HTA Austria
Austrian Institute for
Health Technology Assessment
GmbH

Child and adolescent mental health care models

A scoping review

Final report

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Project Team

Project leader: Dr.med.univ. Reinhard Jeindl

Authors: Dr.med.univ. Reinhard Jeindl
Viktoria Hofer, MSc

Project Support

Hand search: Dr.med.univ. Reinhard Jeindl
Viktoria Hofer, MSc

Visualisations: DI Smiljana Blagojevic

Internal review: Dr. Ingrid Zechmeister-Koss, MA

External review: Prof. Dr. med. Dr. P.H. Christian Bachmann (Child and adolescent psychiatrist, Health services researcher)
Brad Morgan (Director of Emerging Minds: the National Workforce Centre for Child Mental Health, Australia)

Correspondence: Reinhard Jeindl, reinhard.jeindl@aihta.at

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List of abbreviations

ADHD.....Attention Deficit Hyperactivity Disorder
AKH .....General Hospital (“Allgemeines Krankenhaus”)
ambBP.....Outpatient care places (“Ambulante Betreuungsplätze”)
Approx .....Approximately
ASVG.....General Social Insurance Act (“Allgemeines Sozialversicherungsgesetz”)
AU .....Australia
AT.....Austria
BMSGPK .....Federal Ministry of Social Affairs, Health, Care and Consumer Protection
BMZvs.....Full inpatient bed number (“Bettenmessziffer vollstationär”)
BÖP .....Professional Association of Austrian Psychologists (“Berufsverband Österreichischer Psycholog*innen”)
CAMH.....Child and adolescent mental health
CAMHS .....Child and adolescent mental health services
CH.....Switzerland
CZ.....Czechia
DE .....Germany
e.g. .....exempli gratia
e.V.....registered association (“eingetragener Verein”)
ES .....Spain
FGÖ.....Austrian Health Promotion Fund (“Fonds Gesundes Österreich”)
GFSG .....Society for the Promotion of Mental Health (“Gesellschaft zur Förderung seelischer Gesundheit”)
GÖG .....Gesundheit Österreich GmbH
HBSC .....Health Behaviour in School-aged Children
HDI .....Human Development Index
ICD-10 .....International Classification of Diseases, 10th Revision
KAKuG .....Federal Hospital Act (“Krankenanstalten- und Kuranstaltengesetz”)
KiJu .....Children and adolescents (“Kinder und Jugendliche”)

KMZ.....Capacity indicator (“Kapazitätsmessziffer”)
LKH .....Regional Hospital (“Landeskrankenhaus”)
LKL.....Regional Clinic (“Landesklinikum”)
MHAT.....Mental Health in Austrian Teenagers
NA .....not available
NO.....Norway
NR .....not reported
ÖBVP .....Austrian Federal Association for Psychotherapy
(“Österreichischer Bundesverband für Psychotherapie“)
ÖGKJP .....Austrian Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy
(“Österreichische Gesellschaft für Kinder und Jugendpsychiatrie“)
ÖSG.....Austrian Health Care Structure Plan (“Österreichischer Strukturplan Gesundheit”)
ÖZPGS.....Austrian Centre for Psychological Health Promotion in Schools
(“Österreichisches Zentrum für psychologische Gesundheitsförderung im Schulbereich”)
p.m.....post meridiem
p. .....page
PMZ .....Place measuring number (“Platzmessziffer”)
PSD .....Psychosocial Services (“Psychosoziale Dienste”)
Pts.....Patients
RdK.....Association Save the Children (Verein “Rettet das Kind”)
RQ .....Research question
RSG .....Regional Structure Plan for Health of Styria
(“Regionaler Strukturplan Gesundheit Steiermark)
SDW.....Addiction and Drug Coordination Vienna (“Sucht- und Drogenkoordination Wien”)
SPD .....School psychology service (“Schulpsychologischer Dienst”)
Ö .....Austria (“Österreich”)
UbG.....Involuntary Placement Act (“Unterbringungsgesetz”)
UK.....United Kingdom
UNICEF .....United Nations Children’s Fund
WHO.....World Health Organization

Executive Summary

Background and project aims

mental disorders: most common worldwide, high burden of disease; limitations in care

Mental health disorders are one of the most common conditions among children and adolescents worldwide, with a prevalence between 9 and 22 percent. The increasing need for care in this group of patients, with concurrent staffing and infrastructural limitations in child and adolescent psychiatric care, leads to considerations of adapted care models.

need for prevention because mental illness often start in childhood

In addition, the need for prevention is becoming increasingly apparent. For many adults suffering from mental disorders, the symptoms already occurred in early childhood and adolescence, but were often not identified or treated as such.

project aim: overview of international care models & indicators

The aim of this report is to provide an overview of international models of prevention and care of mental disorders in children and adolescents. We also want to give an overview of measurable characteristics (indicators) for a systematic monitoring of mental health care in this age group. The findings on prevention and care are intended as a basis for decision-making for the further development of Austrian child and adolescent psychiatric care structures.

Methods

hand search & expert consultations: Vienna, Styria, and nationwide for Austria

Performing a hand search and expert consultations, we collected information on current prevention and care services for children and adolescents nationwide for Austria, as well as for two provinces (Vienna and Styria).

12 documents from 7 selected countries: AU, CH, CZ, DE, ES, NO & UK

Based on selection criteria that should enable a broad variety of models but also transferability to Austria, we chose seven countries from which we analysed strategies and models for child and adolescent mental health. The selected countries were Australia, Switzerland, Czechia, Germany, Spain, Norway and the United Kingdom. By hand search, we identified 128 national documents, of which we selected twelve for further data extraction.

qualitative content analysis of topic areas

Data on various topic areas from the documents (e.g. target group, involved professionals, model components, care pathways) were extracted and presented in tabular form. We then conducted a qualitative content analysis of the topic areas and summarised them. We did not check whether the recommendations of the respective country strategies are already implemented.

hand search on indicators, classification & Excel-table

By hand search, we identified indicators that could be used for planning services and monitoring the mental health of children and adolescents at the population level. Subsequently, we classified the indicators according to different category systems (health indicators, quality indicators, and the classification system of Peitz et al). We presented the information on the indicators through a data synthesis, and provided them in an Excel table in the supplement.

comparison of 2 Austrian strategies with int. recommendations

In order to describe the similarities and differences between the Austrian care situation and the international strategies/models, we examined the contents of two strategies from Austria in relation to the previously mentioned topic areas. These two strategies were the child and adolescent health strategy, and the national mental health strategy. Furthermore, we compared to which extent the current prevention and care of mental health in children and adolescents corresponds to the international recommendations.

comparison of Austrian data sources with int. indicators

In addition, we compared the indicators already used in Austria with the previously identified international indicators. Using one to two examples per indicator group, we tried to create a basis for an in-depth comparison of Austrian data sources with international indicators.

methodology for alignment with int. strategies & indicators

The aim was to develop a possible systematic methodology for identifying differences to more closely align the Austrian prevention and care structures with international strategies, models and indicators.

Results

Current prevention and care situation in Austria

deterioration of mental health after COVID-19

The prevalence of mental disorders among children and adolescents remained relatively constant at 20 percent until 2019, but deteriorated substantially thereafter, mainly due to the COVID-19 pandemic. Available data, however, mainly refers to adolescents, with less data available for younger children.

broad range of services, in prevention mostly on project basis; currently no stand-alone strategy for CAMH

The promotion of mental health and prevention of mental disorders is mainly carried out on a project basis, with different offers in the individual federal states. Regarding care of manifest illnesses, in addition to the medical sector, there is a wide range of services in the social and educational sector with differing funding constellations. Overall, the data points to massive gaps in care, capacity limitations, regional inequalities and a lack of cross-sectoral coordination. Currently, there is no stand-alone national strategy for the mental health of children and adolescents that gives a higher priority to prevention measures.

International strategies and models

14 topic areas identified from int. documents

In the selected countries, a general mental health strategy exists, and in most countries, there is an additional strategy on child and adolescent mental health, as well as a suicide prevention strategy. From the documents, we identified 14 topic areas: information activities, prevention/promotion, detection, treatment, telemedicine, care pathways, transitional psychiatry, vulnerable patient groups, user participation, infrastructure, workforce development, implementation, digital tools for case management, and data acquisition/research.

promotion/prevention in the educational sector (additional staff)

In all selected countries, the importance of promotion and prevention is highlighted. For both, the educational sector, starting from kindergarten, plays an essential role. As recommended, this sector should be supported by additional staff on one hand, and the training of educators on topics of mental health on the other. The country strategies recommend a stronger involvement and user participation, especially of vulnerable groups (e.g. children and adolescents of parents with mental disorders). For better coordination, single points of access ("one-stop-shops") with staff to support system navigation are recommended.

needs-based approaches, outreach services (home treatment), participation of vulnerable patient groups

The key principles of the documents are described as increased flexibility of structures, open-mindedness, strengths orientation (instead of focusing on deficits and diagnoses). In this context, outreach services in different settings (e.g. "home treatment"), and other outpatient and telemedicine services are of greater importance. Predefined age thresholds in transitional psychiatry (e.g. from adolescence to adulthood) are critically questioned by the country strategies.

Regarding better cross-sectoral collaboration, the countries propose a shared vision, goals planning and funding. To support this, the strategies recommend national databases for child and adolescent mental health, with coordinated data acquisition and health services research.

cross-sectoral collaboration, national CAMH datasets

To better address care limitations, an expansion of the traditional health workforce with additional workers is recommended (e.g. allied health professionals, peer workers, LGBTIQ+ and diversity workers). A key recommendation is the further development of the mental health literacy of educators, which should be guided by mental health professionals.

expansion of the workforce, mental health literacy

Indicators for planning and monitoring

For this report, we identified 121 indicators for care planning and monitoring of child and adolescent mental health care. These indicators in general focus on the process and outcome quality, as well as health services and risk factors. Very few of the indicators deal with mental health promotion, mental health literacy, self-harm/suicide or associated costs.

121 indicators for planning and monitoring

Comparison of Austrian structures with the recommendations of international models and indicators

In the two existing Austrian strategies, six of the 14 topic areas are not specifically described for the mental health of children and adolescents. For the eight remaining topic areas, the strategies give recommendations, but only to a limited extent. Currently, there are several examples where Austrian structures correspond to the international recommendations – but often on a project basis and not nationwide. For some recommendations, however, we could not identify any equivalent in Austria (e.g. involvement of users in planning). For some of the international recommendations we did not have enough Austrian data for a detailed comparison. Regarding the indicators, we found that only a few have been used in Austria so far. They mainly focus on monitoring medical care, especially the inpatient setting.

topic areas in Austrian strategies not sufficiently addressed

Discussion

Interpretation of the findings

While there are many projects and services for child and adolescent mental health care in Austria, they are not linked to an overall national strategy and there are regional inequalities in access to services and a lack of coordination. In comparison with international recommendations, we were able to identify possible improvements in several areas: cross-sectoral strategy development, increased capacities and improved coordination.

areas for improvement: joint strategy, capacities, coordination

So far, extended care settings (e.g. home-treatment, inpatient equivalent care and other outreach approaches) have only been implemented to a limited extent in Austria. These could be further expanded in line with international recommendations to counterbalance inpatient limitations. The expansion of information activities and mental health promotion, as well as a nationwide early detection system including risk factors, are also desirable.

extended treatment settings (e.g. home treatment) necessary

While a nationwide integration of mental health and mental disorder topics in the teaching content was initiated, the strategies of other countries also recommend the introduction of additional school staff (e.g. well-being staff). Further potential of improvement lies in the cross-sectoral integration (with clear points of access) and adequate consideration of vulnerable patient groups

additional school staff, cross-sectoral integration, consideration of vulnerable patient groups

(e.g. juvenile criminal offenders with mental disorders). For a better alignment towards international recommendations, the user involvement and participation (children/young people and their families/carers) in the design of care structures is essential.

Limitations

some countries not taken into account; extent of strategy implementation not within scope

The data in this report was identified through a targeted hand search (instead of a systematic literature search). In addition, we were only able to consider a selection of countries for this report. Hence, there is a possibility that other novel child and adolescent mental health policies, models or indicators exist that are not included in this report. Furthermore, we did not collect data on the extent to which the strategies have already been implemented in the selected countries.

possibly additional information in excluded documents

Furthermore, we excluded the following documents: indication-specific (e.g. medical guidelines), or general health (instead of specific to mental health), or all ages (instead of specific to children and young people). These excluded documents might contain some supplementary information.

no specific indicator calculations collected

Regarding the indicators, no specific calculations were extracted. Additional data for the calculation of the indicators are available but are beyond the scope of this report.

assignment of content to defined categories sometimes challenging

The information in this report on the identified topic areas could not always be clearly assigned to the identified categories due to overlaps. The same was true for the mapping of indicators into the category systems. Many aspects of mental health care are intertwined, and although we have tried to match them carefully with the topic areas and categories, there may have been alternative ways of assignment.

Conclusion

creation of a stand-alone national strategy for this population group

For further adapting the Austrian child and adolescent mental health care structure, we recommend the creation of a stand-alone national strategy that focuses on the mental health of children and adolescents. This new strategy could integrate mental health promotion, prevention and care in a shared vision.

participatory, cross-sectoral, taking into account vulnerable groups and care limitations

The development of the strategy preferably is participatory and cross-sectoral (health, education, social and youth justice sectors). For this purpose, health services research should accompany the development and implementation, using prioritised indicators as a basis. The aim is to create a better way of dealing with shortcomings in care in general and for vulnerable patient groups specifically.

additional resources and more flexible care settings necessary, strengthening needs-based services

In order to meet the current shortage of hospital beds and psychiatrists, the outpatient sector (e.g. home treatment) and other needs-based services should be expanded with increased participation of internationally recommended professional groups. Overall, however, sufficient resources are needed (e.g., for the further development of care pathways, staff training, as well as developing evidence-based guidance of programmes and initiatives) to achieve improvements. In all steps of planning and implementation, a stronger involvement of users should be promoted.

Zusammenfassung

Hintergrund und Projektziele

psychische Erkrankungen: weltweit häufigste Erkrankung bei Kindern, hohe Krankheitslast; gleichzeitig Engpässe in der Versorgung

Zu den weltweit häufigsten Erkrankungen bei Kindern und Jugendlichen zählen psychische Erkrankungen, mit einer Häufigkeit (Prävalenz) zwischen 9 und 22 Prozent. Depressive Erkrankungen, Angsterkrankungen und Selbstverletzungen sind die häufigsten psychiatrischen Diagnosen mit einer hohen Krankheitslast. Der steigende Bedarf nach Versorgung dieser Patient*innengruppe, bei gleichzeitigem personellen und infrastrukturellen Engpass in der kinder- und jugendpsychiatrischen Versorgung, führt zu Überlegungen zu anderen Versorgungsmodellen.

Symptombeginn oft im Kindes-/Jugendalter, aber nicht adäquat erkannt

Zusätzlich wird immer deutlicher, wie wichtig die Prävention psychischer Erkrankungen bei Kindern und Jugendlichen ist. Denn bei vielen Erwachsenen, die an psychischen Störungen leiden, traten die Symptome bereits in der Kindheit und Jugend auf, wurden aber oft nicht als solche identifiziert oder behandelt.

Ziel des Projekts: Überblick über internationale Versorgungsmodelle & Indikatoren

Das Projektziel dieser Arbeit war es, eine Übersicht über internationale Modelle der Prävention und Versorgung von psychischen Erkrankungen bei Kindern und Jugendlichen zu geben. Außerdem wollten wir einen Überblick über messbare Merkmale (Indikatoren) für eine zielgerichtete Planung und Steuerung der Versorgungsstrukturen geben. Die Erkenntnisse zu Prävention und Versorgung sollen als Entscheidungsgrundlage für die Weiterentwicklung österreichischer Versorgungsstrukturen im Bereich der psychischen Erkrankungen bei Kindern und Jugendlichen dienen.

Methoden

Aktuelle Präventions- und Versorgungssituation in Österreich

Handsuche & Expert*innenbefragung: österreichweit, Wien u. Steiermark

Mittels Handsuche und Expert*innenbefragung wurden Informationen zu verschiedenen Präventionsmaßnahmen sowie zu Versorgungsangeboten für Kinder und Jugendliche österreichweit, sowie beispielhaft für zwei Bundesländer (Wien und Steiermark) erhoben. Neben den unterschiedlichen (präventiven) Maßnahmen und Angeboten wurden auch die Finanzierung und Zahlen zur Inanspruchnahme beschrieben.

Internationale Strategien und Modelle

Strategien aus 7 Ländern ausgewählt: AU, CH, CZ, DE, ES, NO & UK

von 128 Dokumenten 12 ausgewählt

Basierend auf Auswahlfaktoren wurden weltweit sieben Länder ausgewählt, von denen wir Strategien und Modelle für die psychische Gesundheit von Kindern und Jugendlichen analysierten. Diese Auswahlfaktoren, die uns eine möglichst große Vielfalt an Modellen aber auch die Übertragbarkeit auf Österreich ermöglichen sollten, waren „Human Development Index“ (Wohlstandsindikator), Mindestbevölkerung und geografische Region. Die ausgewählten Länder waren Australien, Schweiz, Tschechien, Deutschland, Spanien, Norwegen und das Vereinigte Königreich. Mittels Handsuche wurden 128 nationale Dokumente identifiziert, von welchen zwölf für die weitere Datenextraktion ausgewählt wurden.

qualitative Inhaltsanalyse der Themenfelder

Daten zu Themenfeldern aus den Dokumenten (z. B. Zielgruppe, involvierte Berufe, Modellkomponenten, Versorgungspfade) wurden extrahiert und tabellarisch dargestellt. Anschließend führten wir eine qualitative Inhaltsana-

lyse der Themenfelder durch und fassten diese zusammen. Dabei wurde nicht überprüft, ob die Empfehlungen der jeweiligen Länderstrategien bereits umgesetzt werden.

Indikatoren zur Planung und zum Monitoring

Handsuche nach Indikatoren, Einteilung nach Kategoriensystemen & Excel-Übersicht

Mittels Handsuche identifizierten wir Indikatoren, welche für die Planung und zum Monitoring von Angeboten im Bereich psychischer Gesundheit von Kindern und Jugendlichen auf Bevölkerungsebene eingesetzt werden können. Anschließend wurden die Indikatoren nach verschiedenen Kategoriensystemen unterteilt (Gesundheitsindikatoren, Qualitätsindikatoren, und das Klassifizierungssystem von Peitz et al). Informationen über die Indikatoren wurden durch eine Datensynthese präsentiert, und sind zusätzlich in einer Excel-Tabelle einsehbar.

Übereinstimmung/Abgleich der österreichischen Strukturen mit den Empfehlungen der internationalen Modelle und Indikatoren

2 Strategien aus Österreich int. Empfehlungen gegenübergestellt

Um die Gemeinsamkeiten und Unterschiede zwischen der österreichischen Versorgungssituation und den internationalen Strategien/Modellen zu beschreiben, untersuchten wir die Inhalte von zwei Strategien aus Österreich in Bezug auf die zuvor genannten Themenfelder. Diese zwei Strategien waren die Kinder- und Jugendgesundheitsstrategie und die nationale Strategie zur psychischen Gesundheit. Weiters verglichen wir beispielhaft, inwieweit die aktuelle Prävention und Versorgung von psychischen Erkrankungen bei Kindern und Jugendlichen den internationalen Empfehlungen entspricht.

Abgleich österreichischer Datenquellen mit int. Indikatoren

Zusätzlich stellten wir die in Österreich bereits verwendeten Indikatoren den zuvor identifizierten internationalen Indikatoren gegenüber. Anhand von ein bis zwei Beispielen pro Indikatorengruppe versuchten wir eine Grundlage für einen zukünftig vertieften Abgleich von österreichischen Datenquellen mit internationalen Indikatoren zu schaffen.

Methodik zur Orientierung an int. Strategien & Indikatoren

Ziel war es, eine mögliche Methodik zu entwickeln, Unterschiede zwischen österreichischen und internationalen Versorgungsansätzen zu identifizieren, um sich in Zukunft stärker an den internationalen Strategien, Modellen und Indikatoren orientieren zu können.

Ergebnisse

Aktuelle Präventions- und Versorgungssituation in Österreich

Verschlechterung psychischer Gesundheit durch COVID-19

Die Prävalenz psychischer Erkrankungen bei Kindern und Jugendlichen lag bis 2019 relativ konstant bei 20 Prozent. Sie verschlechterte sich danach vor allem durch die COVID-19 Pandemie jedoch drastisch. Verfügbare Daten beziehen sich allerdings vorwiegend auf Jugendliche, während für jüngere Kinder weniger Daten vorhanden sind.

breites Angebot, aber im Präventionsbereich großteils auf Projektbasis; derzeit keine eigenständige Strategie spezifisch für die psych. Gesundheit von Kindern und Jugendlichen

Die Förderung der psychischen Gesundheit und die Prävention psychischer Erkrankungen findet hauptsächlich auf Projektbasis statt, mit unterschiedlichen Angeboten in den einzelnen Bundesländern. Für die Versorgung bereits erkrankter Kinder und Jugendlicher gibt es neben dem medizinischen Bereich (stationäre Einrichtungen, Ambulanzen, niedergelassene Fachärzt*innen, und andere spezialisierte medizinische Einrichtungen und Berufsgruppen) auch im sozialen und pädagogischen Bereich ein breites Angebot mit unterschiedlichen Finanzierungskonstellationen. Insgesamt deuten die Daten auf deutliche Versorgungslücken, Kapazitätsengpässe, regionale Ungleich-

heiten beim Leistungszugang und eine mangelhafte sektorenübergreifende Koordination hin. Derzeit gibt es keine eigenständige nationale Strategie für die psychische Gesundheit von Kindern und Jugendlichen, die den Gesundheitförderungs- und Präventionsmaßnahmen einen höheren Stellenwert als bisher einräumt.

Internationale Strategien und Modelle

14 Themenfelder aus int. Dokumenten identifiziert

In den ausgewählten Ländern gibt es eine allgemeine Strategie zur psychischen Gesundheit, und in den meisten Ländern gibt es eine zusätzliche Strategie zur psychischen Gesundheit von Kindern und Jugendlichen sowie eine Suizidpräventionsstrategie. Aus den Dokumenten identifizierten wir 14 Themenfelder: Informationsmaßnahmen, Prävention/Gesundheitsförderung, Früherkennung, Behandlung, Telemedizin, Behandlungspfade, Transitionspsychiatrie, gefährdete Patient*innengruppen, Patient*innenbeteiligung, Infrastruktur, Entwicklung/Ausbildung der Fachkräfte, Implementierung, digitales Fallmanagement, und Datenerfassung/Versorgungsforschung.

Förderung/Prävention im Bildungssektor (zusätzliches Personal)

In allen ausgewählten Ländern wird die Bedeutung der Förderung psychischer Gesundheit und Prävention hervorgehoben. Für beides spielt der Bildungssektor, beginnend ab dem Kindergarten, eine wesentliche Rolle. Dieser Sektor sollte gemäß den Empfehlungen durch zusätzliches Personal einerseits, und die Ausbildung von Pädagog*innen zu Themen der psychischen Gesundheit andererseits unterstützt werden.

bedarfsorientierte Ansätze, stärkere Einbindung gefährdeter Gruppen, Unterstützung bei Systemnavigation

Die Länderstrategien empfehlen einen Ansatz der Prävention und Versorgung, der sich an den Bedürfnissen der Kinder und ihrer Familien orientiert, während Diagnosen in den Hintergrund rücken. Dabei wird eine stärkere Einbindung und Beteiligung der Nutzer*innen empfohlen, insbesondere von gefährdeten Gruppen (z. B. Kinder und Jugendliche von Eltern mit psychischen Erkrankungen). Für eine bessere Koordination werden zentrale Anlaufstellen („one-stop-shops“) mit Personal zur Unterstützung zur Systemnavigation empfohlen.

aufsuchende Dienste (z. B. Home-Treatment)

mehr Flexibilität in Strukturen, Stärkenorientierung

Die wesentlichen Prinzipien der Dokumente äußern sich durch gesteigerte Flexibilität der Strukturen, Aufgeschlossenheit und Stärkenorientierung (statt Fokus auf Defizite). Dabei kommen den aufsuchenden Diensten im häuslichen Setting („Home-Treatment“), sowie ambulanten und telemedizinischen Angeboten eine größere Bedeutung zu. Auch vordefinierte Altersschwellen in Bezug auf Übergangsphasen – z. B. vom Jugend- in das Erwachsenenalter – (Transitionspsychiatrie) werden von den Ländern kritisch hinterfragt.

sektorenübergreifende Zusammenarbeit, nationale Datenbanken für die psych. Gesundheit

In Bezug auf eine bessere sektorenübergreifende Zusammenarbeit wird von den Ländern eine gemeinsame Vision, Zielsetzung, Planung und Finanzierung gefordert, etwa durch gemeinsame zweckgebundene Budgets. Zur Unterstützung werden nationale Datenbanken für die psychische Gesundheit von Kindern und Jugendlichen, mit koordinierter Datenerfassung und Versorgungsforschung empfohlen.

Erweiterung der Fachkräfte, psychische Gesundheitskompetenz

Um Versorgungslücken gerecht zu werden, wird eine Erweiterung des traditionellen Gesundheitspersonals durch zusätzliche Arbeitskräfte empfohlen (z. B. Gesundheitsfachberufe, Peer-Einsatzkräfte, LGBTIQ+ und Diversitäts-Personal). Eine Schlüsselempfehlung ist die (Weiter-)Entwicklung der psychischen Gesundheitskompetenz von Pädagog*innen, welche von Fachleuten für psychische Gesundheit angeleitet werden sollte.

Indikatoren zur Planung und zum Monitoring

121 Indikatoren für Planung und Monitoring

Für diesen Bericht konnten wir 121 Indikatoren für die Planung der Versorgung und das Monitoring der psychischen Gesundheit von Kindern und Jugendlichen ermitteln. Diese Indikatoren betreffen eher die Prozess- und Ergebnisqualität (und weniger die Strukturqualität), sowie die Gesundheitsdienste und Risikofaktoren (und weniger den Gesundheitszustand oder Versorgungsgrad). Keine oder nur sehr wenige der Indikatoren befassen sich mit psychischer Gesundheitsförderung, Gesundheitskompetenz, Selbstschädigung/Suizid oder Kostenaspekten.

Übereinstimmung/Abgleich der österreichischen Strukturen mit den Empfehlungen der internationalen Modelle und Indikatoren

Themenfelder in AT-Strategien nicht ausreichend beschrieben

internationale Empfehlungen nur tlw. in Österreich abgebildet, mehr Daten für Kontrastierung nötig

In den beiden bestehenden Strategien aus Österreich werden sechs der 14 Themenfelder nicht konkret für die psychische Gesundheit von Kindern und Jugendlichen beschrieben. Für die acht weiteren Themenfelder geben die Strategien Empfehlungen für die psychische Gesundheit von Kindern und Jugendlichen, allerdings in begrenztem Umfang. Gegenwärtig gibt es mehrere Beispiele, wo österreichische Strukturen den internationalen Empfehlungen entsprechen – häufig allerdings auf Projektbasis und nicht flächendeckend. Bei zahlreichen Empfehlungen konnten wir hingegen keine Entsprechung in Österreich identifizieren (z. B. Einbindung von Betroffenen in die Planung). Für einige der internationalen Empfehlungen lagen uns nicht genügend Daten vor, um weitere Beispiele der Umsetzung in Österreich zu beschreiben.

Indikatoren in AT: vorwiegend (stationärer) medizinischer Sektor

Bezüglich der Indikatoren zeigte sich, dass bisher nur wenige der international eingesetzten Indikatoren in Österreich in Verwendung sind. Diese fokussieren sich vorwiegend auf ein Monitoring der medizinischen Versorgung, insbesondere des stationären Settings.

Diskussion

Interpretation der Ergebnisse

Verbesserungsmöglichkeiten: gemeinsame Strategie, Versorgungskapazitäten, Koordination

Es gibt eine Vielzahl an bestehenden Projekten und Angeboten im Bereich der psychischen Gesundheit für Kinder und Jugendliche, allerdings fehlt eine Anknüpfung an eine nationale Gesamtstrategie und es bestehen regionale Ungleichheiten beim Zugang zu Leistungen und Koordinationsmängel. Im Vergleich mit internationalen Empfehlungen konnten wir Verbesserungsmöglichkeiten in mehreren Bereichen aufzeigen: gemeinsame Strategieentwicklung, Ausbau/Flexibilisierung von Versorgungskapazitäten, und verbesserte Koordination (zwischen Sektoren, aber auch zwischen Fachpersonal).

Ausbau der erweiterten Behandlungssettings (z. B. Home-Treatment) und frühe Intervention notwendig

Erweiterte Behandlungssettings (z. B. Home-Treatment, stationsäquivalente Behandlungen und andere aufsuchende Ansätze) wurden in Österreich bisher nur in geringem Ausmaß umgesetzt und könnten, entsprechend den internationalen Empfehlungen, weiter ausgebaut werden um stationären Engpässen entgegenzuwirken. Auch der Ausbau von Informations- und Förderungsmaßnahmen zu psychischer Gesundheit sowie ein flächendeckendes Früherkennungssystem unter Einbeziehung von Risikofaktoren sind wünschenswert.

Im Bildungsbereich gibt es in Österreich eine beginnende, landesweite Integration von Lehrinhalten über psychische Gesundheit und Krankheit. In den Strategien anderer Länder wird zudem die Einführung von weiterem Schulpersonal empfohlen (z. B. spezielles Personal für psychisches Wohlbefinden). Weitere Verbesserungspotenziale liegen im Bereich der sektorenübergreifenden Integration (mit klaren Anlaufstellen) und einer adäquate Berücksichtigung von gefährdeten Patient*innengruppen (beispielsweise junge Straftäter*innen mit psychischen Problemen).

weiteres Schulpersonal, sektorenübergreifende Integration, Berücksichtigung gefährdeter Patient*innengruppen

Eine verstärkte Orientierung an internationalen Empfehlungen erfordert außerdem eine wesentlich stärkere Einbeziehung und Mitbeteiligung der Nutzer*innen (Kinder/Jugendliche, und deren Familien/Betreuungspersonen) in die Gestaltung und Versorgungsplanung.

stärkere Einbeziehung der Nutzer*innen (Partizipation)

Limitationen

Anstelle einer systematischen Literatursuche wurden die Daten in diesem Bericht mittels gezielter Handsuche identifiziert. Außerdem konnten wir nur eine Auswahl an Ländern für diesen Bericht berücksichtigen. Dadurch besteht die Möglichkeit, dass weitere neuartige Strategien, Modellen, oder Indikatoren für die psychische Gesundheit von Kindern und Jugendlichen existieren, welche in diesem Bericht nicht abgebildet sind. Außerdem wurde nicht erhoben, inwieweit die Strategien in den ausgewählten Ländern bereits umgesetzt sind.

nicht alle Länder berücksichtigt, Ausmaß der Umsetzung der Strategien nicht erhoben

Weiters gab es mehrere Ausschlussgründe für Dokumente: indikationsspezifische (z. B. medizinische Leitlinien für bestimmte psychische Erkrankungen), oder die allgemeine Gesundheit betreffende (anstatt spezifisch für die psychische Gesundheit) oder alle Altersgruppen betreffende (anstatt spezifisch für Kinder und Jugendliche). Diese ausgeschlossenen Dokumente könnten einige ergänzende Informationen enthalten.

ergänzende Information in ausgeschlossenen Dokumenten

Bei den Indikatoren extrahierten wir keine spezifischen Berechnungsmethoden. Diese sind vorhanden und müssten bei Bedarf in einer weiterführenden Arbeit aufgearbeitet werden.

keine spezifischen Berechnungen der Indikatoren erhoben

Die Informationen aus den internationalen Dokumenten waren aufgrund von Überschneidungen nicht immer eindeutig den identifizierten Themenfeldern zuzuordnen. Ebenso verhielt es sich mit der Zuordnung der Indikatoren in die Kategoriensysteme. Zahlreiche Aspekte der psychischen Gesundheit und Versorgungsstruktur sind miteinander verknüpft. Obwohl wir bemüht waren eine sorgfältige Zuordnung zu Themenfeldern und Kategorien zu finden, könnten einige Inhalte auch anders zugeordnet werden.

Einteilung in Klassifikationen nicht immer trennscharf

Conclusio

Für die Weiterentwicklung der österreichischen kinder- und jugendpsychiatrischen Versorgungsstruktur empfehlen wir die Schaffung einer eigenständigen nationalen Strategie, welche die psychische Gesundheit von Kindern und Jugendlichen in den Mittelpunkt rückt. In dieser neuen Strategie könnte die Förderung psychischer Gesundheit, Prävention und Versorgung in einer gemeinsamen Vision integriert sein.

Schaffung einer eigenständigen nationalen Strategie für diese Population

partizipativ, sektorenübergreifend, Berücksichtigung von gefährdeten Gruppen und Versorgungslücken

Die Strategieentwicklung sollte partizipativ und sektorenübergreifend erfolgen (Gesundheit, Bildung, Soziales und Jugendjustiz). Dafür sollte eine Versorgungsforschung anhand priorisierter Indikatoren die Entwicklung und Umsetzung begleiten. Das Ziel ist einen besseren Umgang mit Versorgungslücken und gefährdeten Patient*innengruppen zu schaffen.

Bereitstellung notwendiger Ressourcen; Stärkung bedarfsorientierter Dienste

Um dem derzeitigen Mangel an Krankenhausbetten und Psychiater*innen entgegenzuwirken, könnte der ambulante Bereich (z. B. Home-Treatment) und weitere bedarfsorientierte Dienste unter verstärkter Beteiligung international empfohlener Berufsgruppen ausgebaut werden. Insgesamt bedarf es jedoch ausreichend Ressourcen (etwa für die Weiterentwicklung der Versorgungspfade, Personalausbildungen, wissenschaftlich fundierte Steuerung von Programmen und Initiativen), um entsprechende Verbesserungen zu ermöglichen. In allen Schritten der Implementierung ist eine stärkere Einbeziehung der Nutzer*innen anzustreben.

1 Introduction

1.1 Background

psychische Erkrankungen bei KiJu mit weltweiter Häufigkeit zwischen 9-22 Prozent

Mental disorders are complex and can present in many forms. These conditions are among the most common worldwide in children and adolescents, with prevalences ranging between nine and 22 percent [1]. In this population, the most common psychiatric diagnoses and symptoms with a high burden of disease are depressive disorders, anxiety disorders and self-harm [2]. Adolescents with mental health conditions are particularly vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviours, physical ill-health and human rights violations [3].

steigender Bedarf bei gleichzeitigen Versorgungsengpässen

Symptombeginn häufig frühzeitig, aber nicht adäquat erkannt; Bedeutung der Prävention zunehmend

The increasing demand for care for child and adolescent mental health (CAMH) is combined with infrastructural and staff limitations in child and adolescent psychiatric care. This leads to considerations for an adaptation of child and adolescent mental health services (CAMHS) and care models. In addition, the importance of preventing mental conditions in children and adolescents is becoming increasingly apparent. According to the World Health Organization (WHO), mental health is an important part of overall health for children as well as adults. For many adults who have mental disorders, symptoms were present – but often not recognised or addressed – in childhood and adolescence [4, 5]. Regarding age at onset of mental disorders, perhaps half of all adult mental health disorders have begun by the teenage years [6]. For a young person with symptoms of a mental disorder, the earlier treatment starts, the more effective it can be. Early treatment can help prevent more severe, lasting problems as a child grows up [4].

Spektrum der psychischen Gesundheitsmaßnahmen

In this context, an example of a visualisation of mental health services is the spectrum of interventions. This spectrum shows the range of services from prevention, early intervention and treatment to continuing care, with mental health promotion overarching all components of this spectrum (see Figure 1-1).

WHO Versorgungsmodell-Komponenten: informelle & formelle Angebote

The components of mental health care models, according to the World Health Organization (WHO), give a detailed look into the aspects of care. These components can be classified as informal or formal services. They range from self-care and informal community care (informal services), to primary care mental health services, psychiatric services in general hospitals, community mental health services, and long stay facilities and specialist psychiatric services (formal services). An overview of the recommended optimal mix of services is depicted in Figure 1-2.

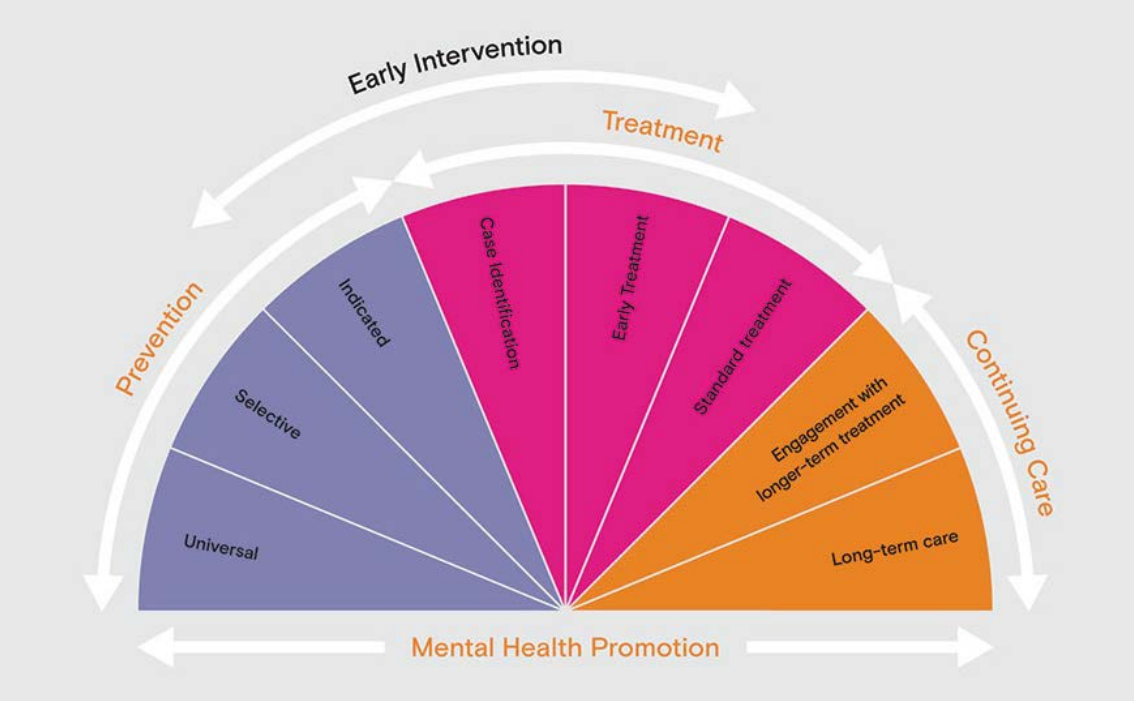

Figure 1-1: The spectrum of interventions for mental health [7]

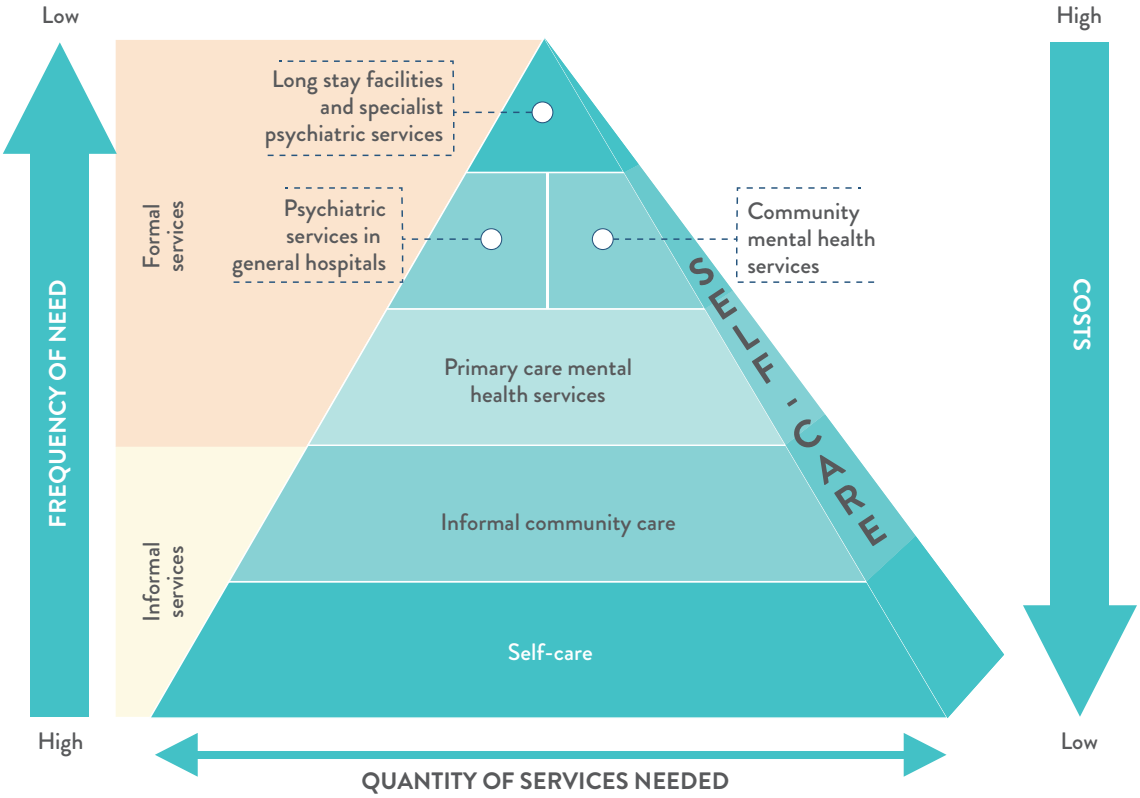

Figure 1-2: WHO recommended optimal mix of mental health services [8]

1.2 Definitions

Mental Health

Vielzahl an Definitionen für psychische Gesundheit

There is a multitude of terms and terminologies for (child and adolescent) mental health and disorders, as well as for mental health services. The following definitions give an overview how these terms are interpreted for this report.

WHO Definition

According to the World Health Organization (WHO), mental health can be defined as:

> *"A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[9].*

alternative Definition

An example of another definition of mental health is:

> *"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium" [10].*

Children, adolescents, young people, young adults

WHO:
<10 Jahre = Kinder
10-19 Jahre = Jugendliche

According to the WHO, the following differentiation between children and adolescents can be made:

- Children: persons below the age of 10 years.
- Adolescents: persons aged between 10 to 19 years [11].

weitere, variable Altersdefinitionen

Another often used term is "Youth", defined as persons between the ages of 15 to 24 years (according to the United Nations [12]). However, as with mental health, there are different approaches to define this population group. In Belgium, for example, child can refer to a person below 12 years, and adolescents are persons between 12 and 18 years. Sometimes, the term "Children" refers as a more generic term to all persons under the age of 19 years (e.g. in the Convention on the Rights of the Child) [13].

Professionals, types of facilities

breite Palette an involviertem Fachpersonal

According to the Mental Health Atlas 2020 the types of professionals working with persons suffering from mental conditions can be divided into nurses, occupational therapists, other specialized mental health works, primary health care doctors, primary health care nurses, psychiatrists, psychologists, social workers and speech therapists.

Arten von Einrichtungen (z. B. stationär, ambulant, andere)

Further, a classification of the types of facilities is given in the Mental Health Atlas 2020. According to that, persons with mental conditions can be treated in mental hospitals, psychiatric units in a general hospital, mental health community residential facilities, mental health day treatment facilities, mental health outpatient facilities, other residential facilities and primary health care clinics.

Definitionen im Anhang

For definitions of *professionals,* as well as *types of facilities* relevant in the field of mental health, a summary (according to the Mental Health Atlas 2020 [11]) is given in the Appendix chapter "Mental health professionals and facilities".

1.3 Context

COVID-19: massiver Einfluss auf die psychische Gesundheit von KiJu

In the context of the COVID-19 pandemic, the mental health of children and adolescents was particularly affected [14, 15]. In comparison with data from before the pandemic, two-thirds of the children and adolescents reported being highly burdened by the COVID-19 pandemic. Statistically significant changes include a reduction in health-related quality of life (40.2% vs. 15.3%), more mental health problems (17.8% vs. 9.9%), and higher anxiety levels (24.1% vs. 14.9%) [16]. The current geopolitical situation raises further concerns regarding threats to mental health and the increased demand for adequate care [17].

weitere Bedenken durch aktuelle geopolitische Krise

Umfrage zu Sorgen der jungen Menschen: Krieg, Klimawandel, Schere zwischen Arm und Reich

A non-representative survey from March/April 2022 among young people in Austria (n=24,000, age between 16-25 years), presented the current worries among the youth as following (Figure 1-3). In these, the three most reported topics of concern were war, climate change and the gap between poor and rich [18]:

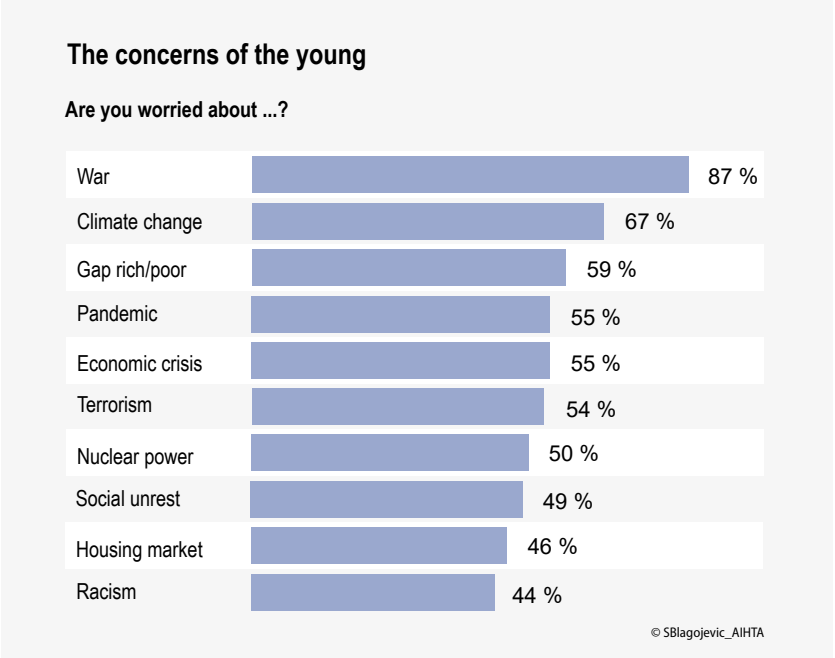

Figure 1-3: The concerns of the young Austrians, adapted from: [18]

Feb. 2022: Gefährdungsanzeige in KiJu-Psychiatrie in Wien: Überlastung, strukturelle Defizite, Personalmangel

In February 2022, child and adolescent psychiatrists at a mental health department of a clinic in Vienna brought in a danger notice ("Gefährdungsanzeige"), to draw attention to the myriad of problems in mental health care for children and adolescents: overload, structural deficiencies and a lack of staff. According to this danger notice, the situation is no longer manageable, and damages to patients' health or other contractual violations can no longer be excluded given the existing resources [19].

Mai 2022: Volksbegehren zur psychischen Gesundheit von KiJu mit 138.000 Unterschriften

Other sectors (e.g. school system for the promotion of mental health literacy) can complement the health care sector in an integrated care model [13]. In May 2022, a national petition referendum ("Volksbegehren") was held in Austria. Initiated by schoolchildren, it managed to receive just over 138,000 signatures in support. In this petition, more measures for improving the mental health of children and young people are requested: accessible, unbureaucratic and comprehensive offers for prevention and early recognition of mental stress, both for teachers and carers as well as for children and adolescents. Examples include information material and special workshops as well as an expansion of school support staff in the form of school psychologists, social workers, liaison teachers and youth coaches. The petition emphasises that if children and adolescents were specifically informed about topics such as bullying, exclusion, racism and addictive substances at a young age, much suffering could be avoided in the future [20].

digitale Technologien: Potenziale, aber auch Gefahren

OECD: balancierte Nutzung essenziell

Furthermore, advances in digitalisation and telemedical/telepsychiatric care should be considered [21]. However, at the same time, there are concerns that digital technologies and social media could exacerbate feelings of anxiety and depression, disturbing sleep patterns, distort body image and lead to cyberbullying. Additional problems arising from digital use are access to inappropriate content and exposure to other online risks. According to the Organisation for Economic Cooperation and Development (OECD), a little bit of internet use for children and adolescents is positive, while excessive use has a negative impact on their mental wellbeing [22] In this context, a recent non-representative survey in Germany showed that following the COVID-19 pandemic, 16.7 percent of pupils are affected by cyberbullying, with as many as 25 percent among 14- to 16-year-olds [23].

bisher unzureichende Verwendung von Indikatoren zur Planung und Monitoring von psychischen Gesundheitsmaßnahmen

To further improve the child and adolescents' mental well-being and support, it is necessary to identify and monitor relevant CAMH (care) indicators. These indicators can also play an important role in the planning and evaluation of mental health services [24]. In this context, a report from the United Nation's Children's Fund (UNICEF) highlights that routine monitoring of mental health and mental healthcare is seriously lacking, especially for CAMH [25].

2 Project aims and research questions

Projektziel: Übersicht über internationale Versorgungsmodelle für psychische Erkrankungen von KiJu

This review aims to provide an overview of international child and adolescent mental health care strategies and models (e.g., identifying elements of care, coordination, professional groups involved, comprehensive mental health strategy). Mental health care may include prevention, treatment and other types of support. Additionally, we will describe indicators for monitoring child and adolescent mental health (care). The project should support decision-making in developing Austrian child and adolescent mental health care structures further.

und: Indikatoren zu Planung und Monitoring

A detailed planning/implementation of the care models in Austria, or an effectiveness analysis of individual care components, is ***not*** within this project's scope.

