impose additional cognitive and administrative burdens on providers, who must track, document, and justify outcomes across multiple metrics. This parallels Sanders et al.'s (2023) critique of cost-effectiveness analysis, in which the system prioritized what could be measured, cured and counted, rather than what could be prevented, supported, or addressed holistically. Both analyses underscore how neoliberal logics of efficiency and measurability reshape health care delivery, privileging quantifiable outcomes over equity, participation, and holistic well-being.

Parallels in Stepped Care and Neoliberalism

The operationalization of stepped-care models is increasingly shaped by evidence-based therapy (EBT) protocols, algorithmic triage, and outcome-driven classifications. These features reflect not only clinical priorities but also the broader neoliberal logics currently structuring health care, where efficiency, scalability, and cost-effectiveness are paramount. In this context, stepped care functions simultaneously as a vehicle for expanding access and as an instrument of system rationalization, embedding therapeutic delivery within infrastructures that privilege measurable outcomes and algorithmic decision-making. Historical analyses reinforce that these dynamics are not new. Gooding (2016) shows how earlier reforms in Victoria, Australia, framed

around empowerment and consumer choice, were deeply intertwined with neoliberal restructuring that shifted responsibility onto individuals while reducing public investment. His account illustrates how market-aligned governance logics have long shaped mental-health policy, providing a lineage for understanding why contemporary stepped-care models so readily align with efficiency-driven, outcome-oriented infrastructures.

Evidence. Stepped care is consistently framed around EBT protocols (Mediavilla et al., 2024; Mughal et al., 2023; Scott & Henry, 2017), outcome monitoring (Richard, 2009; Smith et al., 2020; Wakefield et al., 2021), and clinical trial validation (Delgadillo et al., 2022; Harter et al., 2018; Olsson et al., 2025), all of which serve as central pillars of neoliberal governance in health systems (Sanders et al., 2023). Large-scale evaluations such as Richards and Suckling's (2009) Phase IV cohort study of IAPT and Richards et al.'s (2012) analysis of routine implementation illustrate how stepped care is operationalized through standardized outcome measures and productivity-driven performance indicators. Systematic reviews and meta-analyses further reinforce the dominance of cost-effectiveness and symptom-reduction metrics (Jeitani et al., 2024; Wakefield et al., 2021), the very indicators most compatible with market-oriented accountability frameworks.

Randomized controlled trials including Härter et al. (2018) on guideline-based collaborative care, Olsson et al. (2025) on youth anxiety, and Delgadillo et al. (2022) on stratified versus stepped care solidify stepped care's legitimacy through methodologies that fit neatly within neoliberal preferences for predictability, comparability, and auditability. Complementary international evaluations (Compri et al., 2025; Nisarga et al., 2024) further position stepped care as a model that can be scaled and monitored across jurisdictions, aligning with global health systems increasingly oriented toward measurable performance. Qualitative

and mixed-methods studies (Berger et al., 2022; Igelström et al., 2020; Mareya et al., 2024) show that even local adaptations tend to occur within this overarching logic. Collectively, this evidence base demonstrates how stepped care has become anchored in measurement-driven accountability structures, a hallmark of neoliberal health policy.

Algorithms. Stepped care is also increasingly mediated by algorithmic systems that convert subjective distress into standardized data points, enabling triage decisions that reflect both clinical utility and the neoliberal imperative for efficient resource allocation. Wen et al. (2023) and Wolitzky-Taylor et al. (2025) show how predictive algorithms in the STAND model automate care level assignment for emerging adults, while Mak et al. (2023) demonstrate how stratified stepped care is embedded in web-based platforms architected for scale and interoperability. Symptom metrics like the PHQ-9 and GAD-7, analyzed by Smith et al. (2020), function as algorithmic triggers for treatment progression, reinforcing a model in which classification and throughput, understood as how many clients can be moved through a system, become central markers of system performance.

Digital interventions, including Jagayat et al.'s (2024) iCBT trial and Mediavilla et al.'s RESPOND program (2022, 2023, 2024), illustrate how automated monitoring, threshold-based triage, and data-driven risk detection have become integral to stepped-care delivery. Critiques such as Arns et al. (2023) call for biomarker-driven matched care reveal the degree to which stepped care is now imagined through the lens of precision optimization, further aligning with neoliberal preferences for personalization as efficiency, rather than personalization as holistic care (Church, 2018). These studies demonstrate that stepped care has evolved into a model governed not only by clinical evidence but by algorithmic decision infrastructures that reflect

and reproduce neoliberal health-system values: standardization, predictability, cost-effectiveness, measurement, and performance management.

Evidence-Based Therapy: "Gold Standard" or Neoliberal Subterfuge?

Questioning the Motivations and Rationale for EBT

This compels us to ask: what would it mean to return to the foundational values and principles of health care, in order to fully grasp how far neoliberal and profit-driven systems have taken us, and the rationales we have used to justify those trajectories? Sturmberg and Taher (2025) note that the business framework used in health care upholds free-market principles, individualism, and choice, which are embedded in evidence-based treatment service delivery. However, Mullaly (1997) stipulates that choice, in this respect, is not truly choice, since the machinations of the free market are devoid of scruples and ethics, thereby inhibiting transparency. In this framing, what is presented as choice is, in fact, neoliberal choice: the freedom to participate in a competitive marketplace, rather than an informed or equitable decision. Ironically, evidence-based treatments, widely promoted within a business framework and rooted in randomized controlled trials, are positioned as the "gold standard," a designation that evokes associations with money, profit, and material wealth and underscores how deeply the language of health care is entangled with economic values.

This narrowing of "choice" is not only theoretical but evident in policy. Smith (2022) critiques Ontario's decision to privilege iCBT as the sole publicly funded therapy option within the Mindability program, delivered through private providers such as MindBeacon (Government of Ontario, 2020; MindBeacon, 2020), illustrating how "evidence-based" was operationalized to mean what could be measured and monitored (e.g., symptom scores, completion rates, and compliance metrics). Thus, evidence-based practice becomes tethered to efficiency frameworks,

reinforcing neoliberal priorities of accountability and cost-effectiveness while relying on measurable indicators that biomedicalize emotional distress and behavioral difference, thereby labeling clients as deficit-laden rather than considering systemic factors contributing to their mental health challenges. By privileging standardized interventions, this approach restricts client autonomy to choose alternative therapies that could better address trauma or reduce systemic barriers to well-being. Smith (2022) further argues that the ideological underpinnings of neoliberalism are particularly hostile to persons with disabilities, as those who cannot be 'cured' or 'fixed' by CBT are deemed unable to responsibly self-manage and return to the workforce.

While these critiques highlight the narrowing and exclusionary effects of evidence-based practice when operationalized through neoliberal policy frameworks, other scholars defend the principle of EBT. By contrast, Lee and Hunsley (2015) argue that evidence-based practice is essential for distinguishing science from pseudoscience and ensuring that clinical decisions are grounded in empirical evidence rather than intuition or anecdote. Their position emphasizes EBT as a safeguard against unvalidated or potentially harmful practice. This discussion is directly relevant to the research question because the dominance of EBT within neoliberal policy environments shapes the therapeutic options available to clients, the constraints counsellors and interns must navigate in publicly funded systems, and the degree to which practice can remain responsive to client needs rather than to efficiency metrics or market logics.

Methodological and Structural Biases in EBT

Lee and Hunsley (2015) defend the methodological hierarchy of evidence-based practice, arguing that peer-reviewed RCTs are of the highest quality and therefore the most reliable evidence. They show that studies comparing research trials with real-world practice find similar

results, suggesting that evidence-based treatments work even for patients with multiple or complex problems. Further, they argue that treatments using manuals build therapeutic alliance.

Conversely, Sijercic et al. (2021) found that the structure and demanding format (e.g., manuals, trauma focus, cognitive tasks), the pace (e.g., asking for deep engagement before alliance is secure), and rigidity (e.g., heavy reliance on manual protocols instead of client's needs) of cognitive processing therapy (CPT), an EBT, inhibited the requisite early bonding required to sustain commitment, resulting in higher drop-out rates.

Building on this concern, Shedler (2018) directly refutes Lee and Hunsley's confidence in manualized approaches, noting that treatments such as manualized CBT, though widely promoted as "evidence-based," often fail to deliver lasting benefits for many patients with conditions like depression and panic disorder, as symptoms frequently recur within six to twelve months. He further highlights that randomized controlled trials for CBT routinely exclude up to 80% of prospective participants and rely on contrived control groups that do not represent legitimate alternative therapies. These practices inflate apparent effectiveness while rendering the majority of patients invisible in the research record. The "evidence-based" label has thus been appropriated by advocates of brief, manualized interventions, narrowing the scope of debate about what constitutes effective therapy. Critiques of this paradigm are frequently dismissed as anti-scientific, illustrating how the rhetoric of evidence can be mobilized to silence dissent and entrench a market-driven conception of care.

Howick (2019) similarly found that evidence-based medicine is strongly shaped by financial bias, influencing how studies are designed, implemented, and whether they reach publication. Jureidini and McHenry (2022) extend this critique to the structural level, contending that privatization concentrates ownership and control of knowledge in the hands of industry

elites, leading to the suppression of unfavorable trial results, the withholding of adverse event data, and restricted access to raw datasets. Together, these critiques underscore how methodological exclusions, financial bias, and privatized control distort the evidence base, with profound consequences for scientific integrity and patient safety.

Rebuilding Health care on Foundational Values

Competing Value Systems in Health care Delivery

Sturmberg and Taher (2025) identify two distinct types of health care delivery: (1) cost-effective, evidence-based services driven by business and economic values rooted in investment and profit, and (2) needs-based patient care guided by ethically and socially focused values grounded in humanistic principles of caring, collaboration, and equity. They argue that these competing value systems reflect divergent worldviews so starkly opposed that they generate cognitive dissonance. For example, values in a business frame (e.g. return on investment, profit, markets, products, services, customers, and employees) are antithetical to humanistic values of benevolence, equity, collaboration, sustainability, and diversity, including culture, meaning, and religion. Without moralizing on either framework, Sturmberg and Taher contend that conscious societal reflection is required to determine how health care systems should define their purpose. They further suggest that the organizing elements embedded in a health care system's structure are inseparable from the values driving them, so society must consciously decide on those aims rather than accept the status quo.

Philosophical Worldviews: Cnidus vs. Cos

Sturmberg and Taher (2025) further point out that the ethics embedded in each worldview reflect deeper philosophical beliefs. Evidence-based approaches emphasize treatable and curable diseases through disease classifications; a perspective aligned with the Greek school of Cnidus.

This orientation is rooted in values of individualism and libertarianism, leading to professional fragmentation into specializations, reliance on randomized controlled trials focused on cause-and-effect, and prescribing remedies. By contrast, these values are misaligned with the Hippocratic Oath and the School of Cos, which emphasized holistic, patient-centered care that prioritizes the whole person and highlights the interdependencies across somatic, social, emotional, and cognitive domains. This approach shapes consultation styles that focus on listening, sense-making, and shared decision-making to achieve the patient's best possible quality of life (Sturmberg & Taher, 2025).

Re-Aligning Stepped Care with the Principles of Health

In sum, the mental health care system has drifted far from the principles that originally guided public health and primary care, particularly those enshrined in the WHO's vision of CPHC (Sanders et al., 2023). These principles of equity, universal access, holistic attention to health and well-being, prevention, and community participation were designed to ensure that health systems served the needs of all people, not just those who could navigate or pay for specialized services (Sanders et al., 2023). Over time, however, the infusion of neoliberal ideology has reshaped these systems, privileging market logic, efficiency, competition, and profit over social justice, collective well-being, and holistic care (Church, 2018; Harvey, 2005; Sanders et al, 2023). Under this paradigm, "freedom" is defined as the ability to pursue self-interest without state interference, rather than as the capacity for all members of society to access care and participate fully in their health (Mullaly, 1997).

This ideological shift has had profound effects on how health care is structured and delivered. Evidence-based treatments, framed as the "gold standard", have become instruments not just of clinical rigor but of economic rationality (Howick, 2019; Juredidini & McHenry,

2022; Sturmberg & Taher, 2025). Interventions are valued primarily for their measurability, scalability, and cost-effectiveness, rather than for their capacity to promote comprehensive well-being or equity (Sturmberg & Taher, 2025). Services are often rigidly categorized, triaged, and rationed according to algorithms, standardized protocols, and hierarchical professional judgment. While this has produced efficiencies and reproducible outcomes, it has also introduced fragmentation, excluded complex or non-conforming patients, and constrained the diversity of approaches that might be beneficial (Mughal et al., 2023; Shedler, 2018). Digitalization and P3s have amplified these trends, embedding systems in technological infrastructures that prioritize data output, compliance, and measurable results over humanistic care (Government of Ontario, 2020; MindBeacon, 2020; Smith, 2022).

Yet, within this landscape, stepped care offers a glimmer of what could be possible. Its strengths are evident in expanding access for rural populations, reducing barriers of stigma and logistical constraints, accommodating the realities of everyday life, and allowing resources to be deployed efficiently according to intensity needs (Cornish, 2020, 2024; Mental Health Commission, 2021). These elements suggest that a system designed to scale care, preserve flexibility, and reach underserved populations has real potential to support more equitable access.

The challenge lies in the ways stepped care has traditionally been operationalized. By tethering treatment access and progression to rigid protocols, algorithmic triage, and clinician-driven decisions, the model often reproduces the very inequities it seeks to alleviate (Cornish, 2020, 2024). Access remains conditional, client autonomy is limited, and the narrow focus on measurable outcomes privileges interventions that fit within the existing economic and clinical paradigm (Berger et al., 2022; Cornish, 2020, 2024). In essence, the system preserves the logic of

neoliberal health care (Cornish, 2020, 2024) while superficially appearing flexible or client-centered (Mughal et al., 2023).

These critiques illuminate the need for a reorientation: rather than bending ethical and humanistic principles to fit the machinery of efficiency and profit, the system must be rebuilt so that these principles form the foundation of health care (Cornish, 2020, 2024). Across the literature, values such as equity, collaboration, holistic well-being, and client autonomy should drive how care is designed, delivered, and evaluated. Reimagining stepped care as a recovery-based framework is presented not just as a service delivery adjustment, but a transformative approach that empowers individuals to actively engage in their own mental health journey while preserving the accessibility, scalability, and flexibility that make stepped care effective. By emphasizing client choice, readiness, and lived experience, and enabling individuals to self-direct and access a wider array of supports, the literature suggests that the strengths of stepped care can be preserved while its structural constraints are reduced. In this synthesis, stepped care becomes practice-based, evidence-informed, and values-driven, restorative rather than purely transactional, and genuinely aligned with the foundational goals of comprehensive, equitable health care (Cornish, 2020, 2024). Having outlined the systemic limitations, ideological constraints, and practical inequities embedded in current stepped-care approaches, the next section presents a recovery-based reinterpretation designed to realign care with foundational humanistic and equitable principles.