4 Forschungsfragen

The following research questions (RQ) will be addressed in this review:

- **RQ1:** How is prevention and care of mental illness in children and adolescents currently organised in Austria?
- **RQ2:** What are the recommendations in strategies and models for child and adolescent mental health in selected countries?
- **RQ3:** Which indicators/parameters can be used to plan and monitor the quality of child and adolescent mental health and psychiatric care?
- **RQ4:** How aligned are current mental health care structures in Austria to the recommendations of international care and prevention models and indicators?

3 Methods

The research questions will be answered using the following methods:

3.1 Research question 1: Current organisation of prevention and care of mental illness in children and adolescents in Austria

Literature search

Handsuche nach Präventions- und Versorgungsangeboten für KiJu mit psychischen Erkrankungen in Ö

A hand search was conducted to overview the current prevention and care structure of mentally ill children and adolescents in Austria. The core data sources for the service mapping exercise are grey literature reports on service planning, health reports, legal documents, and national and regional (health) statistics. In addition to the hand search, expert interviews were conducted:

Expert*innenkonsultation

- May 2022, telemeeting with employees of the mental health department of Gesundheit Österreich GmbH [26]
- May 2022, expert consultation with various institutions (within the framework of a symposium "Fachtag Jugendarbeit" by WIENXTRA) [27]
- July 2022, expert consultation with Psychosoziale Dienste Wien (PSD) [28]

Region selection

Fallbeispiele: eine rurale (Steiermark) und eine urbane (Wien) Region

In Austria, child and adolescent mental health care varies between regions. To gain insight into the supply situation of prevention and care in the individual Bundesländer (regions/provinces), we selected two regions as case examples: a rural (Styria) and an urban (Vienna) province. Those will be described in detail in addition to the national overview.

Data extraction and analysis

narrative Datenextraktion und …

Data and information on the different measures in the areas of promotion and prevention, as well as offers and services in Austria for children and adolescents were extracted narratively from the data sources.

… Info zu Angeboten aus Wien und Steiermark in Tabellen extrahiert

Data about the different services in Styria and Vienna were extracted in data extraction tables and clustered according to the facility types described in the Mental Health Atlas 2020 [29]. Further they were subgrouped to the corresponding care region where the respective services are located. Then, the type of provider (private or public), the target group, the professional groups involved in support and care (based on the types of workers listed in the Mental Health Atlas 2020 [29]), the setting of service provision and the corresponding web links were extracted.

Data synthesis

Beschreibung der Angebote in Ö, …

The topic is conceptually addressed from different angles. Firstly, the sectors within which relevant services may be available for mentally ill children and adolescents throughout Austria were described (healthcare, social affairs, education). In addition to the different preventive measures and offers in various areas, the financing of the measures and figures on utilisation were also described.

… Wien und der Steiermark

Secondly, the relevant services in prevention and care were described in a more detailed form for Styria and Vienna. A qualitative synthesis of the evidence was conducted. After extracting data in data extraction tables and tabular presentation, the aspects were reported in a narrative form. Examples from the extraction tables were synthesised to describe the identified preventive and care services in Austria. Finally, key figures of in- and outpatient services for the two exemplary regions are given.

Quality assurance

The process steps were carried out by one researcher (VH) and controlled by a second researcher (RJ).

3.2 Research question 2: Recommendations in child and adolescent mental health strategies and models in selected countries and cross-national documents

Country selection

Kriterien für Länderauswahl

For this report, we selected 7 countries for analysis of child and adolescent mental health care strategies and models. A population of at least five million people was a necessary criterion for inclusion (rationale: we expected countries with this minimum population to be more likely to have documents on child and adolescent mental health available).

pro geografischer Region in Europa: Länder mit hohem HDI ausgewählt

We aimed to include one country from each of the four regions in Europe according to the United Nations Geoscheme for Europe [30] representing different types of health care systems. In order to increase transferability of the results to Austria, , we selected the country with the highest Human Development Index (HDI) from each of the four regions, according to the 2019 Human Development Index (2020 report) [31]. In addition, Germany was included (rationale: proximity to Austria, high comparability of the health systems).

außerhalb EU: Australien, UK ausgewählt

Countries outside of the European Union we also selected according to the HDI rank: However, countries in Asia (e.g. Hong Kong or Singapore) were excluded due to the low comparability of the health systems to Austria. As a result, we included Australia and the United Kingdom.

7 Länder ausgewählt: AU, CH, CZ, DE, ES, NO, UK

With this methodological approach, the final selection includes the following countries (see Figure 3-1):

- Australia (AU),
- Switzerland (CH),
- Czechia (CZ),
- Germany (DE),
- Spain (ES),
- Norway (NO),
- United Kingdom (UK).

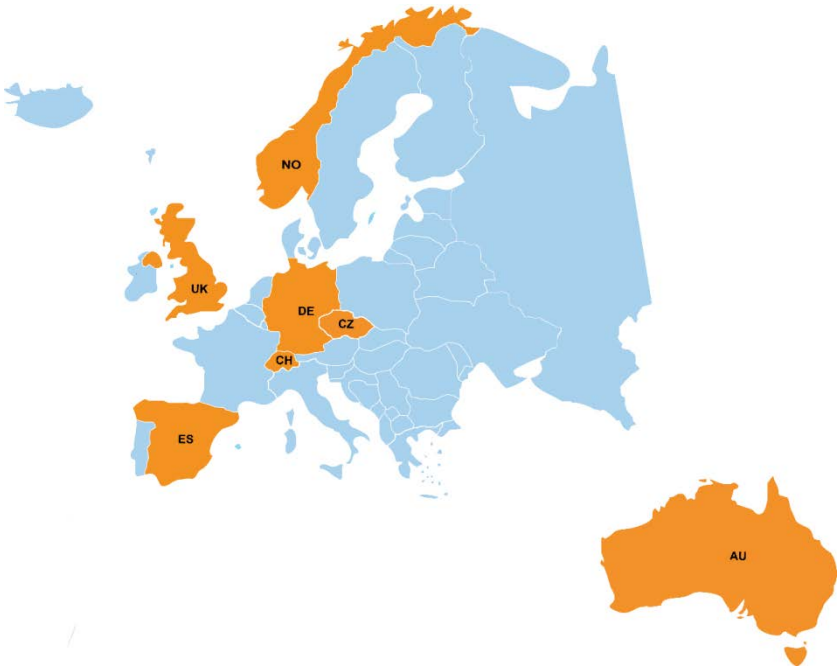

Figure 3-1: Country selection

Literature search

Literatursuche nach Strategien/Modellen zur psychischen Gesundheit von KiJu

We then conducted a hand search between April and June 2022 in the following databases and websites of the selected countries for information on strategies and models addressing child and adolescent mental health care and prevention:

- Google/Google Scholar,
- Websites of ministries of health, relevant national institutions (e.g., public health institutes),
- World Health Organization MiNDbank (an online platform bringing together country and international resources, covering mental health, substance abuse, disability, general health, human rights and development) [32],
- Europe encyclopedia of National Youth Policies YouthWiki (an online platform presenting information on European countries' youth policies) [33].

For the literature search, various keywords relating to child and adolescent mental health were combined with the respective country as well as with relevant keywords such as strategy, model, care pathway, prevention.

Document selection

128 nationale Dokumente identifiziert

From the literature search, we identified 128 national references (Australia=14, Switzerland=20, Czechia=17, Germany=11, Spain=16, Norway=15, United Kingdom=35).

Table 3-1 gives an overview of criteria for document selection. Following these criteria, we selected 12 documents for the data extraction.

Dokumente speziell für KiJu (oder: zumindest Unterkapitel)

For document inclusion, we included national documents that describe a strategy or model of care specific for children and adolescent mental health. In case no such specific document was available for a country, we included a general mental health strategy or model that has a subchapter for children and adolescents (e.g. Czechia).

diverse Ausschlussgründe (z. B. indikationsspezifisch)

We excluded documents that were regional (if national ones exist), and documents that were indication specific (e.g. depression, substance abuse, suicide). Further exclusion reasons were evaluation documents, surveys, fact sheets, call for applications, workforce guidances, web portals/information campaigns, situational analyses, funding information, presentations.

maschinengestützte Übersetzung eingesetzt

If a country had no relevant document available in German or English language, we used the automated translation tool deepL for document translation [34].

Table 3-1: Criteria for document selection

Publication type	National child and adolescent mental health care strategies/models Exclusion: regional care models (if national ones exist), indication-specific care models Exclusion: evaluation documents, surveys, fact sheets, call for applications, workforce guidances, web portals/information campaigns, situational analyses, funding information, presentations.
Publication period	No restriction
Settings	Country selection based on various relevant criteria (Global North, countries with different public health traditions and types of healthcare system; representing all geographical regions in Europe) Exclusion: South America, Africa, Asia
Language	German, English

Data analysis and synthesis

WHO Atlas zur psychischen Gesundheit: Länderprofile extrahiert

For each of the included countries, we extracted some information from the respective World Health Organization Mental Health Atlas country profiles [35-41]:

- availability of a stand-alone or integrated policy or plan for child and adolescent mental health,
- availability of a stand-alone or integrated policy or plan for general mental health,
- availability of a stand-alone law for mental health,
- availability of a suicide prevention strategy/policy/plan,
- availability of mental health promotion and prevention programmes.

iterativ Themenfelder definiert (z. B. Zielgruppe, Berufsgruppen, Modellkomponenten)

In an iterative process, we identified content categories from the documents, building on a preselection of categories (e.g. addressed age, target group, professions, model components and additional characteristics). These categories were further added to and adapted in an iterative process when extracting data from the documents. The final definition and description of the categories is listed in chapter 4.2.2.

Datenextraktionstabellen im Anhang

We then prepared a data extraction table for the document(s) of each country. The tables can be found in Appendix chapter “Extraction tables ...”.

keine Erhebung, ob Empfehlungen bereits implementiert sind

For the data synthesis, we performed a qualitative content analysis of the categories and synthesised the information in a narrative approach.

An assessment on whether the recommendations in the strategies/models are already implemented in the respective countries was beyond the scope of this report.

Quality assessment

Qualitätsbewertung mittels adaptierter AGREE-II Checkliste

Since we did not identify a specific tool which can be used for the quality assessment of the documents describing the CAMH models and strategies, we used an adapted version of the Appraisal of Guidelines for Research & Evaluation II (AGREE II) instrument [42]. The AGREE II instrument was developed to assess the methodological rigour and transparency in which a guideline is developed. The tool consists of 23 key items organised within six domains followed by an overall assessment. The six domains are scope & purpose, stakeholder involvement, rigour of development, clarity of presentation, applicability and editorial independence. Each item is rated on a 7-point scale (1-7 points; higher score means better quality).

11 Punkte aus AGREE-II ausgewählt

We selected the following 11 items to assess the quality of the identified documents:

- Item 1: The overall objective(s) of the [document] is (are) specifically described.
- Item 3: The population (patients, public, etc.) to whom the [docu-ment] is meant to apply is specifically described.
- Item 4: The [document] development group includes individuals from all the relevant professional groups.
- Item 5: The views and preferences of the target population (patients, public, etc.) have been sought.
- Item 6: The target users of the [document] are clearly defined.
- Item 7: Systematic methods were used to search for evidence.
- Item 12: There is an explicit link between the recommendations and the supporting evidence.
- Item 17: Key recommendations are easily identifiable.
- Item 18: The [document] describes facilitators and barriers to its application.
- Item 20: The potential resource implications of applying the recommendations have been considered.
- Item 21: The [document] presents monitoring and/or auditing cri-teria.

The results of the quality assessment for the documents can be found in “Quality assessment of the included documents” in the Appendix.

Quality assurance

Qualitätssicherung

The process steps were carried out by one researcher (RJ) and controlled by a second researcher (VH). In the process of adapting the preliminary categories, a third researcher (IZ) was consulted for advice.

3.3 Research question 3: Indicators for planning and monitoring child and adolescent mental health and psychiatric care

Literature search

Handsuche nach Datenquellen für Indikatoren

A hand search was conducted to identify relevant data sources and indicators for planning and monitoring CAMH and CAMHS. There were no restrictions on the type of data sources for the hand search of CAMH(S) indicators. Initially, we aimed to include all identified data sources without restriction on the publication period. However, due to the high number of identified references, we limited our search to those published within the last ten years (publication data after 2012).

Literature selection

Einschlusskriterien der Datenquellen

Data sources were included if they contained indicators intended to evaluate CAMH(S), were available in English or German and focused on population-level assessment. In case of several documents available from the same source, the newest document was selected as reference.

Indicator selection

Einschlusskriterien der Indikatoren

Indicators were included from the identified data sources if they are intended to assess CAMH(S), have a clear title and/or description, and a calculation (denominator/nominator) or recommendation for measurement. Furthermore, the indicators should be able to be collected more than once and be relevant for Austria. Indicators that are only relevant for a specific country or indicators that are general for the whole population and not explicitly described/evaluated for children and adolescents were excluded.

Data extraction and analysis

Datenextraktion in eine Microsoft Excel-Tabelle

The eligible indicators were extracted qualitatively. To do so, a standardised data charting form was created in Microsoft Excel, including the following information: title, description, country of origin and data source (incl. examples of the source, if available). The indicators were checked for duplicates and similarities and, if so, combined into one indicator. For this reason, some indicators may be broader than others, and several different data sources per indicator may be listed.

3 Kategorisierungssysteme zur …

Different categorisation systems were sought via hand search to classify the identified indicators. We decided to categorise the indicators according to the following classification systems:

1. health indicators [43],
2. quality indicators [44-46] and
3. the categorisation system by Peitz et al. [24] (a recent published classification for indicators of mental health for adults).

… Klassifizierung der Indikatoren

The classification of the indicators according to the respective clusters were done in the Microsoft Excel spreadsheet. Each of the indicators could thus be allocated to a maximum of three different classification systems and the subcategories within those.

Data synthesis

qualitative Datensynthese

A qualitative synthesis of the evidence was conducted: data was interpreted according to the three different category systems and regarding the data sources needed for calculating them. Information on the categorisation and examples from the different indicators are provided by synthesising the data from the Excel table in a narrative form.

Quality assurance

Qualitätssicherung

The indicator selection and categorisation were performed by one researcher (VH) and a second researcher provided the quality assurance (RJ). In case of discrepancies in the categorisation of the indicators, a third researcher (IZ) was consulted for advice.

3.4 Research question 4: Alignment of Austrian child and adolescent mental health care structures to recommendations of international models and indicators

2 Strategien aus Ö den int. Empfehlungen gegenübergestellt

For describing the similarities and differences between the Austrian mental health care situation and the international strategies/models, we screened two CAMH relevant strategies from Austria (child and adolescent health strategy [47], national mental health strategy [48]) for information regarding the categories described in the international models (following from research question two). This was to see to what extent Austrian and international strategies cover similar topics.

Ist-Situation in Ö mit int. Empfehlungen verglichen:

exemplarische Darstellung als erster Ansatz zur systematischen Erhebung

Furthermore, based on the findings from research question one (current prevention and care of mental illness in children and adolescents in Austria), we then compared to what extent the Austrian situation addresses the content that we identified in the international documents. Since we do not have detailed data from all nine Austrian regions, this exercise is to be understood as exploratory rather than as an assessment of the Austrian care situation. The aim was to establish a possible methodology on how to systematically identify differences between international recommendations and the care situation in Austria and how to identify mental health care elements that might be more aligned with international strategies and models in the future.

Datenquellen aus Ö beispielhaft mit int. Indikatoren verglichen

In addition, we contrasted indicators in use in Austria (based on the findings from research question one) with the identified indicators (research question 3). In this context we tried to identify if further indicators might be calculated in Austria based on data sources already available as described in chapter 4.1. By using one to two examples per indicator category, we aimed to create a starting point for a more in-depth matching of Austrian data sources with international CAMH indicators.

4 Results

4.1 Prevention and care of mental illness in children and adolescents in Austria

4.1.1 Epidemiology: Austria

Prävalenz von psychischen Erkrankungen bei KiJu bis COVID-19-Pandemie relativ konstant

Before the COVID-19 pandemic, the prevalence of child and adolescent psychiatric disorders in Austria has been relatively constant at about 20.0 percent over the last decades [49]. However, for certain diagnostic groups, e.g. eating disorders and self-injurious behaviour, an increase in cases was observable. At the same time, an increasingly earlier age of onset of so-called "adult-typical" disorders, as well as new disorders such as gender dysphoria and internet addiction, can be observed [49].

wenig Information zu jüngeren Kindern, die meisten Daten für Jugendliche

MHAT-Studie (3.615 Teilnehmer*innen): Alter von 10 bis 18 Jahren

In Austria, there is little to no valid epidemiological data for younger children – most data is for adolescents/teens. The best-known representative prevalence study for students aged ten to 18 years in Austria is the so-called "Mental Health in Austrian Teenagers" (MHAT) study of the Medical University of Vienna [50]. This study used validated diagnostic tools to survey the frequency of general mental disorders and the most critical mental illnesses in adolescence. Between 2013 and 2015, 3,615 students (5th, 7th, 9th and 11th grades, approx. 50.0% female) from all nine regions (Bundesländer[1]) were contacted. The participation rate in the study was about 50.0 percent. In addition, 43 unemployed young people (school drop-outs) and 133 young people from psychiatric clinics were interviewed [50].

am häufigsten: Angststörungen (15,6 %)

The most common disorders in the study were anxiety disorders (15.6%), mental and neurodevelopmental disorders (9.3%, including 5.2% with attention deficit hyperactivity disorder (ADHD)), and depressive disorders (6.2%) [50].

Unterschiede bei den Geschlechtern

In terms of gender differences, boys, were three times more likely to suffer from ADHD (15.4% vs. 5.2%) and six times more likely to be affected by social behaviour disorders than girls (7.4% vs. 1.3%). In contrast, girls were twice as likely to have anxiety disorders (19.5% vs. 9.5%) and experienced nearly four times more traumatic disorders (4.9% vs. 1.3%) and eight times more eating disorders (5.5% vs. 0.6%) [50].

Punkt- und Lebenszeitprävalenz von 23,9 % und 35,8 %

nur die Hälfte der Jugendlichen mit Diagnose nimmt Hilfe in Anspruch

The MHAT study showed a point and lifetime prevalence of 23.9 and 35.8 percent, respectively, for at least one mental disorder among ten to 18-year-olds [50]. Applied to the Austrian population, where approximately 772,230 people between the ages of ten and 18 live, it can be estimated that approx. 184,560 young people had a mental diagnosis at the time of this report. Of the patients who had already received a diagnosis, only about half (47.5%) contacted a medical and/or therapeutic care facility. However, of the remaining 52.5 percent not having approached a facility, 18.1 percent would have been interested in treatment [50] (own calculation based on [51]).

[1] The confederation of Austria is made up of nine regions (Bundesländer). Each region (Bundesland), except the capital city, Vienna, is divided into districts (administrative regions), which are themselves divided into local authorities.

HBSC-Studie: größte europaweite Studie zu KiJu-Gesundheit

Lebenszufriedenheit der österreichischen KiJu: 7,8 auf einer Skala von 0-10

The "Health Behaviour in School-aged Children" (HBSC) study is the largest European child and youth health study. It collects data on health, behaviour and influencing factors from students aged eleven to 17 from 42 different European countries, along with Israel and Canada, on a four-year cycle [52]. The latest available data for Austria [53], from 2018, showed that the average life satisfaction of Austrian pupils is 7.8 on a scale from zero to ten. The study assumes a value of less than six as a lower life satisfaction level. In addition, the study revealed an increase in psychological complaints, especially irritability, bad moods, problems falling asleep, nervousness and depression (2010: 7.0-17.0% vs. 2018: 16.0-25.0%) [53, 54].

Statistik Austria 2020: psych.-bedingte Mortalität bei KiJu

According to the Health Statistics Yearbook 2020 of Statistics Austria [55], in 2020 one child/adolescent (age 5-14 years) died as a result of mental illness and three children/adolescents (age 5-14 years) died by suicide and self-harm.

Ergebnisse aus 2 Studien (Februar 2021 und Juni/Juli 2021):

psychisches Wohlbefinden während COVID-19-Pandemie verschlechtert

During the last years of the COVID-19 pandemic, a significant increase in mental illness was observed worldwide and also in Austria, with higher rates of depression, anxiety disorders, eating disorders, suicidal ideation and suicide attempts [56-58]. In February 2021, a cross-sectional study [58] on the mental health status of adolescents in Austria showed that mental well-being and life satisfaction were significantly impaired one year after the onset of the COVID-19 pandemic compared to pre-pandemic data [54, 58]. Another study [57], conducted in June/July 2021, showed no improvement compared to pre-pandemic data after restrictions had been lifted and schools had reopened. However, a slight improvement was observed compared to the February 2021 data [58].

3. Studie (Herbst 2021):

Mädchen schlechtere psychische Gesundheit als Jungen

Suizidgedanken innerhalb der vergangenen 2 Wochen bei: 47 % weiblichen, 32 % männlichen, 90 % non-binären Studierenden

In autumn 2021, one and a half years after the start of the COVID-19 pandemic in Austria, a cross-sectional survey [56] assessing adolescent mental health was conducted among 1,505 students aged 14 to 20 years (female: 1,173, male: 281, non-binary: 51). In addition, the data collected in autumn 2021 were compared with data recorded in February 2021 [58]. Overall, the study showed that all measured variables (well-being, depression, suicidal thoughts, anxiety and sleep) were affected by gender, with non-binary students having the worst scores. Furthermore, girls showed poorer mental health compared to boys. Clinically relevant depression and anxiety symptoms were reported in 61.9% and 49.3% of girls, 38.1% and 28.8% of boys and 94.1% and 70.6% of non-binary students. Clinically relevant moderate insomnia was reported by 27.5% of girls, 16.7% of boys and 43.1% of non-binary students. The prevalence of suicidal thoughts within the last two weeks was 46.8% in girls, 32.0% in boys and 90.2% in non-binary students [56]. Between February 2021 and autumn 2021, girls' mental health worsened in depression (53.2% vs. 61.8%), suicidal ideation (35.3% vs. 47.2%) and sleep (21.0% vs. 26.4%). Among boys, mental health hardly changed from February to autumn, but suicidal thoughts increased significantly (30.6% vs. 33.5%). Non-binary students showed no significant changes between February 2021 and autumn 2021 [56].

4.1.2 National strategies related to child and adolescent mental health

Nationale Strategie zur psychischen Gesundheit: nicht KiJu spezifisch

A number of national strategies exist in Austria that directly or indirectly may address mental health in children and adolescents.

Firstly, there is the national strategy on mental health, which is currently being revised. However, this strategy refers to the whole population and is not specific to children and youth. The strategy contains 10 goals:

Strategie mit 10 Zielen

1. Promote mental health and emphasise its central importance
2. Preventing mental illness and suicide
3. Effectively address stigma and discrimination against people with mental illnesses
4. Provide fair and adequate funding
5. Ensure good primary care for people with mental illnesses
6. Promote appropriate services for vulnerable phases of life
7. Provide effective care for people with severe mental illness through community-based services
8. The involvement of affected persons and relatives in planning and decision-making processes must be ensured. Strengthen human resources, offer attractive training and training conditions
9. Generate reliable data on the mental health of the Austrian population and the psychosocial care landscape
10. Evaluate effectiveness and gain new insights

These targets are to be concretised in national action plans [48] (e.g. the Austrian Health Targets).

Strategie zu Suizid und Suizidprävention (SUPRA), nicht KiJu spezifisch

In addition to the national mental health strategy, a national suicide prevention strategy (SUPRA) was published in 2012. This strategy is also intended for the general population and not specifically for children and young people. The aim of this strategy is to ensure sustainable and high-quality suicide prevention in Austria [59].

Gesundheitsziele Österreich, nicht KiJu spezifisch

Also in 2012, the Austrian Health Targets were officially approved by the Federal Health Commission and the Council of Ministers. These 10-item framework for action for an overall health-promoting policy until 2032 is designed for the general population. However, the healthy development of children and adolescents, as well as psycho-social health, play an essential role in some of the Austrian Health Targets (target 6: make healthy growing up possible for children and adolescents; target 9: promote psycho-social health) [60]. Due to the complexity and persistence of the phenomenon of stigma, the working group on health goal 9 suggested the establishment of a "competence group on destigmatisation", which was later also implemented. The competence group organises several anti-stigma activities all over Austria, of which 28 percent of the activities are aimed at children and adolescents [61].

Kompetenzgruppe "Destigmatisierung" – 28 % der Projekte für KiJu

Kinder- und Jugendstrategie des Bundes (20 Ziele, 2 davon zu psychischer Gesundheit)

The Child and Adolescent Health Strategy developed by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMSGPK) in collaboration with 180 experts, includes 20 targets. Some are related to CAMH (e.g. target 5: Strengthen life skills of children and adolescents or target 15: Improve care in selected areas (child and adolescent psychiatry, psychosomatics, neuro-pediatrics, social pediatrics)) [47]. More recently, the social in-

Kinder- und Jungendstrategie der Sozialversicherungen (12 Ziele, 1 zu psychischer Gesundheit)

surance institutions have also started to develop a strategy for child and youth health (2022-2025) [62]. This strategy is intended to promote the health of children and adolescents. CAMH is addressed in operational objective six (development of "optimised mental health care for children and adolescents").

4.1.3 Child and adolescent mental health promotion and mental illness prevention in Austria

Förderung der psychischen Gesundheit und Präventionsmaßnahmen: Verringerung der Belastung durch psychische Erkrankungen

A reduction in the burden of mental illness can be achieved through mental health promotion and preventive measures for mental illness [63]. Promotional and preventative interventions are based on identifying the individual, social and structural determinants of mental health. Subsequently, interventions are designed to reduce risks, strengthen resilience and create an environment conducive to mental health. Interventions can be designed for individuals, specific groups or whole populations [64].

Gesundheitsförderung: zur Verbesserung von Gesundheit und Wohlbefinden

Promotion is about enhancing people' s health and well-being [65]. The aim of mental health promotion is the protection, support and maintenance of emotional and social well-being and the creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development and improved mental health. At the same time, culture, equality, social justice, and personal dignity should be respected. Mental health promotion targets individuals at risk, but also those suffering from or recovering from mental health problems [63].

Prävention: zur Vermeidung von Krankheiten

Prevention is about the avoidance of diseases [65]. "To prevent literally means to intervene or to take steps in advance to stop something from happening" [63, p. 7]. Preventive strategies usually target risk factors and therefore need to be implemented at specific time points before the onset of the disorder to be maximally effective. However, once the disorder has occurred, the severity, course, duration and associated disability can be reduced by preventive measures throughout the course of the disorder [65]. The aim is to reduce the risk, incidence, prevalence and recurrence of mental disorders and the time spent with symptoms or the risk conditions for mental illness. Further, it aims to prevent or delay relapses and reduce the impact of the illness on the person affected, their families and society [63].

Gesundheitsförderung u. -prävention: enthalten oft ähnliche Aktivitäten welche aber zu unterschiedlichen Ergebnissen führen

Preventive and promotional elements can be present in the same programme and may have different meanings for two groups of the target population. Thus, the two approaches may sometimes include similar activities but lead to different outcomes. For example, a mental health intervention that aims to increase well-being in a community may lead to a decrease in the incidence of mental disorders [65].

Mental health promotion and mental illness prevention activities for children and adolescents in Austria

Präventionsmaßnahmen für psychische Gesundheit von KiJu in Ö vorwiegend auf Projektbasis

Austria has no comprehensive concept for preventing mental illness. However, the BMSGPK has promised additional funding [66]. Mental health promotion and illness prevention in children and adolescents is mainly carried out on a project basis (region-specific or nationwide). The Austrian Health Promotion Fund (Fonds Gesundes Österreich GmbH, FGÖ) is the national competence centre for health promotion and prevention and an essential partner of the Ministry of Health regarding prevention. The FGÖ promotes prac-

tice-oriented and scientific projects and develops activities and campaigns to make healthy lifestyles and living environments accessible to as many Austrians as possible. Further, the Institution encourages cooperation in health promotion and prevention. The target groups "children and adolescents" and the field of action "mental health" are among its legal mandates [67]. The FGÖ has recently launched several projects in the field of promotion/prevention of children's and young people's mental health (e.g. TOPSY – "Toolbox Psychosozial"[2], "STARTHilfe – Tools zur Selbsthilfe für Jugendliche"[3], "#krisen_fest!"[4] and the development of an online suicide prevention programme for children and adolescents[5]).

"Wohlfühlzone Schule": Programm zur Förderung der psychosozialen Gesundheit und Prävention von (Cyber)Mobbing

A multiannual Programme financially supported by the FGÖ in cooperation with the BMSGPK and the Ministry of Education, Science and Research is the project "Wohlfühlzone Schule"[6] (*comfort zone school*). "Wohlfühlzone Schule" is a programme promoting psycho-social health and preventing (cyber-)bullying at Austrian schools. The programme pursues three primary guiding goals: (i) promote psycho-social health and well-being of pupils, (ii) prevent bullying at schools and (iii) promote retention of young people in educational processes (reduce drop-out rate). In several FGÖ project calls, training colleges for teachers (e.g. universities of education) and health promotion institutions were invited to submit projects where 15 to 25 schools each would implement a site-specific school development project for two years or longer [68]. Six projects in six federal states are under the "Wohlfühlzone Schule" initiative.

"Gesund aus der Krise": psychosoziale Versorgung für KiJu in ganz Ö

Psychotherapie für 8000 KiJu

Another project which the BMSGPK financially supports (with 12.2 million euros) is the project "Gesund aus der Krise" (*healthy out of the crisis*). This project was launched by the Professional Association of Austrian Psychologists (BÖP) in close cooperation with the Austrian Federal Association of Psychotherapy (ÖBVP) due to the increase in psychological symptoms among young people caused by the COVID-19 pandemic [69]. The objective of "Gesund aus der Krise" is to offer psycho-social care throughout Austria, in a low-threshold manner and without long waiting times. Children, adolescents and young adults until the age 21 can register for the project by phone or via the website https://gesundausderkrise.at/. The project provides psychotherapy for around 8,000 people, with 15 free clinical psychological, health psychological or psychotherapeutic treatment sessions (individual or group settings) for every participating child, adolescent and young adult [70].

verschiedene anonyme Beratungsdienste

Beratung via Telefon, online, Chat

"Rat auf Draht", "fit4SCHOOL", "Time 4 Friends", "open2talk" are examples of low-threshold and anonymous counselling services that are available and advertised for children and young people all over Austria. "Rat auf Draht" (*advice on wire*) provides children, adolescents and their caregivers counselling by phone (24 hours available), by online contact (similar to an e-mail), and in two different chat formats (Monday to Friday, 06:00-08:00 p.m.). The counselling is provided by an interdisciplinary team of adult experts [71]. The "fit4SCHOOL"-hotline provides psychotherapeutic support in schools.

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2 See: https://fgoe.org/projekt/topsy-toolbox-psychosozial [accessed 22.07.2022]

3 See: https://fgoe.org/projekt/starthilfe-tools-zur-selbsthilfe-fuer-jugendliche-eingereicht-zum-bmsgpk-projektcall [accessed 22.07.2022]

4 See: https://fgoe.org/projekt/krisenfest [accessed 22.07.2022]

5 https://fgoe.org/projekt/entwicklung-eines-online-sebsthilfeprogrammes-zur-suizidpraevention-bei-kindern-und [accessed 22.07.2022]

6 See: https://wohlfuehlzone-schule.at/ [accessed 22.07.2022]

It can be accessed on weekdays from 02:00-03:00 p.m. Psychotherapists with further training in infant, child and adolescent psychotherapy provide the counselling [72]. “Time 4 Friends” is an initiative of the Austrian Youth Red Cross, which offers young people the opportunity to communicate with specially trained young people via WhatsApp chats every day between 06:00 and 10:00 p.m. [71]. Also, the platform "open2chat" follows a peer-to-peer principle, providing young people to be matched with a suitable peer companion (according to main topics and areas of interest). This peer companion stays for the duration of the chat, which can also extend over a longer time. This kind of peer-to-peer principle allows the accompaniment processes to last longer and build a relationship of trust between the young people [71].

Projekte in Ö für Kinder mit Eltern mit psychischen Erkrankungen

Recently, parental mental illness has received increasing attention as a key prevention topic because of the rising awareness that many children grow up with parents with a mental illness and that this often has negative consequence for the children’s health and their general development. Two large research projects have been funded in Lower Austria [73] psychosocial and Tyrol [74] to increase the knowledge base for effective support in addition to existing regional initiatives by non-profit organisations (e.g. Sytria: “Patenfamilien für Kinder psychisch belasteter Eltern” [75]).

Organisation and Funding

meiste finanzielle Mittel für Förder- und Präventionsmaßnahmen: nationale und regionale Gesundheitsbudgets

The national and regional health budgets provide most of the funding for promotion and prevention measures in Austria. Some programmes are also funded by various social insurance institutions [76]. With the adoption of the Health Promotion Act (Gesundheitsförderungsgesetz, GfG), BGBl. No. 51/1998 and the allocation of tasks to the FÖG, Austria has created a legal basis for a more robust anchoring of health promotion and prevention in the health sector. Following the federal target-setting agreement, a national health promotion strategy was developed as a basis for the coordinated use of health promotion funds by the federal government, the regions and the social insurance system. The strategy provides a framework valid until 2022 for broadly coordinated, target- and impact-oriented, quality-assured and partnership-based action in the field of health promotion in Austria (including mental health) [67]. In 2020, € 1.320 million in public health expenditure was spent on prevention [77]. However, there is no information on how much money is invested in preventing mental illness in children and adolescents. In addition, various non-profit and social organisations or donations finance prevention measures in Austria.

4.1.4 Child and adolescent psychiatric and psycho-social care in Austria

The following section will give an insight into the Austrian care structure for children and adolescents with mental illness.

History and legal basis of child and adolescent psychiatry in Austria

Sonderfach: „Fach für Kinder- und Jugendpsychiatrie und psychotherapeutische Medizin“

Between 1975 and 2007, child and adolescent psychiatry in Austria was developed into a modern and humanitarian discipline. Today, the special subject bears the name “Fach für Kinder- und Jugendpsychiatrie und psychotherapeutische Medizin” (*Speciality for Child and Adolescent Psychiatry and Psychotherapeutic Medicine*) and was established by the new medical training

regulations. There are several special features in the field of child and adolescent psychiatry: multimodality, multiprofessionality, the age groups of those affected, different and differently pronounced disorders per age, the restriction to a certain age group (< 19 years) and a high prevalence of disorders, as well as the integration of psychotherapeutic medicine into the specialty [78]. The speciality covers the prevention, diagnosis and treatment, including psychotherapeutic medicine and rehabilitation, of mental illnesses, disorders and behavioural problems occurring in childhood and adolescence, including the psychiatric treatment of developmental mental illnesses and specialised assessment [79, 80].

Versorgungsstrukturen im ÖSG verankert

seit Juni 2016 Mangelfach

The creation of the speciality "Child and Adolescent Psychiatry and Psychotherapeutic Medicine" was accompanied by anchoring the corresponding care structures in the Austrian Health Care Structure Plan (Österreichischer Strukturplan Gesundheit, ÖSG), with the aim of a nationwide expansion of public care structures for mentally ill children and adolescents. [80]. For the implementation of the care plans, a need of 300-350 child and adolescent psychiatrists (including specialists in private practice) was estimated. However, due to the existing shortage of child and adolescent psychiatrists, the speciality was declared a deficiency subject in June 2016 (legislation: 12. Ärztegesetz-Novelle, BGBI. I Nr. 62/2009, in § 10 Abs. 4 Ärztegesetz 1998). This regulation enabled the clinics to expand the training positions per department by up to three posts [78, 81, 82].

Kinderrechtscharta muss immer erfüllt sein; rechtliche Rahmenbedingungen für KiJu in Ö in unterschiedlichen Gesetzen geregelt

Changes in the field of child and adolescent psychiatry are generally subject to the Charter on Human Rights, particularly the Charter on the Rights of the Child [83] and the Convention on the Rights of Persons with Disabilities [79, 84]. In addition, legal framework conditions for child and youth care in Austria are regulated by the Equal Treatment Act, the social insurance law, the Austrian Health Targets and the Child and Youth Health Strategy of the Federal Government, as well as in the Child and Youth Strategy of the Austrian Social Insurance [85] (see Section 4.1.2).

gesetzliche Grundlage der KJP: Krankenanstaltengesetz auf Bundesebene & Ausführgesetze auf Länderebene

gesetzliche Grundlage des ambulanten Bereichs: ASVG

Concerning the hospital inpatient and outpatient sector, the Federal Hospital Act (Bundesgesetz über Krankenanstalten und Kuranstalten, KAKuG) [86] – a fundamental law regulating all hospitals – forms the legal basis of child and adolescent psychiatry in Austria. Furthermore, the individual implementing laws apply at the regions level. For the outpatient sector, the General Social Insurance Act (Allgemeines Sozialversicherungsgesetz, ASVG) [167] applies. In addition, the individual professional laws apply at the federal level for the inpatient and outpatient sectors, e.g. the Medical Act for pediatricians and psychiatrists [82], and the Psychotherapy and/or Psychologists Act for psychologists, psychotherapists and psychiatrists who work therapeutically [168, 169].

weiteres wichtiges Gesetz: Bundes-Kinder- und Jugendhilfegesetz

In child and adolescent psychiatry, the "Bundes-Kinder- und Jugendhilfegesetz" (*Federal Child and Youth Welfare Act*, B-KJHG) is relevant, which deals with the principles of family and educational assistance for children and adolescents [170]. Detailed regulations are made in the implementing laws and ordinances of the federal states [90]. As of January 2020, the legislative competencies for matters of child and youth welfare were transferred in entirety to the regions [171].

UbG: reguliert unfreiwillige Einweisungen; 3 Arten von Einweisungen

The "Unterbringungsgesetz" (*Involuntary Placement Act*, UbG) regulates the admission of patients to a psychiatric hospital or department without or against their will. It applies whenever persons with a mental illness put themselves or others at serious and substantial risk due to their illness and when

adequate treatment respectively protection of the affected person and their environment can only be ensured by means of an inpatient stay in a psychiatric hospital or department. (§ 3 UbG) [87]. The UbG, differentiates between different types of admission to the hospital resulting in different subsequent monitoring mechanisms:

1. referral by a doctor in the public medical service (*öffentlicher Sanitätsdienst*), by a police doctor or by a doctor from a primary care unit,
2. referral by a public security authority (*öffentlicher Sicherheitsdienst*),
3. referral without application of the UbG (e.g. from a general practitioner, self-referral) [88].

unfreiwillige oder freiwillige Einweisung

Once a patient is admitted based on the UbG, a distinction between admission with involuntary commitment (means that patients were involuntarily admitted to the hospital), admission with commitment (patients were voluntarily admitted to the hospital/happens rarely in practice) and admission without application of the UbG exists (see Figure 4-1 for the access and admission types) [88].

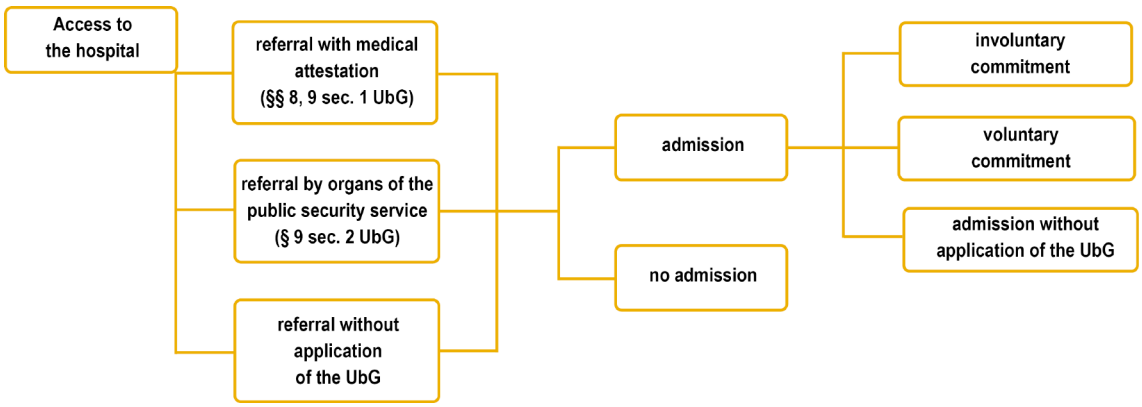

Figure 4-1: Overview of referral and admission types, translated from [88]

UbG regelt auch gesetzliche Vertretung der eingewiesenen Person

eigener Abschnitt für KiJu in Arbeit

In addition to the placement of patients (including voluntary and involuntary commitment), the UbG also regulates the legal representation of the admitted persons and provides for judicial control mechanisms that protect the patients' rights and create legal certainty for treating specialists [88]. The UbG focused mainly on adults in the past, which is why representatives of child and adolescent psychiatry have criticised the law for not considering the unique needs of admitted minors. A law containing a separate section to regulate admission for children and young people is currently being drafted [89].

Further information on the history and the legal basis of child and adolescent psychiatry can be found in a previous report (see: [81]).

Child and adolescent mental health care services, involved institutions and professional groups

Übersicht zu Angeboten für KiJu in Ö

The following section gives an overview of CAMH care services in Austria, including a description of the institutions and professional groups involved and the care structure and capacities.

Mental Health Atlas 2020: Einteilung der Einrichtungen zur Versorgung von Menschen mit psychischen Erkrankungen

In the Mental Health Atlas 2020 [29], institutions involved in the treatment of a mental illness are classified into: mental hospitals, psychiatric units in general hospitals, mental health community residential facilities, mental health day treatment facilities, mental health outpatient facilities, other residential facilities and primary health care clinics (see Appendix Table A-2 for a more detailed description of the different services).

Kernversorgung von KiJu in Ö:

stationär, ambulant, niedergelassene Fachärzt*innen, KJP-Ambulatorien, spezialisierte Einrichtungen

In Austria, the core treatment of children and adolescents with manifest mental illnesses takes place in:

- hospital inpatient facilities (especially in child and adolescent psychiatry and child and adolescent psychosomatics),
- in the outpatient clinics attached to the departments,
- by specialists in child and adolescent psychiatry in private practice,
- by established specialists in pediatrics with additional training in psychosomatics,
- in child and adolescent psychiatric outpatient facilities, or
- in other specialised medical facilities [81, 90].

KiJu-psychiatrische Versorgung: ambulant vor stationär

Child and adolescent psychiatric care follows the principle of being close to the community and the basic rule of prioritising outpatient care above inpatient care [91]. Outpatient clinics, outpatient departments, and health insurance funded practices are essential elements of care. These different services provide different access points to child and adolescent psychiatric care, and thus a higher utilisation of care can be achieved [92]. Further, specific care for different patient groups has been established in outpatient facilities all over Austria, where special treatment services have been set up. Many of these specific services (e.g. transcultural outpatient clinic, forensics, gender dysphoria) are offered in several departments, focusing on outpatient facilities offered by university hospitals [92].

Abteilungen mit spezifischer Versorgung z. B. transkulturelle Ambulanzen

therapeutische Angebote für KiJu mit psychischen Erkrankungen

In addition to medical professionals, numerous therapeutic disciplines from various health care professions provide CAMH care both within and outside the core care. These include psychotherapy and other non-medical services, e.g. occupational therapy and speech therapy. Another relevant professional group are psychologists, who can take on diagnostic and therapeutic tasks [29, 81, 93]. A description of different types of workers according to the Mental Health Atlas 2020 [29] can be found in the Appendix (see Table A-2).

auch Angebote im nicht med. Bereich

In the case of mental health problems in childhood and adolescence, in addition to the health sector, "non-medical sectors", including the social and educational sectors, are also relevant [81, 93].

Kinder- und Jugendhilfe wichtiger Akteur im sozialen Bereich

Child and youth welfare plays a central role in the social sector. The Austrian child and youth welfare system comprise services provided by public and private child and youth welfare organisations. It contributes to the promotion of the rights of children and adolescents to develop and grow up into responsible and socially competent personalities (e.g. educational counselling, support in family crises, risk assessment and assistance planning). The aim is to counteract violence and strengthen families' education [90]. The social

sector also includes psycho-social counselling, mobile psycho-social care and day structures, assisted living facilities, crisis services and support services in the field of work (e.g. vocational rehabilitation) [93].

Sozialpädagogik: verbindet Bildung mit Prävention und Intervention

In the context of education, social pedagogy should be mentioned in particular. Social pedagogy combines education with prevention and intervention. It promotes the independent interaction of people with their environment and society and has a preventive effect against social disadvantages. Social pedagogy aims to support people in different situations and phases of life and offer stabilisation, for example, care for children placed in a crisis accompanied by social pedagogues for 24 hours. A special field of social pedagogy is social pedagogical family support. Social pedagogical family support involves outreach/mobile counselling and support services by professionals who use social work, social pedagogy, psychology and other relevant methods to provide active help in coping with problems or empower families to solve problems themselves. Furthermore, psycho-social services are also offered in schools and kindergartens, e.g., psychological counselling centres for pupils, teachers or parents, or special kindergarten teachers in kindergartens [81, 93].

Supply structure and capacities

verschiedene Zielgrößen für KJP im ÖSG für:

The medical care of children and adolescents is regulated in the ÖSG [94], which defines the following targets for child and adolescent psychiatric care in Austria [92, 94, 95]:

stationäre Betten, Ambulanzplätze, psychosomatische Versorgung, Ärzt*innen für KJP, psychiatrische Ambulanzen

- child and adolescent psychiatric full inpatient beds: 0.05 to 0.09 beds per 1,000 inhabitants[7],
- child and adolescent psychiatric outpatient care places: 0.04 per 1,000 inhabitants,
- psychosomatic care: 0.02 to 0.04 beds per 1,000 inhabitants,
- medical child and adolescent psychiatrist: 1 per 80,000 inhabitants,
- child and adolescent psychiatric outpatient ambulatory: 1 per 250,000 inhabitants.

Maßzahlen: Bettenmessziffer (BMZvs), Platzmessziffer (PMZ) u. Kapazitätsmessziffer (KMZ)

The ÖSG [94] specifies various measurement figures that can be used to evaluate the actual capacities in Austria. For the evaluation of capacities in the child and youth mental health sector the "Bettenmessziffer vollstationär" (*full-impatient bed measure*, BMZvs), the "Platzmessziffer" (*place-measuring number*, PMZ) and "Kapazitätsmessziffer" (*capacity-measuring number*, KMZ) are used (see Table 4-1 for a short description).

Table 4-1: Description of the measurement figures

Measure	Description
BMZvs	Bed requirements for stays with at least one day of admission
PMZ	Need for day hospital places and/or outpatient care places for treatments completed during one calendar day or, in the case of observation requirements, in outpatient primary care units within a maximum of 24 hours.
KMZ	Overall structural parameter that indicates the capacity requirement for a needs-based overall (full inpatient to outpatient) care (sum of BMZvs and PMZ).

Abbreviations: BMZvs – Bettenmessziffer vollstationär (full-inpatient bed measure), KMZ – Kapazitätsmessziffer (capacity-measuring number), PMZ – Platzmessziffer (place-measuring number)

Source: [94]

[7] Reference for inhabitants is the total population of Austria.

Hospital inpatient/outpatient capacities in Austria

2020: 349 vollstationäre Betten für KJP in Ö = unter ÖSG-Zielwert

According to a monitoring report [95] by the GÖG with data from 2020, a total of 349 full inpatient beds are available for child and adolescent psychiatry in Austria. Therefore, the nationwide BMZvs is 0.039 actual beds per 1,000 inhabitants. This value is under the benchmark of need defined in the ÖSG (0.05 beds per 1,000 inhabitants). Looking at the individual regions, only Lower Austria and Vorarlberg and Salzburg are above the desired minimum benchmark; all other regions are below [95] (see Table 4-2 for the inpatient care beds in Austria).

120 Betten für psychosomatische Versorgung in 7 Bundesländern

For psychosomatic inpatient care of infants, children and adolescents, seven regions have facilities with a total of 120 beds. The bed measurement number is thus 0.013 beds per 1,000 inhabitants, with Upper Austria and Salzburg, Carinthia, Styria and Vienna exceeding the national average. There is no offer for psychosomatic care for children and adolescents in Burgenland and Tyrol [95].

Table 4-2: Inpatient beds for children and adolescents in Austria

Region	Psychiatry	BMZvs (child and adolescent psychiatry)	Psychosomatic	BMZvs (psychosomatic)
Burgenland	0	0	0	0
Carinthia	24	0.043	11	0.020
Lower Austria	89	0.053	6	0.004
Upper Austria	54	0.036	40	0.027
Salzburg	39	0.070	15	0.027
Styria	33	0.026	21	0.017
Tyrol	28	0.037	0	0
Vorarlberg	21	0.053	0	0
Vienna	61	0.032	27	0.014
Austria	**369**	**0.039**	**120**	**0.013**

Abbreviations: BMZvs – Bettenmessziffer vollstationär (full-inpatient bed measure)

116 ambulante Plätze für KiJU = unter ÖSG-Zielwert

One hundred sixteen outpatient places are documented for child and adolescent psychiatric care in the hospital setting, resulting in a PMZ of 0.013 places per 1,000 inhabitants. The desired PMZ-value of 0.04 is not achieved yet.

4 ambulante Plätze für psychosomatische Versorgung in Vorarlberg

Outpatient psychosomatic care places for children and adolescents are only available in Vorarlberg (4 places). In Burgenland and Tyrol, there are neither inpatient nor outpatient psychosomatic care facilities for children and adolescents [95] (see Table 4-3 for the outpatient places in Austria).