Recovery-Based Model of Stepped Care

Shifting Beyond the Risk Paradigm

While earlier implementations of stepped care have been shaped by risk-based, efficiency-driven logics, the literature presents SC2.0 as a recovery-aligned reinterpretation of the model rather than a historical evolution. This framing positions SC2.0 as a direct response to

the limitations identified in traditional stepped-care systems. Cornish (2020, 2024) argues that traditional stepped care, modeled on the UK systems widely adopted internationally, is anchored in a risk paradigm in which clinicians or algorithms triage clients according to severity, risk, or deficit. Yet empirical evidence shows weak correlations between such assessments and actual outcomes, and the ability to predict risk of harm to self or others remains limited (Arns et al., 2023; Cornish, 2020, 2024; Smith, 2020). Even advances in machine learning and deep learning have not resolved these limitations; while AI tools can provide supplementary insights, the evidence base remains early, and these models cannot replace human judgment or meaningfully reduce uncertainty (Thakkar et al., 2024). This means that risk-based triage operates with a veneer of precision it does not actually possess. As a result, it reproduces inequities, conditional access, and deficit-based labeling, while reinforcing neoliberal logics of efficiency, accountability, and risk management rather than supporting client autonomy. Cornish (2020, 2024) explicitly links the dominance of risk paradigms to neoliberalism, noting that the obsession with measurable outcomes, accountability frameworks, and efficiency metrics narrows the scope of what counts as legitimate care. Understanding this shift matters for the research question because it changes the conditions under which counsellors and interns practice, moving them from systems that prioritize risk management and throughput toward models that emphasize collaboration, autonomy, and recovery-oriented engagement with clients.

Recovery-Aligned Stepped Care (SC2.0)

Cornish (2020, 2024) contends that mental health systems must shift away from risk as the organizing principle of service delivery. Instead of classifying clients by deficits or risk, SC2.0 emphasizes choice, flexibility, and strengths-based approaches. Its person-centered design deliberately incorporates the cultural landscape of each client by drawing on community-based practices and customs, while removing the façade of professional expertise that often reinforces

hierarchy. Cornish further argues that recovery-aligned systems must be explicitly anti-oppressive and attentive to the cultural and relational contexts in which healing occurs. SC2.0 therefore draws on community-rooted practices, relational healing traditions, and, where invited, Indigenous knowledge systems such as circle practices and the medicine wheel. He is careful to avoid cultural appropriation, emphasizing humility, co-design, and respect for cultural sovereignty. SC2.0 also decentralizes clinical authority by positioning clinicians as collaborators rather than gatekeepers, and it treats autonomy, dignity, and lived experience as therapeutic mechanisms rather than variables to be managed (Cornish, 2020, 2024). Because SC2.0 offers a buffet of treatment options from the outset through open-access delivery, and approaches each encounter using a start-simple / start-strong philosophy drawn from both single-session therapy (a model designed to make one session complete and sufficient) and one-at-a-time therapy (a recovery-oriented stance that treats each session as meaningful while allowing clients to choose whether to return), thereby maximizing efficiency and client-directed care, clients can afford to make mistakes, fail forward, and eventually find a fit that works for them; an approach that reframes trial and error as a natural part of recovery rather than a sign of noncompliance, reinforcing humanistic principles of client-centered care. This pluralistic, low-barrier structure also reduces stigma and expands accessibility by eliminating diagnostic gatekeeping and allowing clients to move fluidly between modalities without re-assessment or justification.

Cornish (2020, 2024) insists that triage, staged care, and pathway models are essentially variations of the same logic: all rely on clinician-driven classification and conditional access, thereby reproducing inequities and undermining autonomy. He critiques the narrow way evidence-based practice is operationalized, arguing that it entrenches deficit-based labeling and restricts care to what can be measured. In contrast, SC2.0 treats practice-based evidence, cultural

knowledge, and client-defined goals as legitimate sources of guidance, and it is intentionally designed to be fluid, pluralistic, and adaptive rather than linear or prescriptive. The SC2.0 model has no triage gatekeeping, no waitlists, no risk-based sorting. Clients choose what they want to access, and when. The system assumes readiness, not risk.

Practice-Based Evidence and Client Choice

In contrast, Cornish (2020, 2024) advocates for practice-based evidence (PBE), where knowledge emerges from lived experience, iterative practice, and client-guided adaptation. In this paradigm, clients, and not protocols, become the primary source of insight about what works. Importantly, he emphasizes that therapists must remain attentive to therapeutic processes, approaching each session as if it were the client's only session, maximizing efficiency and therapeutic impact, beginning with accessibility and meeting clients where they are. Because PBE depends on accessibility, this translates directly into open access, with therapy delivered on the client's terms rather than following a predetermined number of sessions or rigid schedules. Clients guide the frequency, duration, and mode of intervention. The recovery-based model is inherently multi-modal process-driven, self-correcting, and responsive to client readiness, offering in-person, e-mental health, phone, text, chatbots, and web-based options, along with a wide array of treatment modalities ranging from self-directed programs, walk-in services, wellness initiatives, group work, and life coaching to intensive therapy, psychiatric oversight, and inpatient care. This pluralism is not simply variety; it is the structural expression of client autonomy, self-correction, and humanistic engagement.

Cornish's (2020, 2024) version of stepped care (SC2.0) is therefore not a pathway model. It rejects staging and triage and instead offers a progressive, fluid system designed to maximize client choice and flexibility. Care is not "stepped up" or "stepped down" based on risk or severity; rather, clients move freely among options guided by preference, readiness, and

strengths. Cornish's central claim is that escaping neoliberal risk paradigms requires abandoning evidence-based frameworks in favor of practice-based evidence, and replacing pathway-based triage systems with progressive, client-directed models. In doing so, mental health systems become emancipated to realign with the humanistic principles of universal, equitable, participatory care outlined in WHO's vision for CPHC (Sanders et al., 2023; World Health Organization, 1978).

Task Shifting and Task Sharing in Stepped Care

A core principle of WHO's CPHC is the reliance on, and utilization of, "all health workers" - a term that encompasses both specialists and non-specialist workers in the community who collaborate to deliver health care services to the entire population (Sanders et al., 2023; World Health Organization, 1978). As laid out in the 1978 Alma-Ata Declaration, community health workers (CHWs) were central to CPHC, and health systems were expected to mobilize local communities, train lay and paraprofessional workers, and integrate them into multidisciplinary teams in order to extend care to underserved populations (Sanders et al., 2023; World Health Organization, 1978). These workers, often referred to as paraprofessionals, lay counsellors, community mental health workers, advocates, educators, midwives, faith-based or traditional healers, and *promotoras*, delivered health care services that would otherwise have been unavailable to their communities (Sanders et al., 2023). This emphasis on community-rooted care reflects the foundational PHC principle that health systems must be built around people, not professions.

Numerous studies have demonstrated that health care systems, both in Canada and globally, cannot sustain centralized models in which specialized professionals deliver the majority of care (Barnet et al., 2018; Heetderks-Fong & Bobb, 2023; Hoeft et al., 2018). Barnett

et al.'s (2018) systematic review strengthens this conclusion by synthesizing evidence across diverse settings, highlighting consistent findings that trained community health workers can safely and effectively deliver mental health interventions, a pattern supported by transparent methods, validated outcome measures, and convergence across multiple studies. High demand, limited resources, long waitlists, high burnout rates, staffing shortages, and persistent social inequities indicate that simply investing more money is insufficient to resolve systemic challenges. Shifting tasks to CHWs to deliver frontline mental health care services allows specialists to concentrate on high-needs clients, increases access, decreases costs, and provides culturally appropriate care to diverse populations (Adewuya et al., 2019; Liani & Windarwati, 2021; Mukherjee et al., 2025; Pangagua-Avila et al., 2024; Sangraula et al., 2024). Canadian physicians Orkin and Oandasan (2025) argue that the growing demand for PHC services cannot be met without transitioning toward team-based care and implementing task sharing with community health workers. This message has been reinforced internationally by the WHO, as well as in both low- and high-income countries: to meet the needs of populations, WHO guidance emphasizes the need to embrace not only stepped care systems but also task shifting and task sharing (WHO, 2007; WHO, 2018; WHO, 2021). In this sense, task sharing is not an optional enhancement to stepped care but a structural requirement for any system claiming to be equitable, scalable, and recovery-aligned.

CHWs have formed the bedrock of PHC in rural and underserved regions across South Asia, Southeast Asia, East Asia, Latin America, and sub-Saharan Africa, offering accessible and culturally congruent support long before formalized mental health professions entered these spaces, and research further demonstrates their continued use in rural and low-income regions within high-income countries, challenging the assumption that task shifting is limited to low- and

middle-income contexts (Adewuya et al., 2019; Liana & Windarwati, 2021; Paniagua-Avila et al., 2024; Sangraula et al., 2024). This historical and ongoing contribution underscores the need for health care systems to realign with the original goals of universal health care promoting access, equity, client choice, and social justice rather than reinforcing centralized, credential-driven hierarchies that limit service delivery. To achieve this, care must be designed around the agency of individuals to choose treatments that match their readiness, needs, and values. This aligns directly with the SC2.0s philosophy of start-simple / start-strong, open access, and single session approaches, as well as its rejection of professional gatekeeping and its commitment to decentralizing authority across the workforce.

Studies increasingly focus on task shifting and task sharing arrangements in which CHWs, and particularly Community Mental Health Workers (CMHWs), assess and deliver mental health interventions, including evidence-based treatments, within stepped-care systems (Barnett et al., 2018; Hoeft et al., 2018; Mukherjee et al., 2025; Waitzkin et al., 2011). Hoeft et al.'s (2018) systematic review provides strong methodological grounding for these claims: by synthesizing evidence across diverse rural and low-resource settings using transparent search procedures, validated outcome measures, and cross-study convergence, the review demonstrates that non-specialist providers can effectively deliver mental health interventions despite heterogeneity and variable study quality, making its conclusions both credible and reliable. While these practices are well documented in low-and middle-income countries, it is less widely recognized that trained CMHWs have been part of the United States health workforce for more than seventy years, working both independently in community settings and within multidisciplinary teams in stepped-care arrangements, often serving in roles such as lay counsellors who deliver EBT to marginalized, vulnerable, and rural populations (Heetderks-Fong

& Bobb, 2024; Mukherjee et al., 2025). Heetderks-Fong and Bobb's (2024) mixed-methods design strengthens the credibility of these claims by combining survey data with qualitative interviews, allowing the authors to map CMHW roles, workplace conditions, and perceived impact with methodological transparency; although limited by self-report and sample size, the convergence across data sources and alignment with broader CHW literature make the findings both valid and reliable. These international patterns directly mirror the pressures facing Canadian mental health systems, where shortages of specialized providers, long waitlists, and rising population needs are driving a similar shift toward distributed, team-based, and stepped-care models, conditions that shape the practice environments, responsibilities, and expectations placed on counsellors and interns. Their roles vary by training and context and may include providing peer support, psychosocial assistance, care coordination, liaison work, and supporting client engagement with services. These functions mirror the relational, practical, and culturally grounded supports that recovery-oriented systems identify as essential but that professional models often overlook.

Although some CMHWs are trained to deliver evidence-based treatments, a role that may be contested by "experts" who guard the boundaries of professional jurisdiction, this is not the core of their contribution (Barnett et al., 2018; Hoeft et al., 2018). Their everyday work is fundamentally transdiagnostic, as they support clients around common experiences such as stress, trauma, stigma, worry, interpersonal difficulties, and social isolation, all of which cut across diagnostic categories (Waitzkin et al., 2011). Many CMHW programs rely on flexible, modular, common-elements approaches, including problem-solving, psychoeducation, behavioural activation, relaxation strategies, and strengthening social support, techniques shown to be effective across a wide range of mental health concerns (Barnett et al., 2018; Hoeft et al.,

2018; Ó hAnrachtaigh et al., 2024; Sangraula et al., 2024). These interventions are routinely adapted to local languages, community norms, and lived realities, highlighting the culturally and contextually grounded nature of CMHW practice (Liana & Windarwati, 2021; Waitzkin et al., 2011). This adaptability reflects the very principles of practice-based evidence and client-guided care that SC2.0 elevates as central to recovery-aligned systems.

This orientation closely aligns with Barlow's (2010) critique of siloed, diagnosis-bound treatments, emphasizing that shared transdiagnostic mechanisms of distress rather than strict diagnostic categories should guide intervention (Barlow, 2010, pp. 28–31). Barlow's Unified Protocol (UP) was developed in response to the limitations of disorder-specific clinical trial manuals and is now widely used as a flexible, transdiagnostic, evidence-informed framework across diagnoses (Barlow et al., 2017, 2018). Cornish (2024) extends this shift by demonstrating how recovery-based models increasingly rely on practice-based evidence, using continuous self-report monitoring and feedback-informed treatment to centre the client's lived experience of change. In this sense, CMHWs are already operating within the very paradigm that contemporary mental health systems are moving toward: transdiagnostic, flexible, culturally grounded, and guided by client experience rather than rigid diagnostic protocols. Their work embodies the SC2.0 principles of open access, start-simple / start-strong, client-directed, and humanistic care, showing that the future of stepped care lies not in increased specialization, but in community-rooted, relational, and recovery-aligned practice.

Conclusion

The literature reviewed in this chapter identifies several consistent findings across global and Canadian mental health systems. Research on primary health care, including the Alma-Ata and Astana Declarations, shows that international health frameworks have long emphasized

equity, community participation, and team-based models of care. Studies examining neoliberal reforms document how efficiency metrics, risk-based triage, and evidence-based treatment hierarchies have shaped service delivery structures in many countries, including Canada. Literature on stepped care demonstrates a shift from traditional, risk-driven models toward recovery-oriented approaches that prioritize client choice, flexibility, and practice-based evidence. Research on task shifting and task sharing consistently shows that community health workers and community mental health workers can effectively deliver mental health interventions when supported by appropriate training and supervision. Systematic reviews and mixed-methods studies highlight the feasibility, acceptability, and cultural relevance of these models across diverse contexts.

In summary, these findings outline the structural, historical, and policy conditions that shape the organization of mental health services within publicly funded systems. They establish the empirical context for the research question by identifying system-level trends that influence how counsellors and interns encounter, understand, and carry out their work within contemporary Canadian mental health settings.