KMZ = unterhalb der unteren Intervallgrenze

In the ÖSG, the KMZ was set at a value of 0.11 with a range of 0.08 to 0.14 beds/outpatient care places per 1,000 inhabitants. The KMZ, according to the "KA-Kostenstellenstatistik" (*cost-centre statistics*) 2020 for Austria, is 0.052 beds/outpatient care place per 1,000 inhabitants, which is below the lower interval limit. Currently, only Salzburg and Vorarlberg cover the minimum number of capacities. No hospital inpatient and outpatient child and adolescent psychiatric centres are available in Burgenland [95].

Table 4-3: Outpatient places for children and adolescents in Austria

Bundesland	Outpatient places	PMZ (child and adolescent psychiatry)	Psychosomatic outpatient places	PMZ (psychosomatic)
Burgenland	0	0	0	0
Carinthia	9	0.016	0	0
Lower Austria	23	0.014	0	0
Upper Austria	22	0.015	0	0
Salzburg	10	0.018	0	0
Styria	7	0.006	0	0
Tyrol	11	0.015	0	0
Vorarlberg	12	0.030	4	0.010
Vienna	22	0.012	0	0
Austria	**116**	**0.013**	**4**	**0.000**

Abbreviations: PMZ – Platzmessziffer (place-measuring number)

heterogene Krankenhauskapazitäten in Ö

The geographical heterogeneity of hospital capacities within Austria can result in a decrease in the use of outpatient hospital services with an increasing distance between the place of residence and the location of the hospital, and an even higher demand for inpatient stays or an increase in the duration of inpatient stays [81]. In some regions, day-clinical services separate from the child and adolescent psychiatric and psychotherapeutic departments have been established. This is to ensure a regionally more efficient offer and thus enable better, locally coordinated treatment and post-inpatient reintegration of children and adolescents into their social environment [80].

Table 4-4 gives an overview of the inpatient/outpatient hospital care in psychiatric and psychosomatic care for children and adolescents in Austria (Status "Krankenanstalt Statistik" (*healthcare infrastructure statistics*) 2020) [95].

Table 4-4: Full inpatient/outpatient care in psychiatric and psychosomatic care for children and adolescents ("Krankenanstalt Statistik" Status 2020)

Federal state	Hospital	Child and adolescent psychiatry	Child and adolescent psychosomatic	Offer
Burgenland	-	-	-	-
Carinthia	LKH Klagenfurt (Centre for Mental Health)	x	x	Inpatient care for child and adolescent psychiatry and psychosomatic and outpatient care for child and adolescent psychiatry
	LKH Villach		x	Inpatient care
Lower Austria	Krems UnivKL		X	Inpatient care
	LKH Mauer	x		Inpatient and outpatient care
	Tulln UnivKL	X		Inpatient and outpatient care
	Baden-Mögling-Hinterbrühl LKL (child- and adolescent psychiatry: location Hinterbrühl)	X		Inpatient care
	LKL Zwettl-Gmünd-Waidhofen/Thaya (child and adolescent psychiatry: location Waidhofen/Thaya)	X		Outpatient care

Federal state	Hospital	Child and adolescent psychiatry	Child and adolescent psychosomatic	Offer
Upper Austria	KL Pyhrn-Eisenwurzen (child and adolescent psychosomatic unit: location Steyr)		X	Inpatient care
	Klinikum Wels-Grieskirchen (child and adolescent psychosomatic unit: location Grieskirchen)		X	Inpatient care
	Neuromed Campus – Kepler UnivKL	X		Inpatient and outpatient care
	Med Campus IV	X	X	Inpatient care in psychosomatic and inpatient and outpatient care in child and adolescent psychiatry
	Gmunden-Bad Ischl-Vöcklabruck KL (psychosomatic: location Vöcklabruck)	x		Inpatient care
Salzburg	LKH Salzburg		X	Inpatient care
	Christian-Doppler-Klinik Salzburg	X		In- and outpatient care
	KH Schwarzach/Pongau (Kardinal Schwarzenberg Klinik)	X	X	Inpatient care in psychosomatic and psychiatry
Styria	LKH Graz (Psychiatric University Clinic)		X	Inpatient care for child and adolescent psychosomatic
	Leoben-Bruck/Mur LKH (psychosomatic and psychiatriy: location Leoben)	X	X	Inpatient care for child and adolescent psychosomatic and outpatient care for child and adolescent psychiatry
	Graz Süd-West LKH	X		In- and outpatient care for children and adolescent psychiatry
Tyrol	LKH Hall in Tirol	X		In- and outpatient care in child and adolescent psychiatry
	LKH Innsbruck (Psychiatric University Clinic)	X		Outpatient care for child and adolescent psychiatry
Vorarlberg	LKH Rankweil	X	X	Inpatient care for child and adolescent psychiatry and outpatient care for psychosomatic and psychiatry
Vienna	AKH Wien (University Hospital for Psychiatry)	X		In- and outpatient care for child and adolescent psychiatry
	Klinik Hietzing	X		In- and outpatient care for child and adolescent psychiatry
	Klinik Ottakring		X	Inpatient care for child and adolescent psychosomatic
	Klinik Floridsdorf	X		Outpatient care for child and adolescent psychiatry

Abbreviations: AKH = General Hospital, Klinik(um) = Clinic, LKH = Regional Hospital, LKL = Regional Clinic, UnivKL = University Clinic

Source: [95]

Utilisation of services

2020: 3049 Patient*innen in KJP-Abteilungen

Mehrheit wurde in KJP behandelt

In 2020, 3,049 patients overall were admitted to a child and adolescent psychiatric unit, with 62 percent female patients. The total number of admissions was 5,196 resulting in 79,532 treatment days, corresponding to about 26.1 days per patient and about 15 days per admission. The readmission rate to a child and adolescent psychiatric unit was 1.7. The majority of young patients with F-main diagnoses (according to the ICD-10 catalogue) admitted to acute hospitals in Austria were treated in child and adolescent psychiatry (2,975 patients (pts)), paediatrics units (1,263 pts) and psychosomatic facilities (781 pts) [95].

häufigste Diagnose von Patient*innen in einer KJP-Abteilung: F40-F48 Neurotische, Belastungs- und somatoforme Störungen

Most patients in a child and adolescent psychiatric unit in 2020 had a diagnosis from the diagnosis group F40-F48 "neurotic, stress and somatoform disorders" (29%; female: 681 pts, male: 325 pts), followed by the diagnosis group F30-F39 "affective disorders" (23%, female: 637 pts, male: 165 pts) and the diagnosis group F90-F98 "behavioural and emotional disorders with onset in childhood and adolescence" (22%, female: 289 pts, male: 469 pts) [95] (see Table 4-5 for the classification of the mental and behavioural disorder according to the ICD-10).

meiste Belagstage pro Patient*in und Aufnahme mit Diagnose F90-F98 Verhaltens- und emotionale Störungen mit Beginn in der Kindheit und Jugend

Most exposure days per patient in child and adolescent psychiatric units were recorded for patients diagnosed with "behavioural disorders with physical disorders and factors" (on average 56 days). These are followed by patients with a diagnosis from the diagnosis group F00-F09 "organic, including symptomatic mental disorders" (on average 48 days), F20-F29 "schizophrenia, schizotypal and delusional disorders" (on average 30 days) and F60-F69 "personality and behavioural disorders" (on average 26 days). The most exposure days per admission were also recorded for patients diagnosed with "behavioural disorders with physical disorders and factors" (on average 43 days), followed by patients with a diagnosis from the diagnosis group "schizophrenia, schizotypal and delusional disorders" (on average 21 days) [95].

Table 4-5: Mental and behavioural disorders classified according to the ICD-10 Version 2019

Code	Block
F00-F09	Organic, including symptomatic mental disorders
F10-F19	Mental and behavioural disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood (affective) disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behaviour
F70-F79	Mental retardation
F80-F89	Disorders of psychological development
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99-F99	Unspecified mental disorders

Abbreviations: ICD-10 – International Classification of Diseases, 10th Revision

Einweisung nach den im UbG geregelten Prozessen

Anstieg der Einweisungen in den letzten Jahren

In 2019 approximately 13 percent of all inpatient admissions to child and adolescent psychiatric wards were via the procedures regulated in the UbG (Sections 8, 9(1) and 9(2)) (see Section History and legal basis of child and adolescent psychiatry in Austria for information about the UbG) [88]. About 87% of admissions according to the UbG of children and adolescents under the age of 18 in Austria in 2019 took place in departments for child and adolescent psychiatry, the rest (about 13%) in other wards [88] (e.g. adult wards). Compared to previous years, the share of placements in child and adolescent psychiatric wards increased slightly in 2018 and 2019 [88]. Girls made a higher proportion in UbG-based admission (63%) than boys (37%). The majority of them (79%) was older than 14 years. The number of child and adolescent admissions based on UbG rose considerably over the last years, both in absolute terms and in relation to the population. For example the rate of admit-

ted adolescents ≥14 years rose from 188 to 278 per 100,000 inhabitants. The duration of the UbG-based admission is mostly short (involuntary admissions are terminated after 4 days in two third of the cases) [88].

Changes over time

Patient*innenzahl bis 2018 kontinuierlich gestiegen

The number of patients in the child and adolescent psychiatric departments rose continuously until 2018. Since then, a decrease has been recorded. Notably, the decrease in 2019 is due to fewer admitted patients, while the number of female patients increased slightly. In 2020, there was a decrease in both males and females. A similar picture emerges for the number of admissions, with the decline from 2018 to 2019 even more pronounced [95].

2019 u. 2020 Anzahl der Aufnahmen …

… u. Belagstage gesunken

Exposure days per patient varied between 31 and 34 days from 2010 to 2018 and were lower in 2019 and 2020 (27 and 26 days respectively). Exposure days per admission were relatively constant at around 17 days from 2010 to 2017 and have been slightly lower since 2018 [95].

laufende Ambulantisierung trägt zu Verringerung stationärer Behandlungen bei

Since 2018 (starting already from 2017), the "Ambulantisierung" (*shift to outpatient care*, meaning an increase of outpatient treatment options in the form of day-clinic and day-structuring treatment) has contributed to the reduction of inpatient stays and treatment days throughout Austria. Considering inpatient and outpatient sectors together, however, a slight increase in the related services up to 2019 and a significant decrease in 2020 can be observed, the latter presumably due to COVID-19 [95].

Outpatient care area for children and adolescents with mental illness

ambulante Versorgung in KJP: KiJu-Psychiater*innen in privater Praxis u. ambulante Einrichtungen

Outpatient care in child and adolescent psychiatry includes child and adolescent psychiatrists in private practice and in child and adolescent outpatient facilities. These outpatient units are child and adolescent psychiatric services in multi-professional outpatient facilities for children and adolescents with mental problems or illnesses and with integrated specialist treatment [93]. The outpatient units are intended to ensure low-threshold and comprehensive primary care in child and adolescent psychiatry [80].

2020: laut ÖSG 106 Vetragsärzt*innen in privater Praxis für KiJu vorgesehen

32 praktizierende Vertragsärztinnen in Ö

Based on the ÖSG target of one child and adolescent psychiatrist in private practice with a health insurance contract per 80,000 inhabitants, 106 contract physicians would be assumed for the Austrian children and adolescents [81, 96]. In 2020, only 32 contracted physicians for child and adolescent psychiatry and 51 elective physicians were practising in Austria. The contracted physicians are distributed among all regions except Burgenland and Styria. These two regions cover their outpatient medical care of children and adolescents exclusively through child and adolescent psychiatric outpatient units. In the regions of Carinthia, Styria and Vienna, the number of elective doctors for child and adolescent psychiatry is highest (see Table 4-6 for the distribution of psychiatrists in the regions) [95].

2022: 112 Kassenärzt*innen für Kinder- und Jugendpsychatrie nötig, aber nur geringer Teil der Stellen besetzt

A recently published needs analysis for contract physicians in Austria showed that 112 contracted physicians in the field of child and adolescent psychiatric outpatient care are recommended in 2022. Compared to the target values, these are still clearly below the targeted level in all regions and Austria wide only 37.75 of the positions are filled (see Table 4-7 for the number of contracted physicians and the target values). Further, compared to the situation in 2020, there have been some changes in the numbers of contracted physicians in the regions. One of the biggest changes is that there are now two contracted physicians in Styria [97].

Table 4-6: Distribution of outpatient child and adolescent psychiatrists in the regions 2020

Region	Contracted physicians	Elective physicians
Burgenland	0	0
Carinthia	2	10
Lower Austria	9	6
Upper Austria	5	7
Salzburg	2	2
Styria	0	10
Tyrol	4	1
Vorarlberg	4	0
Vienna	6	20
Austria	**32**	**56**

Source: [95]

Table 4-7: Actual and target situation of contracted physicians in 2022

Region	Contracted physicians (filled positions)	Target values
Burgenland	0	4
Carinthia	2	7
Lower Austria	8	21
Upper Austria	7	19
Salzburg	2	7
Styria	2	16
Tyrol	4	9
Vorarlberg	3,75	5
Vienna	9	24
Austria	**37,75**	**112**

Source: [97]

fehlende Information zu Anzahl der KJP-Ambulanzen

The extent to which the target of one child and adolescent psychiatric outpatient ambulatory per 250,000 inhabitants is met cannot be precisely determined, as there are no apparent structural criteria and very different facilities use this designation [96].

Further services

zusätzlich zu KJP-Ambulanzen: Entwicklungspsychologie, Entwicklungsdiagnostik und sozialpädiatrische Ambulanzen

Along with the child and adolescent psychiatric outpatient clinics, developmental psychology, developmental diagnostics, and social pediatrics outpatient clinics are also available in most of the regions. However, these do not specifically target children and adolescents with psychological problems and illnesses and usually do not have specialist child and adolescent psychiatry services. Nevertheless, these outpatient clinics are effective in providing care, as they usually also offer the possibility of free psychotherapy, occupational therapy, speech therapy and physiotherapy [98].

> 1.000 Psychotherapeut*innen für KiJu in Ö

Psychotherapeutic work with infants, children and adolescents differs substantially – depending on the age group – from psychotherapy with adults [99]. However, psychotherapeutic care in Austria was designed primarily for adults, which is why the individual provinces have developed different structures to care for children. More than 1,000 psychotherapists with further training in infant, child and adolescent psychotherapy are available for treating children and adolescents [100]. The Austrian Federal Association for psychotherapy (ÖBVP) lists 1,178 registered psychotherapists for infant, child and adolescent psychotherapy[8] (status July 2022). Since January 2020, psychotherapy for children and adolescents has been financed by the health insurance funds in every region, but access varies, and the number of hours is limited [100]. Furthermore, children and adolescents must wait several months for health insurance-funded psychotherapy [71, 101]. There is no data available on how many children are currently in psychotherapeutic treatment (according to the ÖBVP, the coverage rate throughout Austria is currently around 1.23%), but it is assumed that there is a need of five percent in the group of children and adolescents [102].

lange Wartezeiten für kassenfinanzierte Behandlungen

keine aktuellen Zahlen zu sozialtherapeutischer und sozialpädagogischer Betreuung

For social-therapeutic and socio-educational care, data on residential places are only available for 2013. In the surveys, a distinction was made between socio-therapeutic residential places with special therapeutic offers for children and adolescents with mental problems and socio-educational residential places for children and adolescents with less necessary care intensity. In 2013, there were a total of 585 socio-therapeutic residential places (3.3 residential places per 10,000 inhabitants) and 5,701 socio-educational residential places (33.3 per 10,000 inhabitants) available in Austria [81, 93]. In addition, outreach counselling and support services of socio-educational family assistance are offered in all nine regions. In 2013, there were 53 providers of outreach services of socio-educational family assistance throughout Austria [81, 93]. They are financed by the child and youth welfare departments, whereby the quotas differ between the regions [81, 93]. More up-to-date data are not available at present.

2021: 216 Schulpsycholog*innen in Ö tätig

In 2021 (cut-off date 31.08.2021), 151 school psychologists of the federal government and 65 school psychologists of the "Österreichisches Zentrum für psychologische Gesundheitsförderung in Schulen" (*Austrian Centre for Psychological Health Promotion in Schools*, ÖZPGS) were working in 67 school psychological counselling centres across Austria. About 22,729 pupils received comprehensive psychological counselling, and 110,379 sessions were held with pupils, teachers, guardians, school supervisors and other cooperation partners [103].

keine Daten zu anderen Angeboten im Sozial- und Bildungsbereich

There are no data on the structure of care in Austria for other child and adolescent psychiatric institutions in the social and educational sector, e.g. child and youth welfare, psycho-social counselling centres and crisis services [81].

Strafjustiz und Polizei = wichtige Kooperationsparter im Bereich psychisch erkrankte KiJu

The criminal justice sector and the police may be important cooperation partners in the area of mentally ill children. In addition to the important role of child protection (e.g. in cases of child abuse), the criminal justice and police services also have to deal with mentally ill children and adolescents in case of crime conviction. In the case of children and adolescents' aggressive, impulsive and delinquent behaviour, the police often arrange or conduct admission to the psychiatric departments (e.g. via the UbG, see Section 4.1.4)[49]

[8] ÖBVP-psychotherapist search: https://www.psychotherapie.at/patientinnen/psychotherapeutinnen-suche

but some may also be referred to prison. In these cases, cooperation and coordination between the social sectors (child and youth welfare, child and youth welfare institutions, police, public health officers, child and youth psychiatry) are necessary [49]. There is no information on the level and quality of communication between the various sectors.

2011: 88 % der Jugendlichen in Strafvollzugsanstalten hatten mind. eine psychische Erkrankung

Juvenile delinquents and detainees are another important group requiring coordination between the justice system, the police and child and adolescent psychiatry [49]. According to a study published in 2011, 88 percent of detained juveniles suffered from at least one psychiatric disorder (female prisoners: 91 percent, male prisoners: 87 percent) and over 60 percent had two or more co-existing disorders [104]. Compared to other countries (e.g. Swiss standards of juvenile forensics), the quality of care for juveniles who have committed offenses and suffer from a mental illness in Austria still has to be improved [49].

Erwachsenenpsychiatrie auch relevant für KiJu mit psychischen Erkrankungen

In addition, adult psychiatry providers can also play a role in child and adolescent psychiatric care because many children with mental illness have parents with mental illness [105], who are ideally treated in parallel or – in family-oriented approaches – even together [81].

seit 2021: Forschungszentrum für Translationspsychiatrie

Regarding transitional phases (e.g. when entering schools, or from adolescent to adult psychiatry), in December 2021 a new research centre for transitional psychiatry was established in Tulln (Lower Austria), focusing on topics of mental health promotion for young people, prevention of mental illness and early intervention [106].

Digitalisation

durch COVID-19 Pandemie mehr digitale Angebote

Many of the services mentioned have expanded their services digitally in recent years. Mainly due the COVID-19 pandemic, a changeover to digital therapy measures took place.

verschiedene Kommunikations-möglichkeiten: z. B. E-mail, Chats, Foren o. Apps

The increasing digitalisation in the last decade has led to an expansion of eHealth services in preventing and treating mental illnesses [107]. Various communication channels, such as e-mail, chat, forums or apps, are used for communication. Counselling and therapy can take place exclusively online or be combined with already established settings, e.g. to initiate face-to-face counselling or therapy, aftercare or complementary support [108]. Furthermore, different degrees of formalisation of online services can be distinguished. On the one hand, professional services are offered by outpatient facilities and counselling centres and by psychotherapists and psychologists in private practice. And on the other hand, there is semi-formalised help offered by semi-professional or trained lay helpers in moderated chats as well as informal (self-)help by peers and peers in public or partly public online forums or groups [108].

Funding and access to services

Überblick zu Finanzierung in Ö

In order to guarantee a needs-based services for children and young people, sufficient funding is needed. The next paragraph gives an insight into Austrian funding in the field of care for children and adolescents with mental illness.

alle regionalen Behörden, sowohl auf Bundes- als auch auf Länderebene, sind für Finanzierung zuständig

In child and adolescent psychiatric care, the health sector, the social sector and the educational sector are involved, as well as the inpatient and outpatient sectors within the health sector. For this reason, all Austrian regional authorities, both at federal and provincial, sometimes even at the district/municipal level, are involved in the planning, management and financing of services (see [109] for the example of Tyrol). While inpatient child and adolescent psychiatric care are financed by social insurance, the federal government and the regions, the responsibility for financing outpatient care lies with the social insurance. The regions finance child and youth welfare services. Services of education are the responsibility of either the federal government or the Regions, depending on the type of school [81].

stationäre Versorgung: 100 % öffentlich finanziert

Kostendeckung für psychiatrische Behandlungen in Privatpraxen nur bei Vertragsärzt*innen

Depending on the type of service, the ratio of public to private funding can be very different. Inpatient services for children and adolescents are 100.0 percent publicly financed. Child and adolescent psychiatric specialists and therapeutic services in the outpatient sector are only fully financed if doctors or therapists have a contract with the health insurance or are utilised within the framework of public treatment contingents. Some insurance providers charge a deductible. However, if an elective physician/non-contracted physician doctor or therapist of choice is consulted (e.g. due to a lack of available contracted doctors), the service must first be paid privately. Upon application, part of the fee will be reimbursed [81, 110].

Finanzierung der KiJu-Hilfe abhängig von Dienstleistungsart und regionalen, gesetzlichen Bestimmungen

The financing arrangements for child and youth welfare services depend on the service type and the respective law provisions of each region. Some services are fully publicly financed, and in some cases (income-dependent), cost contributions must be paid. Services in the education system (e.g. school psychological services, school social work) are free of charge for pupils [81, 110].

Anspruchsvoraussetzungen = unterschiedlich geregelt

In addition, the conditions of entitlement are regulated differently. Health care benefits fall within the scope of insurance benefits that can be claimed when treatment is needed. However, chief medical authorisations are required for several child and adolescent psychiatry services. For example, such authorisation must be obtained for speech therapy treatment from the second session onwards [110]. On the other hand, child and youth welfare services may be subject to certain access restrictions, as they are not insurance benefits. However, access restrictions also arise indirectly in child and youth psychiatric care through waiting lists or the capacity bottlenecks described above [81].

mangelhafte Koordination und Kommunikation zwischen Institutionen und Berufsgruppen

In this context, coordination and communication deficits, as well as unclear responsibilities between institutions and professional groups, were noted not only within the medical fields (e.g. between pediatrics and child and adolescent psychiatry) but also between the different care settings (inpatient, outpatient, registered doctors) and the health, social and educational sectors in the broader sense [81, 109, 111, 112].

4.1.5 Case examples: Styria and Vienna

Steiermark (Stmk.) & Wien (W) als Fallbeispiele

Two Austrian regions were selected to get a more detailed insight into regional variations regarding preventive measures of mental illness in children and adolescents and child and adolescent psychiatric and psycho-social services: We selected a rural area (Styria) and an urban area (Vienna).

Styria

Epidemiology

6 Versorgungsregionen (VR) in Stmk.

Styria is divided into six care regions (Graz, Liezen, Eastern Upper Styria, Eastern Styria, West/South Styria, Western Upper Styria) [113]. Overall, there are approx. 1,252,922 inhabitants, including approx. 180,736 people aged three to 18 years (approx. 14% of total population as of January 2022) [51].

ca. 24.239 Jugendliche mit psychischen Erkrankungen (Schätzung)

Without robust regional epidemiological data, the prevalence of mental illness among children and adolescents in Styria is not precisely known. Assuming an Austrian point prevalence of 23.9 percent among ten to 18-year-olds [50] (approx. 101,420 people, the estimated number (own calculation) of affected adolescents based on demographic data, see [51]) is about 24,239 in Styria.

Prevention

regionale Projekte zur Förderung und Prävention von psychischer Gesundheit

In addition to the nationwide projects for preventing mental illness in children and adolescents (see Section 4.1.3), there are also programmes at the provincial level in Styria. Most projects are funded by the "Gesundheitsfond Steiermark" *(Health Fund Styria)*.

"Verrückt? Na und?" = Präventionsprogramm auf Schulebene

A prevention programme at the school level approach is the project "Verrückt? Na und?" *(Crazy? So what?)* by "Irrsinnig Menschlich e.V." in cooperation with the "Dachverband der sozialpsychiatrischen Vereine und Gesellschaften Steiermark" *(umbrella organisation of social psychiatric associations and societies Styria)* and the financial support of the Health Fund Styria. In the project, students from 13 to 25 years of age and their teachers learn to talk openly about mental crises at school. The project aims to reduce fears and prejudices, provide confidence and solutions, and promote the well-being of the class. The team, which visits the school for 5 hours, consists of a professional expert (e.g. psychologist, social pedagogue) and a personal expert who has already mastered a mental crisis [114].

Hilfe und Unterstützung durch Beratungsstellen

In Styria, mainly in Graz, various counselling centres can be contacted if children and adolescents need help, support or counselling on various mental health issues (e.g. Courage, women's counselling centre for sexual violence Styria).

verschiedene Online-Plattformen zu psychischer Gesundheit und Suizidprävention

As mentioned earlier, digitalisation in recent years has led to changes in therapy and prevention in the field of mental illness, which has resulted in many online platforms where people can get help or information. In Styria, online platforms are offered for children and young people, providing general information on mental health[9] or suicide prevention[10].

Präventionsmaßnahmen über die ganze Stmk. verteilt

The majority of preventive offers are provided by private non-profit organisations e.g. "Irrsinnig Menschlich e.V."; they are distributed across Styria and address mostly the age groups of adolescents and young adults. The professional groups involved are mainly psychologists, but other specialised mental health workers also work in the preventive sector of mental illness in children and adolescents. The support consists mainly of counselling and informative talks and takes place face-to-face, over the phone and online.

[9] See: https://gesundheitsfonds-steiermark.at/plattform-psyche/kinder/

[10] See: WEiL – Weiter im Leben: http://weil-graz.org/hilfe/hilfe-fuer-betroffene/, bittelebe: https://bittelebe.at/anlaufstellen/steiermark/, GO-ON Suizidprävention Steiermark: http://suizidpraevention-stmk.at/

For a more detailed overview of mentioned services and other mental health and psychological support for children and adolescents in Styria, as well as information on the target group, workers, type of support and the setting of the service, see Table A-3 and Table A-4 in the Appendix.

Psychiatric and psychosocial care in Styria

psycho-soziale Versorgung in Stmk.

The following information is mainly based on data from a folder on psychosocial care in Styria published by the Province of Styria and the Health Fund Styria [115].

stationäre Versorgung im Krankenhaus (KH) hauptsächlich in Graz

versch. Berufsgruppen involviert

Inpatient care in Styria in a hospital setting is mainly provided in the care region and provincial capital Graz (LKH Graz II and the "Heilpädagogisches Zentrum des Landes Steiermark"). Since 2019, the first rehabilitation centre in Austria for 24 children and adolescents with mental health problems has been available in the care region of Western Upper Styria (district of Murtal). The main professional groups involved in the inpatient care for children and adolescents with mental illness are psychologists, psychiatrists, other specialised mental health workers, and social workers. The target group are children and adolescents up to 18 years.

ambulante Versorgung im KH-Setting in 3 VR

ambulante Versorgung im „nicht KH-Setting" in jeder VR

ambulante gemeindenahe psychosoziale Einrichtungen mit Schlafmöglichkeiten in Graz

Outpatient care in hospital facilities is provided in Graz (LKH Graz II) in Eastern Styria (LKH Hartberg) and Eastern Upper Styria (LKH Hochsteiermark). These facilities are mainly for children from the age of five and young people up to the age of 18. The most common professionals in these facilities are psychologists, psychiatrists and nurses. Outpatient facilities in non-hospital settings for CAMH are offered in every care region. The providers are mainly non-profit organisations such as "Rettet das Kind Steiermark GmbH" (*Save the children Styria*, RdK) or the "Gesellschaft zur Förderung seelischer Gesundheit GmbH" (*Society for the Promotion of Mental Health*, GFSG). Further outpatient, community-based mental health facilities, with overnight accommodation for children and adolescents with mental illness, are offered in Graz (e.g. "tartaruga" and youth emergency shelter "Schlupfhaus"). In these outpatient facilities, most staff are psychologists, social workers and other specialised mental health workers.

Tageskliniken und Tagesbetreuungen in mehreren VR

Day care for children and adolescents is not only offered in the hospital sector (e.g. Provincial Hospital Upper Styria) in the form of a day clinic but also by various non-profit organisations (e.g. a creative factory by the GFSG). Other residential facilities where children/adolescents with mental illnesses, among others, can be accommodated are located in Eastern/Southern Styria ("Ubuntu"), Eastern Upper Styria ("trapez") and Graz ("4Raum"). Other specialised mental health workers mainly care for children and young people in these placements.

meiste KiJu psychiatrische und psychosoziale Angebote in Stmk. = ambulante Angebote

Most psychiatric and psycho-social services in Styria work in the outpatient sector and are provided by private non-profit organisations e.g. GFSG and "Jugend am Werk" (*Youth at work*). Most of the mental health services are located in the region of Graz, and the fewest services are available in the service region of Liezen (see Figure 4-2 for an overview of the different CAMHS in the care regions in Styria). Overall, there are offers for children and young people of all ages, with the majority being for teenagers up to 18 years of age. The main professional groups involved in care and support are other specialised mental health workers, psychologists, psychiatrists and social workers. The type of support ranges from diagnostic and counselling to accommodation. The setting of service provision is office-based, via telephone or online, as well as in the form of inpatient care.

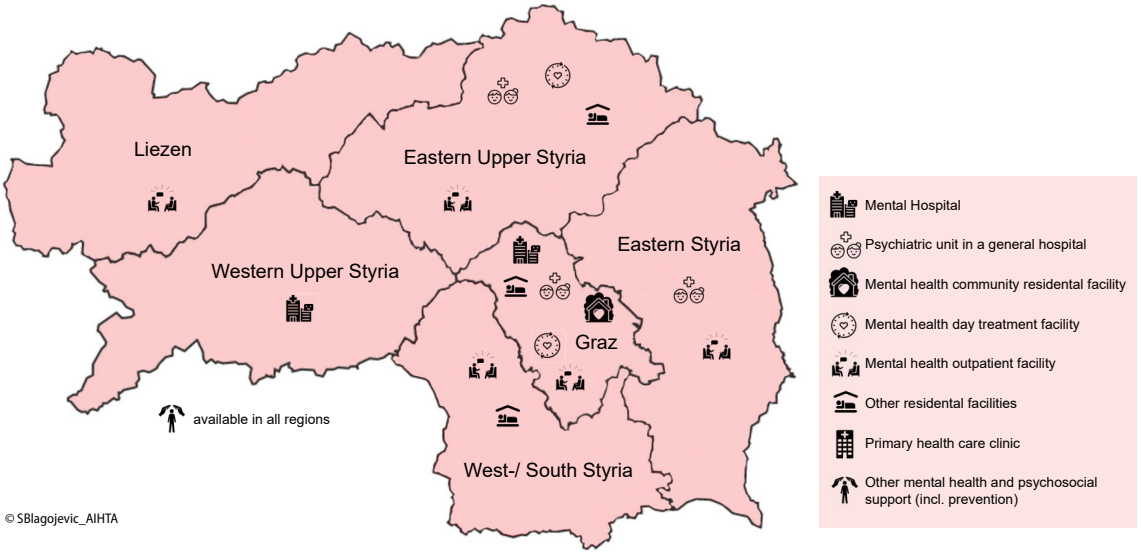

Figure 4-2: CAMHS in the care regions of Styria

For a more detailed overview of mentioned services and other mental health and psychological support for children and adolescents in Styria, as well as information on the target group, the type of workers in support and care, the type of support and the setting of the service, see Mental health services in Styria and Vienna (Austria), Table A-3 in the Appendix.

Key figures of in- and outpatient services in Styria

BMZvs, PMZ und KMZ unter ÖSG-Planwert

The latest data (2020) [95] for child and adolescent psychiatric inpatient care in Styria, with 0.026 beds per 1,000 inhabitants, show that available capacities are clearly below the indicator of 0.05 to 0.09 inpatient beds per 1,000 population [116]. The psychosomatic care beds for children and adolescents in Styria amount to 0.017 beds per 1,000 inhabitants and, therefore, are also below the requirement guideline value of the ÖSG (0.02 to 0.04 beds per 1,000 inhabitants). Outpatient care places are offered in Styria at 0.006 places per 1,000 inhabitants, again below the planned value of the ÖSG (0.11 (min = 0.08, max = 0.014) beds/outpatient care places (ambBP) per 1,000 inhabitants).

RSG Steiermark: Ausbau von KJP geplant

In the Regional Health Care Structure Plan (RSG) for Styria, twelve psychosomatic beds for children and adolescents, 59 beds for child and adolescent psychiatry and 25 day clinic places/ambBP are planned for the future [95].

2022: zwei Vertragsärzt*innen in Stmk.

In Styria, there were no contract physicians for child and adolescent psychiatry [95] in the outpatient sector (see Table 4-8 for the distribution of psychiatrists in Styria) in 2020. Psychiatric care for children and adolescents in Styria was therefore provided in hospitals or by elective doctors [95]. In 2022, there are two contract physicians in Styria in the area for children and adolescents mental health care [97] (see Table 4-7).

Table 4-8: Distribution of outpatient child and adolescent psychiatrists in Styria in 2020

Care region	Contracted doctors	Elective doctors
Graz	0	9
Liezen	0	0
Eastern Upper Styria	0	0
Eastern Styria	0	0
West-/South Styria	0	1
Western Upper Styria	0	0
Styria	**0**	**10**

Source: [95]

Vienna

Epidemiology

ca. 38.351 Jugendliche in W mit psychischer Erkrankung (Schätzung)

About 1,931,593 people are living in Vienna, and about 293,797 (approx. 15.2%) are aged between three and 18 years [51]. Assuming an Austrian point prevalence of 23.9 percent, among ten to 18-year-olds [50] (approx. 293,797 people [51]), the estimated number (own calculation) of affected adolescents is about 38,351 adolescents in Vienna. Vienna is divided into three care regions: Vienna-West (districts: 12 to 19 and 23), Vienna-Centre-Southeast (districts: 1 to 11 and 20) and Vienna-Northeast (districts: 21 and 22) [94].

3 VR in W

Prevention

versch. Angebote für Prävention in W, z. B. „Talkbox" der Stadt Wien oder …

In Vienna, various projects aim to have a preventive effect on the mental health of children and young people. For example, the City of Vienna offers the "Talkbox", an e-mail counselling service of the Child and Youth Welfare Services. This service allows children and adolescents to exchange their problems with two psychologists by e-mail.

… Projekt BASTA: Abbau von Vorurteilen gegenüber psychischen Erkrankungen und Info zu versch. Unterstützungsangeboten

A project that helps to destigmatise people with mental illness is called BASTA. The project is free of charge to Viennese school classes from 10th grade through funding from the "Landesgesundheitsförerungsfonds" (*Regional Health Promotion Fund*), set up by the Social Insurance and the City of Vienna. BASTA is implemented in cooperation with the Health Insurance, the "Psychosoziale Dienste Wien" (*Psychosocial Services Vienna*, PSD-Vienna) and the "Sucht- und Drogenkoordination Wien" (*Addiction and Drug Coordination Vienna*, SDW). At the centre of the project is the encounter lesson with a BASTA team consisting of a trained person with psychiatric experience (experience expert) and a specialist expert. BASTA helps students to overcome prejudices against mental illness and to learn about different support services in Vienna. The project is conducted directly in the classroom, online workshops or in an interlinked form. More than 370 pupils and teachers have joined BASTA [117].

versch. Angebote im Bereich Streetwork

There are also various offers in the field of street work for children and youths in Vienna (among others by various non-profit organisations such as RdK Vienna and the "Verein zur Förderung innovativer Jugendarbeit im Stadtteil" (*Association for the Promotion of Innovative Youth Work in the Community*). In the offers, mainly social workers provide help and information on various topics, entertainment activities, and accompaniment in various activities (e.g. visits to authorities).

finanziert durch öffentliche Gelder und non-profit Organisationen

versch. Berufsgruppen involviert in Präventionsangebote

In Vienna the preventive offers are provided by public (e.g. project BASTA) and private non-profit organisations e.g. social streetwork. The offers are distributed all over Vienna and address, same as in Styria, mainly the age groups of adolescents and young adults. The professional groups involved are mainly psychologists, but other specialised mental health workers also work in the preventive sector of mental illness in children and adolescents. The type of support consists mainly of counselling and informative talks and takes place face-to-face, over the phone and online (for more information, see Table A-4 in the Appendix).

Psychiatric and psycho-social care in Vienna

The following information is mainly based on data found on the website of the the Vienna Social Fund [118], on information from experts and handsearch.

3 stationäre Versorgungsangebote für KiJu + 2 transitions-psychiatrische Abteilungen in W

Inpatient care for children and adolescents in Vienna is mainly provided in the care regions Vienna-Centre-Southeast (at the Medical University of Vienna) and Vienna-West (Clinic Hietzing and Clinic Ottakring). Further, two transition areas for adolescents and young people (16-25 years) in a closed area in the adult section of the psychiatric ward (with four beds) are provided in the Clinic Ottakring and Clinic Floridsdorf (care region: Vienna-Northeast). The main professional groups involved in the inpatient care for children and adolescents with mental illness are psychologists, psychiatrists, other specialised mental health workers, and social workers. The target groups are children and adolescents up to 18 years.

ambulante Versorgung im med. Bereich in 3 VR

Outpatient care in hospital facilities is provided in Vienna-Centre-Southeast (Medical University of Vienna, Sigmund Freud Private University Vienna) in Vienna-West (Clinic Hietzing, Clinic Ottakring), and in Vienna-Northeast (Clinic Floridsdorf). Psychiatrists, psychologists, nurses and other specialised mental health workers care for the children and adolescents (up to 18 years).

ambulante Versorgung im nicht-med. Bereich in 3 VR

Psychosoziale Dienste (PSD)-Wien wichtiger Anbieter: 2 ambulante Einrichtungen mit angeschlossener Tagesklinik

Outpatient facilities in non-hospital settings for CAMH are offered in all three care regions. An important provider is the PSD-Vienna funded by the City of Vienna. The PSD aims to offer comprehensive help to people with severe mental illnesses and their relatives. Each of the individual outpatient clinics of the PSD is responsible for its region in Vienna. They are thus close to home, easily accessible, and can be reached by telephone anytime during opening hours. In addition, a social psychiatric emergency service is available and open around the clock. Facilities specialising in specific diagnoses complement the regional care. For children and adolescents, there are two outpatient clinics for child and adolescent psychiatry (both with associated day clinic), located in Hietzing ("Extended Soulspace") and at Kölblgasse. Both child and adolescent psychiatric outpatient units are dedicated to the special assessment, treatment and care needs of children and adolescents with psychological problems and disorders. The main objective is to provide medical treatment and support for the children and adolescents' personal, social, educational and professional development. Psychiatrists, psychologists, social workers, occupational therapists and other specialised mental health workers care for the children/adolescents from three to 18 years.

ambulante Angebote durch non-profit Organisationen

Furthermore, non-profit organisations such as SOS Children's Village, "Die Boje", "Kinderschutzzentrum Wien" (*Child Protection Centre Vienna*) etc. also offer outpatient care. In these facilities manly psychiatrists, psychologists, and other specialised mental health workers treat children and adolescents. Further outpatient, community-based mental health facilities, with overnight

accommodation for adolescents (twelve to 18 years) with mental illness, run by non-profit organisations are offered in different locations across Vienna (e.g. TRANSITION and WGFestland). Social workers, psychologist and other specialised mental health workers are mainly involved in the care of adolescents.

Angebote für Tagesbetreuung: in KH-Bereich und nicht-med. Bereich durch PSD

Day care for children and adolescents is not only offered in the hospital sector (e.g. Medical University Vienna, Vienna-Centre-Southeast) in the form of a day clinic but also by the PSD-Vienna (day clinic Kölblgasse, Vienna-Centre-South, and day clinic Hietzing, Vienna-West). The day clinics from the PSD associated to the before mentioned outpatient facilities offer an intensive treatment setting for acute cases as an outpatient alternative to full inpatient treatment, especially for the adolescents accommodated in the associated residential groups. The additionally offered home treatment represents a day clinic-like treatment by a multi-professional mobile team in the home environment of children and adolescents.

auch andere Wohneinrichtungen in W für KiJu, unter anderem mit psychischen Erkrankungen

Further, in Vienna other residential facilities exist where children/adolescents with mental illnesses, among others, can be admitted (e.g. residential communities for children and young people run by "Jugend am Werk" (*Youth at Work*) or 'a_way' run by Caritas). Other specialised mental health workers mainly provide the care of children and adolescents in these structures.

Angebote für KiJu in ganz Wien verteilt

Overall, there are services for children and young people of all ages distributed across Vienna, with the majority for teenagers up to 18 years (see Figure 4-3 for an overview of the CAMHS in the care regions of Vienna). The main professional groups involved in care and support are other specialised mental health workers, psychologists, psychiatrists and social workers. The type of support ranges from diagnostic and counselling to accommodation. The setting of service provision is office-based, via telephone or online as well as in the form of inpatient care and home based.

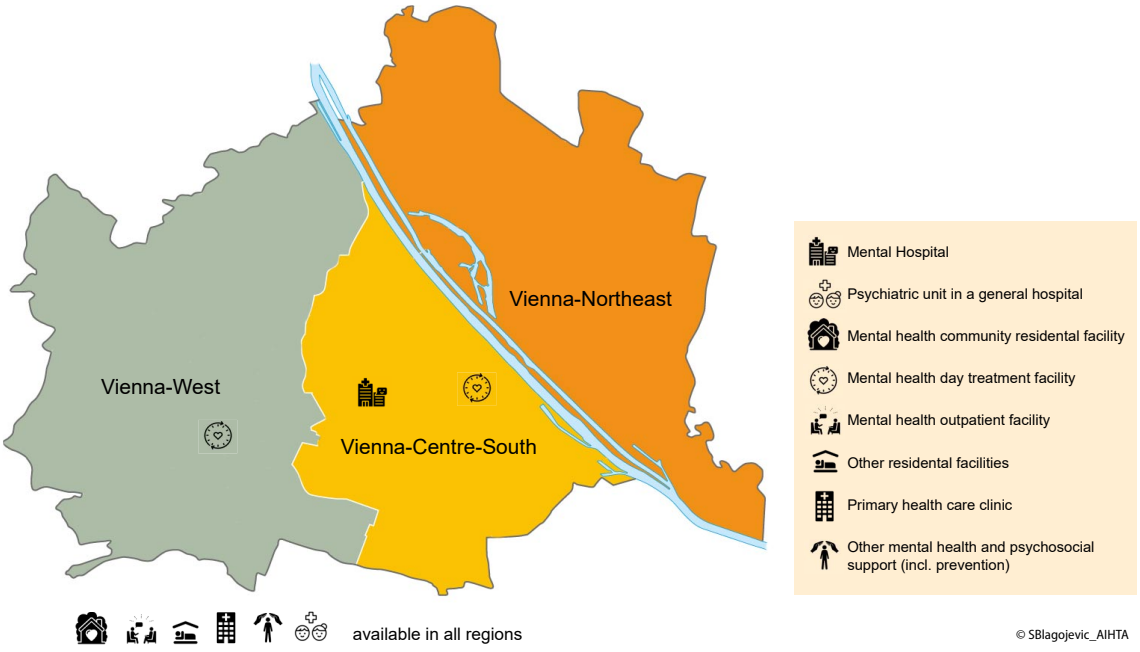

Figure 4-3: CAMHS in the care regions of Vienna

For a more detailed overview of mentioned services and other mental health and psychological support for children and adolescents in Vienna, as well as information on the target group, workers, type of support and the setting of the service, see Table A-4 in the Appendix.

Key figures of in- and outpatient services in Vienna

BMZvs unter ÖSG-Ziel

PMZ knapp über ÖSG-Ziel

The psychiatric care of children and adolescents in the inpatient sector in Vienna with 0.032 beds per 1,000 population is below the planned value of 0.05 to 0.09 inpatient beds per 1,000 population. Also, the psychosomatic care beds for children and adolescents in Vienna (0.014 beds per 1,000 inhabitants), do not achieve the planned value from the ÖSG. Outpatient care places are offered in Vienna at 0.012 per 1,000 inhabitants, just above the planned value of ÖSG.

RSG Wien: Ausbau von Betten für KiJu-Psychosomatik

PPV Wien: pro VR ein Standort mit stationärer psychiatrischer Versorgung und zwei angegliederte Ambulanzen mit ambulanten und tagesklinischen Leistungen

In the Regional Health Care Structure Plan (RSG) Vienna, 106 psychosomatic child and adolescent beds are planned for the future [95]. Furthermore, according to the "Psychiatrischer und Psychosomatischer Versorgunsplan Wien 2030" (*Psychiatric and Psychosomatic Care Plan Vienna 2030*, PPV) published in 2018, one location with inpatient psychiatric care and two associated outpatient clinics with outpatient and day-clinic services are planned for each care region in the field of child and adolescent psychiatry by 2030. In total, there should be three inpatient and six outpatient facilities for children and adolescents in Vienna by 2030. The already existing specialised outpatient resources will be integrated into the regional outpatient care structures to be established. In addition, cross-sectoral regional care platforms are planned in the care regions, in which the inpatient and outpatient or day-clinic facilities in the region will coordinate and exchange information on an ongoing basis. Furthermore, there will also be measures to coordinate and optimise the services throughout Vienna beyond the regional care platforms [119].

2022: 9 Vertragsärzt*innen in Wien

In Vienna, six contracted physicians were working in the field of child and adolescent psychiatry in 2020 [92, 95] (see Table 4-9) and nine in 2022 [97] (see Table 4-7).

Table 4-9: Distribution of outpatient child and adolescent psychiatrists in Vienna in 2020

Care region	Contracted physicians	Elective physicians
Vienna-Centre-Southeast	4	13
Vienna-West	2	7
Vienna-Northeast	0	1
Vienna	**6**	**21**

Source: [95]

4.2 Child and adolescent mental health care models, strategies and recommendations

Ergebnisse und Empfehlungen aus int. Strategien/Modellen

In this chapter, we present the findings and recommendations from the international child and adolescent mental health care models and strategies. First, we present profiles of the selected countries regarding the existing mental health governance (e.g., available mental health strategies and laws). Then we give an overview of the selected document(s) characteristics (target audiences, addressed age groups, key principles and general themes of the documents). Finally, we describe the iteratively identified categories on the documents' content, followed by a narrative data synthesis of all 14 categories defined.

4.2.1 Mental health governance in the selected countries

Übersicht über psychosoziale Systeme in ausgewählten Ländern

The following overview of mental health system governance of the included countries is based on the WHO mental health atlas 2020 [29].

As seen Table 4-10, all countries described in this report have a mental health strategy that addresses all age groups. From these, five countries (CZ, DE, ES, NO, UK) have a mental health strategy that is specific for children and adolescents. However, in some of these countries this is not listed as a stand-alone document and instead a subchapter of the all-age mental health strategy (e.g. CZ) [35-41].

Vorhandensein von Strategien, Suizidprävention, Gesetzen, Förderungs-/ Präventionsprogramme

All except one country (DE) have a national suicide prevention strategy in place. Regarding a stand-alone law for mental health, for more than half of the included countries (AU, DE, NO, UK) such a law was reported, while three (CH, CZ, ES) do not yet have such a stand-alone law implemented. Almost all countries had mental health promotion and prevention programmes reported in the WHO Mental Health Atlas country profiles (AU, CH, CZ, DE, ES, NO, UK). [35-41].

Table 4-10: Country profiles regarding availability of mental health strategy/policy/plan

Selected country	Availability of strategy/policy/plan				
	All-age mental health strategy	Child and adolescent mental health strategy	National suicide prevention strategy	Stand-alone law for mental health	Mental health promotion and prevention programmes
AU – Australia [35]	✓ (2017)	NA	✓ (2017)	✓ (2015)	✓
CH – Switzerland [41]	✓ (2016)	NA	✓ (2016)	NA	✓
CZ – Czechia [40]	✓ (2020)	✓ (2020)	✓ (2020)	NA	✓
DE – Germany [39]	✓ (2006)	✓ (2008)	NA	✓ (2016)	✓
ES – Spain [38]	✓ (2015)	✓ (2011)	✓ (2011)	NA	✓
NO – Norway [37]	✓ (2019)	✓ (2019)	✓ (2020)	✓ (2018)	✓
UK – United Kingdom [36]	✓ (2019)	✓ (2019)	✓ (2019)	✓ (2007)	✓

Abbreviations: AU – Australia, CH – Switzerland, CZ – Czechia, DE – Germany, ES – Spain, NA – not available, NO – Norway, UK – United Kingdom

4.2.2 Data synthesis of document characteristics

Auswahl von 12 Dokumenten

The following Table 4-11 gives an overview of the included document(s) per country. A total of twelve documents were selected, published between 2013 and 2022. The process of document selection is described in the Methods chapter 3.2.

Table 4-11: Overview of selected documents per country

Selected country	Included Document(s)				
	Title	Publisher	Year	Language	Reference
AU – Australia	Head to Health Kids National Service Model	Australian Government Department of Health	2022	English	[120]
AU – Australia	The National Children's Mental Health and Wellbeing Strategy	Australian Government	2021	English	[121]
AU – Australia	Child and Adolescent Mental Health Service Model of Care	Australian Capital Territory Government Health	2013	English	[122]
CH – Switzerland	Versorgungspfade in der psychiatrisch-psychotherapeutischen Ver-sorgung von Kindern und Jugendlichen – SPD Basel	Swiss Confederation	2020	German	[123]
CH – Switzerland	Die Zukunft der Psychiatrie in der Schweiz	Swiss Confederation	2016	German	[124]
CH – Switzerland	Beabsichtigte Massnahmen zur psychischen Gesundheit in der Schweiz	Swiss Confederation	2016	German	[125]
CH – Switzerland	Psychische Gesundheit in der Schweiz, Bestandsaufnahme und Handlungsfelder	Swiss Confederation	2015	German	[126]
CZ – Czechia	National Mental Health Action Plan (NÁRODNÍ AKČNÍ PLÁN PRO DUŠEVNÍ ZDRAVÍ 2020-2030)	Ministry of Health of the Czech Republic	2020	Czech	[127]
DE – Germany	Further development of psychiatric-psychotherapeutic assistance and prevention of mental disorders in childhood and adolescence in Germany – development and coordination of recommendations for action (*„Weiterentwicklung der psychiatrisch-psychotherapeutischen Hilfen und der Prävention seelischer Störungen im Kindes- und Jugendalter in Deutschland – Entwicklung und Abstimmung von Handlungsempfehlungen"*)	Aktion Psychisch Kranke e.V.	2021	German	[128]
ES – Spain	Roadmap: Recommendations for promoting mental health and emo-tional well-being in young people	Red PROEM (PROmotion of Mental Health and Emotional Well-being in the Young)	2018	English	[129]
NO – Norway	National guideline for health promotion and preventive work in the child and youth health centres and school health service, 0-20 years	Norwegian Directorate of Health	2020	English	[130]
UK – United Kingdom	Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing	National Health Service England, Department of Health	2015	English	[131]

Abbreviations: NR – Not reported; SPD – Schulpsychologischer Dienst (eng.: School psychology service)

Quality assessment

When applying the adapted version of the AGREE II instrument [42] (see methods chapter 3.2), the assessment of the overall quality of the documents ranged from 62% to 95%. Reasons for lower ratings were, among others:

- the views and preferences of the target population not always included,
- target users of the documents not always clearly defined,
- no application of systematic methods to search for evidence,
- recommendations not always explicitly linked to supporting evidence.

A summary of the quality assessments of all included documents is in the Appendix, Table A-12.

Target audience

If stated, the documents had different target groups. On the one hand, those potentially affected (children, adolescents) and their carers (parents, caregivers) are stated as target audience (NO, UK). Additionally, in five out of seven countries, the policy-level and decision-makers are addressed by the documents, such as ministries, governments, planning committees and relevant working groups or the legislative or judicial branches. Finally, the Norwegian documents' target audience are service providers in the health, social and educational sector and their staff. Two countries did not report a target audience for the documents (AU, CZ).

Zielgruppe: Betroffene und deren Familien/ Betreuungspersonen und: Entscheidungsträger*innen, Ministerien, Arbeitsgruppen

Addressed age groups

Only two countries (AU, NO) indicated the age groups for which the documents are intended with an age number. The document from Norway addresses the age group 0-20 years. Two Australian documents cover the age groups 0-12 years and ages up to 25 years respectively.

adressierte Altersgruppe teilweise definiert (0-25 Jahre), teilweise „Kinder" und/oder „Jugend(liche)"

In the documents which did not specify the age, named target groups were "children" (AU), "children and adolescents" (CH, DE), "young people" (ES) and "children and young people" (UK). The documents from two countries address the total population, with a subchapter for "children and adolescents" whose age is not specified (CZ, CH).

Key principles and general themes

All documents stated key principles, child and adolescent mental health care should be based on. These varied broadly across countries. Principles that were most often stated by countries were to increase the focus on prevention and early intervention/early detection including efforts on improving health literacy, to improve coordination and that child and adolescent mental health care should be evidence-based including the need for more mental health services research.

Grundprinzipien: sehr häufig Prävention/ Früherkennung/ Gesundheitskompetenz/ Versorgungsforschung

A number of principles were related to the care philosophy and the attitude towards care. Examples are to work strength-based (AU, UK) and participatory (AU, DE, NO). This requires specific behaviours and attitudes by the staff such as being positive, open-minded, unprejudiced, and trustworthy, willing to listen to, trust and believe in the child or young person (UK). The Australian documents in particular emphasised that the models should be child- and family-centred, focussing on the child's functioning rather than a diagnosis and they should move away from stigmatising or restrictive terminology. Similarly, some countries, such as Norway or the UK stress the principles to be needs-based and to care for the most vulnerable groups including being culturally sensitive.

stärkenorientiert, partizipativ, aufgeschlossen, vertrauenswürdig, kinder- und familienzentriert, Fokus auf Stärken (statt auf Defizite/Diagnosen)

In contrast to other countries, in the German documents, some of the principles are addressing the setting, which should be given priority, such as strengthening pre-hospital and outpatient treatments. Another unique characteristic in the UK and Australian documents is that they are regarding workforce-development as one of their key principles. Finally, a few principles address the system as such and emphasise the need for responsibility (NO), accountability and transparency (UK).

Stärkung prä-klinischer und ambulanter Behandlungen

Stil: strategisch und/oder konkrete Modelle

Fokus: Evidenz und/oder Gesetze und/oder Partizipation

The general style of the documents differed in some regard. Some documents were rather strategic (CZ, DE, ES), others were rather describing concrete models (AU, NO, UK), and one country had both strategic and concrete model documents (CH). Some documents particularly provided an evidence base for each recommendation (e.g. CZ, NO), while others gave more jurisdictional context (CH, DE). One document in particular followed a thorough participatory approach, with the foreword of the document directed at children and adolescents in easy to understand language (UK).

4.2.3 Description of categories

14 Themenfelder:

Informationsmaßnahmen, Prävention/Gesundheitsförderung, Früherkennung, Behandlung, Telemedizin, Behandlungspfade, Transitionspsychiatrie, gefährdete Patient*innengruppen, Patient*innenbeteiligung, Infrastruktur, Entwicklung/Ausbildung der Fachkräfte, Implementierung, digitales Fall-management, und Datenerfassung/ Versorgungsforschung

In the iterative process of data extraction from the selected documents, we defined 14 categories as components of the models/strategies. These are:

- **Information:** All activities for informing children and adolescents, as well as extended target groups (e.g. parents or carers), including awareness raising activities, mental health literacy topics, as well as stigma-reducing activities.
- **Prevention:** Approaches of promoting mental health, preventive education programmes, emotional wellbeing and healthy lifestyle activities.
- **Detection:** Screening methods for early identification of children and adolescents with psychosocial risk, assessment approaches of mental health.
- **Treatment:** Modalities in care for treating children and adolescents, e.g. psychological counselling, psychotherapy, medication therapy, other therapeutic offers (e.g. ergotherapy), specialised treatments (e.g. interventions for highly traumatised children).
- **Digitalisation for telehealth:** the use of digital tools, such as digital apps or telepsychiatry for children and adolescents (preventative and/or treatment offers).
- **Care pathways:** the integration of care and coordination of health in all policies, included sectors, responsibilities, system navigation and paths of access.
- **Transitional psychiatry:** aspects to be considered for the transition into different developmental phases (e.g. from adolescence to young adulthood) with the associated health challenges.
- **Vulnerable patient groups:** factors that can make a patient group vulnerable regarding mental health (e.g. risk factors, comorbidities, disabilities, ethnic minorities, sexual diversity and/or differing gender identity, social or economic disadvantages, etc) and applicable model components (e.g. transcultural care).
- **Involvement:** modalities of increased user participation, such as patients and/or parents and carers, in the planning, delivery and evaluation of services.
- **Infrastructure:** necessary resources for mental health infrastructure for children and adolescents, including structural description of services and financing/budgeting aspects.
- **Professions**: qualification of the workforce of services in the child and adolescent mental health care models, workforce availability, staffing ratios, and the continuous training for workforce development.

- **Implementation:** strategies and processes for implementing the child and adolescent mental health care models, including policy requirements.
- **Digitalisation for management:** digital tools for case management (e.g. bed management systems, electronic health records) for documentation.
- **Data acquisition:** trials, evidence generation, research for child and adolescent mental health, evaluation of different measures and programmes.

Übersicht der Themenfelder pro Land

In the following Table 4-12 we give an overview which of the categories were depicted in the included documents. The majority, but not all of these categories were described in all included documents. The Czech document addressed the fewest number of categories. Australia and Spain were the only countries addressing all categories.

Table 4-12: Category description in selected documents

Categories of model/strategy	Availability of information in selected document(s)						
	AU	CH	CZ	DE	ES	NO	UK
Information, awareness raising activities	✓	✓	✓	✓	✓	✓	✓
Prevention, mental health promotion	✓	✓	✓	✓	✓	✓	✓
Detection, screening	✓	✓	✓	NR	✓	✓	✓
Treatment	✓	✓	✓	✓	✓	✓	✓
Digitalisation: Tools for detection, intervention, telehealth	✓	NR	NR	✓	✓	✓	✓
Care pathways, integrated care, health in all policies	✓	✓	NR	✓	✓	✓	✓
Transitional psychiatry	✓	✓	NR	✓	✓	✓	✓
Vulnerable patient groups	✓	✓	NR	✓	✓	✓	✓
Involvement, user participation	✓	✓	NR	✓	✓	✓	✓
Infrastructure, resources	✓	✓	✓	✓	✓	✓	✓
Professions, workforce development	✓	✓	✓	✓	✓	✓	✓
Implementation strategy, process	✓	✓	✓	✓	✓	✓	✓
Digitalisation: Tools for case management and documentation	✓	✓	NR	✓	✓	NR	NR
Data acquisition, research	✓	✓	NR	✓	✓	✓	✓
Overall	**14**	**13**	**7**	**13**	**14**	**13**	**13**

Abbreviations: AU – Australia, CH – Switzerland, CZ – Czechia, DE – Germany, ES – Spain, NO – Norway, NR – not reported, UK – United Kingdom

4.2.4 Data synthesis of categories

Information, awareness raising activities

Informationsmaßnahmen

To some extent, all countries listed information or awareness raising activities for children and adolescents, describing the target audience and the general aim of the activities:

Zielgruppe: Kinder, Jugendliche, Eltern, Betreuungspersonen, teilweise Personal

The *main target groups* of the activities were children, adolescents, parents and carers. In some countries, the target groups of the initiatives include service providers, such as services working with children in Australia, or members of the education and health community in Spain. More specific target groups, such as children and adolescents with specific disorders, were listed in Ger-

many. In general, the activities focus on children and adolescents of all age groups, with Norway addressing all lower secondary school pupils as the target audience.

Zweck: Stigmareduktion, Steigerung der Gesundheitskompetenz

The *aim* of the information and awareness raising activities is to identify early signs of struggling in children, to reduce stigma that may prevent families from seeking help, and to increase mental health literacy In Spain and Switzerland, the aim is to build adolescent health and emotional well-being literacy, as well as respect, empathy and tolerance towards diversity, and to reduce stigma towards vulnerable and social minority groups and individuals (see Example 1). The Czech document outlines a programme aimed at developing parenting skills, especially for families under psychosocial stress.

Mehrere Arten der Informationsvermittlung

The *modes of delivery* of information or awareness raising activities to recipients planned to be used include a broad range of delivery methods, from conventional media to online, web-based delivery as well as personal information deliveries.

webbasierte Medien, Print, Audio, Video, Apps, Informationsportale

persönlich: Sozialarbeit, Schulsektor

Regarding the conventional mode of delivery, print, audio, video format is suggested (DE, ES). Regarding web-based media, apps, information portals or YouTube are examples (DE, UK). The personal delivery methods are parental counselling or school social work and school psychology (AU, CH, CZ, NO). This includes antenatal and parenting courses with emotional wellbeing modules embedded, evidence-based resources building on existing initiatives, providing education sessions for schools and the general community, providing information and resources on mental health issues and illness (AU), and making all adolescents aware of location and opening-hours of services that are provided (NO).

klare, einfache, altersentsprechende Sprache

The information should be delivered in clear, simple and age-appropriate *language and wording* (DE, UK). In the UK, an example of a successful anti-stigma campaign is given: the initiative "time to change".

relevante Themen für Informationsmaßnahmen

Three countries reported on *relevant topics to be included* in the information and awareness raising activities (AU, ES, NO). These range from building health literacy, education on healthy lifestyles, and proper identification of symptoms. In general, physical activity, nutrition, sleep habits, and family/social/school support networks are described as relevant topics (ES, NO). Two countries specifically state the topic of culture, language background and end-users language use, as it can impact the way struggling children show symptoms (AU, ES). Additional topics include puberty, sexual health, use of tobacco, alcohol and other drugs, violence and abuse (NO), appropriate use of new technologies (ES), as well as further information on other risk factors that may influence mental health (NO).

Example 1: Information, awareness raising activities (Spain)

Roadmap: Recommendations for promoting mental health and emotional well-being in young people:

In Spain, it is planned to involve the media for disseminating information from health professionals, counsellors, parent's associations and end-users, with the aim of eliminating any type of stigma.

Source: [129]

Prevention, mental health promotion

Prävention/ Gesundheitsförderung

All countries reported on prevention and mental health promotion activities for children and adolescents.

These can be grouped as *aims of the mental health promotion activities*, which *target groups* are addressed and by *whom*, the *type* of prevention, and in what *context and setting* the prevention is performed.

Zweck: emotionales Wohlbefinden, Resilienz, Respekt, Toleranz, Vorbeugung von Mobbing

The *aims* of the prevention activities are to promote mental health, emotional wellbeing, healthy lifestyles (ES) resilience, prevention and early intervention (UK, CH), to ensure an early referral in the case of exhausted family systems (CH), to encourage peer-to-peer respect and tolerance, preventing victimization or any other kind of interpersonal violence (ES), to prevent bullying and truancy (the intentional, unjustified, unauthorised or illegal absence from compulsory education) (CZ), and to promote a broad national conversation about mental health issues for children and young people (UK). In two countries, the aim of the existing programmes for maternal, perinatal and early year health services are to strengthen the attachment between parent and child, to avoid early trauma, build resilience and improve behavior (NO, UK).

Zielgruppen: Kinder, Jugendliche, Eltern mit psych. Erkrankungen

For the *target groups*, besides addressing children/adolescents directly (NO), parents can also be regarded as a target group, e.g. using the International Child Development Programme for systematic parent education (NO). A particular emphasis in all countries except Spain is on parental mental illness which has been identified as a core risk factor for child and adolescent mental illness. The recommendations are mostly for early identification and support in case of perinatal mental health problems. An example is to install a "specialist perinatal mental health clinician" in each birth clinic in the UK or screening for postnatal depression during home visits after birth in Norway. However, there is less advice on how to deal with parental mental health problems when children are older are.

diverse involvierte Berufsgruppen

Target groups are to be *addressed by* different organisations and professionals, such as the school health service (NO, UK), psychotherapists (DE) or public health nurses (NO). In Germany, in psychotherapy consultations it should be clarified whether other help options (e.g. preventive measures) are indicated. It is recommended that the "medical certificate" (according to § 26 Paragraph 1 Sentence 4 SGB V) should be abolished in favor of a corresponding "psychotherapeutic certificate" with prevention recommendations included.

individuell oder in Gruppen

The *type* of the prevention is described as individually/targeted (ES, NO), or in groups/universal (see Example 2), (ES, NO). Regarding the *context and setting*, i.e. the method of delivering the prevention and mental health promotion programmes, the development of psychosocial competences and emotional literacy is described as important condition for functional social behavior and the prevention of behavioral disorders at an older age (CZ). Psychosocial education and management of student behavior shall be implemented in the common core training of undergraduate teaching staff. Similarly, for kindergartens, primary and secondary schools, the inclusion of psychosocial literacy in the framework education programmes is depicted. These approaches are based on recommendations by the WHO (CZ). Further, the aspects of strength-based services building on the wellbeing continuum are part of the prevention and mental health promotion activities (building on the positive attributes in a holistic child and family centred approach, see Figure 4-4 and Example 3) (AU).

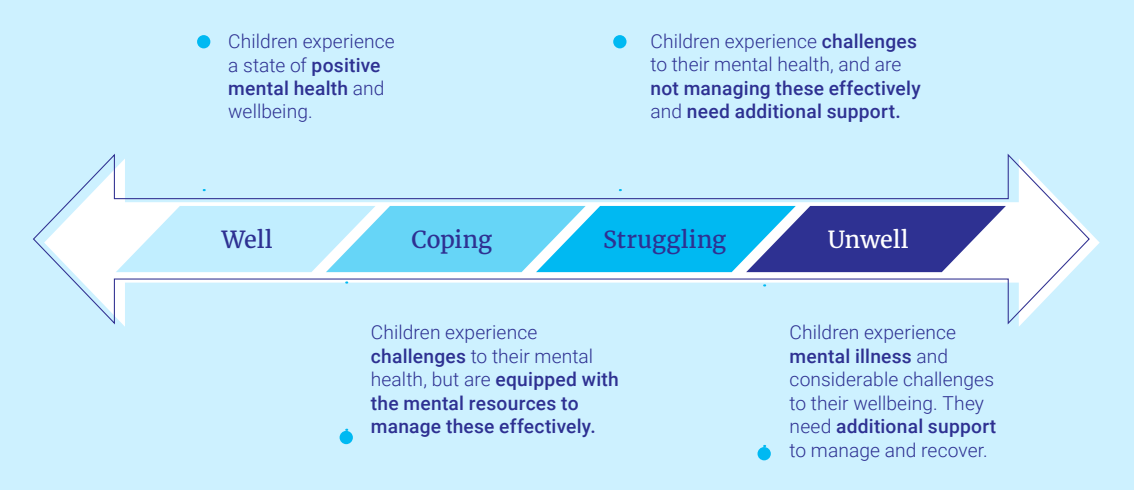

Figure 4-4: The mental health wellbeing continuum [121]

Example 2: Prevention, mental health promotion (Norway)

National guideline for health promotion and preventive work in the child and youth health centres and school health service, 0 – 20 years:

In Norway, the school health service is in charge of promoting a good psychosocial environment, preventing unhappiness, bullying and mental health problems through universal, group and individually oriented measures. As one possible approach, the establishment of divorce groups is mentioned. These can offer group counselling to support children and adolescents who experience break-ups or divorce between their parents.

Source: [130]

Example 3: Prevention, mental health promotion (Australia)

The National Children's Mental Health and Wellbeing Strategy:

This strategy proposes a fundamental, cultural shift, whereby a continuum-based model of mental health and wellbeing is proposed, to prevent terminology that may be too narrow or stigmatising. Australia further highlights the need to differentiate between the diagnosis and the child's functioning (as an example, a child with a diagnosis may still function well socially and educationally (i.e. "coping"), and another child might be struggling without requiring a diagnosis, but still experiencing a decline in the usual functioning or anticipated developmental trajectory).

According to this continuum-based approach, opportunities to promote wellbeing and possibly intervene before a child becomes unwell are possible.

Source: [121]

Detection, screening

(Früh-)Erkennung

All countries, except Germany reported on detection and screening methods as part of the model/strategy.

Zielgruppen: Kinder mit psychosozialen Risikofaktoren (und deren Familien)

Regarding the *target groups*, the countries describe that the early identification is for children with psychosocial risk (AU, CH, CZ, ES) and their families (AU, CZ). Two countries make more specific statements on children with psychosocial risk: these include children at the earliest age, and of women with psychosocial distress during pregnancy or after childbirth (CZ), as well as young people with learning disabilities and/or challenging behaviours (UK).

The *aim* of the screening is described by one country (ES). The early detection programmes are proposed to be aligned with the Convention on the Rights of the Child. The prevention protocols and evidence-based psychotherapy interventions are designed to prevent mental disorders, (cyber-)victimisation, self-harm, suicidal ideation and behaviour.

Zweck:
Erkennung und Vorbeugung von Erkrankungen, Mobbing, Suizidalität

Four countries (CH, CZ, NO, UK) describe *the setting of the screening*. These range from detection in the school setting, in the clinical setting, or in collaborative approaches. Little information is available on who/which professional group should do the screening.

Settings:
Schule, klinisch, kollaborativ

Three countries (AU, CH, NO) describe the *screening method* in the school setting. The screening of mental health problems by school professionals, such as the canton of Basel City (CH), or the school-entry health consultation as well as a health consultation in the 8th grade are described as methods for detection and screening (see Example 4), (NO). In these consultations, the health professionals shall notify the Child Welfare Service, when there is reason to believe that a child is being abused or suffering from neglect, or when a child has displayed persistent behavioural difficulties. In this context, the pupils should be partly undressed during the somatic part of the school-entry health consultation, to observe possible indications of violence, abuse and neglect (NO). The third country describing screening methods in the school setting follows the approach of proactive outreach procedures to respond to student disengagement (AU). Australia also describes the difficulties of diagnosing children and adolescents, as disruptive behaviours may occur in the context of developmental growth. Therefore, the Australian model of care suggests the classification of mental health presentations as symptom-based, on the level of dysfunction and impact on functioning, rather than relying solely on a mental health diagnosis (see Example 3).

Methodik:
Schuluntersuchungen, Einbeziehung Kinder- und Jugendhilfe

Regarding the clinical setting, one country (UK) describes to perform an assessment of mental health in admission gateways for inpatient care of children and young people (UK).

klinisch:
psych. Assessment in stationärer Pädiatrie integrieren

One country (CZ) plans multidisciplinary collaborative approaches (health, social or educational) for the screening and detection of mental health problems, and subsequent support for accessing appropriate forms of intervention in different sectors.

Example 4: Detection/screening (Norway)

National guideline for health promotion and preventive work in the child and youth health centres and school health service, 0-20 years:

In Norway, for all children from 0-5 years of age, regular consultations at health centres should be offered. These include a standardised programme of 14 consultations, including a home visit to new-born babies. The aim is to detect physical and mental developmental anomalies at an early stage, and to support the child in receiving necessary follow-ups and referrals when required).

Further targeted interventions are possible (in connection with vaccinations, when a child or adolescent contacts the service via drop-in, or through the general collaboration with the school).

Source: [130]

Treatment

Behandlung

Almost all countries reported on aspects of mental health treatment modalities for children and adolescents (AU, CH, DE, ES, NO, UK). In Czechia, no treatment approaches specific for children and adolescents are mentioned in the document, however, for young adults (students and applicants for studies) an academic and psychological counselling is reported to be set up.

zugänglich, kinder-/familienzentriert, kostenlos

Diagnose keine Voraussetzung

The *core principles* of treatment interventions are to be accessible, child centred, family focused and available at no cost (AU), and to reduce all stigmas associated with mental health (ES). Another described aim is to provide an efficient network for early intervention following the context of early detection (ES). Further, the eligibility for the service is not based on a child having a diagnosable mental illness; rather consideration is given to emotional wellbeing, behavioural and developmental challenges, physical symptoms, mental distress, and family functioning (AU).

individuell od. in Gruppen, persönlich od. telemedizinisch

The services can be provided face-to-face, in telehealth approaches, in group settings (DE), or any combination of these (AU). Regarding who is involved in the treatment interventions, these range from caregivers, siblings and relatives (DE) or more broadly defined as "family focused" (AU).

aufsuchende, präklinische Therapien

Gesundheitszentren + stationäre Therapien

The general characteristics of care and treatment were described by four countries (AU, DE, ES, UK). The described settings range from outreach services (DE, UK), pre-hospital treatments (DE), to health centres (NO) and inpatient services (AU). The pre-hospital treatment is to use the waiting times for a preparation of hospital treatment, by offering participation in group offers or specialised therapeutic offers (e.g. ergotherapy), in parallel to the medical diagnosis and treatment.

Alternativen vor stationärer Behandlung ausschöpfen, spezielle Behandlungen für Traumata

In Australia, based on an analysis of available capacities and needs, community options for treatment will be considered before deciding on a hospital admission for children and young people up to 25. More specialised treatments (e.g. interventions for highly traumatised children) would be provided in a limited number of locations that network across the country. Alternatively, the specialised locations would provide targeted support to other service providers (e.g. general practitioners) using face-to-face or telehealth approaches.

aufsuchende Therapien, "Home-Treatment"

stationsäquivalent

Two countries reported on outreach services in the included documents (DE, UK). In the UK, based on evidence-based pathways, the implementation of intensive home treatment modalities is recommended. Germany also mentions home treatment which called "stationsäquivalente Behandlung" (*inpatient-equivalent treatment*) that may be used in a gradual manner with flexibility of scope and duration to shorten or replace inpatient stays (see Example 5).

Example 5: Treatment (Germany)

Further development of psychiatric-psychotherapeutic support and the prevention of mental disorders in childhood and adolescence in Germany – development and coordination of recommendations for action:

To further increase flexibility in treatment, Germany aims to make these outreach work by social pediatric centers possible in all contracts with the German statutory health insurance. The duration of these outreach services is set at three to six months, with the possibility to be extended if necessary. These intensive treatments in the home environment (including youth care centers, schools and daycare centers) can be assisted by telemedical forms of treatment. For these outreach services, the document recommends special reimbursement arrangements on a case-by-case basis.

Source: [128]

Psychotherapie und Beratung: Adaptierungen und Ausweitung der Abdeckung

Regarding counselling and psychotherapy, a paradigm shift is reported in Switzerland: the current "delegation model", whereby psychotherapists work under medical supervision requiring a doctor's order, is to be replaced by the prescription model. In the prescription model, psychological psychotherapists with appropriate qualification and a professional license are able to provide their services independent from a doctor's order and still fall within the framework of compulsory health care insurance. In addition, the coverage of psychotherapy services by basic health insurance is planned to be expanded, to further improve the coverage of needs.

medikamentöse Therapien: Off-Label-Use erfordert zusätzliche Daten zur Sicherheit

Two countries reported on medication therapy in the included documents (DE, NO). In Norway, in regards to medication management, it is proposed that the health centres are to establish routines for managing medications in kindergartens, schools and after-school programmes. The routines should cover the training of personnel regarding safe storage, handout and administration of medication for children who require pharmacological treatment. Germany plans to strengthen the safety of off-label use of medical treatments: currently a large part of mental health medication for children and adolescents is prescribed off-label. Additional generation of safety data is necessary, and is proposed to be changed by national or European legislation, and involving relevant stakeholders (Federal Institute for Drugs and Medical Devices, Commission for Drugs for Children and Adolescents, professional societies, as well as the Federal Ministry of Health) in a problem analysis and solution proposals.

Digitalisation for telehealth, detection and intervention

Telemedizin

The majority of countries reported on digital tools for intervention, telehealth and telepsychiatry for children and adolescents (AU, DE, ES, NO, UK). In particular, digital apps for preventive measures as well as treatment are mentioned by three countries (AU, DE, UK).

Weiterentwicklung digitaler Angebote, Akkreditierung von qualitativ hochwertigen Tools

Two countries are explicitly promoting the development of digital approaches to support mental health (UK, DE). In the UK, the development of new apps supporting self-care is planned to be incentivised. Consideration will be given to an accreditation system for good quality tools, helping young people and their parents navigate the offers. Similarly, in Germany, innovative approaches in digital mental health are recommended to be funded by health insurance funds. In one country (ES), for the early detection of emotional problems in adolescents, a digital language analysis with decision-support computer systems is recommended.

zur Unterstützung von Home-Treatment und anderen aufsuchenden Therapien

Three countries (AU, DE, NO) mention the way of action of telehealth services. These are described as being available by phone, SMS, or through other digital solutions. In two countries (AU, DE), using telemedical forms of treatment for enabling intensive care in the home environment or other outreach services are to be considered by individual sites. Norway highlights the access to the telehealth services with an attendance from children, adolescents and their parents to be possible without an appointment or referral (drop-in).

derzeitige Limitationen: z. B. geografische Anforderung wie Postleitzahl

However, current restrictions on access to telehealth services are described such as the requirement of specific postcodes, or limited access by nurse practitioners (AU). In addition, the use and abuse of information and communications technologies by adolescents is addressed. Different mental health problems (e.g. depression, anxiety) can be aggravated in places where social interactions happen online (ES).

telemedizinische Dienste während COVID-19 bedarfsgerichtet weiterführen

On the other hand, the growing confidence between service providers and service users has led to the Australian senate committee recommending that telehealth tools that were introduced during the COVID-19 pandemic to become permanent, as well as continuing to build expertise around these tools, and expanding their availability. As a priority action, the trialing of sites with innovative service delivery (combination of face-to-face and telehealth consultations, digital interventions and phone helplines) is stated.

Two countries did not report on digital tools for intervention, telehealth and telepsychiatry in the respective documents (CH, CZ).

Care pathways, integrated care, health in all policies

Behandlungspfade

All countries except Czechia reported on care pathways, integrated care and health in all policies.

Verantwortlichkeiten: Bezugspersonen, zentrale Anlaufstellen

Three countries reported on *responsibilities* for coordinating integrated care (DE, NO, UK). In these, a single point of access ("one-stop-shop" service) is proposed: these are defined as a Health and Wellbeing Board (UK), a coordinating reference person/case manager (DE) or the municipar coordination unit (NO). The aim of this coordinated integrated care is to ensure that the mental and physical health needs of children, young people and their families are addressed effectively and comprehensively (UK), and to ensure a holistic coordination of services between the school health service and the youth health centres (NO). One country reports that the selection of the coordinating reference person is to be selected by the patients and the guardians from the participating service providers (DE). For the single point of access, the UK recommends harnessing the contribution of the voluntary sector.

We identified the following relevant sub-categories: *paths of access to hospital care* (AU, UK), *system navigation* (AU, CH), *transferring/referral processes* (AU, NO, UK), and *integrated service deliveries* (AU, UK).

Zugangswege klar definiert

For the *paths of access to hospital care*, comprehensive standards for access and waiting times, that bring the same rigour to mental health as to physical health services, are discussed (UK). The different paths of access are listed as: via the emergency department, directly from community teams, transfer wards within a hospital, or direct transfers from other hospitals (AU).

In case of not showing up to appointments, reasons for not attending should actively be followed up and participants should not be discharged from the services (UK).

Systemnavigation: klar definierte Wege, unterstützt durch Fachpersonal

The need for improved *system navigation* is based on a lack of clear, consistent information about where to seek help and how to access services both among families and professionals. A focus should be on expanding existing navigational tools (AU). To improve navigation within the system, several approaches are listed: interprofessional collaboration, monitoring of therapy installation by school psychology service, referral forms for administrative facilitation, networking on different levels (at institutional management level, professional exchange meetings of different professional groups), case management at coordination offices, and targeted preparation of the family for psychotherapy (CH).

Überweisungen: wesentliche Bedarfe kommunizieren

When *transferring between locations or services*, staff needs to ensure that there is continuity of care (AU). An example are "warm referrals": to actively communicate with other services to which the child is connected, providing essen-

tial information about needs before their care is transferred (AU). For better referral processes and communication, a named point of contact for children and young people's mental health should be assigned for all schools and general practitioner practices (UK). An attendance without the need of an appointment or referral is recommended as "drop-in services" (NO).

Regarding the *integrated service deliveries*, new models of integrated service deliveries (rather than tiered systems[11]) are mentioned to be best practice models (UK). The steps of integrated care are described as stabilisation, treatment planning, treatment engagement, review process, therapeutic interventions and discharge planning (see Example 6) (AU).

sektorenübergreifende Kooperation

Almost all countries highlighted the need for cooperation across sectors and for the collaboration of involved personnel (AU, CH, DE, ES, NO, UK). The target is to focus on a person-centeredness instead of service exclusion in certain scenarios (DE). An example for this possible exclusion from services is the current barrier of not offering child and adolescent psychotherapy treatment in parallel to treatment in outpatient departments, even though most guidelines have broad scientific evidence for this (DE). Another country recommends that the needs of a child are to be communicated between multiple service providers as well as the families. As a priority action, case conferencing between all providers (regardless of discipline) as part of the child's care is noted. The reason for this comprehensive communication between providers is, that children and families often access multiple service providers at the same time, and a coordination of care becomes necessary, however, it should not be the families' but the system's responsibility (AU).

z. B. ambulante Therapien mit gleichzeitiger Psychotherapie kombinierbar

Kooperationsmöglichkeiten:

The possible or necessary collaborations are listed as:

Betroffene, medizinisches Personal, Gesundheitspersonal, zwischen Angeboten

Between people affected

- the youth themselves (ES),
- families (ES),

with different medical specialists

- general practitioners (AU, NO),
- paediatricians (AU),
- dental services (NO),

with different (health) professionals

- mental health professionals general (ES),
- psychologists (AU),
- school counsellors (AU),
- educators (AU),
- dedicated wellbeing staff (AU),
- other discipline professionals (ES),

with different services

- between the child/adolescent sector and adult sector (CH),
- local providers, community agencies (AU),
- alcohol and drug services (AU),

[11] Tiered model: an escalator model of increasing severity or complexity consisting of four tiers, to differentiate between the forms of support that might be available to children and young people [132].

- private mental health care providers (AU),
- health centres (NO),
- between multiple service providers (AU),
- between psychotherapy treatments and outpatient departments (DE),
- with policymakers and researchers(ES).

Example 6: Care pathways, integrated care, health in all policies (Australia)

Child and Adolescent Mental Health Service Model of Care:

Access into the child and adolescent mental health service (CAMHS) is embedded within community teams. Once a referral is received, an initial assessment over the phone is provided (if necessary, a full assessment by a multidisciplinary team follows at the next available appointment time). Following a multidisciplinary team discussion, the most suitable service to assist the child or young person is determined.

Children under twelve years are admitted to the paediatric ward. Admissions to the paediatric ward are a joint decision between a consultant psychiatrist and a consultant paediatrician. If a mental health issue is present, access to CAMHS support via the CAMHS Consultation Liaison clinician is established. After medical stabilization, and if a mental health admission is still required, a bed is booked via the Patient Flow Coordinator. The CAMHS continues liaison consultations to the paediatric ward for any mental health concerns identified with paediatric inpatients.

Source: [122]

Transitional psychiatry

Transitionspsychiatrie

Traditionally, transitional psychiatry covers the transition time from adolescent to young adulthood with the associated health challenges. The transitional age period can be described from 16 to 25 years, although there is no set general definition [133]. However, in the documents additional phases of transitions are addressed (e.g. into different developmental phases). Generally, almost all countries listed aspects to consider for transitional psychiatry in the respective documents. In these, the need for better coordination and further optimisation of existing services is mentioned (AU, CH, DE, ES, NO, UK). In this context, Germany states that the nationwide expansion of departments for transitional psychiatry is in the duty of all federal states. In Australia, an examination of how policy, services and implementation affect transition phases in the healthcare system is recommended, with a following redesign to improve smooth and supported transitions.

Altersgrenzen schränken reibungslose Übergänge ein

Regarding specific transition phases, the transition from children entering school, as well as young people shifting to adult mental health services are recommended to be given more consideration (AU, ES). In particular, it is mentioned that the timing of transition is often perceived as misaligned with young people needs and developmental stage, and age thresholds don't allow for smooth transitions in care from childhood into adolescence, and later into adulthood (AU). The transition from adolescence to adulthood might be jarring, with a need of helping people with existing emotional problems as well as those at risk of developing such problems (ES).

diverse involvierte Berufsgruppen und Sektoren

For the different transition phases, distinct professionals, sectors or settings as reference points are described as important. For mental health problems in childhood, the paediatricians or the school psychologist service are possible references, while the general practitioners or occupational psychologists are suggested as possible contacts for young adults (CH). To improve continuity of care, the individual circumstances for the transition phases are assessed in

joint working and shared practice between services (UK), such as the possibility of simultaneous care from social psychiatric care for children and adolescents or the psychiatric outpatient department (DE).

flexiblere Übergänge ermöglichen (keine strikten Altersgrenzen)

A few countries further discussed the age of transitions (AU, DE, NO, UK). All four countries recommend more flexible transition arrangements and less strict age boundaries. In particular, the UK taskforce indicates that a transition into adulthood at age 18 is not appropriate for all cases; Germany recommends flexible transition arrangements between ages 18 to 21; Norway discusses an expansion of adolescent health centres to cover young adults up to 25 years (subject to the jurisdiction in charge based on case-by-case assessments); and Australia mentions the established overlapping age groups to increase flexibility of accepting children or young people and reducing transitioning stress (e.g. children 1-12 years, adolescents 11-19 years, young adults 17-25 years).

Only one country did not report on aspects to consider for transitional psychiatry in the respective document (CZ).

Vulnerable patient groups

Almost all countries have identified vulnerable groups within child and adolescent mental health (AU, CH, DE, ES, NO, UK).

gefährdete Patient*innengruppen

Combining all countries, many factors making a patient group vulnerable were identified. Children and adolescents are considered vulnerable if they have/are:

Beeinträchtigungen, Lernschwierigkeiten, körperliche Komorbidität, Minderheiten (ethnisch, kulturell, sexuelle Diversität, Gender-Identität), Flüchtlings-/Asylstatus, Traumata, Obdachlosigkeit/ Nutzer*innen von Kinderschutzangeboten, soziale Faktoren, Kontakt mit Jugendstrafsystem, problematischer Drogenkonsum, familiäre Risikofaktoren

- disabilities and impairments (e.g. intelligence impairments, physical or sensory disabilities, learning disabilities),
- significant somatic comorbidities,
- belonging to a minority group (ethnic minorities, indigenous minorities [e.g. Aboriginal and Torres Strait Islander children], sexual minority [specific gender identity, sexual diversity],
- refugee/asylum seeker status or who have recently migrated,
- experienced trauma/sexual exploitation,
- homeless,
- experienced child protection/out of home care systems,
- social or economic disadvantages,
- involved in gangs/had contact with the youth justice system,
- substance use issues,
- family risk factors (e.g. environment of high family conflict, children of mentally ill parents and/or parents with addiction disorders, other family members with a mental illness or disability).

Erhebung unter Berücksichtigung oben genannter Faktoren

It is highlighted by one country (ES) that these groups have a greater risk of suffering from mental health problems or disorders given their disadvantaged situation compared to social majorities. To improve the detection of vulnerable patients, mental health assessments should include sensitive enquiries about possible neglect, violence and abuse (including child sexual abuse or exploitation). As suggested by another country (UK), these mental health assessments should be performed in routine enquiry, so that every young person is asked about violence and abuse.

erweiterter Behandlungsbedarf (Zeit, adäquates Personal)

The vulnerable patient groups have an additional need for treatment. To improve the care and management for vulnerable groups, four countries describe strategies and measures (AU, CH, NO, UK). These range from providing additional time, personnel and material resources to vulnerable patient groups (DE), developing social and emotional wellbeing services for diverse populations, e.g. LGBTIQ+ groups (AU), and appropriate referrals to specialist mental health services for those who have been sexually abused and/or exploited (UK). Further, a coordinated support for the most vulnerable young people (with multiple and complex needs) is suggested to be performed by a lead professional approach to prevent affected children and adolescents to fall between services or to prevent inappropriate admission to residential care (UK).

qualifizierte Dolmetschdienste

Three countries (AU, CH, NO) particularly give recommendations on care settings with linguistic and cultural differences (e.g. Aboriginal and Torres Strait Islander families). These include the planning and delivery of language services with translation of materials in languages other than English (AU), a necessary financing of interpreters for foreign-speaking families, as a shortage of specialised doctors who have the same socio-cultural background as their patients is predicted (CH), and adjusting the time spent in consultations based on individual needs (taking into account linguistic and cultural differences), by giving extra time when using a qualified interpreter (NO).

Maßnahmen zur Verringerung von Ungleichheiten gefordert

To further improve the care for vulnerable patient groups, the expansion of therapeutic offers especially at young ages is recommended. Additionally, a redistribution of existing therapeutic resources towards psychosocial and/or economically challenged families is recommended, with concepts and measures to reduce inequalities (CH). The Australian documents suggest giving priority access to services and resources for vulnerable children and families. In the UK, it is mentioned that the access should not be based solely on a clinical diagnosis, but also on the presenting needs of the child or young person and the level of concern by family members or professionals.

Faktoren für Vulnerabilität in Ausbildung berücksichtigen

An intensified training of the workforce regarding the care for vulnerable patient groups is highlighted, and also covered separately in the category *Professions, workforce qualification and development* (following category in chapter 4.2.4).

Involvement, user participation

Nutzer*innenbeteiligung

Almost all countries reported on aspects of involvement and user participation (AU, CH, DE, ES, NO, UK).

From these countries, all suggest that parents or carers of children and adolescents should be more involved. Four countries (DE, ES, NO, UK) additionally recommend to further involve patients themselves, sometimes however specifying that in more detail: three mention young people/adolescents suggesting involvement above a certain age (DE, ES, NO), while one explicitely names children (UK). Only one country addresses involvement of other organisations and sectors, such as professionals belonging to other disciplines, the educational sector, the social and community setting, end-users and policymakers, mental health researchers and professionals (ES).

Zweck: Mitgestaltung von Angeboten, Entscheidungen, Prioritäten, gemeinsamen Behandlungs-vereinbarungen

The aim of the user involvement is

- to increase their influence in dealing with the service (NO),
- to improve health network efficiency (ES),
- to improve decision-making efforts promoting mental health, and preventing/treating mental disorders (ES),
- to make choices about what the users regard as key priorities (UK),
- to better navigate child and adolescent mental health care pathways (CH),
- to ensure a process-oriented and joint treatment agreement (DE),
- to provide flexible, tailored care that considers the role and needs of the whole family (AU),
- to provide evidence-based treatments that meet the goals and address the priorities of users (UK).

individuelle Ebene & systemische Ebene

Most countries give suggestions on how to better organise and implement the user involvement on the individual and/or the system level:

On the individual level, a good cooperation between parents with the relevant professionals is highlighted: this participation is needed for the detection and the acceptance of mental health disorders of the children (CH). Further, at the individual level, listening to what children and adolescents say and asking for their input is recommended (NO).

On the system level, representatives of children and adolescents should be involved in the design of the mental health services (NO). A general increase in effort to involve all actors is also recommended (ES).

Einbeziehung bei Entwicklung neuer Angebote

akzeptierte, zugängliche und nützliche Partizipation

To ensure the better participation and involvement, health centres, the school health services and youth health centres should support children and adolescents to be heard and to get involved when decisions are to be made and new measures are to be designed (NO). Participation needs to be offered in a way that is acceptable, accessible and useful (UK). To improve the participation of parents and make them aware of their responsibilities in care pathways, information material about counseling and therapy options should be handed out in easy-to-understand language (CH). The involvement and participation can be linked with co-designing the planning, delivery and evaluation of services (see Example 7).

Example 7: Involvement, user participation (Australia)

The National Children's Mental Health and Wellbeing Strategy:

As a case example, in Australia, the user participation in different areas of mental health care is particularly highlighted for a genuine co-design in the planning, delivery and evaluation of services. The perspective of those using the service is described as valuable and essential for decision-making in service delivery. In Australia, the scope of user participation is made even broader with giving examples of user participation for evaluating care and treatment plans, staff training and education, and the development of information systems.

Source: [121]

Infrastructure, resources

Infrastruktur

Almost all countries reported on necessary resources for mental health infrastructure for children and adolescents (AU, CH, DE, ES, NO, UK). In Czechia, no resources specific for children and adolescents are mentioned in the document, however, a financial support for setting up an academic and psychological counselling for young adults (students and applicants for studies) is reported.

zugänglich, rollstuhlgerecht, geeignete Öffnungszeiten

Three countries give more specific description of infrastructure for child and adolescent mental health (AU, CH, DE). Of these, one country recommends the infrastructure to have universal design to accommodate for pushchairs/wheelchairs, and to design the opening hours of the services to be suitable for the target group and the objective of the services. In Australia, the approach is to implement place-based infrastructure (targeting defined geographic areas, addressing individual, family, organisational and community level issues). The infrastructure is recommended to be accessible, culturally safe and flexible with opportunity for the development of innovative approaches. These place-based approaches are listed as:

- Child Community Teams (1-12 years old),
- Adolescent Community Teams (11-18 years old),
- Young Adult Teams (17-25 years old),
- Step Up Step Down Adolescent (13-18 years old) and Young Adult (18-25 years old),
- Bimberi Youth Forensic Mental Health (through Forensic Mental Health).

Rechtsvorschrift empfohlen, damit keine Jugendlichen unter 18 Jahren inhaftiert werden können

Three countries make additional statements regarding infrastructure (CH, DE, UK). In one country youth protection programmes in the areas of violence prevention and youth media protection are currently being implemented by a cooperation between the Federal Social Insurance Office and partners (CH). In another country (UK), it is suggested to ensure no young person under the age of 18 is detained in police cells by legislation. The aspect of psychotherapy in rural care is depicted by Germany. The need for psychotherapeutic treatment in accessible proximity is brought up, with the aim of creating a more equitable distribution. One concept is the outpatient complex service across sectors (see Example 8).

Erhöhrung der Finanzmittel

Psychotherapie, Psychoedukation, Vorbeugung von sozialen Ungleichheiten

Five countries report on financing aspects (AU, CH, DE, ES, UK). In these, the general budget amount and a possible increase in financing (in specific areas) is proposed. Two countries (CH, ES) describe an increase in budget for interprofessional collaboration for preventing and treating mental health problems. This increased budget shall provide schools, health systems and social services with resources to identify and treat adolescents exhibiting emotional problems or those at risk of developing them. The Spanish document further recommends that the budget should also promote mental health psychotherapy interventions and psychoeducational programmes as interdisciplinary and inclusive approaches instead of medicalisation as the only and/or priority alternative. Finally, the budget for policies aimed at preventing inequality in youth with emotional problems shall also be increased. In addition, one country (AU) reports a necessary funding to implement evidence-based programmes and quality improvement activities, based on the identified needs from wellbeing plans.

Finanzierungsmodelle: ambulante Komplexleistungen, zweckgebundene Budgets

To support coordinated care on the system level, the described financing models are ring-fenced budgets jointly provided by the health, social and educational ministry (UK), billing options for complex outpatient services (DE), and/or remuneration via weekly flat rates (DE), and adaptions of the billing system "Tarmed" (CH). This billing system is used by paediatric, psychotherapeutic and psychiatric professionals. The adaptation follows the aim of better orientating towards the treatment of children and adolescents with mental disorders. On the individual level, person-related remuneration supplements are intended to ensure participatory treatment planning for the relevant target groups (DE). In two countries (AU, CH), to allocate specific funding for complex cases, the federal government may provide financial assistance. This is based on the Promotion of Child and Youth Act (CH).

Example 8: Infrastructure, resources (Germany)

Further development of psychiatric-psychotherapeutic support and the prevention of mental disorders in childhood and adolescence in Germany – development and coordination of recommendations for action:

In Germany, a financing model that transcends existing sectoral boundaries is proposed. This is needed to coordinate care with complex outpatient services across sectors. As a possibility, weekly flat rates in gradations that cover the time requirements for the individual professional groups is mentioned.

Source: [128]

Professions, workforce qualification and development

Entwicklung/Ausbildung der Fachkräfte

Most of the documents suggest that the services of the CAMH care models should be offered by multiprofessional interdisciplinary teams with a community of practice and shared learnings (AU, DE, NO, UK). The Australian documents specifically highlights the need for a holistic, biopsychosocial manner in service delivery for the child or young person. This means that the interconnection between biology, psychology and socio-environmental factors of the child or young person is taken into consideration.

Bandbreite an involviertem Personal

All countries listed professions that are involved in the CAMH care models. Combining all countries, the mentioned professions include therapists (medical doctors, psychologists, occupational therapists, speech therapists (also known as logopedists), dieticians, physiotherapists, social pedagogues), nurses (psychiatric, somatic, public health), social workers and school teaching staff. Other occupational groups with educational, social work, interdisciplinary or cross-cultural skills are also mentioned (NO).

multiprofessionelle Teams für ambulante/ aufsuchende Angebote

ausreichende Vielfalt von Fähigkeiten, Alter, Geschlecht, Gender, und ethnischer Zusammensetzung

Two countries (AU, DE) outline details on the management of teams for outpatient services and recommend that those could be managed by different professions, e.g., a specialist/psychotherapist/psychiatrist. In three countries (AU, NO, UK) workforce development is linked to a concrete strategy. In one country (NO), emphasis is put on strategic staff development using a strategic competence plan which outlines training plans and budget taking into consideration the local population health profile. Similarly, the two other countries (AU, UK) highlight that the training should include the development of a comprehensive workforce strategy with an audit of skills, capabilities, age, gender and ethnic mix. As described in the UK, this may happen in cooperation with the professional bodies, NHS England, Public Health England and Health Education England. Two countries (AU, UK) highlight that training should provide the workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatment methods.

Personalquoten

Another topic addressed in one document (DE) in relation to workforce is staffing ratios. The document recommends a shift from the current approach (e.g., defining staffing requirements per unit of care such as wards) to basing the staffing requirements primarily on the needs of the patients as determined in a participatory process. In this context, the measurement of staffing requirements are based on criteria of providing treatment on the basis of competence, trust, empathy, avoidance of coercion and under the condition of a defined obligation to provide care.

Arbeitskraftverfügbarkeit als limitierender Faktor

vorübergehende, bedarfsorientierten Versetzung in andere Bereiche

Australia is the only document which specifically addresses challenges of workforce availability. The document suggest innovative approaches such as shared employment and secondment arrangements (temporary transfers of an official worker to another position or employment), access to telehealth and training rotations with supervision. In particular, it is suggested to broaden the scope of the workforce from the traditional mental health and health workforce to an additional workforce (e.g. allied health specialties, specialist family therapists, culturally and linguistically diverse and LGBTIQ+ health workers, peer support workers) where this is able to meet service needs.

Entwicklung von Kompetenzen im Schulbereich und Beratungsstellen

For the further development of the workforce, some countries (CH, CZ, ES, UK) highlight the development of competences in the education workforce (school teaching staff) and school counselling centres, to bring the mental health network and healthcare professionals closer to the educational environment and the general population. The aim of this link is to improve early detection, strengthen the prevention and promotion of children's mental health, as well as developing better individual-oriented psychotherapy interventions. The document from Spain mentions that this workforce development for different agents in contact with young people should be led by mental health specialists (e.g., health psychologists). The document from Czechia mentions that the workforce development is based on a recommendation by the WHO to include school-based programmes on psychosocial skills provided by teachers, and should be implemented by establishing a system of regionally available methodological guidance. One document from the Basel canton in Switzerland mentions an already existing, comparatively high presence of the school psychology service through bi-weekly consultation hours. The UK aims to implement the recommendations of the Carter Review of Initial Teacher Training to produce a framework of core content including child and adolescent development and providing the training for staff directly in schools.

transkulturelle Aspekte, Berücksichtigung gefährdeter Gruppen: in Ausbildung integrieren

Concerning the workforce development, the importance of training in transcultural care and care for vulnerable people is specifically highlighted in some countries (CH, DE, UK). One country (CH) in particular predicted a shortage of child and adolescent psychiatrists and psychotherapists, who have the same socio-cultural background as their patients in the next five to ten years. In another country (DE) the need for additional funding for language mediation is pointed out. In the UK, a pilot of teams specialising in supporting vulnerable patient groups on a sub-regional basis is planned, with a further rolling out if this specialised teamwork is successful. Further aspects for this are described in detail in the category *Vulnerable patient groups* (previous category in chapter 4.2.4).