Chapter 3: Discussion

Situating the Research Question

This capstone examined the research question: How have historical, political, and professional forces shaped publicly funded mental health service models in Canada, and how might counsellors respond to the ethical and systemic tensions embedded within these structures? Drawing on global health history, Canadian policy developments, stepped and stratified care literature, and critiques of neoliberal governance, the findings suggest that contemporary mental health systems are not neutral service structures. Rather, they are shaped by ideological commitments, economic pressures, and professional hierarchies that influence who receives care, what counts as legitimate intervention, and how care is delivered.

The literature demonstrates that the shift from Comprehensive Primary Health Care toward more selective, efficiency-driven models has profoundly influenced mental health service design. Stepped care, stratified care, digital platforms, and metrics-driven accountability systems have emerged within policy environments that prioritize cost-effectiveness, scalability, and measurable outcomes. While these models are often framed as solutions to access barriers, they simultaneously embed new forms of gatekeeping and categorization.

This chapter brings these macro-level findings into direct conversation with the counselling profession. If mental health systems are shaped by ideological and structural forces, then counsellors are not outside these systems. They are situated within them. The implications are therefore ethical, professional, and relational. Because counselling in BC and most of Canada is an unregulated field, professional identity is shaped less by legislation and more by professional culture: the shared norms, values, and boundaries reproduced through training programs, workplaces, and practice communities. Counsellors do not stand outside the systems

they work within; their professional identities are formed by the very ideological and structural forces that shape service models. Understanding this relationship is essential, because it means that system-level change is inseparable from the profession's collective culture and its willingness to support recovery-based, task-shared, population-level approaches.

Systemic Tensions Embedded in Contemporary Mental Health Models

Privatization and Market Logics

The literature consistently identifies the growing influence of neoliberal governance in shaping mental health policy. Within this paradigm, care is increasingly organized through market principles such as efficiency, competition, performance metrics, and cost containment. Publicly funded services often operate under resource scarcity, rigid eligibility criteria, and outcome monitoring systems designed to justify funding. For example, stepped care models, including Stepped Care 2.0 as articulated by Peter Cornish (2020, 2024), aim to expand access by matching intervention intensity to client need. At their best, these models promote flexibility, self-directed care, and resource optimization. However, the literature also highlights that when implemented within austerity-driven systems, stepped care can become a mechanism for rationing services rather than expanding them. Clients whose symptoms do not meet severity thresholds may be directed toward low-intensity or digital interventions regardless of preference, context, or complexity.

This tension reflects a broader shift in public services: care is increasingly conceptualized as a limited commodity to be distributed efficiently rather than a relational and universal public good. The result is a system that simultaneously claims to increase access while embedding structured exclusions.

Evidence Hierarchies and Professional Authority

The findings also illustrate how evidence hierarchies shape service provision. Randomized controlled trials and symptom-based metrics frequently determine which interventions are funded and prioritized. While evidence-informed practice is essential, the privileging of certain methodologies can marginalize relational, contextual, and culturally responsive approaches that are less easily quantified. Historically, public health movements rooted in equity and community-based care emphasized social determinants, relational engagement, and collective wellbeing. The literature suggests that contemporary models sometimes narrow this vision by focusing primarily on symptom reduction and short-term outcomes.

This creates a philosophical tension between two traditions of healing: one aligned with standardization, measurement, and technical intervention, and another grounded in relational presence, contextual understanding, and person-centered engagement. Modern mental health systems often attempt to reconcile these traditions, yet the structural dominance of efficiency-driven metrics can tilt the balance.

Drift from Foundational Public Health Values

The historical trajectory from Comprehensive Primary Health Care toward selective approaches illustrates how broader political and economic forces reshape health systems. Comprehensive models emphasized universality, community participation, and equity. Selective models prioritize targeted interventions deemed cost-effective for specific populations.

Within mental health services, this shift can manifest in narrowly defined eligibility criteria, short-term treatment models, and performance-based funding structures. Although these approaches may increase throughput, or how many clients can be moved through the care

system, they risk undermining relational continuity and holistic care. The literature therefore suggests that contemporary publicly funded mental health services are shaped by competing value systems: equity and universality on one hand, efficiency and fiscal constraint on the other. These tensions form the structural backdrop against which counsellors practice.

Implications for Counsellors and the Counselling Field

Counsellors as Situated Ethical Actors

After engaging with the literature reviewed in the preceding chapters, a new set of questions comes into view, less about what mental health systems do and more about what they ask of those who work within them. The discussion moves beyond evaluating whether stepped care, evidence-based treatments, or risk frameworks are effective on their own terms and instead considers how these organizing logics shape professional identity, ethical sensibilities, and everyday clinical decision-making. It also attends to the broader implications for the health care system as a whole and for the quality of life experienced by the populations it serves.

Within this shift, attention turns toward meaning-making, specifically how systems, assumptions, and "common sense" language, understood here as the taken-for-granted norms that shape everyday practice, may be lived, reproduced, or resisted by counsellors and interns as they navigate training, employment, and professional belonging. The question is not simply what the literature says, but what it makes visible. Across diverse bodies of research, a constellation of assumptions emerges about risk, evidence, efficiency, legitimacy, and choice that quietly organizes how care is delivered and how clinicians are trained to think about their work. A central contradiction becomes visible here. Clinicians often hold deep commitments to equity, universality, and justice, yet they work within systems whose structures, incentives, and norms

can unintentionally undermine those very commitments. Making this contradiction explicit clarifies why meaning-making is not merely reflective but ethically consequential.

Seen this way, and as discussed below, counsellors and interns are not positioned outside the system as neutral observers, nor merely within it as passive recipients. They are shaped by these structures while simultaneously participating in their reproduction through everyday practice decisions. This chapter therefore shifts toward examining what these findings mean for practitioners situated within contemporary mental health systems, particularly for those who hold commitments to equity, access, and social justice while operating within models that may constrain or redirect those values.

The discussion unfolds in two parts. The first focuses on meaning-making: examining how professional identity, authority, and ethical reasoning are formed within dominant frameworks such as risk-based triage, evidence hierarchies, the research we use to justify the work and practices, and both sides of the spectrum of privatized and public models of care. The second turns toward how a transformed understanding or evolved or shifted perspective might look in practice, exploring what alternative orientations could emerge if counsellors and interns understood their choices about settings, modalities, and roles, not as neutral career decisions, but as relational and political acts that help shape the mental health landscape itself.

To support this transition, it is helpful to signal that once the mechanisms shaping professional identity and practice are made visible, the next task becomes imagining how clinicians might act differently within, alongside, or against these structures. This bridge marks a shift from critique toward the exploration of alternative orientations and possibilities for practice.

Making the Invisible Visible

One of the clearest implications of this review is not simply what is present in the literature, but what is conspicuously absent. Across discussions of stepped care, evidence-based treatment, and system design, transdiagnostic approaches and the work of community mental health workers, community health workers, and other community-based providers remain marginal or invisible. This absence is not incidental; it reflects how legitimacy is assigned in mental health research, privileging credentialed professionals, manualized interventions, and outcomes that can be easily measured, while sidelining forms of care that are relational, adaptive, and embedded in everyday community contexts.

This invisibility is not accidental but produced through specific power relations: credentialism, funding structures, evidence hierarchies, and research methodologies that privilege certain forms of knowledge while systematically excluding others. From an ethical standpoint, this raises concerns that resonate with the BCACC and CCPA Codes of Ethics, both of which emphasize justice, equity, and respect for diverse forms of knowledge and experience (British Columbia Association of Clinical Counsellors [BCACC], 2014; Canadian Counselling and Psychotherapy Association [CCPA], 2020). Naming these mechanisms makes clear that what is absent from the literature is shaped by structural decisions about whose work is valued, counted, and made legible. When community-based practices and transdiagnostic approaches are rendered invisible, the profession risks reproducing inequities that its own ethical frameworks call on practitioners to challenge.