Implementation strategy, process

Implementierung

All countries described aspects of implementation strategies and processes.

sektorenübergreifende Arbeitsgruppen, Verantwortliche auf unterschiedlichen administrativen Ebenen

regelmäßige Berichterstattung

Most countries describe the responsibilities for implementation and policy requirements (AU, CH, DE, ES, NO, UK). Two countries (AU, CZ) propose inter-ministerial/cross-sectional working groups or committees to identify the roles of various actors in the health, education and social services sectors (see Example 9). Individual responsibilities range from managers of the health centres and school health services (NO) and municipalities (executive management and municipal council), to federal states being responsible for implementing the action needs and options (DE), or relevant ministries being responsible for the assessment of the impact on the legislative arrangements (CZ). As a priority action, Australia requires all government departments to regularly report on what they do to support children in care (including providing priority access to services). In the UK, the possibility of every local area to re-prioritise resources in favour of child mental health based on existing evidence on need and efficacy is mentioned in this context.

politische Anforderungen

Regarding the policy requirements, one country (ES) describes increasing efforts to implement social and educational policies addressing inequalities among youth with emotional problems or those at psychosocial risk. In addition, policies that improve the access to services by young people are recommended, e.g. mental health literacy, inclusion of mental health topics in school curricula, online assessment and treatment.

von Pilotprojekten und best-practice Modellen lernen

Five countries (AU, CH, CZ, DE, UK) further describe implementation approaches and methods. One suggested approach is to identify what is working in some areas of the country and rolling it out to the whole country, with a commitment to already started initiatives (CH, CZ, DE, UK). However, one country (CH) states that local model projects so far could often not be transferred or implemented sustainably in other regions (cantons).

Transparenz, Verantwortlichkeiten; Beschwerdesysteme

Three countries (CH, DE, UK) raise additional aspects to be considered for implementation strategies, such as the establishment of regional complaint systems with a focus on children's and young people's rights to be implemented (DE), or a focus on transparency, data and accountability to justify the investment in mental wellbeing and care for children and young people (UK).

Beispiele für Projektimplementierungen

Three countries (AU, CH, CZ) give examples of project implementations: a pilot project for identifying children at psychosocial risk to be implemented and evaluated, with a subsequent implementation into the legislation standards within the relevant ministries (CZ), or the implementation of care for children of parents with a mental illness "wikip" (CH). Another example is the nationwide implementation of a specific service for 0-12 year olds with low or moderately complex problems in Australia ("child and family hubs"). Implementation is specified into several phases: an establishment phase, an embedding phase, and a full operational phase. As a priority action, the implementation of a designated wellbeing staff member in all early childhood learning services and primary schools is proposed. This wellbeing staff member is then responsible for developing a wellbeing plan and coordinating wellbeing activities (AU).

Example 9: Implementation strategy/process (Australia)

The National Children's Mental Health and Wellbeing Strategy:

In Australia, a National Steering Committee is recommended to be established by the Commission. This National Steering Committee should represent the health, education and social services sector, as well as representatives from minorities, implementation experts, and people with expertise in the provision of child mental health supports and treatment. In another document, these committees are described as Inter-Departmental Committees that are to be established at the Commonwealth level as well as within each jurisdication. A regular report on their progress on their objectives should be reported, with a national, independent organisation monitoring the change of the proposed indicators. The input for the indicators should come from parents, carers, children and young people as required, to determine the equity of the impact of the strategy.

Source: [121]

Digitalisation for management and documentation

digitales Fallmanagement

The majority of countries reported on increasing the availability of various digital tools that are used for case management and documentation in mental health (AU, CH, DE, ES). These tools are described to facilitate clinical decision-making and make the flow of clinical information more efficient. An example of a digital decision support tool is the national initial assessment guidance developed in Australia. This tool supports clinicians to assess the need for referral from a primary care setting to mental health services, and has been adapted for use with children and young people.

zur Unterstützung sektorenübergreifender Zusammenarbeit

Regarding the case management, some countries describe that digital tools are necessary for cross-sector mental health service networks (CH, DE). In addition, to strengthen interdisciplinary cooperation, the use of digital tools for communication (e.g. video conferences), is highlighted (CH). The necessary training of the workforce on the digital tools for case management and documentation is further addressed (AU).

webbasiertes Bettenmanagementsystem, Datenmanagementsysteme

An example for electronic tools to be used in patient management is the web based bed management system as well as a data management system described in the Australian sources. The bed management system gives an overview on all mental health beds for patient flow coordinators. The booking of an inpatient bed is performed by the patient flow coordinator. In case of unavailability of a hospital bed, information on other programmes or other inpatient units with availability will be provided. The data management system complements this, by enabling the communication of clinical information (including the emergency department) to the public mental health system.

Dokumentation: elektronische Gesundheitsakte zum Austausch verschiedener Organisationen, Datenschutzkriterien

For documentation, two countries (AU, DE) specifically recommend the further development of electronic patient record systems. In Australia, a comprehensive electronic medical record system is described, covering all aspects of mental health management (accuracy and consistency of the assessments, outcome measures and clinical documentation). In case of a network structure of the electronic record with data sharing across organisations, the German document stresses that adequate data protection is necessary. Concerning confidentiality, breach reports are monitored by a digital tool support team and handled by senior management consistent with governmental IT policy (AU).

Three countries did not report on digital tools for case management, detection and documentation (CZ, NO, UK).

Data acquisition, research

Datenerfassung/ Versorgungsforschung

Almost all of the documents reported on data acquisition and research concerning the mental health of children and adolescents (AU, CH, DE, ES, NO, UK). In the included document for Czechia, the category data acquisition/research was not reported specifically for children and adolescents.

Wissenslücken im Bereich der psych. Gesundheit von KiJu

A lack of evidence-based knowledge and high-quality trials in child mental health is described, with the need to further study the natural progression of health conditions, perceived health complaints, as well as the positive and potentially adverse effects of interventions (AU, NO).

verschiedene Studientypen und Settings

The countries also mention different study types and settings in the included documents. Study types described are regular prevalence surveys for children and young people's mental health and well-being (UK), naturalistic cohort studies and observational studies (DE), longitudinal and/or randomised controlled trials (NO) including multi-centre trials (ES). Some countries encourage study settings across different contexts and sectors (e.g. primary healthcare, schools, etc.) with collaboration among teams (ES, NO).

Erhebungen zu Prävalenz, Effektivität von Maßnahmen und Projekten

Themen: z. B. soziale Ungleichheiten, Wartezeiten

The aim of the studies and recommended outcomes are to study (changes in) prevalences of health problems and effects of different measures and programmes. This includes the early identification of emotional problems, (cyber-) victimisation, self-harm and suicide (ES, NO), as well as inequalities in the care pathways of children and adolescents from psychosocially and economically disadvantaged families (CH). The research projects should also relate to mental health services research, treatment and rehabilitation of children and adolescents (DE). Another aim is to allow benchmarking of local services at national level, e.g. access, waiting times, and delivery of evidence-based treatment (UK). Further, the satisfaction with the services from users, relatives, practitioners and collaboration partners in kindergarten and schools can be measured (NO). To better manage ethics processes, the inclusion of children and families in the development of research is suggested (AU).

Datenerfassung: nationale Datenbank (in Kooperation mit diversen Behörden)

The process of data acquisition and data sharing was described by the majority of countries (AU, DE, NO, UK). For data acquisition, the importance of health insurance companies is mentioned (DE). For data sharing, establishing Inter-Departmental Committees for sharing across all relevant sectors (education, justice, community health, etc.), for the purpose of informing child mental health and wellbeing is recommended (AU). For a national dataset on child and adolescent mental health, three countries describe their approaches: a closer cooperation with the Robert Koch Institute for care-oriented research that has better availability of routine data for both outpatient and inpatient settings (DE), the implementation of the CAMHS Dataset by the Department of Health (UK), and using the systematic follow-up data by the health centres and the school health services of nearly all children and adolescents (NO). The included documents didn't report which countries already have such a national data collection or reporting for children's overall mental health and wellbeing in place, with Australia highlighting that such a national data system is currently still missing.

Erhöhung der Forschungsförderung

The need for an increased budget for mental health and emotional well-being research, taking into account the prevalence and severity of emotional disorders, is pointed out by three countries (AU, DE, ES). In particular, the need for a funding parity, to bridge the gap between mental and physical health, is recommended (AU, ES). The funding can be linked to report findings from evaluation embedded into the program designs (see Example 10). This fund-

ing can originate both from public and private bodies. As an example, Germany lists several research financiers: the Innovation Fund, the German Research Foundation, the Health Ministry and the Federal Ministry of Education and Research.

Example 10: Data acquisition, research (Australia)

The National Children's Mental Health and Wellbeing Strategy:

As most programs have no robust evaluation embedded into the program designs, Australia further suggests implementing evaluations already at the beginning of programs, with additional funding linked to the reporting of all findings. As an example, the establishment and implementation of the Australian Hubs will be nationally evaluated for guiding future expansion or amendment of this model of care. On the basis of priorities, targeted funding can be allocated (e.g. for the needs of priority populations or for knowledge gaps in treatments).

Source: [121]

4.2.5 Summary of recommendations by categories

Informationsmaßnahmen: Steigerung von Gesundheitskompetenz, Reduktion von Stigma

All countries propose *information and awareness raising activities*. While the primary target groups are similar across countries (children, adolescents, carers, less often professionals), the aim, topics and modes of delivery vary. An often stated aim is to increase health literacy and reduce stigma. The documents recommend several distribution channels (traditional and social media) and some countries suggest to deliver information in personal encounters (e.g. during parental counselling).

Förderung/Prävention: vorwiegend im Schulsetting, bedarfsorientiert (z. B. für Kinder mit Eltern mit psych. Erkrankungen)

All countries propose strengthening *mental health promotion and illness prevention* activities. The detailed aims vary broadly but many focus on increasing early help-seeking and improving interpersonal relationships (e.g., reducing violence, improving respectfulness). A key target group of preventive activities are parents with a mental illness in the perinatal period because of their high prevalence and the rising awareness of the negative impact parental mental illness can have on children. The key setting of promotion and prevention activities are schools, where universal as well as targeted services are recommended.

Früherkennung durch speziell geschultes Personal in Schulen

In the context of prevention, *screening and early detection* are addressed by almost all countries. The core setting for screening in the documents is the school involving different professionals, whereby primarily health professionals are mentioned (e.g., school health nurses).

Behandlung: Erweiterung der Settings (stationsäquivalente, ambulante & aufsuchende Therapien) mit Involvierung von Familien

präklinische Behandlungen

Regarding *treatment*, the documents suggest broadening the range of settings, ranging from home-treatment or "stations-äquivalente Behandlung" (inpatient-equivalent treatment) and other outreach approaches to inpatient treatment. The alternatives to hospital care are also seen as important to allow family-focused care, involving all family members, which has become a priority philosophy in some countries. Some countries explicitly recommend triage systems to avoid inappropriate admissions to inpatient or residential care. A model to reduce waiting times for admission is pre-hospital treatment, where participation in inpatient group sessions is offered before full admission. Suggestions on the mode of care delivery indicate a trend to broaden them including telehealth and face-to-face approaches in single- or groups settings or a combination of them. Medication as part of treatment is only

rarely addressed: one document recommends improvements in medication management in schools and kindergartens including training of staff and another one suggests to improving safety by installing measures to reduce the wide off-label use.

Digitalisierung: weiterer Ausbau mit begleitender Versorgungsforschung

As part of prevention and treatment activities most countries address *digitalisation* topics. The increased use of digital applications is mainly recommended for detection, self-care and better system navigation. A broad diversity of digital solutions are mentioned to replace or add on to personal contacts with professionals (SMS, online, etc.). Australia has even defined the expansion of telehealth tools a priority activity after they have already been increasingly used during the Covid-19 pandemic, however, with funding extensive evaluation research alongside.

Behandlungspfade: sektorenübergreifende Integration, Bezugskoordinator pro Nutzer*in/Familie

Monitoring von Wartezeiten/ Inanspruchnahmen

Zusammenarbeit zwischen Fachpersonal

Suggestions on *care pathways* and *integrated care* play a prominent role in all but the documents from Czechia. Based on a *health in all policies* approach they aim at integrating services across different sectors such as health and education. A key suggestion to better coordinate services for individual families is to establish a single point of access and provide a coordinator for each patient/family. The care pathways are recommended to be in line with the different developmental stages throughout child and adolescence (e.g. what service networks and interventions are required at each stage of development). Furthermore, pathways to access hospital care should be clearly defined and linked to quality indicators monitoring waiting times or "no shows". Additionally, countries recommend providing better navigation through the different service components for professionals and patients/families, e.g., by supporting patients with referrals, by providing electronic navigation tools or by installing systematic exchange between professionals and organisations involved in treatment across sectors (case conferences). A large number of possible collaborators is mentioned in the documents.

Transitionsphasen (z. B. vom Jugend- ins Erwachsenenalter): Altersgrenzen flexibler und fallbezogen

Most countries recommend to better manage *transitional phases* (e.g. when entering schools, or from adolescent to adult psychiatry). The common recommendation is to move away from age thresholds to needs-based transitions based on developmental stages, including extending ages for transition into adult mental health care up to 25 years. A core recommendation is to install better coordination among the agencies involved, for example by establishing joint needs assessments and care arrangements between adult and adolescent psychiatry units/professionals.

gefährdete Gruppen: bessere Erkennung empfohlen, Fallmanagement durch Fachpersonal

Dolmetschdienste

Across all documents, a broad number of *vulnerable groups* have been identified. Those, firstly, are at greater risk for developing a mental illness and, secondly, often require complex care arrangements (e.g. because they don't speak the national language or need school and child welfare support in addition to treatment). Documents recommend measures to better and routinely detect circumstances that make a child vulnerable (e.g. identifying parental mental illness) and to install a lead professionals for case management so that responsibility for coordination is shifted from the family to the professionals. Suggestions for increasing or re-distributing resources to better care for these patient groups are made (e.g. for interpreter services).

Partizipation stärken: auf individueller Ebene, und auf Systemebene (Gestaltung der Angeboten)

Another topic across most documents is to strengthen *participation and user involvement*. The countries state a number of aims that can be reached by increasing user involvement such as providing more tailored care or better navigating care pathways. Users may include children and adolescents and their caregivers. Documents recommend to not only include them in individual

care planning but also in the design processes of the services. For the latter, some countries suggest to extend participation to professional groups, organisations and communities.

zugängliche, ortsbezogene und sichere Infrastruktur

zweckgebundene Budgets (sektorenübergreifend)

Regarding *infrastructure and resources*, the countries recommend infrastructure to be place-based, accessible and culturally safe. For financing, the countries state that an increase in budget is required for interprofessional collaboration, psychotherapy interventions and psychoeducational programmes, and for policies aimed at preventing inequality in youth. Examples are ring-fenced budgets jointly provided by the health, social and educational ministry. Additionally, new reimbursement mechanisms for providers are suggested, e.g. "ambulante Komplexleistung" to fund a combination of outpatient services for children with complex needs.

Fachkräfte: Aus- und Weiterentwicklung (z. B. zusätzliche Gesundheitsfachberufe, Peer-Einsatzkräfte, LGBTIQ+ und Diversitäts-Personal)

psych. Gesundheitskompetenz von Pädagog*innen durch Fachleute steigern

Another topic described across most documents is *professions, workforce qualification and development*, sometimes linked to a concrete staff development and training strategy. In general, CAMHS should be offered by multiprofessional interdisciplinary teams with a community of practice and shared learnings. Most countries suggest to broaden the traditional health workforce with additional workers (e.g. allied health specialists, family therapists, diverse and LGBTIQ+ health workers, peer support workers). The development of competences for school teaching staff (led by mental health specialists) and the importance of training in transcultural care and care for vulnerable people is specifically highlighted. A proposed key implementation action is the implementation of a designated wellbeing staff member in all schools.

Implementierung: sektorenübergreifende Arbeitsgruppen; bundesweite Ausrollung erfolgreicher regionaler Projekte

For the *implementation strategy and process*, most countries describe the responsibilites and policy requirements. In some countries, these are interministerial/cross-sectional working groups or committees, with individual responsibilities from managers of health centres, school health services and municipalities. Phases of implementation are an establishment phase, an embedding phase, and a full operational phase, with identifying what is working in some regions and rolling it out to the whole country.

Digitalisierung für Fallmanagement, Dokumentation und Kooperation (z. B. Videokonferenzen)

Most countries suggested to increase the availability of *digital tools for management and documentation*. For case management, tools to facilitate clinical decision making and cross-sector networks (e.g. video conferences) may be used. Web based bed management systems and data management systems are further examples for case management digital tools. For documentation purposes, the countries recommend the continued development of a cross-sectoral and trans-organisational electronic patient record systems that collect data from all services a patient uses.

Datenerfassung für begleitende Versorgungsforschung

Forschungsförderung: Parität von physischer und psychischer Gesundheit

Almost all countries recommended increasing *data acquisition and research* with the aim of studying changes in mental disorder prevalences and effects of interventions. Some countries encourage including children and families directly in the development of research. A broad range of specific research topics and study designs are listed, including (cross-sectoral) mental health service research to allow benchmarking of services (e.g. waiting times, evidence-based-treatment, measuring user satisfaction). Several countries are implementing national mental health services datasets for data acquisition and sharing across relevant sectors. For funding, a parity in budget for mental health and physical health research is further highlighted.

4.3 Indicators for planning and monitoring child and adolescent mental health and psychiatric care

Indikatoren: Messung und Monitoring dient verschiedenen Zwecken

Indicators are summary measures that describe different parameters, e.g. aspects of well-being, their determinants or service response [134]. Their measurement and monitoring serve different purposes [46]. Indicators may be essential in monitoring by providing regular and objective feedback on progress. For example, they can be used to assess the impact of policies and provide important information for policy makers to evaluate the effectiveness of policies and make adjustments where necessary [135].

Kriterien für gute Indikatoren

Indicators should rely on the best available evidence, which Sackett et al. [136] describe as *"the integration of best research evidence with clinical expertise and patient values"* [46, p. 524].-According to Mainz et al. [46], an ideal indicator would have the following key characteristics: "(i) based on agreed definitions and described exhaustively and exclusively; (ii) highly or optimally specific and sensitive, i.e. it detects few false positives and false negatives; (iii) valid and reliable; (iv) discriminates well; (v) relates to clearly identifiable events for the user (e.g. if meant for clinical providers, it is relevant to clinical practice); (vi) permits useful comparisons; and (vii) is evidence-based"-[46].

Indikator = definiertes Maß

An indicator is a well-defined measure that describes the subject to be indicated as comprehensively as possible. For its operationalisation, so-called metadata are defined (title of the indicator and definition for quantification, e.g. nominator and denominator). The calculation is subsequently carried out based on pertinent data [137, 138].

Validität und Realibilität kann variieren

Indicators may vary in their validity and reliability [46]. Validity is the ability of an indicator to measure what it is intended to measure. For example, mortality information systems are reasonably helpful tools for calculating deaths in a country but less for estimating the cause of death (e.g. due to coding or diagnosis failures) [139]. Reliability is the extent to which repeated measurements of a stable phenomenon by different data collectors or instruments get similar results at different time points and places. Reliability is essential to compare among or within groups over time when using an indicator. A valid indicator must be reproducible and consistent [46].

Grundlage für Planung, Durchführung und Bewertung von Maßnahmen im Gesundheitswesen

Indicators are crucial for monitoring and preparing relevant information for public health decision-makers. Appropriate indicators are important for planning, implementing and evaluating measures in public health [135, 138]

4.3.1 Indicators in public health

Indikatoren zum Monitoring der öffentlichen Gesundheit

Indicators may be used for surveillance of public health. Surveillance in health is the formal and systematic collection, compilation, analysis, interpretation and dissemination of data on health, well-being and their determinants. Surveillance thus serves as a basis for planning, implementing and evaluating measures to protect and promote the population's health [137]. The concept's core is a defined set of meaningful and reliably measurable indicators. These are continuously collected and reported over time to detect changes and identify specific needs for different population groups (e.g. stratified by age, and gender) [138].

verschiedene Anwendungsbereiche z. B. um die Qualität der Versorgung zu dokumentieren

Indicators are relevant to define health-related goals that national health authorities pursue. Compared to other feedback tools, well-designed indicators provide the advantage that they deliver information that is easy to comprehend [135]. Using indicators allows for measuring given health dimensions in a target population. Indicators can be used to document the quality of care or to compare different institutions [46] (e.g. CAMHs). In addition, they can be used to make judgements and set priorities [46] (e.g. in the organisation of mental health care), which can support accountability, regulation and accreditation, as well as promote quality improvement [46].

Indikatoren sollten alle relevanten Bereiche der öffentlichen Gesundheit abdecken

For comprehensive public health monitoring, indicators should cover all relevant areas of public health action (e.g. prevention and cure) and health and its determinants [138] (e.g. personal, social, economic and environmental factors) [140]. To get an overview of existing or missing indicators for evaluating different aspects in the public health areas, categorising the different indicators could be helpful.

Categorisation of indicators

Health indicators

Gesundheitsindikatoren erfassen Merkmale und Dimensionen des Gesundheitszustandes

Several approaches exist on how to describe and categorise indicators. One set of indicators are the so-called **health indicators**. They capture relevant information on different attributes and dimensions of health status. They attempt to describe and monitor a population's health and health system performance [139].

Kategorisierung der Indikatoren nach:

Health indicators can be divided into different categories, for example, into indicators measuring "health status", "risk factors", "service coverage", or "health services" [43, 139].

Gesundheitsstatus (z. B. Morbidität und Mortalität),

Health status indicators describe a person's state of health and include, among other things, morbidity and mortality indicators. Morbidity indicators give an overview of the incidence and prevalence of diseases, injuries, and disabilities in populations (e.g. prevalence of mental illness in children and adolescents) [43, 139]. Mortality indicators are fundamental sources of demographic, geographic and cause-of-death information. This data quantifies health problems and defines or monitors health priorities and goals [43, 139].

Risikofaktoren (z. B. verhaltensbedingte Risikofaktoren),

Assessing **risk factor indicators** (e.g. behavioural risk factors) is essential for developing health protection and promotion initiatives. Behavioural risk factors are linked to lifestyle and can be improved through health promotion, surveillance and primary health care. Therefore an assessment is critical. In addition to behavioural risk factors, various other factors can affect health (e.g. environmental risk factors) [43, 139]. Social determinants (e.g. education, housing, working life conditions) can also impact health [141]. For example, an unfavourable family constellation or a low socioeconomic status (e.g. the increasing risk of poverty among children and adolescents), can influence the prevalence of mental illness in childhood and adolescence. With an increase in such risk factors, an increase in the prevalence of mental illness is to be expected [112].

Leistungsumfang (spiegelt Prioritäten wider)

Service coverage indicators reflect priorities across the spectrum of health services, including, e.g. non-communicable diseases (NCDs) and mental health. An examples of such indicators in mental health is the "coverage of services for severe mental disorders" [43].

Health service indicators include health facility density and distribution, health workforce, quality and safety of care, and others [43]. Examples of health service indicators are "perioperative mortality rate", "hospital bed density" or "existence of national health sector policy/strategy/plan" [43].

Gesundheitsdienste (z. B. Verteilung von Angeboten)

Quality indicators

Another indicator classification and one of the most widely recognised approaches to evaluating **health services** is the one by Donabedian et al. [44-46], which assesses the quality of health services alongside the indicators "structure", "process", or "outcome". "**Structure**" covers the aspects and characteristics of the environment in which care is provided. Structural indicators describe the type and amount of resources a health system or organisation uses to deliver programmes and services. The indicators also evaluate the presence or number of personnel, patients, money, beds, supplies and buildings. [46].

Qualitätsindikatoren für:

Struktur,

"**Process**" includes everything done in the provision and use of care, e.g. activities from diagnosis through treatment or interaction between the doctor and the patient [46]. Process indicators include those that measure if planned activities have taken place. They capture activities and tasks in the patient's episodes of care as well as the patient's activities in seeking and delivering care [46].

Prozess,

Health care "**outcomes**" are states of health and wellbeing (e.g. patient satisfaction) or events that follow care. Outcome indicators attempt to describe the effects of care on the health status of patients and populations [46].

Ergebnisse,

Professionals and organisations in the care sector can use these indicators to monitor and evaluate what happens to patients. They may evaluate how effective professionals and organisational systems function to meet patients' needs. Further, they can provide a quantitative basis for clinicians, organisations, and planners aiming to improve care and the processes by which patient care is provided [46].

können zum Monitoring und zu Bewertung von Gesundheitssystemen genutzt werden

4.3.2 Indicators in the setting of mental health

There has been a particular increase in international interest in mental health in recent years. Institutions, e.g. the OECD [142] and WHO [143], focus on population mental health and well-being and its continuous recording and monitoring [138].

international steigendes Interesse für psychische Gesundheit

The World Health Organization (WHO) has set four priority objectives in its Mental Health Action Plan 2013-2020 [144]: (i) strengthen effective leadership and governance for mental health; (ii) provide comprehensive, integrated and responsive mental and social health services in community settings; (iii) implement strategies for promotion and prevention in mental health; (iv) and strengthen information systems, evidence and research for mental health [144, 145].

WHO: 4 wichtige Ziele im Mental Health Action Plan 2013-2020

One of the principles for achieving these WHO goals is using indicators to monitor mental health using mental health indicators. Mental health indicators measure mental health by enabling monitoring of the population's mental health [24] and indicating a priority or problem [146].

Ein Grundsatz zum Erreichen der Ziele: Verwendung von Indikatoren

WHO empfiehlt Core-Indikatorenset zum Monitoring

The WHO recommends that 80% of all countries collect and report at least one core set of mental health indicators. Furthermore, by 2020, data should be collected via the respective health and social information systems. The data collected should provide an overview of the current status and trends of the population's mental health, enabling an assessment of mental health prevention, promotion and care measures. Accordingly, the results should serve as a reliable data basis for evidence-based policy advice, enabling political actors to plan, initiate and evaluate necessary health policy measures [137, 144].

besondere Herausforderungen:

Several Countries have already established indicator-based mental health surveillance systems (e.g. Australia), and other concepts for monitoring population mental health are under development as research on mental health progresses [24]. Continuous and indicator-based mental health surveillance poses specific challenges compared to the surveillance of NCDs and infectious diseases [138]:

breites Spektrum der psychischen Gesundheit

1. mental health covers a broad range of topics and is more than the absence of a mental disorder [64].

Indikatoren sind selten direkt beobachtbar oder messbar

2. the population-based, valid and reliable measurement of mental health poses high demands on data collection, as the indicators are rarely observable or directly measurable (in contrast to laboratory parameters) [147, 148].

Stigmatisierung

3. the stigmatisation of mental disorders as a particular source of bias influences data collection in self-report and third-party reporting and can also lead to misclassifications in the health care system [147].

Deutschland: erste Schritte zu einem nationalen Monitoringsystem für psychische Gesundheit

In Germany, recently first efforts toward establishing a national mental health surveillance system have been made. In 2021, a survey was published by a working group of the Robert Koch Institute (RKI) that identified 192 indicators for mental health. In addition, an expert group was consulted to develop clusters to classify the identified indicators. They defined 14 clusters which are:

1. "Mental Health Promotion and Prevention"
2. "Mental Health Resources",
3. "Mental Health Risks",
4. "Mental Health Literacy",
5. "Positive Mental Health",
6. "Psychopathology",
7. "Self-harm and Suicidality",
8. "Supply and Utilization of Mental Health Care",
9. "Needs, Unmet Needs and Barriers in Mental Health Care",
10. "Quality of Care",
11. "Costs of Mental Disorders",
12. "Burden of Disease and Mortality",
13. "Participation"
14. "Sociodemographic Variables with an Impact on Public Mental Health" [24].

unvollständiger Überblick von Indikatoren zur psychischen Gesundheit von KiJu

The indicators described in the mentioned study primarily refer to adults only [24]. So far, there is a lack of a complete overview of mental health indicators for children and adolescents. The following paragraph will give an overview on different CAMH indicators that we have identified in our own search.

Identification of the indicators

10 Datenquellen aus 6 Ländern + UNICEF und WHO

The hand search identified ten data sources. The countries of origin are Canada (two sources: [149, 150]), Scotland (two sources: [151, 152]), Australia [153], Ireland [154], England [155], and Switzerland [156]. Further indicators were found in works/databases of the UNICEF [157] and WHO [158]. The indicators were found in different reports/manuals [149-152, 154, 156, 157] and online data collections (like surveillance systems [153, 155, 158]). It should be considered that, especially in the case of online data sources, the indicators and related information were found in various documents or web links on the given web pages. For this reason, a table with relevant information (links and documents) on the data sources and additional sources was created (see Appendix Table A-14).

insgesamt 121 Indikatoren gefunden

Overall, 121 indicators for CAMH could be identified (see Appendix Table A-13 for all identified indicators. Of these, 66 indicators were found in only one data source (e.g. *indicator: "costs per acute mental health admitted patient day"*), and 39 indicators were reported by two sources (e.g. *"parental mental health problems"*). Ten indicators were identified in three different data sources (e.g. *"discrimination and stigma"*) and two indicators were found in five sources (e.g. *"suicide and suicide attempts"*). Two indicators were reported by six (e.g. *"emotional and behavioural problems/symptoms"*) and one each by four (*"engagement with learning"*) and seven (*"mental disorders in children and young people"*) different sources.

Länder mit den meisten Indikatoren: Schottland und Vereinigtes Königreich

The countries with the highest number of indicators are Scotland and the UK (see Table 4-13 for the number of indicators per country). Most indicators were reported by only one country source (81), but 40 indicators were identified in more than one country or supranational sources[12]. The indicators found by supranational sources relate to the prevalence of various (mental) illnesses and the well-being of children and young people, including their social/ educational environment. Indicators found in sources by more than two countries also place a high value on the prevalence of mental illness, next to the use of various mental health services for children and adolescents.

Table 4-13: Number of indicators per country

Country	No. of indicators	Country	No. of indicators
Scotland	46	**Ireland**	17
UK	33	**Supranational**	11
Canada	26	**Switzerland**	2
Australia	21		

Indikatoren sind sehr spezifisch bis sehr generell gehalten

The indicators varied in their specification from very specific (e.g. *"16-17 year olds not in education, employment or training or whose activity is not known"*) to very generic. The generic range of indicators is because we combined similar indicators listed (in different data sources) into one (e.g. *"engagement in learning"*).

[12] Supranational means the indicator was listed by the WHO or UNICEF, in addition, one or more countries may also report the indicator

4.3.3 Classification of the indicators

As described in the method section, we used different indicator classification options to describe and classify the indicators identified in the area of CAMH. The following section describes the indicators using the different categorisation systems.

Health indicator classification

Gesundheitsindikatoren-klassifizierung:

The first indicator classification is according to "health status", "risk factors", "service coverage", or "health services" [43] (see Figure 4-5 for an overview). Around one-third of the indicators, 43 out of 121, could be classified as "health service indicators", with approximately half evaluating patient's utilisation/admission to various health services. Examples are *"number of children/adolescents admitted to adult mental health inpatient units"* or *"population access to specialised clinical mental health care"*. Further, some indicators are suitable for evaluating existing resources (e.g. staff: *"number of child and adolescents day hospital (teams)"*), and costs (e.g. *"costs per acute mental health admitted patient day"*).

Gesundheitsdienste: 43 Indikatoren, ½ der Indikatoren evaluiert Inanspruchnahme

Risikofaktoren: 36 Indikatoren, beziehen sich stark auf Umweltrisikofaktoren

The second most indicators, 36, were classified as "risk factor indicators" (e.g. *"children in need" or "violence"*). These indicators strongly emphasize the environmental risk factors, such as family, financial, and school factors, that can negatively affect the mental health of children and adolescents, e.g. *"children and adolescents in low income families"* or *"school exclusion"*. The evaluation of behavioural risk factors, such as *"smoking"* or *"risky behaviour"* of children and adolescents, also falls under this categorisation.

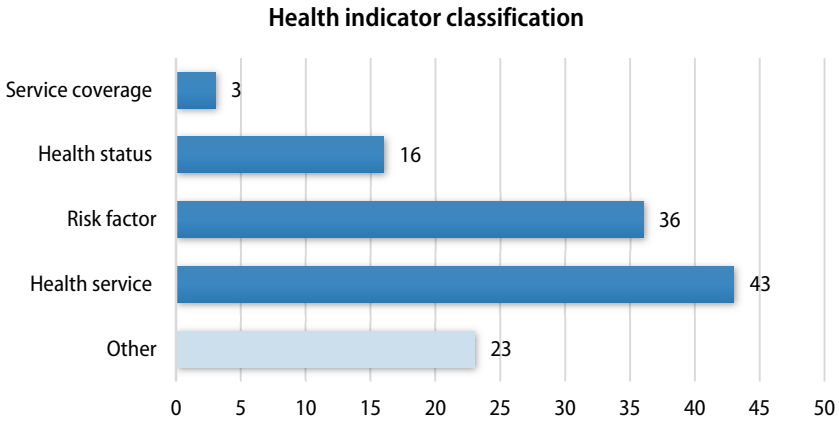

Figure 4-5: Health indicator classification

Gesundheitsstatus: 16 Indikatoren, hauptsächlich Morbididätsindikatoren

For assessing the children and adolescents' health status, 16 indicators were found. These indicators are mainly morbidity indicators concerned with evaluating different prevalences of child and adolescent (mental) health, e.g. *"common mental disorders"* or *"developmentally vulnerable children"*.

Leistungsumfang: 3 Indikatoren

Three of the indicators could be classified as "service coverage" indicators (e.g. *"children and youth were treated for certain indications, mental health or addictions"*). Another 23 indicators could not be assigned to any of the categories mentioned above and were grouped under "other" (e.g. *"play and free time"* or *"acceptance by peers"*).

Quality indicators

Einteilung nach Struktur, Prozess und Ergebnis

Secondly, we categorised the indicators according to "structure", "process" and "outcome" [44, 45, 159] (see Figure 4-6 for an overview). In our categorisation system, the term "outcome" does not only refer to indicators that evaluate health status and post-treatment events as intended by Donabedian et al. [44, 45]. We classified also those indicator as "outcome indicators" if they are intended to evaluate a preventive and promotive effect on the mental health of children and adolescents (e.g. interpersonal relationships or social and environmental factors).

106 Indikatoren den 3 Kategorisierungen zuteilbar

Ergebnis: 56 Indikatoren; 1 Indikator für Ergebnis nach Inanspruchnahme von Diensten; restliche evaluieren Ergebnisse von Gesundheitsförderungs- und Präventionsmaßnahmen

In total, 106 of the 121 indicators could be assigned to one of the categories "structure", "process" or "outcome". About half of the indicators, 56, relate to the category "outcome". From those, only one indicator deals with an outcome after using a service: *"change in mental health consumer's clinical outcomes"*. The other indicators mainly refer to outcomes following promotion and preventive initiatives. These include those addressing interpersonal relationships, e.g. *"relationships with other children and adolescents"*, and the social and family environment of children and adolescents (e.g. *"neighbourhood satisfaction"* or *"play and free time"*). Further, indicators related to different health outcomes in children and adolescents or their carers. Health outcomes of the former address 1) physical health: *"long-term illness, disability or medical condition"*, 2) psychological factors: *"life satisfaction"*, and 3) mental health: *"mental disorders in children and adolescents"*. Indicators evaluating parents' and guardians' (mental) health are for example *"parental mental health problems"* and *"parental health and healthy living"*.

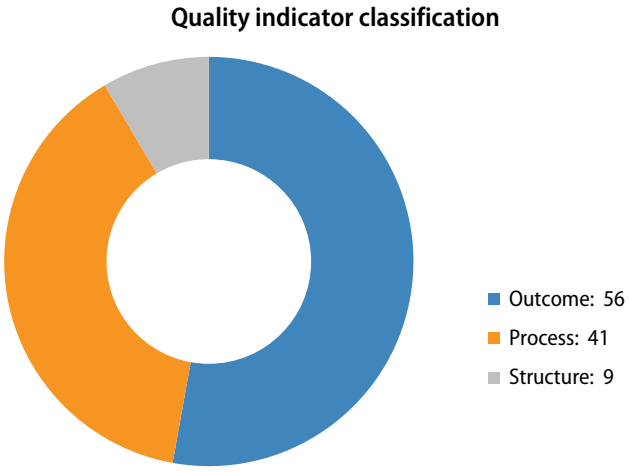

Figure 4-6: Classification according to quality indicators

Prozess: 41 Indikatoren

Großteil evaluiert Leistungen im Krankenhausbereich …

The "process" category has been assigned to 41 indicators. The majority of these indicators describe the (re-)admission and transfer of children and young people to a (mental) health service (e.g. *"rate of readmission after a mental health and addictions-related hospital discharge"*). Most of these indicators evaluate hospital services (e.g. inpatient: *"admissions of children to child and adolescent acute inpatient units"* or emergency department: *"emergency department visits as first point of contact for that resulted in admission"*) Others are intended for outpatient/community facilities (*"post-discharge community mental health care"*) or other services that take care of the well-being of children and young people (e.g. *"children subject to a child protection plan"*).

… wenige laufende Behandlungen oder ob und wie lange Therapien durchgeführt wurden

Fewer process indicators are assessing ongoing treatments (e.g. *"most common prescription mental health drugs"*). Furthermore, some indicators assess whether therapies have been carried out (e.g. *"number of cases closed/discharged by CAMHS services"*) and for how long (e.g. *"bed days used in acute inpatient child and adolescent facilities"*).

Struktur: 9 Indikatoren; Evaluierung der Leistungen (z. B. Anzahl der Angebote, Personal, Zugang für Patient*innen, Kosten)

Nine indicators can assess the care "structure" for children and adolescents with mental illness. In the care setting, the indicators mainly evaluate the number of services or persons working in different care settings (e.g. outpatient: *"child and adolescent community mental health (teams/services)" or* hospital: *"child and adolescent day hospital (teams)"*). Further, indicators for assessing the costs of (mental) health services (e.g. *"costs for care and accommodation of vulnerable children and young people"*), as well as the patient's access to different services (e.g. *"population access to specialised clinical mental health care"*) are also available in this category.

Classification according to Peitz et al.

Klassifizierung nach Peitz et al.

Thirdly the clusters identified by Peitz et al. for adult mental health indicators were used to present our indicators in a structured way [24]. In classifying the indicators, according to the clusters by Peitz et al. [24] (see Section 4.3.2), the indicators could be assigned to twelve of the 14 defined groups. None of the indicators was addressing "**Participation**" and "**Mental Health Promotion and Prevention**". Figure 4-7 provides an overview on the classification of indicators.

keine Indikatoren für „Partizipation" und „Gesundheitsförderung/ Prävention"

„Risiken für die psychische Gesundheit": 30 Indikatoren

Most indicators (30) were assigned to the "Mental Health Risks" category. "**Mental Health Risks**" indicators mainly include the assessment of the child's environment, living conditions and behaviours/feelings. Special attention is given to children in special need (e.g. *"children in care" or "children in need"*), as well as the school or family environment (e.g. *"school exclusion"* and *"family relations and structure"*). In addition, this category also includes indicators that evaluate behavioural risks (e.g. *"smoking"*), children's and adolescents' feelings (e.g. *"pressure and stress"*), and parental health (e.g. *"parental mental health problems"*).

„Angebot und Inanspruchnahme der psychiatrischen Versorgung": 29 Indikatoren

The second largest number of indicators (29) was in the category "**Supply and Utilization of Mental Health Care**". They relate to different settings of CAMH care. About the same number of indicators deal with the use and resources in general (*e.g. "specific services"*) as well as in the hospital environment (e.g. *"child and adolescent day hospital (teams)"*). Most of the indicators addressing the hospital sector are concentrated in the inpatient setting (e.g. *"admissions of children to acute inpatient services for children and adolescents"*), including indicators dealing with the length of stay and the number of bed days required per stay (e.g. *"length of stay for psychiatric hospitalisations"*). Fewer indicators were found for evaluating the outpatient/community mental health sector (e.g. *"number of community-based child and adolescent mental health (teams/ services)"*).

"Ressourcen für psychische Gesundheit": 17 Indikatoren

In the category "**Mental Health Resources**" 17 indicators could be assigned. Some indicators in this group refer to environmental factors, which may have a preventive effect on children and adolescents (e.g. *"support from classmates"* or *"physical environment"*). Others refer to individual mental resources that can benefit the mental health of children and adolescents (e.g. *"positive self-esteem"*).

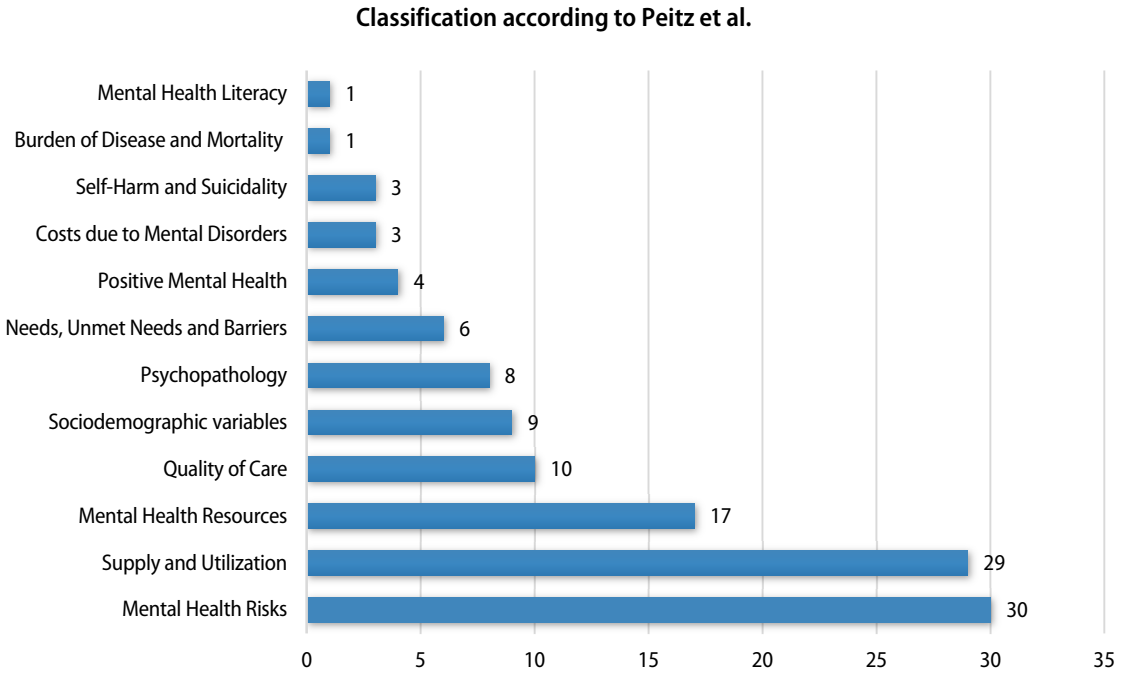

Figure 4-7: Classification according to Peitz et al.

The category "**Quality of Care**" includes ten indicators. These indicators collect data on various factors indicating quality problems of services, e.g. the *"seclusion rate"* and the *"children and adolescents admitted to adult mental health inpatient units"*.

"Qualität der Versorgung": 10 Indikatoren

Nine indicators assess "**Sociodemographic variables with an impact on public mental health**". These indicators mainly refer to the family (e.g. *"workless households"*) and school/educational environment (e.g. *"positive and sustained destinations"*).

"Soziodemografische Variablen mit Einfluss auf die psychische Gesundheit": 9 Indikatoren

Eight indicators could be assigned to the category "**Psychopathology**". Some indicators refer to certain diagnoses (e.g. *"eating disorders"* or *"neonatal abstinence syndrome"*) and others refer to mental disorders in general (e.g. *"common mental disorders"*). However, the generalised indicators also aim to assess the number of children and adolescents with a mental illness overall and differentiated by different disorders (e.g. depression, ADHA, emotional disorders, conduct disorders, hyperkinetic disorders and eating disorders).

"Psychopathologie": 8 Indikatoren

Six indicators assess the "**Needs, Unmet Needs and Barriers in Mental Health Care**" and four indicators "**Positive Mental Health**". An example indicator for the former is *"wait time and total number on waiting list for first appointment"* and one for positive mental health is *"life satisfaction"*.

"(unbefriedigte)Bedürfnisse und Barrieren": 6, "Positive psychische Gesundheit": 4 Indikatoren

The categories "**Self-Harm and Suicidality**" (e.g. *"suicide and suicide attempts"*), and "**Cost due to Mental Disorders**" (e.g. *"costs for care and accommodation of vulnerable children and young people"*) contain three indicators each. Only one indicator could be assigned to each of the categories "**Burden of Disease and Mortality**" (*"functional limitations among adolescents with depression and/or anxiety"*) and "**Mental Health Literacy**" (*"care seeking among adolescents with symptoms of depression and/or anxiety"*).

"Selbstverletzung und Suizidalität", Kosten ": 3, "Krankheitslast, Sterblichkeit", "psychische Gesundheitskompetenz": 1 Indikator

Data sources for calculating the indicators

sekundäre Datenquellen (DQ): 98 Indikatoren, primäre + sekundäre DQ: 11 Indikatoren, primäre DQ: 2 Indikatoren

A further categorisation of the 121 indicators was done by classifying the indicators according to the data source used for the calculation/evaluation – based on secondary or primary data sources [160]. In total, 98 indicators used secondary data sources, eleven used primary and secondary data sources, and two used primary data sources. No data sources were identifiable for ten indicators. Figure 4-8 gives an overview about the indicators classified according to their data sources.

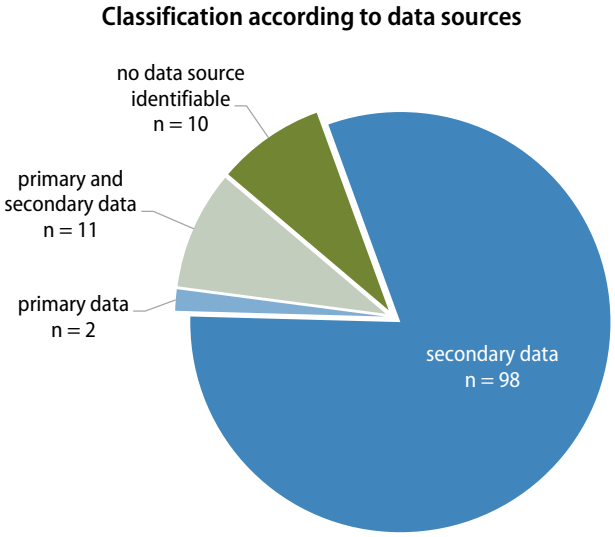

Figure 4-8: Indicators classified according to their data sources

verschiedene Fragebögen für Monitoring Primärdaten

Different questionnaires were used as primary data sources. The Strengths and Difficulties Questionnaire (SDQ-Questionnaire) was used most frequently (six times). The SDQ-Questionnaire is a brief emotional and behavioural screening questionnaire for children and young people [161]. The Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS) [162] were used three times. This 14-item scale was developed to measure mental well-being in the general population and evaluate projects, programmes and policies that aim to improve mental wellbeing. The General Health Questionaire-12 [163], a self-screening questionnaire to detect individuals with a diagnosable psychiatric disorder, was used two times. The CAGE-Questionnaire [164], to analyse alcohol consumption, and Health of the Nation Outcomes Scales for Children and Adolescents (HONOSCA) [165], to evaluate different mental health, social and addiction effects, were used once.

Studien, Onlinedatenbanken, ‚Daten von nationalen Behörden oder Statistiken als Sekundärdatenquellen

Various secondary data sources (e.g. surveys and data from national authorities for “income inequality”) were used to assess different indicators. Some indicators used only one secondary data source, but most were calculated by a combination of different secondary data sources. Secondary data sources were mainly surveys conducted (regularly) in different countries; One of the most often used survey was the Health Behaviour in School-aged Children (HBSC) survey [166], which was source for at least 20 different indicators, e.g., for the indicator “feeling lonely”. Other secondary data sources included various databases that collect, for example, health data (e.g. Mental health

establishments national minimum data set (MHE NMDS)[13] or Ontario Mental Health Reporting System (OMHRS))[14], or sociodemographic data (e.g. Immigration, Refugees and Citizenship Canada – Permanent Resident database (IRCC-PR)[15]). Data from national authorities (e.g. the Department for Education) and national statistics were also used as secondary data sources. Additionally, also administrative data from medical staff and (mental) health services were used for some indicators (e.g. indicator "number of children/ adolescents admitted to adult mental health inpatient units").

All 121 Indicators, a short description, as well as their source, can be found in the Appendix in Table A-13. Under this link (https://aihta.at/uploads/ckEditor/fields_abstract_translation_en/indicatoren-mapping.xlsm) an EXCEL-file can be accessed which allows selecting indicators according to own preferences.

4.4 Alignment of Austrian mental health care situation with international strategies, models and indicators

4.4.1 Comparison with international strategies and models

Abgleich Situation in Ö mit int. Empfehlungen

In this chapter, we compare the CAMH-relevant strategies of Austria (chapter 4.1.2), as well as examples from the Austrian CAMH care situation (chapters 4.1.3, 4.1.4, 4.1.5) with the international strategies and their recommendations (chapter 4.2).

Strategien aus Ö: 6 Themenfelder nicht adressiert, 8 Themenfelder nur in begrenztem Ausmaß beschrieben

As seen in Table 4-14, the Austrian child and adolescent health strategy [47] does not report for mental health in detail. On the other hand, the Austrian national mental health strategy [48] does not specifically address children and adolescents. Putting this in contrast with the 14 categories identified from the international documents, limited information is available in the Austrian documents on the categories covered in international documents: Six categories are not addressed at all. The remaining eight categories are addressed in either the child and adolescent health strategy or the national mental health strategy but none of them outlines recommendations on those categories in the same detail as in the international documents [47, 48].

13 See: National Mental Health Establishments Database [accessed 26.08.2022]

14 See: Ontario Mental Health Reporting System Metadata [accessed 28.08.2022]

15 See: Immigration, Refugees and Citizenship Canada – Permanent Resident database (IRCC-PR) [accessed 26.08.2022]

Table 4-14: Comparison of Austrian mental health strategies to model categories

Categories of model/strategy	Availability of information on category	
	Child and Adolescent Health Strategy [47]	National Mental Health Strategy [48]
Information, awareness raising activities	×	✓
Prevention, mental health promotion	×	✓
Detection, screening	×	×
Treatment	×	×
Digitalisation for telehealth, detection and intervention	NR	NR
Care pathways, integrated care, health in all policies	×	×
Transitional psychiatry	NR	✓
Vulnerable patient groups	✓	✓
Involvement, user participation	×	×
Infrastructure, resources	✓	×
Professions, workforce qualification and development	✓	✓
Implementation strategy, process	✓	×
Digitalisation for management and documentation	NR	NR
Data acquisition, research	✓	×

× – *not reported specifically for child and adolescent mental health;* ✓ – *addressed in the document*

Abbreviations: NR – not reported

Abweichungen von Kernempfehlungen: insbesondere Behandlungspfade, Partizipation, Infrastruktur, Implementierung

Table 4-15 presents an approach of contrasting the key recommendations from the international documents with the current Austrian situation using examples from the Austrian situation analysis (chapter 4.1) for each category. In general, there are discrepancies regarding the recommendations from all 14 categories. Being aware of potential knowledge gaps, the biggest discrepancies seem to exist for *care pathways/integrated care/health in all policies*, *involvement/user participation*, *infrastructure/resources* and *implementation strategy/process*.

Ö: großer Fokus auf stationäre Settings, alternative Angebote (z. B. Home-Treatment) in regionalen Pilotphasen

For some recommendations, project-based activities are available (*information/awareness raising activities*, *prevention/mental health promotion*, *detection/screening*), but no systematic nation-wide process is established. Regarding *treatment*, the current focus in acute care in Austria is on inpatient care, while alternative settings (e.g., home-treatment) have only started on a pilot base in some regions. For *transitional psychiatry*, *vulnerable patient groups*, *digitalisation*, *professions/workforce qualification* and *data acquisition/research*, examples exist where the Austrian situation seems to be consistent with international recommendations to some extent, but further alignment with international recommendations seems possible.

Table 4-15: International core recommendations in contrast with examples from Austria

Categories of models/strategies	Core recommendation	Examples from Austria based on chapter 4.1
Information, awareness raising activities	■ primary target groups: children, adolescents, carers, ■ primary aim: increase health literacy, reduce stigma, ■ several distribution channels (traditional and social media), ■ delivering information in personal encounters (e.g. during parental counselling).	■ Competence group destigmatisation: several anti-stigma activities in Austria, of which 28 percent of activities are aimed at children and adolescents (workshops, seminars, cultural activities with mental health themes, websites, digital communication offers) ■ According to the national mental health strategy, school campaigns with people affected by mental illness (and their relatives) have already been very successful in various provinces and should be provided as a fixed offer in all provinces (e.g. by incorporating it into school curricula).
Prevention, mental health promotion	■ aims: increase early help-seeking and improving interpersonal relationships (e.g., reducing violence, improving respectfulness). ■ one key target group: parents with a mental illness in the perinatal period ■ key setting: schools ■ universal as well as targeted services	■ project-based activities without an overarching national strategy and sustainable funding, ■ school-based projects available, however regional disparities (e.g., not all schools covered), ■ parental mental illness only addressed on project base or in single regions. ■ the national mental health strategy aims to intensify health promotion activities for families, in kindergartens and schools, but unclear to what extent this is implemented.
Detection, screening	■ core setting: school involving different professionals, in particular health pro-fessionals (e.g., school health nurses).	■ currently no nation-wide early detection system in place in schools, ■ lack of skills and capacities in staff, ■ internationally involved professionals only partly available in Austria (e.g. school nurse).

Treatment	■ broadening the range of settings, (home-treatment, inpatient-equivalent treatment, other outreach approaches, inpatient treatment),
	■ allowing family-focused care, involving all family members,
	■ triage systems to avoid inappropriate admissions to inpatient or residential care,
	■ reducing waiting times for admission via pre-hospital treatment (participation in inpatient group sessions before full admission),
	■ broadening the mode of delivery including telehealth and face-to-face approaches in single- or groups settings,
	■ Medication:
	  ■ improve medication management in schools and kindergartens including training of staff
	  ■ improving safety by installing measures to reduce off-label use.
		■ Focus is on inpatient care and severe mental illness; certain regions in Austria without alternative to inpatient care, some regions have started pilot projects on inpatient care alternatives (e.g., home treatment)
		■ familiy-focused care not the standard care philosophy
		■ no triage system in place to handle admissions and prioitise settings other than hospitals and institutions; particular problem: mentally ill offenders (in prison rather than in treatment)
		■ care delivery beyond face-to-face not yet standardised; individual solutions by providers
		■ currently no initiatives to improve medication management in schools and kindergartens; reduction of off-label use so far no policy priority

Digitalisation for telehealth, detection and intervention	■ using digital applications for detection, self-care and better system navigation, ■ digital solutions to replace or add on to personal contacts with professionals (SMS, online, etc.), ■ piloting digital approaches alongside extensive research.	■ expansion of eHealth services in preventing and treating mental illness ■ no standardised process in place to identify and reimburse high quality digital solutions
Care pathways, integrated care, health in all policies	■ aim: integrating services across sectors (e.g. health and education) ■ key suggestion: establishing single point of access and provide a coordinator for each patient/family ■ pathways linked to quality indicators (waiting time, "no shows") ■ provide better navigation for professionals and patients/families (patient referral support, electronic navigation tools) ■ increase collaborations between professionals and organisations (case conferences)	■ currently no clear point of access and no coordinator for each patient/family ■ currently no (or limited) integration of services across sectors

Categories of models/strategies	Core recommendation	Examples from Austria based on chapter 4.1
Transitional psychiatry	■ moving away from age thresholds to needs-based transitions based on developmental stages/extending ages for transition into adult mental health care up to 25 years. ■ installing better coordination among the agencies involved by e.g., establishing joint needs assessments and care ar-rangements between adult and adolescent psychiatry units/professionals	■ some examples available, e.g. Vienna: two transition areas for adolescents and young people (16-25 years) in a closed area in the adult section of the psychiatric ward (with four beds) are provided in the Clinic Ottakring and Clinic Floridsdorf ■ unclear if alternative to age thresholds in place ■ new research centre for transitional psychiatry founded in December 2021
Vulnerable patient groups	■ broad number of vulnerable groups ■ measures to better and routinely detect circumstances that make a child vulnerable (e.g. identifying parental mental illness) ■ lead professionals for case management (shifting responsibility from the family to the professionals) ■ increasing or re-distributing resources (e.g. for interpreter services)	■ The national mental health strategy highlights the need to better identify children of mentally ill parents, and recommends raising awareness among professional groups that work with expectant parents or in the period around birth. But no systematic national approach identified. ■ The child and adolescent health strategy recommends the better integration of vulnerable patient groups in kindergartens (e.g. in Salzburg, following individual assessments by psychologists, kindergarten spots for children with inclusive development support are offered), but no national approach identified.
Involvement, user participation	■ aims: providing more tailored care, better navigating care pathways ■ targets: children, adolescents, and their caregivers ■ inclusion in individual care planning ■ involvement in the design processes of the services (extended participation of professional groups, organisations and communities)	■ No recommendations identified specifically for CAMH in the relevant strategies ■ No data regarding target user participation and involvement identified
Infrastructure, resources	■ aims: place-based, accessible, culturally safe ■ increase in budget for interprofessional collaboration, psychotherapy interventions, psychoeducational programmes ■ funding for policies aimed at preventing inequality in youth ■ example: ring-fenced budgets jointly provided by the health, social and educational ministry.	■ The national mental health strategy recommends to increase coordination and cooperation across sectors with respective financing models, but unclear to what extent this is carried out ■ no information available on how much money is invested in CAMH prevention
Professions, workforce qualification and development	■ aim: multiprofessional interdisciplinary teams with a community of practice and shared learnings, ■ broadening the traditional health workforce with additional workers (e.g. allied health specialists, family therapists, diverse and LGBTIQ+ health workers, peer support workers), ■ training in transcultural care and care for vulnerable people, ■ key recommendation: developing the competences for school teaching staff (led by mental health specialists)	■ interdisciplinary teams available, but unclear to what extent the traditional health workforce is broadened with additional workers According to the national mental health strategy: ■ there is a nationwide integration of teaching content on mental health and illness in schools. ■ Child and adolescent psychiatry is defined as a shortage subject ■ A differentiated range of training opportunities and training conditions for psychosocial care professionals is recommended
Implementation strategy, process	■ defining responsibilities: interministerial/cross-sectoral working groups or committees ■ individual responsibilities from managers of health centres and school health services and municipalities ■ implementation phases: establishment phase, embedding phase, full operational phase ■ identifying what is working in some regions and rolling it out to the whole country ■ key implementation action: designated wellbeing staff member in all schools	■ no cross-sectoral committee for CAMH (a committee for child and adolescent general health exists) ■ no designated wellbeing staff member in all schools ■ some models are implemented on a pilot base (e.g. pilot model Tyrol to early identify and support children of parents with a mental illness) but limited systematic transfer of knowledge across Austrian regions

Categories of models/strategies	Core recommendation	Examples from Austria based on chapter 4.1

Digitalisation for management and documentation	■ increase availability and development of digital tools:
	  ■ tools for facilitating clinical decision-making and cross-sector networks (e.g. video conerences for case management)
	  ■ web based bed management systems
	  ■ data management systems
	  ■ electronic patient record systems
		■ electronic patient record system available and in continued development but currently no linkage with patient records in other sectors
		■ unclear to what extent tools for facilitating clinical decision-making and cross-sector networks are in use

Data acquisition, research	■ aims: studying mental disorder prevalences, effects of interventions (both positive and potentially adverse) ■ broad range of research topics and study designs, with the possibility of cross-sectoral study settings (e.g. primary healthcare, schools, etc.) ■ focus on mental health services research for benchmarking of waiting times, delivery of evidence-based-treatments, user satisfaction with services ■ the need of national mental health datasets for coordinated data acquisition, and enabling sharing across relevant sectors ■ funding parity in budget for mental health and physical health research ■ encouraged inclusion of children and families in the development and delivery of research	■ one-time studies about prevalences exist (mostly for adolescents) but no regular prevalence data collection, effects of interventions beyond drugs are not evaluated systematically using robust study designs ■ monitoring of infrastructure, but focus on full inpatient bed numbers (and less on outpatient and prevention services), data not regularly updated and not publicly accessible ■ currently no national child and adolescent mental health core dataset ■ assumably no funding parity in budget for mental health and physical health research (e.g., no information on how much money is invested in CAMH prevention).

4.4.2 Comparison with international indicators

Abgleich Indikatoren und Datenquellen aus Ö mit int. Indikatoren

In this chapter, we compare the international indicators described in the previous section 4.3.3 with indicators available and used in Austria as described in chapter 4.1. Furthermore, we identified available data sources that might be used to calculate further indicators. This is without guarantee for completeness. It is rather to be regarded as a starting point and inspiration for a more in-depth matching of Austrian data sources with indicators in case an Austrian CAMH-indicator set will be defined in the future.

beispielhafte Darstellung nach Indikator-Kategorien

Table 4-16 presents an overview of the comparison using the indicator classification system by Peitz et al. The table demonstrates that the indicators currently in use in Austria address one of the 14 clusters of internationally existing indicators. Within this cluster (supply and utilization of mental health care), only medical care indicators, primarily for the highest level of care (hospital) are available while no indicators exist for the supply and utilization for other areas of care.

10/14 Indikatorkategorien mit passenden Datenquellen aus Ö, diese jedoch nicht kontinuierlich erhoben

The table also shows that several data sources in Austria exist (as described in chapter 4.1) that might be used for calculating further indicators in the future. In summary, for 10 out of the 14 indicator clusters data sources might be available that could be used as a starting point to calculate more indicators than currently available in Austria. However, only in some of the data sources, data are updated on a regular bases (e.g., the HBSC-survey, administrative data) while others have been collected only once (e.g. the prevalence survey among teenagers/MHAT). The latter are only of limited value for calculating indicators because they do not allow monitoring over time.

Table 4-16: Availability of Austrian data on selective examples of indicator clusters

Indicator categories	Availability of information on category					
	Number of identified indicators	Example(s) of indicator (based on 0)	Indicators already used in Austria	Availability of data	Types of data	Source
Mental Health Promotion and Prevention	0	NA	×	×	×	×
Mental Health Resources	17	Environmental factors (e.g. physical environment), individual resources	×	✓	Survey (HBSC study)	[54]
Mental Health Risks	30	Living conditions (e.g. family relations) and behavioural risks (e.g. smoking)	×	✓	Survey (HBSC study)	[54]
Mental Health Literacy	1	Care seeking among adolescents with symptoms of depression and/or anxiety	×	×	×	×
Positive Mental Health	4	Life satisfaction	×	✓	Survey (e.g. HBSC study)	[54, 56-58]
Psychopathology	8	Number of children and adolescents with a mental illness (overall, and differentiated by disorders)	×	✓	Survey (e.g. MHAT study)	[50, 54, 56-58]
Self-harm and Suicidality	3	Suicidal thoughts	×	✓	Survey and national statistics (e.g. Statistik Austria)	[55-58]
Supply and Utilization of Mental Health Care	29	Inpatient services (admission rates), outpatient (number of community-based teams/services)	✓	✓	Monitoring-studies, administrative data	[88, 95]
Needs, Unmet Needs and Barriers in Mental Health Care	6	Wait time and total number on waiting list for first appointment	×	✓	Survey (MHAT study)	[50]
Quality of Care	10	Children and adolescents admitted to adult mental health inpatient units	×	✓	Survey (monitoring – study)	[88]
Costs of Mental Disorders	3	Costs for care and accomodation of vulnerable children and young people	×	×	×	×
Burden of Disease and Mortality	1	Functional limitations among adolescents with depression and/or anxiety	×	✓	National statistics (Statistik Austria)	[55]
Participation	0	NA	×	×	×	×
Sociodemographic Variables with an Impact on Public Mental Health	9	Family (e.g. workless house-holds), school/educational environment	×	✓	Survey (HBSC study)	[54]

x – not identified within the scope of our hand search, ✓– identified within the scope of our hand search

Abbreviations: HBSC – Health Behaviour in School-aged Children; e.g. exempli gratia; NA– not applicable;

5 Discussion

Major deficits in child and adolescent mental disorder prevention and mental health care have been reported in Austria. As such, adaptations of care models are considered for better dealing with infrastructural and staff limitations and for better responding to the increasing mental health challenges in children and adolescents.

gravierende Engpässe in Versorgungsstrukturen in Ö

In this report, we first gave an overview of the current mental health prevention and care structure in Austria. We then provided a synopsis of international child and adolescent mental health care strategies and models, as well as on indicators for planning and monitoring child and adolescent mental health care. Finally, we contrasted the situation in Austria with the international findings.

Übersicht über Ist-Situation, int. Empfehlungen & Indikatoren -> Kontrastierung

5.1 Summary of the results

Situation in Austria

The prevalence of mental illness in Austrian children and adolescents was relatively stable at 20.0 percent until 2019. In recent years, especially due to the COVID-19 pandemic, the mental health of young people has deteriorated considerably. However, available data are mainly for adolescents, while robust data for younger children are missing.

gravierende neg. Auswirkungen durch COVID-19 auf Psyche; fehlende Daten zu Kindern

Mental health promotion and mental illness prevention in children and adolescents are mainly carried out on project basis. These projects take place region-specific or nationwide and are funded from different sources.

Präventionsangebote vorwiegend auf Projektbasis

In the area of mental health care, services differ between the regions (Bundesländer). The most detailed information is available on medical care of children and adolescents, the supply of which is regulated in the Austrian Health Care Structure Plan ("Österreichischer Strukturplan Gesundheit"). Core medical services for children and adolescents with mental disorders include:

unterschiedliche Angebote je nach Bundesland

- hospital inpatient facilities (especially in child and adolescent psychiatry and child and adolescent psychosomatics),
- outpatient clinics attached to the departments,
- specialists in child and adolescent psychiatry in private practice,
- specialists in pediatrics with additional training in psychosomatics,
- child and adolescent psychiatric outpatient facilities, or other specialised medical facilities.

In addition to the medical sector, there is also a broad variety of services in the social and educational sectors, with a mix of funding and provider arrangements. However, no Austrian-wide comprehensive overview exists. Furthermore, a broad variety of different medical specialities and health, social care and educational professionals are involved in promotion, prevention and care activities.

Sozial- und Bildungssektor: verschiedene (regionale) Angebote

Versorgungslücken, begrenzte Kapazitäten, Zugangsungleichheiten

Overall, the data indicate severe gaps in services, limited capacities, regional disparities and a lack of coordination across sectors for promoting, protecting and improving children's and young people's mental health and wellbeing in Austria.

derzeit keine eigenständige Strategie für psych. Gesundheit von KiJu in Ö

While some Austrian health strategies address mental health issues for children and adolescents (e.g., the child and adolescent health strategy), currently no stand-alone national child and adolescent mental health strategy is in place, integrating mental health promotion, illness prevention and mental health care and giving promotion and prevention activities a higher priority than they currently have.

International care models

12 Modelle/Strategien aus 7 Ländern: AU, CH, CZ, DE, ES, NO, UK

For getting to know international approaches, we identified twelve documents from seven selected countries (Australia, Switzerland, Czechia, Germany, Spain, Norway and United Kingdom). These were published between 2013 and 2022. All of the countries included have a general mental health strategy and in the majority, additionally a child and adolescent mental health strategy and a suicide prevention strategy exists. We defined 14 content components from the documents (description in chapter 4.2.3).

verschiedene Zielgruppen der Dokumente

The documents' target groups were decision makers, service providers but also young people and their families. They cover CAMH care for children and adolescents, partly including young adults up to 25 years.

Modelle: Stärkung der Förderung/Prävention, Miteinbeziehung u. a. des Bildungssektors

sektorenübergreifende Verantwortung

All countries advocate a public mental health approach that is characterised by encouraging mental health promotion and prevention. For this aim, the educational sector plays an essential role and should be supported with additional staff and mental health training for educators. In this cross-sectoral approach, in terms of professionals involved and their responsibilities, CAMH is shifting from a psychiatry-focused (more medical-oriented) model to multiprofessional teams with shared responsibility and equal contributions from different professional groups.

bedarfsorientierte Herangehensweise

Partizipation, gefährdete Gruppen, verbesserte Koordination

For adapting the CAMHS, country documents suggest that prevention and care should be based on the needs of children and their families, rather than on the existing care structures. In most countries, the needs-based approach becomes visible through stressing the relevance of user participation and increased involvement, focusing on special support for vulnerable groups, and through creating structures within CAMHS that promote coordination of services according to individual needs (e.g. single points of access, coordinators for improved system navigation).

flexiblere Angebotsstrukturen (z. B. Home-treatment)

Stärkenorientierung (statt Fokus auf Defizite)

The CAMHS can be made more flexible by changing the care philosophy and attitude, by incorporating key principles: open-minded, strengths-based (rather than deficit-oriented) and focusing on child's functioning (rather than on the diagnosis). To become more needs-based and increase access to care, countries additionally suggest more flexible treatment settings: more outreach, home-based, online and outpatient services (rather than institution-based or hospital-centred) and more flexible care arrangements in transitional psychiatry (rather than predefined age thresholds).

Adaptierung der Finanzierung: zweckgebundene Budgets

The countries made further suggestions on structures, processes and financing mechanisms to strengthen this type of care on the system level, including cross-sectoral cooperation for a shared vision, setting goals, planning and financing. The financing can be adapted by implementing separate budgets and

adequate reimbursement models (e.g. ring-fenced budgets, tariffs on complex outpatient services).

Versorgungsforschung, nationale Datenbanken zur psych. Gesundheit (und weitere digitale Tools)

To support these approaches, the countries recommend additional health service research (studying the effects of interventions with the possibility of cross-sectoral study settings), implementing a national mental health dataset for coordinated data acquisition, increase availability and development of digital tools for management and documentation, and a workforce training initiative with a community of practice and shared learnings.

Erweiterung des traditionellen Gesundheitspersonals durch weiteres Personal

In this regard, the countries recommend to broaden the traditional health workforce with additional workers (e.g. allied health specialists, family therapists, diverse and LGBTIQ+ health workers, peer support workers). A key recommendation is to further develop the mental health competences for school teaching staff, guided by mental health specialists.

Indicators

121 Indikatoren identifiziert

We identified 121 indicators for planning and monitoring child and adolescent mental health (care). They came from ten data sources from six countries, and databases of UNICEF and WHO. To classify the indicators, we used different classification systems.

Mehrheit bezieht sich auf Angebote und Risikofaktoren …

When applying the "health indicator classification" system, the analysis revealed that most indicators address health services and mental health risk factors, while few deal with the health status or service coverage. When using the "quality indicator" classification, we saw that most indicators focus on process and outcome dimensions and very few addressed structural parameters.

… Förderung, Gesundheitskompetenz, Suizidalität und Kosten weniger oft berücksichtigt

Applying the classification system by Peitz et al., which consists of 14 different categories that were originally developed for adult mental health, revealed that most international indicators address mental health risks, supply and utilization of mental health care and mental health resources while no or very few indicators deal with mental health promotion, health literacy, self-harm/suicide or costs. The remaining categories such as "psychopathology" or "positive mental health" were in between in terms of the frequency they had been addressed. To populate the indicators, most often secondary data sources (e.g., regular surveys such as the HBSC) are used but a few also used primary data sources (e.g. collected with the strength and difficulty questionnaire), sometimes in combination with secondary sources.

Comparison of Austrian with international findings

in 2 Ö-Strategien Themenfelder nicht ausreichend beschrieben

In contrast to most countries addressed in this report, there is no Austrian child and adolescent mental health strategy available. Existing strategies cover slightly more than half of the topics addressed in international documents but only to a limited extent. We found several examples within the current Austrian CAMHS structure which follow some of the recommendations in the international documents. However, most of the recommendations are not applied systematically and nationwide but more on a project basis or in some regions. For a number of international recommendations we did not have sufficient information to identify potential Austrian implementation examples.

Beispiele für Umsetzung int. Empfehlungen vorhanden, aber meist nur regional

Indikatoren in Ö bisher vorwiegend für medizinischen (stationären) Bereich

Contrasting the international indicators with those currently used in Austria showed that only few indicators are in use in Austria and those are restricted to monitoring medical care, in particular hospital care. A number of data sources were identified which could be used as a starting point to calculate more of the international indicators for Austria.

5.2 Interpretation of the findings

gemeinsame Strategie, sektorenübergreifende Koordination

Our results demonstrate that many services and projects exist for CAMH care in Austria but, even without comprehensive data on the Austrian situation, when compared with international recommendations a need for improvement regarding strategic development, capacities and coordination across different sectors and professionals involved has become apparent.

bundesweite Förderung der psych. Gesundheit und Früherkennung von Erkrankungen

One noticeable discrepancy between the current system and the international recommendations was the need to provide information, awareness raising activities and mental health promotion as a systematic, nation-wide offer (rather than project-based activities without sustainable funding). Regarding detection and screening, a nation-wide early detection system (including risk factors such as parental mental illness) is desirable.

Erweiterung der Versorgungssettings (aufsuchende, stationsäquivalente Therapien)

Regarding treatment options, in Austria in terms of resources and awareness and monitoring there is currently a strong focus on inpatient care and severe mental illness. The international recommendations to broaden the range of settings (home-treatment, inpatient-equivalent treatment and other outreach approaches) have only been implemented to a limited extent and may be extended in the future to increase capacities. This extension would then also be more in line with the optimal mix of mental health services as recommended by the World Health Organization. Furthermore, introducing more flexible treatment settings may help to increase access, where currently severe barriers have been reported resulting in under-use of services by young people with manifest mental health problems.

Erweiterung des Schulpersonals

In the educational sector, an integration of teaching content on mental health and illness is implemented nationwide, however other countries additionally consider to broaden the school staff range (e.g., introducing dedicated well-being staff or school nurses in all schools) for providing universal or targeted prevention activities.

gefährdete Gruppen stärker berücksichtigen & miteinbeziehen

Further room for improvement was identified regarding integration of services across sectors (e.g. no clear point of access) and adequate care for all vulnerable patient groups identified in the international documents. An example in Austria are young criminal offenders with mental health problems for whom neither detailed data nor adequate treatment exists. To be more aligned with international care recommendations, users in Austria need to become involved in the design processes of services and in individual care planning. Further participation and involvement of vulnerable patient groups could address key issues regarding health equity, such as equity of mental health service distribution in geographic regions, equity of support across life stages and equity in relation to social, economic, and cultural groups.

Weiterentwicklung der Transitionspsychiatrie, digitale Anwendungen (Telemedizin)

Some alignment was shown for transitional psychiatry and digital tools. For transitional psychiatry, examples in Vienna exist and a newly established research centre is currently examining the nation-wide situation. Regarding digital tools, an electronic patient record system is available. However, tools for telehealth, detection, intervention and documentation will require additional development and a standardised process to identify high quality services.

Übertragbarkeit der int. Empfehlungen auf Ö zu überprüfen

begleitende Versorgungsforschung

The approach explored in this report to compare international recommendations with the Austrian situation could be applied in more depth as a methodology to ensure that the CAMH situation in Austria goes towards the international recommendations. While health care system differences may limit transferability of some of the recommendations, they may serve as an inspiration for developing the Austrian system further or to pilot some approaches, such as the ring-fenced budget for CAMH funded from different sectors. However, more data on the current situation (in particular on regions not covered within our report) need to be collected, for example on the expenditure on CAMHS in Austria. Some approaches recommended may work differently in the Austrian context and some may need more discussions to begin with (e.g., whether the described school-entry health consultation to detect mental health problems or risk factors in Norway would be feasible and acceptable in Austria). Thus, applying approaches to Austria will likely require re-design, ideally in a participatory co-design approach and evaluation alongside piloting.

Grundprinzipien: Aufgeschlossenheit, bedarfsorientierte Versorgung, "Kontinuum des Wohlbefindens"

In addition to specific (components) of care models, it became apparent from the documents that a key aspect in some countries is to change the overall philosophy of care, for example to move towards a "wellbeing continuum", focusing on needs and early intervention in case children start struggling rather than on diagnoses as a basis for initiating support and selecting the type of support. The care philosophy was also linked to emphasising specific attitudes staff need to have, such as being unprejudiced and open-minded. Implementing such philosophies will require training and qualification measures for staff across sectors.

Partizipation von KiJu und deren Bezugspersonen

As mentioned earlier, a national CAMH care strategy, as it is existing in the majority of countries selected, is missing in Austria. The advantage of having such a strategy is to achieve nationwide consensus on common visions and shared goals between the relevant stakeholders. Following the international recommendations involving young people and carers in addition to experts from different fields seems to be crucial to increase acceptance and align the strategy to the needs of young people and their families. The content categories covered in the international documents may serve as a starting point for the content covered in an Austrian strategy.

Qualität der int. Versorgungsmodelle: einerseits viele Interessensvertreter*innen, jedoch limitierte Patient*innenperspektive und Link zu Evidenz

In the quality assessment (using the adapted AGREE II methodology) we assigned an overall sufficient level of quality of the documents. Scope and purpose of the documents were in general clearly described. In the development of the majority of documents, individuals from many different relevant professional groups were involved. In contrast, the involvement of the views and preferences of the target population was rather limited. A limitation in the documents is that in none of the documents a systematic search for evidence was conducted/described, and for many of the recommendations no explicit link to supporting evidence was established.

Indikatoren in Ö: kontinuierliches Monitoring und Berücksichtigung aller relevanten Sektoren anzustreben

Our results also demonstrate that there is room for development regarding CAMH indicators for planning and monitoring. Many of the indicators (e.g. prevalence) are not collected continuously and a defined core-indicator set is missing in Austria. The indicators currently in use represent a narrow view on CAMH, mainly addressing psychiatric high level care, while indicators for successful mental health promotion, prevention activities or service delivery beyond medical care are missing.

Datenbank für Indikatoren als Ausgangspunkt zur Definition priorisierter Indikatoren

The creation of a document/database in which all indicators (whether collected once or on a continuous basis) for monitoring the mental health (care) of children and adolescents can be retrieved would be desirable. The myriad of identified international indicators can serve as a starting point but they will require contextualization and priortisiation. Defining this set of indicators will likely require additional research and data acquisition, especially in areas where robust information is currently lacking (e.g. prevalence data in children < 10 years).

Limitations

Handsuche nach grauer Literatur: nicht allumfassend

In this scoping review, we chose to perform an extensive hand search instead of a systematic literature search for the international care models, as well as for indicators. We expected that these references are usually not published in scientific journals, but rather as grey literature on relevant websites (e.g., ministerial or public health). However, we may have missed relevant data sources of child and adolescent mental health strategies or models, as well as indicators for planning and monitoring. As such, there is no guarantee for completeness in our findings.

nur eine Auswahl an Ländern berücksichtigt

For this report to be manageable we had to restrict the number of countries considered. While we had clearly defined criteria for achieving a consistent country selection allowing for a maximum of diversity regarding mix of health care systems and regions, we may have missed interesting strategies from countries excluded.

Evt. weitere Information in ausgeschlossenen Dokumenten (z. B. indikationsspezifische)

From the included countries, documents in languages other than English or German were excluded if at least one document in English or German was available from a country. We also excluded documents that were indication-specific, such as medical guidelines, as well as documents focusing on the general health of children and adolescents (not mental health specific), or documents focusing on mental health in general (but not specific for children and adolescents). These documents might contain some complementing information.

spezifische Berechnungen der Indikatoren nicht erhoben

Further, we chose not to extract specific descriptions on the calculation of the indicators. We placed higher priority in identifying CAMH indicators and assigning them to a classification system as a first step. Additional Austrian data to calculate indicators may be available, but were beyond the scope of this report.

Einteilung in Klassifikationen nicht immer trennscharf

Furthermore, the information from the documents was not always clearly separable into the defined categories, i.e. there is overlap between the categories 'information activities' and 'prevention'. The same is true for the assignment of indicators into clusters. We consider several of the many aspects of mental health to be intertwined with each other, and have used our best judgement in assigning the data into the categories and clusters, but some may also fit into other classifications.

The documents analysed presented recommendations and strategies. However, we do not know to what extent those have already been implemented and what the current service structures are in the selected countries. Furthermore, an effectiveness and safety assessment of recommended prevention and treatment modalities was outside the scope of this report.

Ausmaß der Implementierung nicht erhoben; keine Wirksamkeitsanalyse einzelner Maßnahmen

6 Outlook for Austria

Based on the international recommendations and our comparison with the Austrian situation, the following learnings from other countries may serve as a starting point for health policy discussions on CAMHS development:

int. Empfehlungen Ausgangspunkt für Weiterentwicklung

Entwicklung einer eigenständigen Strategie für die psych. Gesundheit von KiJu

gemeinsame Ziele, sektorenübergreifend, Arbeitsgruppe zur Priorisierung der Indikatoren (mit Nutzer*innenpartizipation)

- Developing a national child and adolescent mental health strategy (Figure 6-1):
  - creating a common vision and shared goals for child and adolescent mental health between the relevant stakeholders, integrating mental health promotion, illness prevention and mental health care,
  - Creating a cross-sectoral (health, social care, education, criminal justice) national child and adolescent mental health committee with clear defined responsibilities,
  - Establishing a cross-sectoral working group for continued identification and prioritisation of indicators, creating a "basic indicator set" (at best with user participation) for monitoring implementation of the strategy,

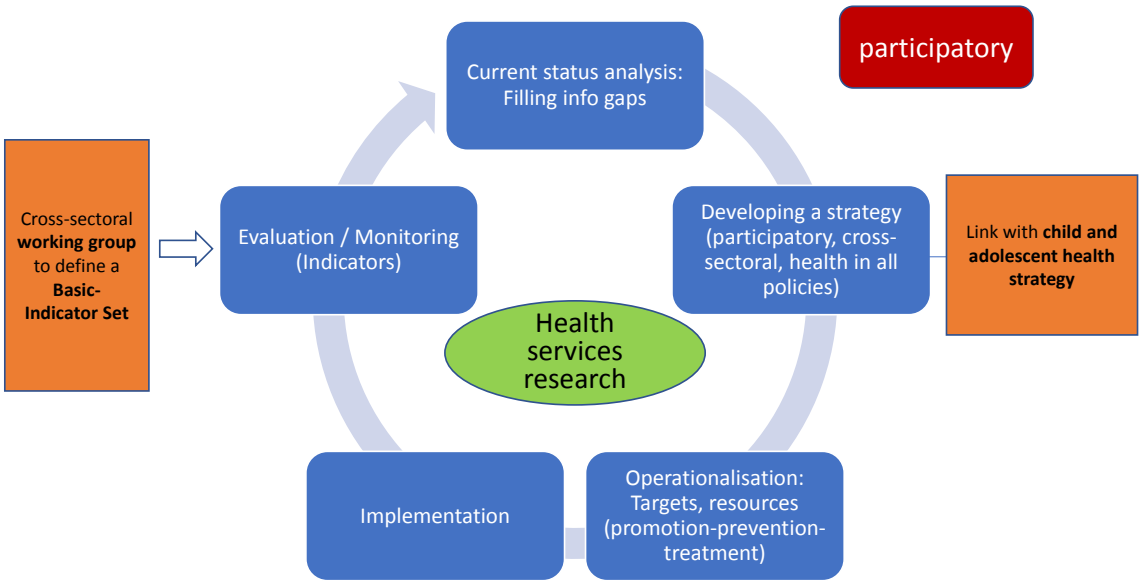

Figure 6-1: Inspirations for a national CAMH strategy in Austria

Partizipation, Reduktion von Stigma, Berücksichtigung gefährdeter Gruppen, bedarfsorientierte Angebote, ambulanten Bereich stärken

- Strengthening participation and user involvement, including better listening to children and adolescents using appropriate tools and skills,
- Increasing efforts on awareness raising activities to reduce stigma,
- Focusing on vulnerable patient groups, acknowledging which of these are particularly affected or often overlooked (e.g. juvenile justice cases) and develop needs-based services,(e.g. transitional psychiatry based on joint needs assessment rather than age thresholds)
- Further strengthening the outpatient area (e.g. home-treatment services) to overcome hospital bed and psychiatrist shortage and enable family-focused care close to home, as well as informal care offers,

- Establishing a "stepped-care" model that includes mental health literacy offers, ranging from informal outpatient services to full inpatient treatments (and post-hospital rehabilitation services).

Systemnavigation und Behandlungspfade: lokale Anknüpfungspunkte, regionale Planungsteams, zweckgebundene, sektorenübergreifende Budgets

- Improving the pathways of care (Figure 6-2):
  - Creating regional planning teams and strengthening individual case management,
  - Improving system navigation by creating single points of access ("one-stop-shops"),
  - Increasing the budget and resources for child and adolescent mental health, i.e. a funding parity between mental and physical health, considering ring-fenced budgets derived from the sectors involved

begleitende Versorgungsforschung, Ausbildungsoffensive

- Investing in research, implementation and evaluation for evidence-based guidance of programmes and initiatives,
- Establishing a workforce development strategy for all professional groups involved in the promotion, prevention and treatment activities across sectors.

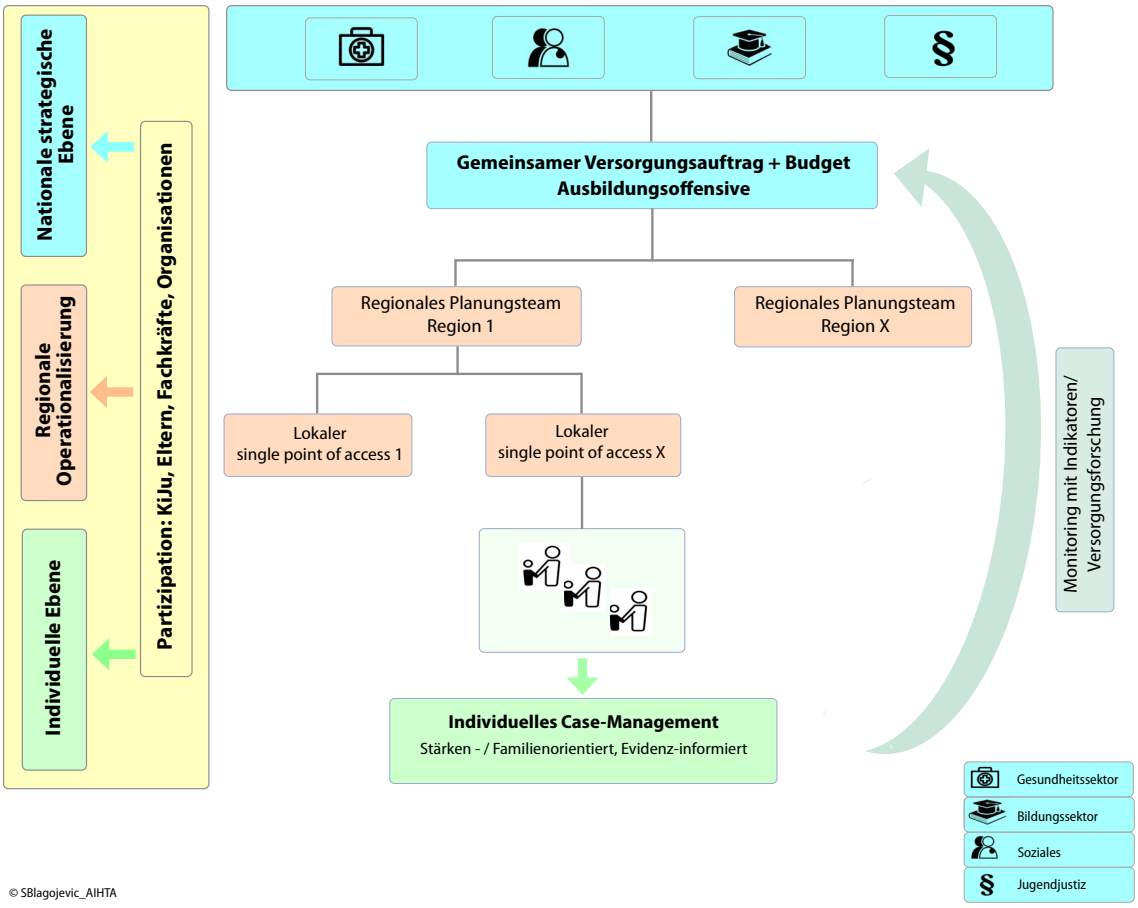

Figure 6-2: CAMH model of care – Draft for Austria

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Appendix

Mental health professionals and facilities

Table A-1: Types of professionals according to the Mental Health Atlas 2020 [37]

Type of professional	Description
Nurse	A health professional who has completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.
Occupational therapist	A health professional who has completed formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy
Other specialized mental health worker	A health or mental health worker who possesses some training in health care or mental health care (e.g. occupational therapist) but does not fit into any of the defined professional categories (e.g. medical doctors, nurses, psychologists, social workers). Includes: Non-doctor/non-nurse primary care workers, psychosocial counsellors, and auxiliary staff. Excludes: General staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).
Primary health care doctor	A general practitioner, family doctor or other non-specialized medical doctor working in a primary health care clinic.
Primary health care nurse	A nurse working in a primary health care clinic.
Psychiatrist	A medical doctor who has had at least two years of postgraduate training in psychiatry at a recognized teaching institution. This period may include training in any subspecialty of psychiatry.
Psychologist	A professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. The Mental Health Atlas asks for information only on psychologists working in mental health care.
Social worker	A professional who has completed formal training in social work at a recognized, university-level school for a diploma or degree in social work. The Mental Health Atlas asks for information only on social workers working in mental health care.
Speech therapist	A professional who has completed formal training in speech therapy at a recognized, university-level school for a diploma or degree in speech therapy. In some countries, speech therapy is a part of audiology training. The Mental Health Atlas asks for information only on speech therapists working in mental health care.

Table A-2: Types of facilities according to the Mental Health Atlas 2020 [37]

Type of facilities	Description
Mental hospital	A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental health conditions. Other names include mental health hospital and psychiatric hospital. *Includes:* Public and private non-profit and for-profit facilities; forensic inpatient facilities; mental hospitals for children and adolescents and other specific groups (e.g. older adults). *Excludes:* Community-based psychiatric inpatient units; facilities that treat only people with alcohol and substance use problems or intellectual disability; psychiatric units in general hospitals; and mental health community residential facilities.
Psychiatric unit in a general hospital	A psychiatric unit that provides inpatient care within a community-based hospital facility (e.g. general hospital); the period of stay is usually short (weeks to months) and the hospital also provides services related to other medical specialties. *Includes:* Public and private non-profit and for profit facilities; psychiatric wards or units in general hospitals, including those for children and adolescents or other specific groups (e.g. older adults). *Excludes:* Mental hospitals; community residential facilities; facilities for alcohol and substance use problems or intellectual disability only.
Mental health community residential facility	A non-hospital, community-based mental health facility providing overnight residence for people with mental health conditions. Both public and private non-profit and for-profit facilities are included. *Includes:* Staffed or unstaffed group homes or hostels for people with mental health conditions; halfway houses; therapeutic communities. *Excludes:* mental hospitals; facilities for alcohol and substance use problems or intellectual disability only; residential facilities for older adults; institutions treating neurological disorders or physical disability problems.
Mental health day treatment facility	A facility providing care and activities for groups of users during the day that last for half a day or one full day (including those for children and adolescents only or other specific groups, e.g. older adults). *Includes:* Day or daycare centres; sheltered workshops; club houses; drop-in centres. Both public and private non-profit and for-profit facilities are included. *Excludes:* Day treatment facilities for inpatients; facilities for alcohol and substance use problems or intellectual disability only.

Type of facilities	Description
Mental health outpatient facility	An outpatient facility that manages mental health conditions and related clinical and social problems. *Includes:* Community mental health centres; mental health outpatient clinics or departments in general or mental hospitals (including those for specific mental health conditions, treatments or user groups, e.g. older adults). Both public and private non-profit and for-profit facilities are included. *Excludes:* Private practice; facilities for alcohol and substance use problems or intellectual disability only.
Other residential facility	A residential facility that houses people with mental health conditions but does not meet the definition for community residential facility or any other defined mental health facility. *Includes:* Residential facilities specifically for people with intellectual disability, for people with substance use problems or for people with dementia; residential facilities that formally are not mental health facilities but where most residents have diagnosable mental health conditions.
Primary health care clinic	A clinic that often offers the first point of entry into the health-care system. Primary health care clinics usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities that have staff with a higher level of training.
Mental health and psychosocial support	The composite term "mental health and psychosocial support" (MHPSS) is used in the Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings to describe "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders". The global humanitarian system uses the term MHPSS to unite a broad range of actors responding to emergencies (such as the COVID-19 outbreak), including those working with biological approaches and sociocultural approaches in health, social, education and community settings, as well as to "underscore the need for diverse, complementary approaches in providing appropriate support."