If these missing voices are brought into view, the picture of mental health care, and of transdiagnostic practice in particular, begins to look markedly different. Community mental health workers routinely engage in transdiagnostic work, supporting individuals around shared

mechanisms of distress such as trauma, stress, social isolation, and stigma rather than discrete diagnostic categories. Their practice is often flexible, culturally grounded, and responsive to immediate needs, yet it rarely appears in dominant research narratives. By deconstructing whose knowledge is counted and whose is excluded, and then reconstructing the discussion to include these forms of practice, transdiagnostic care emerges not as a novel innovation but as an already existing, widely practiced approach that has simply been underrecognized.

This process of reconstruction highlights the value of making visible what has long been treated as peripheral. It also challenges the assumption that meaningful reform requires starting from scratch. While the literature critiques P3s and neoliberal restructuring, existing systems, services, and infrastructures already operate within these arrangements. The question, then, is not whether these systems exist, but how they are being used, whose work within them is acknowledged, and whose remains unexamined. Supported housing programs, nonprofit services, and community-based mental health initiatives often rely on workers who are not credentialed within dominant professional hierarchies. As a result, both their labour and the outcomes experienced by the people they serve are largely absent from research and policy discourse.

If mental health systems are to be reimagined in more equitable and recovery-aligned ways, these forms of care cannot remain unstudied or undervalued. Research practices themselves must expand to include the knowledge generated through community-based work, lived experience, and practice-based evidence. Including community mental health workers and other community stakeholders in both research and system design is not an optional enhancement; it is a necessary step in understanding how care is actually delivered and how existing resources might be mobilized more justly. Seen in this light, the task is not only to

critique dominant models, but to broaden the field of vision. By recognizing and valuing what has been rendered invisible, the discussion shifts from asking how to build new systems to asking how to more fully see, study, and support the systems and practices that are already sustaining care in communities.

The Personal Is Political in Health Care

The literature encourages health care workers to reflect critically on the systems in which they practice. The personal is political: the values, beliefs, and mechanisms through which people are pathologized, as well as the attitudes embedded in health care systems, all carry political ramifications. Macdonald et al. (2018) note that the clinician's role is largely determined by the structure of public and private systems. By extension, personal choices regarding where clinicians work and the value-based tools they employ ultimately reinforce the political and economic arrangements that govern workplaces, procedures, and policies (Mullaly, 1997). Mullaly (1997, p. 164) argues that radical humanism, expressed through consciousness-raising at both personal and collective levels, is required to transform social and economic paradigms so that they more accurately reflect the wishes and needs of society.

These structural and epistemic dynamics do not remain at the level of policy or research. They shape the everyday realities of practice. What is rendered visible or invisible in system design becomes felt in clinical encounters; what is legitimized or marginalized in research becomes internalized in professional identity. In this way, the broader forces described above are not abstract, they are lived. The micro-level experiences of clients, counsellors, and interns reflect the same power relations that organize the system as a whole.

The Micro-Level Experience of Structural Forces

At the micro level, macro-level policies become lived experiences. A client who does not qualify for publicly funded services experiences exclusion. A counsellor who must triage under rigid criteria experiences constraint. An intern navigating these systems learns, implicitly or explicitly, what kinds of care are valued. These micro-level experiences reflect what might be understood as isomorphic dynamics: the pressures embedded in larger systems are reproduced within professional relationships. When care is organized around scarcity and efficiency, these logics can subtly shape clinical interactions. For counsellors, awareness becomes an ethical intervention in itself. Recognizing how structural forces shape practice enables counsellors to engage in reflective decision-making rather than unconscious reproduction of institutional priorities.

Ethics

Ethical Meaning-Making and Professional Accountability

After engaging with this body of literature, the central task is no longer simply synthesis, but reflection on what these findings ask of clinicians themselves. Both the BCACC and CCPA Codes of Ethics emphasize commitments to justice, equity, and fair access to services, positioning counsellors as responsible not only to individual clients but also to the broader public good (BCACC, 2014; CCPA, 2020). These codes call for awareness of systemic barriers and for practice decisions that do not inadvertently contribute to inequity. Against this backdrop, the literature raises an unavoidable question: counsellors and other health care clinicians frequently articulate commitments to universal access, social justice, and equity, but do prevailing practice choices ultimately support these commitments, or do they reinforce a gradual shift toward privatization and a two-tier health care system?

Within market-based societies, private business ownership is often associated with autonomy, success, and professional legitimacy. These values, however, take on different ethical implications when applied to health care. When clinicians move into private practice, they do not merely make a neutral career decision; they participate in and reinforce a privatized model of care that is structurally distinct from needs-based, universal health care. Over time, this participation contributes to the normalization of a two-tier system in which access is shaped by ability to pay rather than by clinical need.

Fee-for-service (FFS) models further illustrate how market logics become embedded in clinical practice. The BCACC emphasize that financial arrangements must not compromise client welfare or distort clinical judgment, and that counsellors must avoid exploiting clients or allowing economic pressures to shape care (BCACC, 2014). Yet when care is structured around billable units of time, clinical encounters are necessarily shaped by economic constraints. Decisions about session length, frequency, and intensity become tethered to reimbursement structures rather than client need. Time itself becomes commodified, and therapeutic care is implicitly assigned monetary value. These dynamics subtly but powerfully shift practice away from collective, needs-based principles and toward transactional forms of care delivery.

The literature reviewed in this paper suggests that such shifts are rarely experienced as overt ethical dilemmas. Instead, they are absorbed through professional norms, training expectations, and “common sense” assumptions about what constitutes legitimate practice. As a result, clinicians may unknowingly reproduce systems that contradict their stated commitments, not through malice or indifference, but through unexamined alignment with dominant structures. This is precisely why both BCACC and CCPA emphasize reflective practice, social

responsibility, and awareness of how professional participation can sustain or challenge systemic inequities (BCACC 2014; CCPA 2020).

From this perspective, meaning-making is not an abstract or purely intellectual exercise. It is an ethical process that requires clinicians and interns to critically examine how their professional identities, practice settings, and economic arrangements either sustain or disrupt inequitable systems. The question is not whether individual clinicians intend harm, but whether their participation, taken collectively, reinforces models of care that prioritize efficiency, profitability, and professional status over universality, equity, and access. This returns us directly to the research question: if historical, political, and professional forces shape publicly funded mental health systems, how might counsellors respond to the ethical tensions embedded within those structures?

Ethical Meaning-Making in Practice

These micro-level experiences show how structural forces become lived realities in practice, shaping the decisions counsellors make and the limits they encounter within those systems. The exclusions clients face, the constraints counsellors navigate, and the norms interns absorb are not isolated events; they are the lived expression of broader ideological and structural arrangements. This means that the question of how counsellors respond to systemic tensions is not abstract or optional, it is embedded in daily practice. With this in mind, the discussion now turns to ethical meaning-making and professional accountability, examining how clinicians interpret, enact, or resist the very forces that organize the mental health landscape.