Mental health services in Styria and Vienna (Austria)

Table A-3: Mental health offers for children and adolescents in Styria

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Mental hospital								
Graz								
Abteilung für Kinder- und Jugendpsychiatrie und Psychotherapie Standort Süd[16] *(Department of Child and Adolescent Psychiatry and Psychotherapy South location)*	LKH Graz II, Steiermärkische Krankenanstaltengesellschaft m.b.H. *(Provincial Hospital Graz II, Styrian Hospitals Ltd.)*		x	Children and adolescents (until 18 years)	Psychiatrists, psychologists, other specialised mental health workers, nurses, social workers	Treatment spectrum includes all psychiatric disorders of childhood and adolescence, including the family environment (33 inpatient beds)	In- and outpatient care	https://www.lkh-graz2.at/abteilungen/abteilung-fuer-kinder-und-jugendpsychiatrie-und-psychotherapie#c15287
Stationärer Bereich – Heilpädagogisches Zentrum des Landes Steiermark *(Inpatient area – Curative Education Centre of the Province of Styria)*	Heilpädagogisches Zentrum des Landes Steiermark *(Curative Education Centre of the Province of Styria)*		x	Children and adolescents (6-15 years)	Psychiatrists, psychologists, social workers, other specialised mental health workers	Diagnostic and treatment (four accommodation units for six children each)	Inpatient care	https://www.soziales.steiermark.at/cms/beitrag/10175044/4819501/
Western Upper Styria								
Stationäre Rehabilitation für Kinder und Jugendliche – Wildbad/Einöd *(Inpatient rehabilitation for children and adolescents – Wildbad/Einöd)*	OptimaMed Gesundheitstherme Wildbad Betriebs GmbH *(OptimaMed Health Spa Wildbad Ltd.)*	x		Children and adolescents (1-18 years)	Psychiatrists, occupational therapists, and other specialised mental health workers	Personalised treatment (24 inpatient beds)	Inpatient care	https://www.kinderreha-wildbad.at/mental-health/

[16] With outpatient clinic for adolescents with personality (developmental) disorders, outpatient clinic for patients with drug and addiction disorders, outpatient clinic for patients with juvenile psychoses, intercultural outpatient clinic, outpatient clinic for adolescents with gender identity disorders

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Psychiatric unit in a general hospital								
Graz								
Abteilung für Kinder- und Jugendpsychiatrie und Psychotherapie Standort Süd *(Department of Child and Adolescent Psychiatry and Psychotherapy South location)*	LKH Graz II, Steiermärkische Krankenanstaltengesellschaft m.b.H. *(Provincial Hospital Graz II, Styrian Hospitals Ltd.)*		x	Children and adolescents (until 18 years)	Psychiatrists, psychologists, other specialised mental health workers, nurses, social workers	Treatment spectrum includes all psychiatric disorders of childhood and adolescence, including the family environment (33 inpatient beds)	Outpatient care, office based	https://www.lkh-graz2.at/abteilungen/abteilung-fuer-kinder-und-jugendpsychiatrie-und-psychotherapie#c15287
Eastern Styria								
Dislozierte Ambulanz für Kinder und Jugendpsychiatrie und -psychotherapie *(Dislocated outpatient clinic for child and adolescent psychiatry and psychotherapy)*	LKH Hartberg, Steiermärkische Krankenanstaltengesellschaft m.b.H. *(Provincial Hospital Hartberg, Styrian Hospitals Ltd.)*		x	Children and adolescents	Psychiatrists, psychologists, nurses	Diagnostic and care	Outpatient care, office based	https://www.lkh-hartberg.at/abteilungen/psychiatrische-ambulanz/kjp
Eastern Upper Styria								
Dislozierte Ambulanz für Kinder- und Jugendpsychiatrie und Psychotherapie (Standort Leoben) *(Dislocated outpatient clinic for child and adolescent psychiatry and psychotherapy (location Leoben)*	LKH Hochsteiermark, Steiermärkische Krankenanstaltengesellschaft m.b.H. *(Provincial Hospital Upper Styria, Styrian Hospitals Ltd.)*		x	Children and adolescent (5-18 years)	Psychiatrists, psychologists, psychiatric nurses, occupational therapists, social workers, other	Child and adolescent psychiatric diagnosis and treatment	Outpatient care, office based	https://www.lkh-hochsteiermark.at/abteilungen/kinder-und-jugendpsychiatrie#c25204
Mental health community residential facility								
Graz								
tartaruga	Jugend am Werk *(Youth at work)*	x		Adolescents (13-18 years)	Other specialised mental health workers	Crisis intervention centre and crisis accommodation for young people	In- and outpatient care	https://jaw.or.at/ueber-uns/standorte/einrichtung/s/tartaruga/

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Jugendnotschlafstelle Schlupfhaus *(Youth Emergency Shelter Schlupfhaus)*	Caritas	x		Adolescents and young adults (14-21 years)	other specialised mental health workers, other staff	emergency shelter with outpatient services	In- and outpatient care	https://www.caritas-steiermark.at/hilfe-angebote/kinder-jugendliche/wohnen/notschlafstelle-fuer-jugendliche-schlupfhaus
Mental health day treatment facility								
Graz								
Tagesklinik *(Day clinic)*	Heilpädagogisches Zentrum des Landes Steiermark *(Curative Education Centre of the Province of Styria)*		x	Children and adolescents (6-15 years)	Psychiatrists, psychologists, social worker, other specialised mental health workers	E.g. social training and individual support, diagnostics and individual psychotherapy	Partial-stationary facility	https://www.soziales.steiermark.at/cms/ziel/4819630/DE/
Projekt Heidenspass *(Project „Heidenspass")*	Fensterplatz – Initiative für Arbeitssuchende *(Window seat – Initiative for jobseekers)*	x		adolescents (until 25 years)	Social worker, other staff	Job creation for disadvantaged groups of people	Office-based	https://www.heidenspass.cc/
AusbildungsFit Graz *(ApprenticeshipFit Graz)*	GFSG – Gesellschaft zur Förderung seelischer Gesundheit GmbH *(Society for the Promotion of Mental Health Ltd.)*	x		Adolescents and young adults	Other specialised mental health workers, occupational therapist, psychologists, social worker	Offer for adolescents and young adults with psycho-social and/or psychiatric problems who are looking for support regarding their further schooling or vocational training after completing their compulsory schooling	Office-based	https://gfsg.at/kinder-jugend
Digitaldruck – Graz *(Digital printing – Graz)*	Pro-mente Steiermark *(Pro-mente Styria)*	x		Young adults (15 and older)	Other specialised mental health workers	Youth work training, clarification of employability, vocational orientation assistance, individual training measure	Office-based	https://www.promentesteiermark.at/projekttyp/individuelle-trainingsmassnahme-graz-und-graz-umgebung/
Kreativwerkstatt *(Creative Studio)*	GFSG *(Society for the Promotion of Mental Health Ltd.)*	x		adolescents (15-24 years)	Social worker, psychologist, other specialised metal health workers	Young people with mental illnesses can work and develop perspectives for education, career and the personal future	Office-based	https://gfsg.at/kinder-jugend

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Eastern Upper Styria								
Dislozierte Tagesklinik für Kinder- und Jugendpsychiatrie und Psychotherapie (Standord Leoben) *(Dislocated day clinic for child and adolescent psychiatry and psychotherapy (location Leoben))*	LKH Hochsteirmark, Steiermärkische Krankenanstaltengesellschaft m.b.H. *(Provincial Hospital Upper Styria, Styrian Hospitals Ltd.)*		x	Children and adolescents (5-18 years)	Psychiatrists, psychologists, nurses,	Accompanying children and their families through treatment	Office-based	https://www.lkh-hochsteiermark.at/abteilungen/kinder-und-jugendpsychiatrie#c25288
Mental health outpatient facility								
Styria								
Psychosoziale Beratungsstelle für Kinder und Jugendliche[17] *(Psychosocial counselling centre for children and young people)*	Rettet das Kind Steiermark GmbH *(Save the Child Styria Ltd.)*	x		Children and adolescents	Psychologists	Diagnostic, support, psychotherapie	Office-based	http://www.rettet-das-kind-stmk.at/joomla/index.php?option=com_content&view=article&id=206&Itemid=313
Beratung & Therapie[18] *(Counselling & Therapy)*	Institut für Familienförderung *(Institute for Family Support)*	x		Children and adolescents	Psychologists and other specialised mental health care workers	Diagnostics, psychological treatment and psychotherapy	Office-based	https://www.familienfoerderung.at/wo-wir-sind/deutschlandsberg/beratung-therapie/
West-/South Styria								
Psychosoziale Beratungsstelle für Kinder & Jugendliche, Kinderschutzzentrum (KITZ) *(Psychosocial Counselling Centre for Children & Adolescents, Child Protection Centre (KITZ))*	GFSG *(Society for the Promotion of Mental Health Ltd.)*	x		Children and adolescents	Psychiatrists, psychologists, other specialised mental health workers,	Counselling centre including individual and group services, psychological diagnosis and treatment	Office-based	https://gfsg.at/kinder-jugend

[17] Three locations in Styria: Deutschlandsberg (West-/South Styria), Kapfenberg (Eastern Upper Styria), Weiz (Eastern Styria)

[18] Four locations in Styria: Graz (Graz), Leoben (Eastern Upper Styria), Gleisdorf (Eastern Styria), Deutschlandsberg (West-/South Styria)

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Eastern Styria								
KIJUZ – Kinder- und Jugendpsychiatrisches Zentrum Feldbach *(KIJUZ – Child and Adolescent Psychiatric Centre Feldbach)*	Hilfswerk Steiermark GmbH *(„Hilfswerk" Styria Ltd.)*	x		Children and adolescents (0-18 years)	Psychiatrists, psychologists, occupational therapist	Comprehensive child and adolescent psychiatric, clinical psychological and occupational therapy diagnosis and treatment	Office-based	https://www.hilfswerk.at/steiermark/psychosoziale-dienste/kinderjugend/kinder-und-jugendpsychiatrisches-zentrum
JuKiTz – Psychosoziale Beratungsstelle für Kinder und Jugenliche Hartberg-Fürstenfeld *(JuKiTz – Psychosocial Counselling Centre for Children and Young People Hartberg-Fürstenfeld)*	GFSG *(Society for the Promotion of Mental Health Ltd.)*	x		Children and adolescents	Psychiatrists, psychologists,	For example: individual and group services, psychological diagnosis and treatment, psychotherapy, specialist care, crisis intervention	Office-based	https://gfsg.at/kinder-jugend
Psychologische Diagnostik, Behandlung und Therapie für Kinder, Jugendliche und Familien *(Psychological diagnosis, treatment and therapy for children, adolescents and families)*	DiBeTh[19]	x		Children, adolescents and their parents/ guardians	Psychologists,	Diagnostics, therapy, counselling	Office-based	https://www.dibeth.at/
Graz								
Psychosoziale Beratungsstelle für Kinder und Jugendliche *(Psychosocial counselling centre for children and young people)*	GFSG *(Society for the Promotion of Mental Health Ltd.)*	x		Children and adolescents	Psychiatrists, social worker, psychologists	Counselling and treatment	Office-based	https://gfsg.at/kinder-jugend

[19] According to the website also with locations in Leibnitz and Graz

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Neuland – Mobile sozialpsychiatrische Betreuung für Jugendliche und junge Erwachsene *(Neuland – Mobile social psychiatric care for adolescents and young adults)*	GFSG *(Society for the Promotion of Mental Health Ltd.)*	x		Adolescents (15-24 years)	Social worker, pychiologists	Adolescents and young adults will be visited in their living environment and accompanied in their daily life	Mobile support	https://gfsg.at/kinder-jugend
Psychotherapeutische Beratungsstelle *(Psychotherapeutic Counselling Centre)*	Heilpädagogisches Zentrum des Landes Steiermark *(Curative Education Centre of the Province of Styria)*		x	Children and adolescents	Psychiatrists, psychologists, social worker, other specialised mental health workers	E.g. performance and personality diagnostics, individual, couple and family therapy, medical and psychosocial counselling, crisis intervention	Office-based	https://www.soziales.steiermark.at/cms/ziel/4819567/DE/
Eastern Upper Styria and Liezen								
Psychosoziale Beratungstelle[20] *(Psychosocial counselling centre)*	Psychosoziales Netzwerk gemeinnützige GmbH *(Psychosocial network non-profit Ltd.)*	x		Children and adolescent, as well as parents, educators or teachers	Psychologists, social worker, other specialised mental health workers	Diagnostics, support, assistance	Office-based	https://www.psn.or.at/index.php/psychosoziale-beratungsstellen-fuer-kinder-und-jugendliche/
Other residential facility								
West-/South Styria								
Ubuntu		x		young men (16-30 years)	Other specialised mental health workers	Rehabilitation with full-time supervised living, medical-psychiatric and therapeutic treatment as well as withdrawal treatment	Inpatient stay, office-based	https://www.ubuntu.or.at/
Eastern Upper Styria								
kids@home	RdK *(Save the child)*	x		children and adolescents who require out-of-home care	Other specialised mental health workers	Care and support (two residential groups with 8 children/adolescents each)	Inpatient stay, office-based	http://www.rettet-das-kind-stmk.at/joomla/index.php/kids-at-home

[20] One councelling centre in Judenburg (Eastern Upper Styria) and one in Liezen (Liezen)

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
trapez – Sozialpädagogische Wohngemeinschaft *(trapez – Social Pedagogical Living Community)*	Jugend am Werk *(Youth at work)*	x		adolescents (12-18, up to the age of 21 if required)	Psychologists, social workers other specialised mental health workers	Individual support, personal counselling and guidance as well as support in everyday life	Inpatient stay	https://jaw.or.at/ueber-uns/standorte/einrichtung/s/trapez/
Graz								
4Raum	Jugend am Werk *(Youth at work)*	x		Children and adolescent (6-18 years)	Other specialised mental health worker	Immediate accommodation with 24-hour care	Inpatient stay, office based	https://jaw.or.at/ueber-uns/standorte/einrichtung/s/4raum/
Primary health care clinic								
Styria								
Gesundheitszentren mit medizinischen Leistungen – Steiermark[21] *(Health centres (PVE) with medical services – Styria)*		x		All persons with different cases of illness	Primary health care doctor, primary health care nurses, psychiatrists, psychologists	Treatment of acute and chronic diseases, anamnesis, initial diagnostics, graduated further diagnostics and therapy	Office-based	https://gesundheitsfonds-steiermark.at/gesundheitszentren/#PVE
Other mental health and psychosocial support (incl. Prevention)								
Styria								
Schulpsychologie *(School psychology)*	Bildungsdirektion Steiermark *(Styrian Education Directorate)*		X	Pupils, teachers, guardians and leaders in the school system	Psychologists	Psychosocial counselling on various topics	Telephone, online, office-based	https://www.bildung-stmk.gv.at/service/schulpsychologie.html
WEiL – Weiter im Leben *(WEiL – On with life)*	Volker Paul Goditsch Fonds	x		suicidal young people (up to 25 years), their relatives and friends	Other specialised mental health workers	online counselling, Lectures and Coaching, Peer Group Education	online, telephone	http://weil-graz.org/ueber-weil/angebote/
Schulprojekt: Verrückt? Na und? *(School project: Crazy? So what?)*	Irrsinnig Menschlich e.V. und Dachverband der sozialpsychiatrischen Vereine und Gesellschaften Steiermarks	x		Pupils and teachers	Psychologists, other specialised mental health workers, people who are familiar with mental are familiar with crises and illnesses and have experience with crisis management	Prevention programme	in schools	https://www.verrueckt-na-und.at/steiermark/

[21] A total of 12 locations: Mariazell, Eisenerz, Joglland, Friedberg, Weiz, **Graz**, **Graz Gries**, Gratwein-Straßengel, Mureck, Fehring, **Admont**, Liezen

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private non-profit	Public					
Graz								
TARA	Frauenberatungs-stelle bei sexueller Gewalt Steiermark *(Women's counselling centre for sexual violence Styria)*			Girls and women who have experienced a sexual assault	Other specialised mental health workers	Diagnostics and psychotherapy for children and adolescents, dyslexia and dyscalculia assessment, psychological-therapeutic counselling & coaching	Office-based	https://www.taraweb.at/
Beratungsstelle *(Counselling Centre)*	Courage – die Partner*innen-, Familien- & Sexualberatungstelle *(partner, family & sexual counselling centre)*	x		People seeking advice and help on relationships and sexuality as well as violence and sexual assault	Psychologist, social workers and other specialised mental health workers	Partner, family & sexual counselling	Office-based, online, telephone	https://www.courage-beratung.at/
West-/South Styria								
akzente – psychosoziale und rechtliche Beratung für Frauen und Mädchen *(Psychosocial and legal counselling for women and girls)*	Verein akzente *(Association akzente)*	x		Girls and woman (14 years and older)	other staff	Counselling in challenging life situations, occupation, institutions and subsidies	Office-based	https://www.deutschlandsberg.at/rathaus/mitarbeiterinnen-des-rathauses-der-stadtgemeinde-deutschlandsberg/mitarbeiterinnen-alle/2-uncategorised/857-akzente; https://www.akzente.or.at/

Abbreviations: e.V. – eingetragener Verein; GFSG – Gesellschaft zur Förderung seelischer Gesundheit GmbH; Ldt. – Linear Displacement Transducer; LKH – Landeskrankenhaus; RdK – Rettet das Kind

Table A-4: Mental health offers for children and adolescents in Vienna

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Mental hospital								
Vienna-Centre-Southeast								
Kinder und Jugendpsychiatrie – Universitätsklinik[22] *(Child and Adolescent Psychiatry – University Hospital)*	Medizinische Universität Wien, Universitäts-klinikum AKH Wien *(Medical University of Vienna, University Hospital General Hospital of the City of Vienna)*		x	Children and adolescents (until 18 years)	Psychiatrists, psychologists, nurses, social workers, occupational therapists, speech therapists, other specialised mental health workers	Specialised care in several disciplines; ambulance and two fully inpatient areas with a total of 28 beds, divided into two wards	Outpatient care, inpatient/partial inpatient stay	https://kjp.meduniwien.ac.at/
Psychiatric unit in a general hospital								
Vienna West								
Kinder- und Jugendpsychiatrie *(Child and Adolescent Psychiatry)*	Klinik Hietzing – Wiener Gesundheitsverbund *(Clinic Hietzing – Vienna Health Network)*		x	Children and adolescents (2-18 years)	Psychiatrists, psychologists, other specialised mental health workers, occupational therapists, speech therapists	Interdisciplinary diagnostics and treatment – 3 wards	Out- and inpatient care	https://klinik-hietzing.gesundheitsverbund.at/leistung/kinder-und-jugendpsychiatrie-abteilung/
Psychosomatische Ambulanz und Station für Kinder und Jugendliche *(Psychosomatic outpatient clinic and ward for children and adolescents)*	Klinik Ottakring – Wiener Gesundheitsverbund *(Clinic Ottakring – Vienna Health Association)*		x	Children and adolescents (until 18 years)	Psychiatrists, psychologists, nurses, social worker, other specialised mental health workers	Different methods such as behavioural therapy, systemic family therapy	Out- and inpatient care	https://klinik-ottakring.gesundheitsverbund.at/leistung/abteilung-fuer-kinder-und-jugendheilkunde-mit-ambulanz/
Vienna-Northeast								
Kinder- und Jugend-psychiatrie und Psychotherapeutische Medizin[23] *(Child and Adolescent Psychiatry and Psychotherapeutic Medicine)*	Klinik Floridsdorf – Wiener Gesundheitsverbund *(Clinic Floridsdorf – Vienna Health Association)*		x	Children and adolescents (until 18 years)	Diagnostics and therapy are interdisciplinary, i.e. many different professional groups are involved in the process	Medical care for temporary and long-term mental illnesses – outpatient and day hospital	Outpatient care, office based	https://klinik-floridsdorf.gesundheitsverbund.at/leistung/kinder-und-jugendpsychiatrie-ambulanz/

[22] With special outpatient clinics for eating disorders in childhood and adolescence, forensic and trauma diagnostics, clinical-psychological outpatient clinic, psychotherapeutic outpatient clinic and an outpatient clinic for transcultural psychiatry

[23] Special outpatient clinics in the Klinik Floridsdorf for children/adolescents with special needs and for early detection of juvenile psychoses

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Vienna-Centre-Southeast								
Kinderpsychologisches Zentrum *(Child Psychology Centre)*	Sigmund Freud Privatuniversität Wien *(Sigmund Freud Private University Vienna)*	x		Children	Psychologists	Diagnostic, counselling, therapy	Outpatient care, office based	https://psychologie-ambulanz.sfu.ac.at/de/kinderpsychologisches-zentrum/
Psychotherapeutische Universitätsambulanz Kinder und Jugendliche *(Psychotherapeutic University Outpatient Clinic for Children and Adolescents)*	Sigmund Freud Privatuniversität Wien *(Sigmund Freud Private University Vienna)*	x		Children and adolescents	Psychiatrists, psychologists, other specialised mental health workers	Counselling, therapy	Outpatient care, office based	https://ambulanz.sfu.ac.at/de/kinder-und-jugendliche/
Mental health community residential facility								
Vienna								
TRANSITION	Oasis Socialis gemeinnützige GmbH *(Oasis Socialis non-profit Ltd.)*	x		Adolescents and young adults (16-26 years)	Social workers, psychologists, occupational therapists, nurses, and other specialised mental health workers	Consultant psychiatric and multi-professional (full) care (housing project with 12 small flats)	Within the housing project	https://www.oasis-socialis.at/Unser-Angebot-TRANSITION/
TURN	Oasis Socialis gemeinnützige GmbH *(Oasis Socialis non-profit Ltd.)*	x		Adolescents (12-18 years)	Social workers, psychologists, occupational therapists, nurses, and other specialised mental health workers	Support mentally ill adolescent residents to lead a self-determined life (three residential groups with four social psychiatric care places each)	Within the housing project	https://www.oasis-socialis.at/Unser-Angebot-TURN/
TWiST	Oasis Socialis gemeinnützige GmbH *(Oasis Socialis non-profit Ltd.)*	x		Adolescents (12-18 years)	Social workers, psychologists, occupational therapists, nurses, and other specialised mental health workers	Professional (full) care for e.g. children and adolescents after a stay in a child and adolescent psychiatric ward (two residential groups with six social-psychiatric care places each for adolescents)	Within the housing project	https://www.oasis-socialis.at/Unser-Angebot-TWIST/
Vienna West								
WGFestland		x		Adolescents (14-18 years)	Psychologists, social workers, and other specialised mental health workers	Socio-educational, psychological and socio-therapeutic interventions	Within the housing project	https://wg-festland.at/jugendwohnheim-wien/#zielgruppe

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Mental health day treatment facility								
Vienna-Centre-Southeast								
Tagesklinik Kölblgasse[24] *(Day clinic Kölblgasse)*	Psychozosiale Dienste (PSD) Wien *(Psychocosial Services Vienna)*		x	Children and adolescents	Psychiatrist, psychologist, social worker, occupational therapist, other specialised mental health workers, nurses	The day clinic offers an extension of outpatient services if required and can be an alternative to inpatient admission	Office-based	https://psd-wien.at/einrichtung/kinder-und-jugendpsychiatrisches-ambulatorium-mit-tagesklinik
Vienna West								
Tagesklinik Hietzing – Extended Soulspace[25] *(Day clinic Hietzing – Extended Soulspace)*	PSD Wien *(Psychocosial Services Vienna)*		x	Children and adolescents (3-18)	Psychiatrist, psychologist, social worker, occupational therapist, other specialised mental health workers, nurses	Individual and group settings are used to implement therapy plans according to the respective needs	Office-based	https://psd-wien.at/einrichtung/kinder-und-jugendpsychiatrisches-ambulatorium-mit-tagesklinik-extended-soulspace
Mental health outpatient facility								
Vienna-Centre-Southeast								
Kinder- und Jugendpsychiatrisches Ambulatorium Kölblgasse *(Child and Adolescent Psychiatric outpatient department Kölblgasse)*	PSD Wien *(Psychocosial Services Vienna)*		x	Children and adolescents (3-18)	Psychiatrist, psychologist, social worker, occupational therapist, other specialised mental health workers, nurses	Medical treatment, support in personal, social and educational or professional development	Office-based, home treatment	https://psd-wien.at/einrichtung/kinder-und-jugendpsychiatrisches-ambulatorium-mit-tagesklinik https://psd-wien.at/einrichtung/kinder-und-jugendpsychiatrisches-ambulatorium-mit-tagesklinik-extended-soulspace
Psychotherapie, Beratung, Krisenintervention *(Psychotherapy, counselling, crisis intervention)*	Kinderschutzzentrum Wien *(Vienna Child Protection Centre)*	x		Children and adolescents	Psychologists, social worker, general practioner	Psychotherapy, counselling, intervention	Office-based	https://kinderschutzzentrum.wien/
Vienna-Northeast								
Ambulatorium für Kinder- und Jugendpsychiatrie *(Outpatient department for child and adolescent psychiatry)*	SOS-Kinderdorf *(SOS Children's Village)*	x		Children and adolescents	Psychiatrist, psychologist, social worker, occupational therapist, and other specialised mental health workers	Diagnostics and comprehensive treatment	Office-based	https://www.sos-kinderdorf.at/so-hilft-sos/wo-wir-helfen/europa/oesterreich/wien/ambulatorium-wien

[24] works together with the outpatient clinic of the PSD in the Kölblgasse.

[25] works together with the outpatient clinic of the PSD in Hietzing.

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Vienna								
Kinder und Jugend-psychiatrische und psychotherapeutische Versorgung[26] *(Child and adolescent psychiatric and psychotherapeutic care)*	Institut für Erziehungshilfe *(Institute for Educational Support)*	x		Children and adolescents	Psychiatrist, other specialised mental health workers	Diagnostic, therapy, counselling, intervention	Office-based	https://erziehungshilfe.org/konzepte/kinder-und-jugendpsychiatrie/
Ökids-Beratungstellen[27] *(Ökids advice centres)*	Ökids – Österreichische Gesellschaft für Kinder- und Jugend-psychotherapie *(Austrian Society for Child and Adolescent Psychotherapy)*	x		Infants, children, adolescents and their parents and families	Psychologists, social worker, other specialised (mental) health care workers	Child and adolescent psychotherapy with a focus on contact and relationship work between child and parents	Office-based	http://www.oekids.at/
Vienna West								
Kinder- und Jugendpsychiatrisches Ambulatorium Hietzing[28] *(Child and adolescent psychiatric outpatient department Hietzing)*	PSD Wien *(Psychosocial Services Vienna)*		x	Children and adolescents (3-18)	Psychiatrist, psychologist, social worker, occupational therapist, other specialised mental health workers, nurses	Medical treatment, support in personal, social and educational or professional development	Office-based, home treatment	https://psd-wien.at/einrichtung/kinder-und-jugendpsychiatrisches-ambulatorium-mit-tagesklinik https://psd-wien.at/einrichtung/kinder-und-jugendpsychiatrisches-ambulatorium-mit-tagesklinik-extended-soulspace
Ambulatorium für Kinder und Jugendliche in Krisensituationen *(Outpatient department for children and adolescents in crisis situations)*	Die Boje *(The buoy)*	x		Children and adolescents (until 18 years)	Psychiatrists, psychologists, and other specialised mental health workers	Crisis intervention, diagnostics, child neuropsychiatric treatment, short-term therapy, occasionally long-term therapy, group therapy and work with parents or caregivers	Office-based	http://www.die-boje.at/

[26] Four locations in Vienna

[27] Three locations in Vienna

[28] The Child and Adolescent Psychiatric Outpatient Centre with Day Clinic – Extended Soulspace in Hietzing places a special focus on the psychiatric treatment and care of children and adolescents of the Vienna Children's and Youth Welfare Services who are accommodated elsewhere. As an additional service, an acute day hospital, associated residential groups, liaison services, home treatment and liaison services are offered.

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Other residential facility								
Vienna West								
a_way	Caritas	x		Adolescents and young adults (14-20	Social workers	Emergency sleeping facility	Inpatient stay	https://www.caritas-wien.at/hilfe-angebote/obdach-wohnen/notschlafstellen/a-way
Clara Fey Wohnen für Kinder und Jugendliche *(Clara Fey Living for Children and Young People)*	Clara Fey der Schwestern vom armen Kinde Jesus *(Clara Fey of the Sisters of the Poor Child Jesus)*	x		Children and adolescents with and without disabilities	Doctors, therapists and social workers, other specialised (mental) health workers	Care and support	Inpatient stay	https://www.sozialwerke-clara-fey.at/wohnen-Kinder.html
Vienna								
Kinder- und Jugend-wohngemeinschaften[29] *(Residential communities for children and young people)*	Jugend am Werk *(Youth at work)*	x		Children and adolescents with and without disability	Other specialised (mental) health workers	Care and support for independence	Inpatient stay	https://www.jaw.at/de/kontakt/standortekiju
Primary health care clinic								
Vienna								
Primärversorgungszentren Wien[30] *(Primary care centres Vienna)*		x		All persons	Primary health care doctors, nurses, psychiatrist, psychologists, other specialised mental (health) care workers	Care and support	Outpatient care	https://primaerversorgung.gv.at/wien
Other Mental health and psychosocial support (incl. Preventionprogramms)								
Vienna-West								
BASTA	PSD Wien *(Pschosocial Services Vienna)*	x		School classes from the 10th grade	Person with psychiatric experience (experience expert) and a subject matter expert	reduction of prejudices against people with mental illnesses and psychiatric support facilities, increasing knowledge about mental illnesses, promoting an open and critical examination of prejudices	in schools and/or online	https://darueberredenwir.at/basta/

[29] With six locations in Vienna

[30] Eight locations in Vienna: Primärversorgung Küniglberg, Primärversorgung Josefstadt, Primärversorgungsnetzwerk Döbling, PVE Sonnwendviertel, Medizin Mariahilf – Primary Health Care, PVE – Meidling Regionalmedizinisches Zentrum, Primärversorgung Donaustadt – Ihre ERstversorgung und Hausarztordination, Medizin Augarten – Primary Halth Care

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Hemayat – Betreuungs-zentrum für Folter- und Kriegsüberlebende *(Care centre for torture and war survivors)*		x		All people who have suffered extreme trauma through torture or war[31]	Psychologist	Therapeutic support (with special therapy for children and adolescents)	Office-based	http://www.hemayat.org/hemayat-hilft/zielgruppe/kinder-und-jugendliche.html
Beratungstelle *(Counselling Centre)*	Courage – die Partner*innen-, Familien- & Sexual-beratungstelle *(partner, family & sexual counselling centre)*	x		People seeking advice and help on relationships and sexuality as well as violence and sexual assault	Psychiatrists, psychologist, social workers and other specialised mental health workers	Partner, family & sexual counselling	Office-based, online, telephone	https://www.courage-beratung.at/
Vienna								
Die Möwe		x		Children, young people and their caregivers	Psychologists, social worker, other specialised mental health workers	Concrete support and professional help in the event of physical, psychological and sexual experiences of violence	Office-based, by phone, online	https://www.die-moewe.at/
Talkbox	Stadt Wien *(City of Vienna)*		x	Children and adolescents	Psychologist	Support in everything that moves children and young people	E-mail	https://www.wien.gv.at/menschen/kind-familie/servicestellen/e-mail-beratung.html
Servicestelle der Kinder- und Jugendhilfe *(Service point for child and youth welfare)*	Stadt Wien *(City of Vienna)*		X	Families, children and adolescents, intern and extern cooperation-parterners	Social workers, other specialised (mental) health workers	Support, information,	Transfer to further assistance	https://www.wien.gv.at/menschen/kind-familie/servicestellen/servicestelle.html
Bahnfrei – Jugendarbeit auf der Straße…und auf Schiene! *(Rail-free – youth work on the road...and on rail!)*	Verein zur Förderung innovativer Jugend-arbeit im Stadtteil *(Association for the promotion innovative youth work in the district)*	x		Adolescents (12-20 years)	Social worker and other specialised mental health workers	For example: counselling, accompaniment in various activities (e.g. visits to authorities)	Mobile youth work	https://bahnfrei.at/

[31] With special therapy offers for children and adolescents

Name of service	Name of provider	Type of provider		Target group	Professional groups involved (support and care)	Type of support	Setting of service provision	Link
		Private, non-profit	Public					
Streetwork[32]	Rettet das Kind (Rdk) Wien *(Save the child Vienna)*	X		Adolescents (12-24 years) who spend most of their free time in public areas	Social workers and other specialised mental health workers	Various offers such as counselling and leisure and play activities	Mobile youth work	https://www.rdk-wien.at/streetwork.html
Cult.mobil[33]	Verein „Multikulturelles Netzwerk" *(Multicultural Network Association)*	x		Children and adolescents	Social workers	Counselling, psychosocial support	Mobile youth work	https://www.mk-n.org/Cult-mobil.html
Schulpsychologie *(School psychology)*	Bildungsdirektion Wien *(Vienna Department of Education)*		x	Pupils, teachers, guardians and leaders in the school system	Psychologists	Psychosocial counselling on various topics	Telephone, online, office-based	https://www.bildung-wien.gv.at/service/Schulpsychologie.html

Abbreviations: AKH – Allgemeines Krankenhaus; GmbH – Gesellschaft mit beschränkter Haftung; Ldt. – Linear Displacement Transducer; PSD – Psychosoziale Dienste; RdK – Rettet das Kind

[32] Save the child Vienna runs five street work facilities all year round on behalf of the City of Vienna and the districts of Hietzing, Liesing, Meidling and Wieden.

[33] Active in different areas in Vienna

Extraction tables of the national documents on CAMH strategies/models

Australia

Table A-5: Main characteristics of the included CAMH models/strategies from Australia

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Title of the model/strategy	Head to Health Kids National Service Model	The National Children's Mental Health and Wellbeing Strategy	Child and Adolescent Mental Health Service Model of Care
Publisher	Australian Government Department of Health and Aged Care	Australian Government	Australian Capital Territory (ACT) Government Health
Involved stakeholders	*Expert Reference Group:* ■ Mental Health, Department of Health and Aged Care ■ Community Child Health at the Royal Children's Hospital Melbourne ■ Child Health Research Centre, University of Queensland ■ National Workforce Centre for Child Mental Health, Emerging Minds ■ Autism Awareness Australia, Neurodevelopment Australia ■ MacKillop Family Services ■ Australian Psychological Society ■ Speech Pathology, Mental Health Program, Monash Health ■ Northern Territory Primary Health Network ■ National Mental Health Commission ■ RACGP Specific Interests Child and Young Person's Health Network ■ Lived Experience Representative, Mental Health Australia ■ Ngaoara (Aboriginal child and adolescent wellbeing) ■ Child and Adolescent Mental Health Services, Sydney Local Health District	*Expert Advisory Group/Steering Committee/Aboriginal and Torres Strait Islander Reference Group:* ■ Child Health Research Centre, University of Queensland Hospital and Health Service ■ Community Child Health, Royal Children's Hospital ■ National Mental Health Commission ■ Autism Awareness Australia ■ Melbourne Graduate School of Education ■ School of Psychology, University of Queensland ■ Parenting Research Centre ■ Maternal Child and Family Health Nurses Australia ■ Early Childhood Australia ■ Australian Institute of Family Studies ■ South Australia Health ■ Australian Primary Principals Association ■ ACT Health Directorate ■ Western Australian Mental Health Commission ■ Queensland Health ■ Victorian Department of Health and Human Services ■ Tasmanian Department of Health and Human Services ■ NSW Ministry of Health ■ Children's Commissioner Northern Territory ■ Australian Government Department of Health ■ Australian Government Department of Social Services ■ Australian Government Department of Education ■ Australian Human Rights Commission ■ Victorian Aboriginal Child Care Agency ■ Commissioner for Aboriginal Children and Young People ■ Public Health Medical AdvisorEducational, Clinical and Organisational Psychologist ■ General practitioner ■ Forensic Child Psychiatrist ■ Parent representative	The proposed Model of Care is the result of information collated from best practice guidelines, evidence based practice and workshops with key stakeholders, including young people, carers, clinicians and senior managers.

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Contracting entity/funding	Australian Government, Department of Health	Australian Government	Australian Capital Territory (ACT) Government Health
Language	English	English	English
Target users of the document	NR	NR	NR
Aim of the document	Through the 2021-22 Budget, the Australian Government has committed $54.2 million (over four years from 2021-22) to lay the foundations of a network of Head to Health Kids Hubs (Hubs) for children aged 0-12 years. *The Hubs will aim to:* ■ Provide comprehensive, multidisciplinary care which supports children and their families ■ Improve early intervention outcomes for children's mental health and wellbeing, and complement and enhance existing services provided to children and their families. The Hubs are planned to be developed and implemented in partnership with state and territory governments and are intended to complement and integrate with current child health and family services already provided in communities. The Hubs are designed to operate as a secondary level child mental health and wellbeing service, targeting mild to moderate emerging complexity.	The National Children's Mental Health and Wellbeing Strategy (the Strategy) provides a framework to guide critical investment in the mental health and wellbeing of children and families. There is nothing that will have more impact on improved mental health outcomes for all Australians than early intervention. Investing in the wellbeing of children and their families will have radiating benefits throughout our communities as well as through the broader health and education systems. The Strategy uses four focus areas to outline the requirements for an effective system of care for children, and seeks to create a new, shared understanding of the roles of families, communities, services, and educators in promoting and supporting child mental health and wellbeing.	Considerable work has been undertaken by ACT Health to inform the "Health Infrastructure Program" (HIP) a redevelopment of health infrastructure in the ACT. Funds have been allocated under the program for a number of initiatives including the design of inpatient services within Child and Adolescent Mental Health Service (CAMHS). As part of developing a Model of Care (MoC) for a health infrastructure, the CAMHS Redesign Project was undertaken in 2012. The project aimed to review all program areas within CAMHS to deliver a MoC based on contemporary service delivery to inform the health infrastructure design and to include young people in the 18 to 25 years age group.
Addressed age	0-12 years	Children (age not specified)	*Young people up to the age of 25 years:* ■ Childs (1-12 years) ■ Adolescents (11-18 years) ■ Young adults (17-25 years)
Key principles	Continuum-model, moving away from stigmatising or restrictive terminology, focus on child's functioning rather than a diagnosis, prevention focused, integration with local services, early intervention.	Child-centred, strenths-based, preventive focused, equity and access, universal system, evidence-informed best practice and continuous quality education, early intervention, needs based, not diagnosis driven.	Access (timely, no wrong door approach), person&family centred, collaboration and continuity of care, multidisciplinarity, recovery focused, safety and quality (evidence-based, ongoing development).
Components			
Professions, workforce qualification and development	■ Coordinating a network of skilled service providers across the Hubs and related services, including a community of practice and shared learnings. ■ Increasing the knowledge and capacity of the existing mental health workforce and creating more student and training rotations to develop and expand the workforce.	*Skilled workforce:* ■ Increased incentives for training in child and family mental health are required to encourage increased workforce participation, including in regional and remote areas. ■ Professional training and clear guidelines and processes should be developed for educators to follow when they believe a child or family is struggling. ■ Educators should be supported to undertake additional learning on mental health, including with paid protected time for participation. ■ All educators should have access to avenues for support for their own mental health and wellbeing.	*Multidisciplinary:* ■ A flexible and integrated multidisciplinary staffing model will enable staff to rotate between the adolescents and young adult sections of the service. Clinical leadership will be provided by the Psychiatrist of the service through the Clinical Director of CAMHS. ■ CAMHS inpatient services will offer a range of therapies by a range of disciplines including staff specialists, psychiatrists, registered nurses, and allied health staff. Allied health services such as dieticians and physiotherapists will be sourced from the CH&HS. Social workers, psychologists and occupational therapists will form an allied health team providing a range of interventions.

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Professions, workforce qualification and development *(continuation)*	■ Acknowledging the challenges of workforce availability, the Hubs should consider innovative approaches to address workforce shortages and access. This may include shared employment or secondment arrangements, access to specialist clinicians through telehealth, training rotations with appropriate supervision incorporated into the service delivery model and expanding the workforce scope broader than the traditional mental health and health workforce where this is able to meet service needs.	■ Introducing dedicated wellbeing staff and proactively promoting resources and support in education settings will assist educators to build positive wellbeing cultures.	■ The team will work collaboratively and participate in the multidisciplinary ward rounds to review the progress of young people in the unit. ■ CAMHS will offer a multidisciplinary approach to service delivery with a range of staff from different health professional disciplines. Care will be provided in a holistic manner taking into account the biopsychosocial needs of the child or young person. ■ Professional support and training will be available to all CAMHS staff to allow for interdisciplinary collaboration to provide evidence based care.
Involvement, user participation	■ The Model has been developed in consultation with an Expert Reference Group to support consistency in the establishment, implementation, monitoring, and evaluation of the Hubs as well as providing clear expectations regarding functions and quality of care. ■ Child–centred and family focussed – Focussed on the mental health, wellness, and safety of the child. Providing flexible, tailored care that considers the critical role and needs of the whole family.	■ Providing support based on genuine co-design with children and families involved in the design, delivery and evaluation of services ■ Those using services have a valuable and essential perspective for informing service delivery.	■ Collecting and using information from consumers and carers helps staff to deliver the kind of services that service users and the general community want. ■ Opportunities will be provided to make sure that service users are able to contribute to a range of activities – including evaluating care and treatment planning new services, staff training and education, and the development of information systems. These strategies are based on an established commitment to equality and to partnerships between consumers, carers and health professionals.
Information, awareness raising activities	Mental health literacy should be improved to assist families and services working with children to identify early signs that a child is struggling and to reduce the stigma that may prevent families from seeking help.	*Increased mental health literacy:* ■ Parents and carers may not recognise the signs of poor mental health in their child. ■ Signs that children are struggling can look different depending on developmental stage and may be impacted by culture and language background. ■ Increasing mental health literacy and reducing stigma must be supported by the whole community, and children must be supported to participate in conversations and decisions relating to their mental health. *Priority actions:* ■ Routine offering of evidence-based parenting programs at key developmental milestones ■ Emotional wellbeing modules embedded in antenatal and parenting courses ■ Widely accessible evidence-based resources building on existing initiatives ■ A national campaign promoting the value of parenting programs	The Mental Health Promotion Officer will provide health promotional activities to relevant community agencies to increase awareness of mental health issues to populations *most in need:* ■ Providing education and training sessions for schools, other elements of the education system and health and welfare sector and the general community ■ Organising education and training sessions when requested ■ Providing information and resources on mental health issues and illness ■ Working collaboratively to develop and implement mental health promotion programs ■ Offering consultation to the health, welfare and education sectors

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Prevention, mental health promotion	■ Strengths based – All services have a perspective that builds on the positive attributes of the child and family, building a holistic child and family centred approach.	*A wellbeing continuum:* ■ Importantly, beyond individual objectives and focus areas, the Strategy proposes a fundamental, cultural shift in the way we think about the mental health and wellbeing of children. This shift includes a change in language, adopting a continuum-based model of mental health and wellbeing. This moves away from terminology that may be stigmatising or too narrow to capture the full range of a child's emotional experiences. ■ The continuum approach highlights that there are opportunities to promote improved wellbeing and possibly intervene before a child becomes unwell. It also focuses on a child's functioning rather than diagnosis. For example, a child may have a diagnosed mental illness, but function well socially and educationally (i.e. 'coping'). Similarly, a child who is 'struggling' might not require a diagnosis, but would be experiencing a decline in their usual functioning or anticipated developmental trajectory. ■ All early childhood learning services and schools should have a wellbeing plan in place, tailored to meet the needs of their students.	*Early Intervention Program will provide the following functions:* ■ Early Psychosis Program – based on Early Psychosis Prevention and Intervention Centre Guidelines ■ Health Promotion Officer ■ Behavioral Interventions Program ■ Early Identification and treatment of children and young people presenting with early mental health issues
Detection, screening	Identifying and supporting children and families that are struggling or at increased risk of mental illness and behavioural disorders.	■ Proactive outreach procedures should be developed to respond to student disengagement, using trauma informed approaches. ■ Additional guidance is required to enable educators to discuss mental health concerns with parents and carers.	It was identified diagnosing children and adolescents are particularly difficult as difficult and disruptive behaviours may occur in the context of developmental growth. Therefore, in the context of the models of care, moderate and severe mental health presentations *can be identified as:* ■ Not based on diagnosis ■ Symptoms based ■ Should be based on level of dysfunction and its impact on functioning ■ Does not solely rely on a mental health diagnosis
Treatment	Providing an accessible, child centred, and family focused no cost service for children and their families experiencing challenges with their mental health and wellbeing. Ensuring eligibility for the service is not based on a child having a diagnosable mental illness; rather consideration is given to emotional wellbeing, behavioural and developmental challenges, physical symptoms, mental distress, and family functioning.	■ Services would be provided via a combination of face-to-face and telehealth approaches. In rural and remote areas and for families with limited financial resources, this needs to be accompanied by physical spaces in communities (such as community centres, GP clinics, or libraries) where telehealth services can be accessed with support. This is essential to mitigate barriers, including limited internet access or quality, affordability of internet enabled devices and unsuitable home environments. ■ Treatments that are more specialised (for example, interventions for highly traumatised children) would be provided in a limited number of locations. Because these locations would be networked across the country, those with specialised capabilities would undertake strategic	*CAMHS Inpatient Services:* ■ Initial Models of Care development for inpatient services within CAMHS highlighted the need for the services to be located on the CH&HS campus to retain close service integration with paediatric inpatient services and the AMHU. An analysis of the current supply and demand for inpatient beds for children and young people up to the age of 25 has been completed and incorporated into the planning of inpatient services within CAMHS. ■ CAMHS will continue to explore community options prior to making a decision on whether hospital admission is required. A multisystem and a multidisciplinary approach to care will be utilised for CAMHS inpatient services. CAMHS inpatient services will provide short term care and treatment in a safe and

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Treatment *(continuation)*		planning and provide targeted Support for other locations or service providers (such as GPs) to directly help the child/family; Support for the child/family directly using face-to-face or telehealth approaches depending on the nature of the support to be provided.	therapeutic environment to enable to focus on their recovery plans/goals. Medical, social and psychological approaches to managing symptoms and education for the young person, family and carers about their mental health and recovery will be part of the services provided. *Access:* ■ Via the emergency department ■ Directly from the CAMHS Community Teams ■ Transfer from other wards within CH&HS/Calvary Hospital ■ Direct transfers from other hospitals *Arrival/assessment/treatment initiation:* ■ Stabilisation ■ Treatment Planning ■ Treatment Engagement ■ Review Process ■ Therapeutic Interventions ■ Discharge planning *Specialist Day Program:* ■ Specialist assessments and programs (eg. Eating Disorders) ■ Family based therapy/programs ■ Clinical Management ■ Dialectical Behavioral Therapy ■ Open and Closed groups
Coordination			
Care pathways, integrated care/ health in all policies	■ Integrated – Supporting children and families to connect to pathways of care through integration with existing community child and family health and wellbeing services and school supports that are accessible and appropriate. Ensuring families experience services as part of a single pathway meeting their needs, with smooth transitions, including between health, education, and social care components. ■ Needs based – Service delivery based on the individual child and family's needs, with the focus on the child's functioning and a reduced focus on a clinical diagnosis to access services. ■ Providing multidisciplinary collaborative care between providers, both within the service ■ and with external services with clear protocols for sharing of information and care coordination. ■ Children and families will often access multiple service providers at the same time. Regular and comprehensive communication between providers is required to coordinate their care.	*Improved system navigation:* ■ A lack of clear, consistent information about where to seek help delays access to services and creates additional stress and burden for families. ■ Existing navigational tools should be expanded to assist families to find local supports. ■ A model of integrated family care should be established and networked across Australia. ■ The referral process between the locations with specialist services and those with more general services would be managed by staff, including outreach to families to ensure that there is continuity of care. *Collaborative care:* ■ Collaborative care is a model that relies on multiple service providers and family communicating about what a child needs. ■ Increases in collaborative care approaches are required to ensure everyone understands what they need to do to support the child and family.	*Key Partnership Groups:* ■ School Counsellors ■ General Practitioners ■ Headspace ACT ■ Alcohol and Drugs Services ■ Community Agencies ■ Private Mental Health Care Providers *Service relationships:* ■ The three service areas in CAMHS will work together to provide the best care for children and young people accessing CAMHS. Current mental health programs are aligned to a range of different services (eg. ADS) and utilise a MDT approach including social workers, RN's, psychologists, occupational therapists and psychiatrists. CAMHS clinicians will work collaboratively when young people require services from other providers or areas.

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Care pathways, integrated care/ health in all policies *(continuation)*	■ Evidence also shows improvements in health outcomes are best achieved through a coordinated and integrated child and family health system where primary, secondary, and tertiary services sit on a continuum that interfaces with the broader health system, education, and social service sectors.	■ Dedicated wellbeing staff should establish and maintain strong relationships with local service providers such as paediatricians and psychologists, to promote collaborative care. *Priority action:* ■ Trialling (networked) sites in both urban and rural areas of a service model of integrated child and family care that exclusively provides holistic assessment and treatment for children 0-12 years old and their families. ■ Promoting collaborative care: Enabling all providers (regardless of discipline) to claim for case conferencing; Enabling providers to claim for consultations with parents and carers (without the child present) as part of the child's care; Requiring providers to communicate with educators and other service providers about a child's treatment and support plan.	■ As an integrated mental health service, CAMHS will work collaboratively with all other areas to provide the best practice interventions for children and young people. If children and young people who access CAMHS require services that are not limited to CAMHS, care coordination principles will be applied. A coordinated management system between inpatient care and community is integral to CAMHS. This includes clinical managers and treating doctors being actively involved in the care of the child or young person whilst in the inpatient setting. Inpatient staff will also be actively involved in collaborating with community services to commence discharge planning at admission utilising a collaborative approach with all service providers (internal and external). *Access:* ■ Access into CAMHS will be via CAMHS Access which is embedded within the community teams. Once a referral is received by CAMHS a triaging process will occur and an initial assessment over the phone provided. If CAMHS is deemed as an inappropriate service, efforts will be made to link the person into an appropriate service. If further assessment is required, a full assessment will be offered with one of the community team clinicians at the first available appointment time. Following the full assessment a multidisciplinary team discussion will occur to determine the most suitable service to assist the child or young person. ■ Children 12 years and under who require an inpatient admission to hospital for mental health reasons will be admitted to the paediatric ward. Admission to the paediatric ward will be a joint decision between a CAMHS consultant psychiatrist and a consultant paediatrician. Children and young people, who are admitted into the paediatric ward for medical reasons and have a mental health issue, will have access to CAMHS support via the CAMHS Consultation Liaison clinician. After medical stabilization, and if a mental health admission is still required, arrangements will be made by between the CAMHS Psychiatrist and a bed booked via the Patient Flow Coordinator. CAMHS will continue to provide consultation liaison to the paediatric ward for any mental health concerns identified with inpatients on the ward.
Infrastructure, resources	Implementing place-based approaches to ensure services are accessible, culturally safe, and flexible to meet the needs of the local community with opportunity for the development of innovative approaches.	■ Allocating specific funding for care coordination for children and families with complex needs. ■ Providing funding to implement quality improvement activities and delivery of evidence-based programs targeting needs identified in wellbeing plans	*CAMHS Community Teams:* ■ Child Community Team (1-12 years old) ■ Adolescent Community Team (11-18 years old) ■ Young Adult Team (17-25 years old)

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Infrastructure, resources *(continuation)*			■ Step Up Step Down- Adolescent (13-18 years) and Young Adult (18-25 years) ■ Bimberi Youth Forensic Mental Health (through Forensic Mental Health)
Implementation strategy, process	Jurisdictional and regional planning of each Hub may require a review of the current service system from the lens of the continuum model. This is to identify opportunities for integration with the local services and address gaps, with the aim of intervening early on the continuum. Integrating with local services related to the mental health, safety and wellbeing of children including – child protection, universal child health services, child development services, perinatal/child/youth mental health services, education, early childhood education and care services. A phased approach to implementation and integration of the Hubs is proposed: ■ An establishment phase ■ An embedding phase ■ A full operational phase Clinical governance and accountability – appropriate governance to ensure quality standards and clinical competence and reporting requirements are maintained and responded to.	■ For this Strategy to have the intended impact on children's mental health and wellbeing, it must be acted on. To this end, we recommend the Commission establish a National Steering Committee, with representation from across relevant Commonwealth Government portfolios (such as health, education and social services), Aboriginal & Torres Strait Islander representatives, implementation experts, and people with expertise in the provision of child mental health supports and treatment. This Steering Committee would be time limited and support the Commission to develop an implementation plan and initiate the process of monitoring progress against the relevant indicators of change. Input should be sought from parents, carers, children and young people as required. Indicators of change should measure the impact of the strategy in a way that takes geographical location and specific population groups into account, to determine equity of impact. Indicators are also not intended to exclude the use of qualitative data, and/or other measures of quality improvement from the child and family perspective, such as reduction in distance travelled or being able to see the same practitioner for an extended period. ■ To assist with implementation planning, we recommend Inter-Departmental Committees (IDCs) be established at the Commonwealth level as well as within each jurisdiction. Each IDC should regularly (such as every 3 years) report to the Commonwealth and State and Territory Health Ministers on their progress against each of the objectives, with an independent organisation monitoring the proposed indicators of change nationally. The final indicators used and the frequency of reporting should be determined through agreement between the data custodians and IDCs. *Priority action:* ■ Requiring all government departments to outline and regularly report on what they do to support children in State care, including providing priority access to relevant services. ■ Having a designated wellbeing staff member in all early childhood learning services and primary schools who is responsible for planning and co-ordinating wellbeing activities, including the development of wellbeing plans	NR

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Data acquisition, research	■ The Hubs provide a unique opportunity for research to support innovation, improvements to clinical practice and service delivery models. ■ Evidence-informed best practice and continuous quality evaluation – Using data, evidence, research, and child and family experience of care and feedback indicators to create a continuous feedback loop between research, clinical practice and the outcomes for children and families. ■ The establishment and implementation of the Hubs will be nationally evaluated to generate new evidence and to guide any future expansion of this initiative or amendment to this Model. In addition, it is expected that the Hubs will report on and undertake evaluation of the outcomes and experiences for children, families, professionals, and partnering services.	*Meaningful data collection:* ■ Children's mental health is an area where key population data are missing and there is currently no regular national data collection or reporting regarding children's overall mental health and wellbeing. ■ Increased and diversified data collection needs to be undertaken to inform delivery of programs and services. ■ Only a small number of programs have robust evaluation embedded into program design. Service providers should be required to build evaluation into their programs. ■ Evaluations are most useful when they focus on the key outcomes that are important and meaningful to the children and families who have used a service. *High-quality research:* ■ Unlike youth mental health, there have been no national reforms or a framework for research focused on children in Australia. There is also an overall lack of community consultation and trials in child mental health. ■ Current ethics processes often make research with children challenging. Concerns around the vulnerability of children as a cohort could be better managed through including children and families in the development of research. *Priority actions:* ■ Establishing Inter-Departmental Committees to resolve current barriers to relevant data sharing across sectors such as education, justice and community health, for the purposes of informing child mental health and wellbeing ■ Embedding evaluation in program and service delivery from the beginning, with reporting of findings required to receive further funding ■ Including implementation evaluation as a core component of programs delivered in schools and early childhood learning settings to identify what is required to ensure fidelity ■ Funding parity for child mental health research and child physical health ■ Targeted funding allocated on the basis of priorities including gaps in current treatment knowledge and the needs of priority populations	■ The future child and adolescent mental health service model of care will include ongoing provision of teaching and contemporary and innovative research across child and adolescent mental health services.