The discussion of ethics in this context is fundamentally about the values embedded in the next generation of mental health professionals. It raises a rich set of questions regarding how our professional practices shape interns' developing interests, professional identity, and ethical

sensibilities over time. Clinicians are navigating multiple ethical layers simultaneously: the ethics of their own practice choices, the ethics of the care they provide to clients, and the ethics of how they mentor and supervise interns. A key dilemma emerges when commercial pressures intersect with commitments to equitable care. This tension forces clinicians to confront whether their day-to-day decisions genuinely reflect their stated values or whether those values are being quietly reshaped by the economic and institutional logics of the systems in which they work. How do we teach interns to hold both sets of values to provide accessible, just, and recovery-oriented services while also navigating systems that may incentivize efficiency, revenue, or client flow?

Principle of Justice (CCPA Code of Ethics, Principle E)

According to the Canadian Counselling and Psychotherapy Association's Code of Ethics, Principle E defines justice as "respecting the dignity of all persons and honouring their right to just treatment" (CCPA, 2020, p. 2). Viewed through a justice lens, the literature reviewed here reveals an isomorphic pattern between how mental health systems respond to client needs and how they respond to the developmental needs of counsellors and interns. Systems that ration care, prioritize throughput, or condition access on efficiency tend to reproduce similar constraints at multiple levels. Just as clients may be required to fit predefined pathways, time limits, or diagnostic thresholds in order to receive care, clinicians and trainees may be required to conform to productivity expectations, institutional norms, or market logics in order to receive adequate supervision, support, and opportunities for professional growth.

This isomorphism has important implications for professional identity formation. When client care is structured around scarcity, risk management, or economic efficiency, clinicians are implicitly socialized to value speed, containment, and compliance over relational depth, responsiveness, or contextual understanding. In parallel, when training and early career

environments prioritize service delivery over developmental needs, counsellors may learn that their own growth, uncertainty, and learning processes are secondary to institutional demands. In both cases, needs are managed rather than meaningfully met.

Justice, in this sense, is not only about equitable distribution of resources, but about equitable recognition of need across roles and developmental stages. If systems normalize unmet client needs as an unavoidable reality, they may also normalize unmet developmental needs among clinicians. This parallel shapes how counsellors come to understand what is reasonable to expect, both for those they serve and for themselves. Over time, this can narrow professional imagination, limiting the capacity to envision forms of care or training that are more humane, flexible, or responsive.

From an isomorphic perspective, inequities in access are mirrored across the system. Clients who do not fit dominant models may experience exclusion or premature discharge, while counsellors who do not adapt easily to prevailing productivity or privatization norms may experience constrained career pathways, limited mentorship, or diminished professional legitimacy. These patterns are rarely framed as justice issues, yet they directly influence whose needs are prioritized, whose labour is supported, and whose identities are allowed to develop fully within the profession.

Attending to justice therefore requires disrupting these processes. A system that aspires to equitable, recovery-oriented care must also attend to the developmental and relational needs of those delivering that care. Recognizing isomorphism makes visible how justice at the level of client access and justice at the level of professional development are not separate concerns, but mutually reinforcing conditions. Without addressing both, inequity is likely to be reproduced, even within reforms explicitly designed to improve access or efficiency.

Principle of Nonmaleficence (CCPA Code of Ethics, Principle C)

Nonmaleficence, the commitment to avoid harm, is central in this context and applies first to counsellors and clinicians as active participants within contemporary mental health systems (CCPA, 2020). When market demand, efficiency metrics, or institutional pressures shape clinical practice, there is a risk that care becomes increasingly transactional, standardized, or constrained by external imperatives rather than guided by client need. These conditions can produce harm not only for clients, through reduced responsiveness or limited access, but also for clinicians themselves, by narrowing professional judgment, diminishing relational depth, and normalizing practices that conflict with their ethical commitments.

These dynamics extend into training and supervisory contexts, where similar pressures may overshadow the developmental and learning needs of interns. Harm can occur when supervision is insufficient, when meaningful learning opportunities are restricted, or when rigid, risk-based frameworks limit creativity, responsiveness, and client-centered practice. In such cases, the same system logics that constrain client care also shape how emerging professionals are socialized into the field, reinforcing patterns that privilege efficiency and compliance over growth, reflection, and ethical discernment.

Non-maleficence also applies to decisions about clinical models, such as single-session or one-at-a-time therapy. If clinicians resist adopting these models because of financial or comfort-based reasons, or if they impose unnecessarily long or rigid session structures, there may be unintended ethical implications for client autonomy, access, and recovery. Similarly, clinicians must consider how their personal ethical choices about engaging (or not engaging) with transdiagnostic or community-informed models may either support or hinder the delivery of optimal care. In this sense, harm is not limited to clinical missteps but includes the quieter harms

produced when professional comfort, habit, or economic self-protection take precedence over practices that expand access, autonomy, and recovery.

Together, these principles underscore the interconnectedness of ethics, justice, and non-maleficence in contemporary mental health practice. Ethical reflection requires clinicians to consider not only their individual actions but also how systemic structures, supervisory decisions, and professional norms shape the experiences of interns, clients, and the broader community. The challenge is to align personal and professional ethics with social justice commitments, client-centered care, and inclusive, recovery-oriented practice, while acknowledging the structural and economic realities that often constrain these choices.

Applications

Evidence-Based Rhetoric and Practice-Based Reality

Operationalizing a recovery-aligned model requires acknowledging a core tension within contemporary mental health systems. At the level of policy and professional rhetoric, evidence-based treatments are upheld as the gold standard. Yet in everyday clinical practice, the work often looks different. Clients rarely present with a single, neatly defined diagnosis. They present with overlapping stressors, fluctuating readiness, relational strain, trauma histories, and socioeconomic pressures. Strict adherence to manualized protocols can result in disengagement when clients experience the approach as misaligned with their needs or preferences. In response, clinicians adapt. They integrate relational strategies, shift modalities, soften structure, or prioritize alliance over protocol. These modifications are typically made in an effort to remain client-centred and responsive.

What emerges from this reality is not pure evidence-based treatment in its manualized form, but practice-based evidence generated within transdiagnostic, real-world settings.

Operational drift is not necessarily the result of negligence; it may reflect an adaptive response to client complexity and structural constraints. However, because professional discourse continues to privilege tightly controlled evidence hierarchies, this adaptive practice often remains underexamined.

Structuring Flexibility: Recovery-Aligned and Single-Session Approaches

If the field is committed to accessibility and population-level reach, then applications must include studying and legitimizing the work that is already occurring. Recovery-aligned, start simple / start strong, single-session and one-at-a-time approaches offer a way to formally structure this flexibility. Rather than positioning adaptation as deviation, these models recognize variability in client autonomy, readiness, and desired level of support as central variables in care delivery. In this sense, SC2.0 provides a structured framework for the flexibility clinicians are already exercising informally

Measurement Practices That Support Collaborative Care

This shift also requires measurement practices that align with collaborative and responsive care. Traditional outcome measures such as the Outcome Questionnaire-45 (OQ-45) and the Counseling Center Assessment of Psychological Symptoms (CCAPS) can be lengthy and less collaborative (Lambert et al., 1996; Lock et al., 2011). Within Stepped Care 2.0, Cornish (2020, 2024) has noted that earlier tools such as the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) captured relational and functional dimensions but did not adequately assess client preference for autonomy or stepping decisions. The Behavioral Health Measure-20 (BHM-20) has been adopted in some SC2.0 contexts because it is brief, psychometrically sound, and capable of capturing relevant domains while remaining feasible in flexible service environments (Cornish, 2020, 2024). Tools of this nature allow programs to gather structured

outcome data without reverting to rigid, protocol-driven delivery. They also help bridge the gap between evidence-based rhetoric and the realities of adaptive, client-led practice.

AI as Adjunct, Not Centerpiece

Artificial intelligence and digitized services, within this framework, function as adjunctive mechanisms rather than centrepieces. They can expand reach, support navigation, and assist with data collection, but they do not replace relational care. The central pivot is philosophical: a movement from a system that primarily reacts to severity toward one that offers multiple entry points and levels of support across the continuum of need. AI becomes one tool among many, not a substitute for human connection.

Learning From Community-Based and P3 Settings

Applications should also extend to P3 and community-based settings, where much transdiagnostic work is already occurring. Research in these environments can examine how community mental health workers generate practice-based evidence while delivering responsive care. Rather than treating drift as failure, such research could clarify which adaptations enhance engagement, which preserve outcomes, and how flexibility can be systematized without sacrificing accountability. This is particularly important in settings where CMHWs are already delivering the bulk of frontline care.

Evolving Clinical Roles in Single-Session and Community-Embedded Models

Under single-session and one-at-a-time therapy models, clinicians may assume roles that differ from traditional weekly, office-based practice. In community-embedded and task-sharing environments, clinicians may function not only as direct service providers but also as educators, consultants, and supervisors, while simultaneously learning from community mental health workers about frontline care delivery. This reciprocal exchange reframes expertise as distributed rather than hierarchical, requiring collaboration across disciplines and credential levels.

Such settings often necessitate greater flexibility in how authority and responsibility are negotiated. Clinicians accustomed to independently delivering structured, multi-session treatment may need to adapt to shorter encounters, shared case conceptualization, and fluid stepping decisions. The emphasis shifts from cumulative therapeutic progress across weeks to maximizing the clinical impact of each contact. This transition calls for training that prioritizes session intensity, alliance formation, and collaborative goal clarification within compressed timeframes.

Financial structures also intersect with implementation. In private practice contexts where income is tied to repeated sessions, one-at-a-time models may present economic tensions. In contrast, salaried or unionized public settings may offer greater feasibility for this approach, as clinician compensation is not directly linked to session volume. These structural realities influence how readily such models are adopted and highlight the broader labour and equity considerations embedded within system reform.

Working across multiple sites, including public-private partnerships (P3s) and community agencies, further shifts professional orientation. Rather than operating in isolated private offices, clinicians may collaborate within multidisciplinary teams and engage with families, cultural organizations, peer supporters, and other community stakeholders. This broader engagement aligns with comprehensive primary health care (CPHC) principles, situating mental health within interconnected social and community systems rather than treating it solely as an individual clinical concern.

For recent graduates whose training has been primarily private-practice oriented, these shifts may require significant recalibration of expectations regarding autonomy, authority, and scope of practice. Implementation therefore involves not only procedural changes, but

professional adaptation. How counsellors interpret and negotiate these evolving roles will influence whether recovery-aligned, flexible systems are operationalized or resisted.

A Philosophical Pivot: From Cnidus to Recovery-Oriented Systems

At a structural level, this approach represents a philosophical pivot. A Cnidus-aligned efficiency paradigm privileges symptom thresholds and moderate-to-severe presentations, often leaving subclinical or early distress unaddressed. In contrast, a recovery-oriented model of stepped care (SC2.0) is consistent with the holistic worldview of the School of Cos and with comprehensive primary health care (CPHC) principles articulated by the World Health Organization (WHO), prioritizing population-level access and graduated responsiveness. The goal is not to replace clinical expertise with digital tools or task sharing, but to reposition these elements as supports within a broader relational system.

Professional Culture, Identity, and the Conditions for System Change

Finally, implementation requires cultural reflection within the profession. “Counselling” in global mental health discourse refers to a skill set and relational competency rather than a protected title. Community mental health workers, nurses, social workers, peer support workers, and counsellors may all provide counselling functions. Whether recovery-aligned and task-sharing models take root depends not only on administrators but on professional culture itself. Collective attitudes toward role flexibility, collaboration, and shared expertise shape whether new models are resisted or operationalized. Because professional identity is formed within, and reinforced by, professional culture, shifts in practice require shifts in the shared norms, values, and assumptions that define what it means to be a counsellor. Professional identity, in this sense, becomes a determinant of system change.

In this way, application is not merely procedural. It is epistemological. It asks the field to examine the gap between what is claimed as standard practice and what is actually occurring, and to decide whether to deny that gap or to study, refine, and ethically structure it. This is the work of aligning practice with values, systems with ethics, and models with the lived realities of clients and communities.

Chapter 4: Conclusion

This capstone examined how historical, political, and professional forces have shaped publicly funded mental health service models in Canada, and how counsellors might respond to the ethical tensions embedded within these structures. Across the literature, a consistent pattern emerges: contemporary mental health systems are not neutral arrangements but products of ideological commitments, economic pressures, and professional hierarchies that influence who receives care, what forms of intervention are legitimized, and how services are organized. The shift from comprehensive primary health care toward selective, efficiency-driven models has produced systems that prioritize throughput, risk management, and measurable outcomes, often at the expense of relational continuity, universality, and community-grounded practice.

The literature also demonstrates that stepped care, stratified care, and digital platforms have developed within policy environments shaped by neoliberal governance. While these models aim to expand access, they can also embed structured exclusions when implemented within resource-constrained systems. Evidence hierarchies further shape service delivery by privileging standardized, manualized interventions and marginalizing relational, contextual, and culturally responsive approaches. At the same time, research on community mental health workers and transdiagnostic practice reveals forms of care that are flexible, culturally grounded, and widely used in community settings, yet often rendered invisible within dominant research and policy discourse.

These findings have significant implications for counsellors and interns. Because counselling in most of Canada is an unregulated profession, professional identity is shaped less by legislation and more by the norms, values, and expectations reproduced through training programs, workplaces, and practice communities. The literature suggests that clinicians are

situated within the very systems they critique, and that their practice choices regarding setting, modality, and economic arrangements, participate in the reproduction of those systems. Ethical commitments to justice, equity, and nonmaleficence therefore require not only attention to individual clinical encounters but also awareness of how professional participation can sustain or challenge broader inequities.

The discussion and applications sections of this capstone extend these insights by examining how structural forces become lived experiences for clients, counsellors, and interns. They highlight the isomorphic dynamics through which scarcity, efficiency pressures, and evidence hierarchies shape both client access and professional development. They also explore how recovery-aligned, flexible, and transdiagnostic approaches already practiced in many community settings offer pathways for aligning care with values of equity, responsiveness, and population-level reach. Implementing such approaches requires not only procedural adjustments but also cultural reflection within the profession, including a willingness to examine assumptions about expertise, legitimacy, and the boundaries of counselling practice.

Combined, the findings of this capstone suggest that system-level change and professional-level change are inseparable. If historical, political, and professional forces shape publicly funded mental health systems, then counsellors′ responses to these forces through their practice choices, ethical reasoning, and collective culture help determine whether recovery-oriented, equitable, and community-aligned models can take root. The task ahead is not only to critique existing structures but to participate in shaping systems that reflect the values the profession claims to uphold. In this sense, the future of counselling in Canada depends on the capacity of practitioners to align their work with commitments to justice, universality, and

relational care, and to support models that expand access and honour the diverse ways healing already occurs in communities.

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