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Additional characteristics			
Digitalisation for management and documentation	■ The Commonwealth Department of Health has developed a national initial assessment guidance and digital decision support tool (IAR). The IAR supports clinicians to assess and determine the need for referral when consumers present in a primary care setting for mental health assistance. The tool has been adapted for use with children (5-11 years) and youths. This tool may be used to assist referrals of this age group from primary care to the Hubs.	NR	*Web Based Bed Management System:* ■ A web based bed management tool has been developed by MHJHADS to provide a 'snapshot' on all mental health beds (acute and sub-acute) within the Division for patient flow coordinators. A decision for hospital admission will be made in collaboration with the young person, carer, psychiatrist and clinical manager. An inpatient bed will be booked via the patient flow coordinator for the division who has access to the web based bed management tool. If a hospital bed is unavailable in AMHU, information regarding vacancies in other areas such as the Step up Step down Programs or other Inpatient Units of MHJHADS can be ascertained. *Data Management System:* ■ The Mental Health Assessment Generation Information Collection (MHAGIC) system is a comprehensive electronic medical record system built around the workflow of mental health practitioners. This system has a complete coverage of all aspects of mental health management to ensure accuracy and consistency of the assessments, outcome measures and clinical documentation. ■ This software program supports the effective communication of clinical information when presenting to the public mental health system in Canberra including the ED's at CH&HS and Calvary Hospital. ■ Information provided by accessing MHAGIC can facilitate clinical decision-making and the efficient flow of clinical information. ■ Staff receive training on MHAGIC and any MHAGIC breach reports concerning confidentiality are monitored by the MHAGIC support team and action is taken by senior management consistent with ACT Government IT policy.
Digitalisation for telehealth, detection and intervention	■ Individual sites will need to consider the mode of delivery to best meet the population requirements including in-house (at the Hub), out-reach and telehealth services.	■ Telehealth services are also an important adjunct to face-to-face service delivery. However, there are currently restrictions on who can access telehealth services (i.e. specific postcodes) and which professionals can deliver services (for example, nurse practitioners cannot access Medicare-funded telehealth items). Given the success of this measure during the COVID-19 pandemic, it is an optimal time to continue to build expertise in delivering telehealth services effectively, as well as expanding their availability. There is growing confidence between service providers and service users with this modality of care, and a recent senate committee recommended that telehealth items introduced during the pandemic become permanent.	NR

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Digitalisation for telehealth, ... *(continuation)*		*Priority action:* ■ Trialling sites with innovative service delivery models that integrate face-to-face and telehealth consultations, digital interventions, and phone helplines.	
Vulnerable patient groups (e.g. Transcultural care)	Research indicates there are cohorts of children who are at increased risk of mental ill health and behavioural disorders: ■ experienced child protection and out of home care systems ■ family member with a mental illness or disability, or substance use issues ■ living in an environment of high family conflict ■ have experienced trauma ■ disability or chronic illness ■ Aboriginal and Torres Strait Islander children ■ refugee or asylum seeker status or who have recently migrated ■ social or economic disadvantage The Hubs should be developed and co-designed to support and prioritise access to services and resources for vulnerable and/or at-risk children and families. For Aboriginal and Torres Strait Islander families, culturally and linguistically diverse populations and LGBTIQ+ families, this will also include culturally safe healing and social and emotional wellbeing services. Consideration should be given to planning and delivery of language services including translated in languages other than English and plain English materials and interpreting services. ■ Equitable and inclusive – a no-cost, welcoming, compassionate, culturally safe, and appropriate environment that is inclusive for all children, families and carers accessing services or supports.	*Built for complexity:* ■ Children with complex needs are more likely to be turned away from support, as providers may not have the skills or resources required. ■ Priority access should be given to at-risk cohorts, including children in, or at-risk of entering, State care or in contact with the justice system. ■ Aboriginal Community Controlled Organisations should deliver supports for Aboriginal and Torres Strait Islander communities wherever possible.	NR
Transitional psychiatry	Hubs will be cognisant of the different services/systems involved at these different phases of the child's development and ensure that transitions are smooth, supported, and informed.	Age thresholds for different services don't allow smooth transitions in care from childhood into adolescence, and later into adulthood. For example, infant mental health (0-4 years) can be a source of relatively consistent care via a single service, however children are then ineligible to continue with the service when they reach school. For young people who have been receiving care via Child and Adolescent Mental Health Services (CAMHS), the shift to adult mental health services can be jarring. The timing of transition is often seen by young people as arbitrary and misaligned with their needs and developmental stage. ■ Consideration should be given to the transition between child and adult services. ■ Examine how policy, services and implementation affect transition from childhood to adulthood in the healthcare system, and redesign to allow for a seamless transition.	The division of children and young people in the above age group is appropriate given the needs of each age group. The rationale for the overlapping of age group in each of the community teams is to ensure flexibility for each team to accept children or young people who fall between the age groups to reduce the stress of transitioning to different teams.

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Conclusion			
Conclusion of the document	To meet the key elements of this Model there are core services that all Hubs will be expected to provide in line with funding frameworks: ■ Access and Referral ■ Initial Assessment ■ Treatments and Therapies ■ Care Coordination ■ Supported Transition ■ Workforce	The Strategy provides clear pathways for proactively promoting child wellbeing and helping those who are struggling as early as possible to reduce long-term impacts of poor mental health. The Strategy adopts a broad scope to consider all settings in which children should be supported. ■ Child-centred ■ Strengths-based ■ Prevention-focused ■ Equity and access ■ Universal system ■ Evidence-informed best practice and continuous quality evaluation ■ Early intervention ■ Needs based, not diagnosis driven *The strategy contains four focus areas:* ■ Family and Community ■ The Service System ■ Education Settings ■ Evidence and Evaluation	The future Child Adolescent and Youth Mental Health Service (CAMHS) Model of Care will include: ■ The provision of CAMHS across the spectrum of: Promotion/prevention and early intervention; A range of treatment modalities that focus on recovery ■ The service is flexible and responsive for children and young people with a moderate to severe mental health presentations. ■ CAMHS operates in a highly responsive manner, providing assessment, treatment, consultation, support/outreach to the ACT community which includes specialised inpatient and subacute facilities. ■ Seamless transitions across each program/service to ensure continuity of care. ■ The division of CAMHS into three streams: community, inpatient, specialist. ■ The division of CAMHS community teams into 3 teams: Child Team (1-12 year olds), Adolescent (11-18 years old) and Young Adult Team (17-25 years old). ■ An appropriately skilled workforce where staff can work within their scope of practice. ■ Collaboration with stakeholders to ensure best practice and outcomes for children and young people. ■ A Perinatal and Infant Mental Health Consultation Service (PIMHCS). ■ Consideration for appropriate inpatient facilities to best meet developmental and acute mental health needs. ■ A health promotion officer to provide mental health promotion and secondary consultation to government and community agencies. ■ A youth worker embedded in the CAMHS community team to engage young people into CAMHS for therapy. ■ A behavioural intervention program for the early identification and management of young people presenting with conduct disorders. ■ An ACT wide Early Intervention Program to include a specialist Early Psychosis Program. ■ Capacity for peer support work involving a consumer consultant who has a lived experience in supporting young people experiencing a mental illness. ■ Ongoing provision of teaching and contemporary and innovative research across CAMHS.

Country, year (reference)	Australia, 2022 [120]	Australia, 2021 [121]	Australia, 2013 [122]
Conclusion of the document *(continuation)*			*Services provided by CAMHS will include:* ■ Early Intervention ■ Trauma informed care ■ Individual and family based therapeutic support ■ Family therapy ■ Early Psychosis Prevention and Intervention ■ Outreach to other services ■ Health Promotion ■ Inpatient Services ■ Consultation Liaison ■ Perinatal and Infant Mental Health ■ Eating Disorders ■ Dialectical Behavioral Therapy ■ Therapeutic Group Programs *Based on the services provided, it was identified that CAMHS be divided into 3 streams:* ■ Community ■ Inpatient/Acute ■ Specialist Services
Additional relevant document(s)			
Title of the document(s)	■ The Royal Commission into Victoria's Mental Health System Final Report, 2021: https://finalreport.rcvmhs.vic.gov.au/download-report/ ■ Children's Strategy, Mental Health: Productivity Commission: Inquiry Report, 2020: https://mhaustralia.org/our-work/productivity-commission-inquiry ■ National Action Plan for Children and Young People 2020-2030, 2019: https://www.health.gov.au/sites/default/files/documents/2021/04/national-action-plan-for-the-health-of-children-and-young-people-2020-2030-national-action-plan-for-the-health-of-children-and-young-people-2020-2030.pdf ■ Revision of the National Framework for Protecting Australia's Children 2009-2020, 2009: https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf		

Abbreviations: NA – not available, NR – not reported

Switzerland

Table A-6: Main characteristics of the included CAMH models/strategies from Switzerland

Country, year (reference)	Switzerland, 2020 [123]	Switzerland, 2016 [124]	Switzerland, 2016 [125]	Switzerland, 2015 [126]
Title of the model/strategy	Care pathways in psychiatric-psychotherapeutic care for children and adolescents – SPD Basel (*„Versorgungspfade in der psychiatrisch-psycho-therapeutischen Versorgung von Kindern und Jugendlichen – SPD Basel*“)	The future of psychiatry in Switzerland (*„Die Zukunft der Psychiatrie in der Schweiz*“)	Intended measures on mental health in Switzerland (*„Beabsichtigte Massnahmen zur psychischen Gesundheit in der Schweiz*“)	Mental health in Switzerland, stocktaking and fields of action (*„Psychische Gesundheit in der Schweiz, Bestandsaufnahme und Handlungsfelder*“)
Publisher	■ Swiss Confederation ■ Federal Office for Health ■ Department of Education of the Canton of Basel-Stadt	■ Swiss Confederation	■ Swiss Confederation	■ Swiss Confederation ■ Swiss Conference of Cantonal Directors of Public Health ■ Health Promotion Switzerland
Involved stakeholders	■ Psychologists ■ School psychology service ■ Educators ■ Social workers ■ Pediatricians ■ Psychiatrists ■ Psychotherapists ■ University psychiatric clinic	■ Swiss health observatory ■ Federal statistics office ■ Federal office of public health ■ Experts from science, administration and practice	■ Federal office of public health ■ Conference of cantonal directors of public health ■ Swiss health promotion ■ Expert group of the mental health networks ■ National health policy dialogue ■ Swiss health promotion foundation	■ Federal office of public health ■ Conference of cantonal ministers of health ■ Swiss health promotion foundation ■ National health policy dialogue
Contracting entity/Funding	Federal Office of Public Health, Promotion Programme Interprofessionalism in the Health Sector	The Federal Assembly – The Swiss Parliament	Committee for Social Security and Health of the Council of States	Dialogue National Health Policy
Language	German	German	German	German
Target users of the document	NR	Scope of responsibility or regulation of the federal government	NR	NR
Aim of the document	The overall aim of the study is to identify weaknesses in the care of children and adolescents with mental health problems and to develop models of good practice with a supraregional exemplary character. In addition, limits and possibilities of interprofessional cooperation in the current framework conditions were to be identified and optimisation proposals developed.	*The following guiding questions were central to the development of the report:* ■ What characterises mental illnesses, how frequent are they and what are their consequences? ■ What are the possibilities and forms of treatment for mental illnesses and how often are treatments used? ■ What is the legal framework for psychiatry? What service structures exist in Switzerland and how are the services provided paid for? ■ How is the shift from inpatient to outpatient service structures developing in Switzerland? ■ How are the interfaces between psychiatry and other areas of society structured?	No brief description available. (*Am 3. Mai 2013 hat die Kommission für soziale Sicherheit und Gesundheit des Ständerats das Postulat 13.3370 “Beabsichtigte Massnahmen zur psychischen Gesundheit in der Schweiz“ eingereicht und am 11. Juni 2013 wurde es vom Ständerat angenommen. Das Postulat fordert, dass der Bundesrat aufzeigt, wie er das umfassende Monitoring des Schweizerischen Gesundheitsobservatoriums (Obsan) “Psychische Gesundheit in der Schweiz“ aus dem Jahr 2012 einschätzt und welche konkreten Massnahmen er zu ergreifen gedenkt. Die Anliegen der Petition 12.2037 “Psychische Gesundheit. Für uns alle – gegen Ausgrenzung“ des Vereins „Aktionsbündnis Psychische Gesundheit“ sollen dabei bei der Beantwortung des Postulats berücksichtigt werden.*)	The report focuses on the promotion of mental health, prevention and early detection of mental illnesses and their interfaces with health care.

Country, year (reference)	Switzerland, 2020 [123]	Switzerland, 2016 [124]	Switzerland, 2016 [125]	Switzerland, 2015 [126]
Addressed age	Children and adolescents.	All age groups.	All age groups.[34]	All age groups.
Key principles	NR	NR	Mental health promotion, prevention and early detection of mental illnessess and their interfaces within healthcare.	Mental health promotion, prevention and early detection of mental illnessess and their interfaces within healthcare.
Components				
Professions, workforce qualification and development	A comparatively high presence of the school psychology service in the schools by means of bi-weekly schoolhouse consultation hours has already been implemented.	For the next five to ten years, however, a shortage of doctors with the specialist title "psychiatry and psychotherapy" or "child and adolescent psychiatry and psychotherapy"" is expected, who have the same socio-cultural background as their patients. ■ Supporting the qualification of professionals in the field of psychiatry	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.
Involvement, user participation	Good cooperation between parents and the professionals involved was repeatedly mentioned as facilitating the psychiatric-psychotherapeutic care pathway. It is clear that parents have a great responsibility in the care pathway from the recognition and acceptance of their children's psychological difficulties to the installation of optimal psychiatric-psychotherapeutic treatment. *Recommendation for action:* ■ Information for parents on counselling and therapy options: Parents should be informed about counselling and therapy options in simple, understandable language. Flyers of the corresponding offers should be handed out in different languages.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.
Information, awareness raising activities	*Reduce stigma and inhibitions towards mental health problems and their treatment methods:* ■ Raising public awareness of mental health problems/stigma reduction ■ Parental counselling and information for parents on counselling and therapy options ■ Low-threshold access to school social work and school psychology ■ Create low-threshold support services	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.

[34] Monitoring provides an overview of the mental health of the Swiss population, the prevalence of mental illnesses and the availability and use of psychiatric care structures. However, the data situation is patchy. For example, no statements can be made on the mental health and psychiatric care of children and adolescents.

Country, year (reference)	Switzerland, 2020 [123]	Switzerland, 2016 [124]	Switzerland, 2016 [125]	Switzerland, 2015 [126]
Prevention, mental health promotion	Especially in the case of exhausted family systems, early referral to support services is central to preventing the development of mental health problems.	The national prevention programmes "Youth and Violence" and "Youth Media Protection and Media Competences" have been implemented since 2011. Media literacy, in the sense of conscious and responsible use of media, is an important aspect of mental health.	The Swiss Health Promotion Foundation will implement or finance a substantial part of the measures in the report "Mental Health in Switzerland". To this end, it will set up cantonal action programmes on mental health. Central implementation elements will be the cantonal action programmes: Networking measures, public relations work, interventions in the target groups (young children, schoolchildren, young adults and older people) and their sustainable dissemination and anchoring will be linked with each other in the respective canton itself, but also among the cantons.	Not reported specific for child and adolescent mental health.
Detection, screening	*Detection of mental health problems:* ■ The results of this study indicate that the recognition of mental abnormalities in pupils by school professionals in the canton of Basel City works relatively well. ■ Due to their proximity to the school, specialists in school social work and school psychology can recognise critical developmental paths or risk constellations and intervene at an early stage. A model of good practice can be derived from this.	Since 2014, a monitoring of the health of children and adolescents has been in clarification within the framework of the project "Child and Adolescent Health", which is also to cover mental stress and mental illnesses.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.
Treatment	*Expansion of psychotherapy services that are covered by basic health insurance:* ■ Improving the coverage of psychiatric-psychotherapeutic needs. Paradigm shift to the prescription model[35]	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.
Coordination				
Care pathways, integrated care/ health in all policies	However, an even stronger integration of school psychology, school-based therapy services and schools would be very desirable for special school programmes that educate children with severe mental health problems or for certain rural regions. *Improve transitions and interprofessional cooperation:* ■ Qualitative improvement of transitions on the basis of concepts.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.

[35] Delegation model: therapists work under medical supervision. Prescription model: psychological psychotherapists can provide their services independently on a doctor's order within the framework of compulsory health insurance – the prerequisite is an appropriate qualification and a professional licence from the canton [https://www.admin.ch/gov/de/start/dokumentation/medienmitteilungen.msg-id-82745.html].

Country, year (reference)	Switzerland, 2020 [123]	Switzerland, 2016 [124]	Switzerland, 2016 [125]	Switzerland, 2015 [126]
Care pathways, integrated care/ health in all policies *(continuation)*	■ Monitoring of therapy installation by school psychology service ■ Case management/examination of a coordination office ■ Administrative facilitation such as referral forms ■ Targeted preparation of the family for psychotherapy ■ Focus on school home presence ■ School-related therapy offers for special school settings *Networking at different levels:* ■ Organisation of networking events or specialist exchange meetings ■ Networking at institutional management level ■ Networking between different professional groups ■ Strengthening cooperation between the psychiatric-psychotherapeutic child/adolescent sector and the adult sector ■ Maintaining information feedback from the therapeutic setting *Perspective of school social workers:* ■ The various prevention projects in the area of mental health from providers outside the school currently take place in a poorly coordinated manner and lead to confusion.			
Infrastructure, resources	*Remuneration of interprofessional cooperation:* ■ Recognition and remuneration of system work ■ Adjustment of the Tarmed billing system (better orientation towards the treatment of children and adolescents with mental disorders). *Improving the care situation for complex cases:* ■ Expansion of the range of therapies for complex cases offered by institutional providers. Change in the billing of complex cases	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	In addition, the Confederation can grant financial assistance based on the Act on the Promotion of Extracurricular Child and Youth Work (Kinder und Jugendförderungsgesetz KJFG). One of the aims of the law is to promote the mental well-being of children and young people. Furthermore, the Federal Social Insurance Office, together with partners, implements youth protection programmes in the area of violence prevention as well as in youth media protection.
Implementation strategy, process	NR	The analysis of the cantonal psychiatric planning concepts shows that the outpatient and intermediate care structures are by no means taken into account by all cantons when planning inpatient psychiatric care. The service structures for mentally ill patients are still strongly oriented towards the two classical poles of outpatient (consultation hours) and inpatient services.	Not reported specific for child and adolescent mental health.	In the canton of Zurich, further measures are currently being implemented in the area of counselling and treatment for specific target groups, such as the project wikip project for children of mentally ill parents and the Zurich Impulse Programme for the Sustainable Development of Psychiatry (ZinEP).

Country, year (reference)	Switzerland, 2020 [123]	Switzerland, 2016 [124]	Switzerland, 2016 [125]	Switzerland, 2015 [126]
Implementation strategy, process *(continuation)*		However, the report showed that the intermediary service structures have doubled within ten years and that new approaches to needs-oriented treatment and care for mentally ill patients could be demonstrated in local model projects. However, the local model projects often could not be sustainably transferred into new service structures or implemented in other cantons.		
Data acquisition, research	As a preliminary study, the present qualitative study intends to set the focus for a subsequent, representative study. Based on the results of this study, the investigation of inequalities of opportunity in the care pathway of children and adolescents from psychosocially and economically disadvantaged families seems to be central.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.
Additional characteristics				
Digitalisation for management and documentation	Improving networks and interprofessional collaboration: Technological tools such as videoconferencing	NR	NR	NR
Digitalisation for telehealth, detection and intervention	NR	NR	NR	NR
Vulnerable patient groups (e.g. Transcultural care)	*Improve care for vulnerable client groups:* ■ Expand therapeutic services in the early intervention sector. ■ Intensify training in the area of internalising disorders and mental retardation ■ Funding interpreters for foreign language speaking families *Ensure that children of psychosocially and economically burdened families do not experience any disadvantage in care:* ■ Concepts and measures to reduce inequality of opportunity. ■ Redistribute existing psychological-therapeutic resources in favour of psychosocially and/or economically burdened families. ■ Putting the focus of training on vulnerable groups ■ Expansion of multifamily work	For the next five to ten years, however, a shortage of doctors with the specialist title "psychiatry and psychotherapy" or "child and adolescent psychiatry and psychotherapy", who have the same socio-cultural background as their patients, is predicted.	The existing cantonal action programmes for children and young people will be expanded to include the topic of mental health. The focus will also be on children and adolescents from the asylum and refugee sector as well as other traumatised persons.	Certain population groups are at higher risk of developing a mental health condition. These include: Elderly people, migrants and their children, asylum seekers, single parents and their children, disabled people, relatives of mentally ill people, people who are victims of violence, the unemployed and recipients of social assistance.

Country, year (reference)	Switzerland, 2020 [123]	Switzerland, 2016 [124]	Switzerland, 2016 [125]	Switzerland, 2015 [126]
Transitional psychiatry	NR	NR	In field of action 2 (implementation of activities in the areas of health promotion, prevention and early detection), the aim is to better support transitions between phases of life and critical life events, and existing measures and services are better coordinated and optimised.	Depending on the phase and transition, different sectors or settings as well as reference and specialist persons are important. For example, in the case of psychological problems in childhood, the paediatrician or the school psychology service, and in adulthood, the family doctor or, in larger companies, the industrial psychologist are possible contact persons.
Conclusion				
Conclusion of the document	The greatest need for improvement is in the care of psychosocially and/or economically disadvantaged and resource-poor families. Children from these families are not only more likely to develop a mental disorder and receive less support from their parents, they are also affected by longer waiting times, more frequent treatment discontinuations and less favourable cooperation between parents and professionals in the psychiatric-psychotherapeutic care pathway. In order to improve the general quality of care in Switzerland, it seems indispensable to focus care more on families with few resources and to provide services that counteract the existing disadvantages.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.	Not reported specific for child and adolescent mental health.
Additional relevant document(s)				
Title of the document(s)	■ The impact of the COVID-19 pandemic on the mental health of the Swiss population and psychiatric-psychotherapeutic care in Switzerland („Der Einfluss der COVID-19-Pandemie auf die psychische Gesundheit der Schweizer Bevölkerung und die psychiatrisch-psychotherapeutische Versorgung in der Schweiz"), 2021: https://www.bag.admin.ch/dam/bag/de/dokumente/psychische-gesundheit/covid-19/covid-19-psychische-gesundheit-schlussbericht.pdf.download.pdf/covid-19-psychische-gesundheit-schlussbericht.pdf ■ Suicide prevention in Switzerland – initial situation, need for action and action plan („Suizidprävention in der Schweiz – Ausgangslage, Handlungsbedarf und Aktionsplan") 2016: https://www.bag.admin.ch/dam/bag/de/dokumente/psychische-gesundheit/politische-auftraege/motion-ingold/bericht_suizidpr%C3%A4vention.pdf ■ National Strategy on Addiction 2017-2024 („Nationale Strategie Sucht 2017-2024"), 2015: https://www.bag.admin.ch/dam/bag/de/dokumente/nat-gesundheitsstrategien/nationale-strategie-sucht/stategie-sucht.pdf			

Abbreviations: NA – not available, NR – not reported

Czechia

Table A-7: Main characteristics of the included CAMH models/strategies from Czechia

Country, year (reference)	Czechia, 2020 [127]
Title of the model/strategy	National Mental Health Action Plan *(NAPDZ – NÁRODNÍ AKČNÍ PLÁN PRO DUŠEVNÍ ZDRAVÍ 2020-2030)*
Publisher	Office of the Government of the Czech Republic *(Úřad vlády České republiky)* Ministry of Health of the Czech Republic *(Ministerstvo zdravotnictví České republiky)*
Involved stakeholders	■ Psychiatric society ■ Institute of health information and statistics ■ Executive committee of psychiatry reform ■ Ministry of finance ■ Ministry of health ■ National institute of mental health ■ General health insurance company ■ Psychiatric section of the czech nurses association
Contracting entity/Funding	Ministry of Health of the Czech Republic *(Ministerstvo zdravotnictví České republiky)*
Language	Czech
Target users of the document	NR
Aim of the document	The National Action Plan for Mental Health 2030 (NAPDZ) is an implementation document of three strategic documents. It sets out specific procedures for the implementation of those parts of the Mental Health Care Reform Strategy 2013-2023 (MoH, 2013) where there are obvious implementation deficits. It is one of the implementation documents of the Strategic Framework of the Czech Republic 2030 approved by the Government of the Czech Republic (MoH, 2017) and last but not least, it elaborates a specific area of the parallel Strategic Framework for the development of health care in the Czech Republic until 2030 "Health 2030".
Addressed age	All age groups, subchapter for children and adolescents
Key principles	Not reported specific for children and adolescents.
Components	
Professions, workforce qualification and development	■ Develop the competences of the education workforce (school teaching staff) and school counselling centres, regional school coordinators) in the field of prevention and promotion of children's mental health through further training and providing methodological guidance in this area. Reason for inclusion of the measure: The WHO recommends the inclusion of school-based programmes on psychosocial skills applied by teachers in schools. To be implemented, this area should be included in the further education of teachers and to establish a system of regionally available methodological guidance.
Involvement, user participation	Not reported specific for children and adolescents.
Information, awareness raising activities	■ Introduce specialised programmes aimed at developing parenting skills – especially for families under psychosocial stress (parents with intellectual disabilities, mental illness, addictions, adolescents, etc.) in order to reduce the risk of traumatisation of children. Pilot testing of the Triple P programme and subsequent implementation in the scope of services in the area of support for families with children.
Prevention, mental health promotion	■ Incorporate themes of psychosocial education and management of student behaviour into the common core of the undergraduate training of teaching staff. Reason for inclusion of the measure: Prevention in the Czech Republic focuses primarily on secondary phenomena such as bullying and truancy. However, universally targeted prevention focused on mental health is not systematically available. The WHO recommends the inclusion of school programmes focusing on psychosocial skills, applied by teachers, as part of pathology prevention. This recommendation should be taken into account in the framework of professional training for teaching staff. ■ Revise the inclusion of psychosocial literacy in the framework education programmes for kindergartens, primary and secondary schools. Develop and implement a validated programme to support psychosocial education in primary schools. Reason for inclusion of the measure: WHO recommends the inclusion of school-based psychosocial literacy programmes skills applied by teachers in schools; In order to meet the recommendation, this area needs to be implemented in the professional development programmes of teachers in kindergartens, primary and secondary schools. Moreover, the measure is fully in line with the National Strategy for Primary Prevention, which already covers the level of general prevention in the school environment. The measure fulfils this strategy at its core, which is the development of psychosocial competences and emotional literacy at the level of primary and secondary schools as an important condition for functional social behaviour of children and the prevention of behavioural disorders at an older age.

Country, year (reference)	Czechia, 2020 [127]
Detection, screening	Establish and pilot a system for early identification/deprivation of children in psychosocial children at risk, paying special attention to children at the earliest age. Suggest a model for the early detection of women with psychosocial distress during pregnancy and after childbirth, or mental illness. Develop recommended procedures for multidisciplinary collaborative approach and subsequent support for engagement of the child at psychosocial risk, and their families into appropriate forms of intervention in health, social and educational segment.
Treatment	Not reported specific for children and adolescents; For young adults: setting up an effective system of academic and psychological counselling for students and staff of public universities and applicants for studies, or other persons (e.g. participants in lifelong learning courses), in accordance with legal obligations of universities in the area of counselling and support for students with special needs.
Coordination	
Care pathways, integrated care/health in all policies	Not reported specific for children and adolescents.
Infrastructure, resources	Not reported specific for children and adolescents[36]
Implementation strategy, process	Method of implementation: Establishment of an inter-ministerial working group and elaboration of a proposal for a depistige system with the identification of the roles of the various actors in the health, education and social services sectors and impact assessment and evaluation of the impact on the legislative arrangements under the responsibility of the relevant ministries. Approval of the proposal for an early identification system – depistige of children at psychosocial risk within individual ministries and the creation of a pilot project aimed at its implementation. Implementation and evaluation of the pilot project. Implementation of the system in the legislation standards and methodologies and training of staff within the relevant ministries.
Data acquisition, research	Not reported specific for children and adolescents.
Additional characteristics	
Digitalisation for management and documentation	NR
Digitalisation for telehealth, detection and intervention	NR
Vulnerable patient groups (e.g. Transcultural care)	Not reported specific for children and adolescents.
Transitional psychiatry	NR
Conclusion	
Conclusion of the document	There are 5 strategic objectives: ■ Improve the management and delivery of mental health care led by reliable information and knowledge. ■ Ensuring that every person has a comparable opportunity for mental health throughout their lives, especially those most vulnerable or at risk ■ Ensure that the human rights of people with mental health difficulties are fully respected, protected and promoted ■ Ensure full availability of mental health services in time, place, capacity and cost, ensuring their availability in the community as needed. ■ Build mental health care systems for workers in well-coordinated partnership with other sectors, including equitable access to somatic health care
Additional relevant document(s)	
Title of the document(s)	■ National Action Plan for Suicide Prevention (NAPPS), 2021: https://www.reformapsychiatrie.cz/sites/default/files/2021-07/N%C3%A1rodn%C3%AD-ak%C4%8Dn%C3%AD-pl%C3%A1n-prevence-sebevra%C5%BEd-2020-2030.pdf ■ Distance learning and mental health recommendations ("*Doporučení k distanční výuce a duševnímu zdraví*"), 2021: https://www.edu.cz/methodology/doporuceni-k-distancni-vyuce-a-dusevnimu-zdravi/

Abbreviations: NA – not available, NR – not reported

[36] A financial support for setting up an effective system of academic and psychological counselling for students and staff of public universities and applicants for studies is reported.

Germany

Table A-8: Main characteristics of the included CAMH models/strategies from Germany

Country, year (reference)	Germany, 2021 [128]
Title of the model/strategy	Further development of psychiatric-psychotherapeutic assistance and prevention of mental disorders in childhood and adolescence in Germany – development and coordination of recommendations for action („Weiterentwicklung der psychiatrisch-psychotherapeutischen Hilfen und der Prävention seelischer Störungen im Kindes- und Jugendalter in Deutschland – Entwicklung und Abstimmung von Handlungsempfehlungen“)
Publisher	Aktion Psychisch Kranke e.V.
Involved stakeholders	Professional associations/societies: ■ Paediatrics ■ Child and adolescent psychiatry, psychosomatics and psychotherapy ■ Psychiatry, psychosomatics and neurology ■ Psychosomatic medicine and medical psychotherapy ■ Social paediatrics and adolescent medicine ■ Rehabilitation ■ (School) Psychology ■ Nurses of child and adolescent psychiatry clinics ■ doctors in the public health service ■ Psychotherapists Registered associations: ■ Autism ■ Attention deficit hyperactivity disorder ■ Relatives of mentally ill people ■ Life aid (“Lebenshilfe”) ■ Independent commissioner for questions of sexual child abuse – working group ■ Ministry of social affairs, health, integration and consumer protection ■ Federal centre for health education ■ German family court conference ■ German hospital federation ■ National association of statutory health insurance physicians ■ Robert Koch Institute
Contracting entity/funding	■ Federal Ministry of Health and the Federal Legislator
Language	German
Target users of the document	■ Federal Ministry of Health and the Federal Legislator ■ Self-government and the Joint Federal Committee
Aim of the document	The aim of the project was to develop concrete recommendations for the further development of support for children and young people with mental illnesses in a participatory process.
Addressed age	Children and adolescents (age not specified)
Key principles	Provide information, strengthen participation, enable outpatient complex services, strengthen pre-hospital treatment, participatory integrated treatment and rehabilitation planning in the network, take special treatment needs into account, strengthen drug therapy – safety off-label use, establish outpatient and mobile medical rehabilitation, expand prevention recommendations, further expand health services research.
Components	
Professions, workforce qualification and development	An outpatient complex service shall ■ be multi-professional and team-based and managed by a specialist or psychotherapist (treatment elements: psychiatric/psychotherapeutic treatment, outpatient guideline psychotherapy, somatic or paediatric medical treatment). ■ Psychiatric and somatic nursing care, remedies, in particular occupational therapy, speech therapy, physiotherapy, psychological, socio-educational and remedial services and other therapies. Further develop the staffing policy: ■ In order to ensure good staffing levels in terms of quantity and quality in child and adolescent psychiatric hospitals, the staffing requirements should be further developed in the direction of corresponding quantitative and qualitative staffing levels. In addition, the current reference to wards should be abolished. Staffing requirements should be primarily oriented towards the needs of the patients to be treated and their families, which are determined in a participatory process, and the tasks of the staff to be described from this. The requirements should be measured against the criteria of providing treatment in child and adolescent psychiatric hospitals on the basis of competence, trust, and empathy, avoidance of coercion and under the conditions of a defined obligation to provide care.

Country, year (reference)	Germany, 2021 [128]
Professions, workforce qualification and development *(continuation)*	■ Consequences of the shortage of specialists in child and adolescent psychiatry on the requirement of 100% staffing with therapeutic personnel by the "Psychiatry and Psychosomatics Staffing Guideline": Coordination with the statutory health insurance association and the German hospital association on sanctions to be expected in the event of failure to meet the minimum staffing requirements. ■ Special treatment needs for the target group of refugee children and adolescents with mental disorders: Qualification of professionals, funding of language mediation
Involvement, user participation	To ensure the participation of patients and relatives/families in a process-oriented joint treatment agreement.
Information, awareness raising activities	An internet presence was set up to publicise the project: https://www.apk-ev.de/projekte/kiju-handlungsempfehlungen/startseite Ensure information and strengthen participation: ■ In addition to conventional media in print, audio and video format, new media (Apps, YouTube, etc.) should also be used for adequate information suitable for children and young people and information in simple language. Information materials should be designed and made available for all age groups (from pre-school to adolescence) as well as for specific disorders. It should be noted that the younger children are, the more attention should be paid to age-appropriate wording about direct consequences, such as side effects of medication and how to observe them. Information should also be provided in 'easy language'. It is central to make patients in child and adolescent psychiatry and psychotherapy into responsible users who can give their own feedback on their treatment and thus contribute to the best possible treatment.
Prevention, mental health promotion	Expand prevention recommendations: ■ The psychotherapy consultation should clarify whether other help options than psychotherapy (e.g. preventive measures) are indicated. The restriction to the previously required "medical certificate" according to § 26 paragraph 1 sentence 4 SGB V is to be abolished and the possibility of a corresponding psychotherapeutic certificate on prevention recommendations is to be included there. An independent prevention recommendation will thus also be possible by psychotherapists in private practice.
Detection, screening	NR
Treatment	Strengthen pre-hospital treatment: ■ To clarify the need for inpatient or day-care treatment, to prepare for hospital treatment and to make effective use of waiting times for inpatient hospital treatment, a period of several weeks may be useful in individual cases. Participation in group offers or specialised therapeutic offers, e.g. occupational therapy offers of the hospital, can be realised accordingly parallel to the medical diagnosis and treatment – also by registered doctors connected in the network. Drug therapy – strengthening safety of off-label use: ■ The practice of drug treatment of mentally ill children and adolescents in Germany, according to which a large part of psychotropic medication has to be prescribed off-label, is to be changed so that safety data are generated and legal certainty for patients and prescribers is improved. Overall, the safety of drug treatment is to be strengthened. This will change a situation that has been known for decades and has not been changed by national or European legislation, namely the lack of marketing authorisations with a focus on pharmacosafety. This applies for the most part to off-patent medicines. ■ An expert discussion must take place with the Federal Institute for Drugs and Medical Devices ("BfArM"), representatives of the Commission for Medicinal Products for Children and Adolescents, and the professional societies as well as the Federal Ministry of Health, in order to analyse the problem situation, previous failed attempts at a solution, etc., as well as to define the actual group of affected medicinal products in child and adolescent psychiatry. Establish outpatient, mobile outreach rehabilitation: ■ The time frame is set at 3-6 months with the possibility of a justified extension. The authorisation of clinics and suitable contract physicians should be supplemented and regulated by law. No duplicate structures with acute treatment should be created. In the preparation of a recommendation agreement on the rehabilitation of mentally ill children and adolescents, outpatient and mobile outreach components should be explicitly anchored in the conceptual part and in the staffing. Enable intensified and outreach treatment in social health insurance-accredited medical and psychotherapeutic care: ■ Intensified treatment of patients with severe or acute disorders should be made possible through special remuneration regulations. Outreach treatment in the home environment (including inpatient youth care and, if necessary, also in schools and day care centres) should be provided on a case-by-case basis and be billable. If necessary, intensive treatment in the home environment should be made possible, as should telemedical forms of treatment. Flexibilisation of inpatient-equivalent treatment: ■ The possibility of being able to implement inpatient-equivalent treatment in a more graduated and flexible manner in terms of scope and duration towards the end of treatment should be included in the agreement on inpatient-equivalent psychiatric treatment pursuant to Section 115 d (2) SGB V.

Country, year (reference)	Germany, 2021 [128]
Treatment *(continuation)*	■ Furthermore, with regard to child and adolescent psychiatric equivalent inpatient treatment, the possibility of having more than half of the services provided by social psychiatric care practices (in suitable cases also individual practices) should be included. Likewise, towards the end of inpatient-equivalent treatment, the outpatient service provider should be included in the treatment in a binding manner in consultation with patients. ■ A background service including short-term inpatient admission capability remains necessary. The scope of services must at least correspond to that of an inpatient-equivalent treatment on 3 days a week. Social paediatric centres – increasing flexibility in treatment: ■ In the sense of a care structure starting from the patients and their families, outreach work by the social paediatric centres is to be made possible in all contracts with the statutory health insurance. Enable family groups and involve caregivers according to need: ■ A treatment structure based on the patients and their families requires the regular inclusion of the relatives of mentally ill children and adolescents. Group therapy concepts lend themselves to this. Purely family groups should therefore be made possible, thus ensuring the needs-oriented inclusion of caregivers. These would also represent an urgently needed expansion of the services for siblings of children and adolescents with mental illness.
Coordination	
Care pathways, integrated care/health in all policies	Participatory, integrated treatment and rehabilitation planning in a network: ■ Building on a few regional experiences, corresponding procedures and structures are to be tested and further developed in selected regions nationwide. Existing structures of assistance planning are to be taken up and further developed. The establishment of network structures should improve the framework conditions. A regional complaints management system with a focus on participation and children's and young people's rights is to be implemented in parallel during the trial phase. A link should be established with the newly anchored complaints system in child and youth welfare. ■ In the area of specialist medical or psychotherapeutic care, an outpatient person-related complex service is to be made possible in the case of highly intensive treatment needs, which is provided on a multi-professional and team-based basis and is led by a specialist doctor or psychotherapist and which is to be implemented in parallel. psychotherapeutic and offers integrated child and adolescent psychiatric/psychotherapeutic treatment, child and adolescent psychotherapy, socio-paediatric treatment, nursing, ergotherapy, speech therapy, physiotherapy and other non-medical/psychotherapeutic (e.g. social or curative education) services. ■ It should be possible to provide the outpatient person-related complex services equally in the practices of contract physicians, contract psychotherapists, child and adolescent psychiatric outpatient departments and social paediatric centres. A central element should be local or regional networks of contract physicians and psychotherapists with child and adolescent psychiatric outpatient departments and, depending on the case constellation, social paediatric centres, which jointly assume responsibility and provide the intensive treatment required through appropriate offers. ■ Appoint a responsible coordinating reference person (case manager) chosen by the patients and their guardians from the service providers involved (the overall responsibility related to the individual patient must be defined). Interfaces and cooperation: ■ Future-oriented forms of treatment beyond existing sectoral boundaries. ■ Cooperation obligations in the interest of mentally ill children and adolescents – networking, interfaces; Person-centredness instead of cross-sectoral exclusions of services: ■ Exclusions of services that hinder joint, outpatient, coordinated treatment oriented towards the individual needs of patients should be avoided. For example, child and adolescent psychotherapeutic treatment should be possible in parallel to treatment in the child and adolescent psychiatric outpatient departments according to the joint Federal Committee guideline. Coordinated parallel treatments should also be made possible in the transitions and in the cooperation between social psychiatric care practices and institute outpatient departments. Such forms of psychiatric/psychotherapeutic treatment are recommended by most guidelines and have broad scientific evidence.
Infrastructure, resources	Enabling complex outpatient services ■ Currently, a major obstacle to coordinated care with complex outpatient services across sectors is the logic of the existing financing systems. Here, financing is required that overcomes the existing sectoral boundaries and is designed to be "extrabudgetary". As a financing mode for outpatient intensive care, weekly flat rates in gradations are conceivable, for example, which cover the weekly and daily time requirements in the several-hour range for the individual professional groups. It could make sense to organise the financing within the framework of a joint cost centre and to leave it up to the regional networks to decide how they want to implement the care services together. This would allow the greatest possible adaptation to the existing regional conditions and at the same time create an incentive for the participants to jointly design and further develop the services in a differentiated manner.

Country, year (reference)	Germany, 2021 [128]
Infrastructure, resources *(continuation)*	Equalise guideline psychotherapy – rural care: ■ The current provision of regions with seats for psychotherapists in private practice for children and adolescents is very heterogeneous. Rural areas in particular (district type 5) should be better supplied in order to achieve an even and fairer distribution. Psychotherapeutic treatment is to be offered in accessible proximity. The introduction of person-related remuneration supplements is intended to ensure participatory treatment planning for the relevant target groups and to significantly increase the quality of treatment. A flat-rate surcharge factor will facilitate intersectoral arrangements.
Implementation strategy, process	■ It should be noted that there are a large number of formulated needs for action or options for action that fall within the responsibility of the federal states and thus not within the area of SGB V that is relevant for the project. ■ Based on a few regional experiences, corresponding procedures and structures are to be tested and further developed in selected regions nationwide. Existing structures of assistance planning are to be taken up and further developed. The establishment of network structures should improve the framework conditions. A regional complaints management system with a focus on participation and children's and young people's rights is to be implemented in parallel during the trial phase.
Data acquisition, research	Further expand health services research: ■ Beyond the Innovation Fund and the German Research Foundation funding, health services research projects should be specifically funded by the Federal Ministry of Health and the Federal Ministry of Education and Research with regard to mental health and the treatment and rehabilitation of mental illnesses in children and adolescents. Closer cooperation with the Robert Koch Institute should be realised with care-oriented research in order to also make routine data from the outpatient and inpatient sector more readily available. Data from the health insurance funds play an important role here. In addition, "natural" or naturalistic cohort studies and observational studies should be promoted.
Additional characteristics	
Digitalisation for management and documentation	Further development of digitalisation in child and adolescent psychiatry: cross-sector digital care networks. Electronic patient file. Inspection by unsuitable guardians. Data protection in the case of a network structure. Use of certified apps for treatment and preventive measures.
Digitalisation for telehealth, detection and intervention	With regard to innovative approaches in digital media, project funding by the health insurance funds on the basis of § 68 a SGB V should be sought. If necessary, intensive treatment in the home environment should be made possible, as should telemedical forms of treatment.
Vulnerable patient groups (e.g. Transcultural care)	Consideration of special treatment needs: ■ Special target groups: Children and adolescents with (further) disabilities or impairments; children and adolescents who have fled; children and adolescents with special risk factors, e.g. children of psychologically and/or addicted parents; ■ Significant additional treatment needs (e.g. in the case of an additional disability such as intelligence impairment; physical or sensory disability and in the case of significant somatic comorbidity, younger children also in the context of parent-child treatment) should be able to receive special consideration in terms of the time, personnel and material resources required for treatment. Equal access for this patient group and a target group-specific qualified treatment offer (inclusion, barrier-free access) must be ensured.
Transitional psychiatry	Flexible transitional arrangements for the transition phase between the ages of 18 and 21 should be made and simultaneous treatment with the social psychiatric care practice or the psychiatric institutional outpatient clinic should be made possible. Area of responsibility of the Laender: to implement regulations for a nationwide expansion of transitional care units in hospital planning.
Conclusion	
Conclusion of the document	From the large number of options for action submitted and discussed, a total of 17 recommendations for action could be prioritised and largely consented to with the associations, professional societies and self-help. Recommendations were addressed to the Federal Ministry of Health and the federal legislator, which focus on further legal and professional development with regard to legislation and design options of the ministry: ■ Ensure information and strengthen participation ■ Enable outpatient complex services ■ Strengthen pre-hospital treatment ■ Participatory integrated treatment and rehabilitation planning in the network ■ Consideration of special treatment needs ■ Strengthening drug therapy – safety off-label use ■ Establish outpatient and mobile medical rehabilitation ■ Expand prevention recommendations ■ Further expand health services research.

Country, year (reference)	Germany, 2021 [128]
Conclusion of the document *(continuation)*	Recommendations on the scope of action of the self-administration and the Joint Federal Committee were prioritised: ■ Person-centredness instead of cross-sectoral exclusions of services. ■ Enable intensified and outreach treatment in social health insurance-accredited medical and psychotherapeutic care ■ Equalising guideline psychotherapy – rural care ■ Enable family groups and involve caregivers according to need ■ Further develop the guideline on staffing ■ Making inpatient equivalent treatment more flexible ■ Continue model project according to § 64 b SGB V ■ Social paediatric centres – increase flexibility in treatment. The central criteria to be considered across all recommendations for action are: ■ Person-centredness or patient/family-centredness incl. siblings ■ Equal access ■ Participation of patients ■ Binding inclusion of all other stakeholders ■ Cooperation (regional, intersectoral) ■ Prevention
Additional relevant document(s)	
Title of the document(s)	■ Final Report of the Working Group on Children of Mentally Ill and Addicted Parents ("*Abschlussbericht Arbeitsgruppe Kinder Psychisch- und Suchtkranker Eltern*"), 2020: https://www.ag-kpke.de/wp-content/uploads/2020/02/Abschlussbericht-der-AG-Kinder-psychisch-kranker-Eltern.pdf ■ Model project "Mentally fit in primary school" – factual report ("*Modellprojekt Psychisch Fit in der Grundschule – Sachbericht*"), 2019: https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Praevention/Berichte/Modellprojekt__Psychisch_fit_in_der_Grundschule__-_Sachbericht.pdf ■ Care for mentally ill children and adolescents in Germany – stocktaking and needs analysis ("*Versorgung psychisch kranker Kinder und Jugendlicher in Deutschland – Bestandsaufnahme und Bedarfsanalyse*"), 2017: https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/K/Kindergesundheit/Versorgung_psychisch_kranke_Kinder_u_Jugendliche_Abschlussbericht.pdf

Abbreviations: NA – not available, NR – not reported

Spain

Table A-9: Main characteristics of the included CAMH models/strategies from Spain

Country, year (reference)	Spain, 2018 [129]
Title of the model/strategy	Roadmap: Recommendations for promoting mental health and emotional well-being in young people
Publisher	Red PROEM (PROmotion of Mental Health and Emotional Well-being in the Young) Member Institutions: ■ University of Jaen (UJA), Jaen ■ Complutense University of Madrid (UCM), Madrid ■ University of Cordoba (UCO), Cordoba ■ Deusto University, Bilbao ■ Miguel Hernández University (UMH), Elche ■ University of the Basque Country (UPV/EHU), San Sebastian ■ Rovira i Virgili University (URV), Tarragona
Involved stakeholders	■ Spanish research teams addressing mental health; ■ participating individuals from the educational sector, ■ young people, ■ minority groups, ■ policymakers, ■ stakeholders and end-users; ■ and professionals working in other fields such as epigenetics, linguistics, information and communication technologies (ICTs), nutrition, physical activity and public and community health
Contracting entity/funding	■ Spanish Ministry of Economy, Industry and Competitiveness ■ Spanish Ministry of Science, Innovation and Universities ■ The State Research Agency (AEI) ■ ERDF Funding

Country, year (reference)	Spain, 2018 [129]
Language	English
Target users of the document	The report seeks to engage all stakeholders and lead to the formation of interdisciplinary working groups tasked with carrying out the measures proposed.
Aim of the document	To design a priority-based roadmap aimed at improving adolescent health and emotional well-being and preventing emotional problems. The report has three specific objectives: ■ to identify the gaps and needs associated with adolescent health and emotional well-being ■ to draw up recommendations based on the previously identified gaps and needs ■ to establish priorities for improving adolescent health and emotional well-being
Addressed age	Young people (age not specified)
Key principles	Building health and emotional well-being literacy, promote early detection, effective and evidence-based psychotherapy interventions and best practices, efficient networks for early detection, early intervention, increasing research budget for prevention of treatment of mental health problems and for promoting mental health and emotional well-being.
Components	
Professions, workforce qualification and development	■ Bringing the mental health network and healthcare professionals closer to the educational environment and the general population in order to: (i) empower citizens; (ii) improve early detection; and (iii) develop better, individual-oriented psychotherapy interventions. ■ Enabling education and healthcare professionals to explore the needs of young people with emotional problems. ■ Increasing mental health training among education and health professionals and those from a social and community setting (all actors/agents in contact with young people) led by mental health specialists (e.g., health psychologists).
Involvement, user participation	■ Increasing efforts to involve all actors to improve health network efficiency. It is recommended that not only the voices of researchers and mental health professionals are heard, but also the voices of professionals belonging to other disciplines, the educational sector, the social and community setting, parents, young people, end-users and policymakers. ■ Involving adolescents, families and all other social actors in decision-making efforts to promote mental health and to prevent and treat mental disorders.
Information, awareness raising activities	To build adolescent health and emotional well-being literacy: ■ Designing health literacy interventions for students and parents/guardians about mental health, its risk and protective factors, as well as knowing how to identify and manage its symptoms properly. These interventions should cover all prevention stages: universal, selective and indicated. ■ Raising awareness of the importance behind emotional well-being and health promotion among adolescents and adults, as well as the maintaining and contributing factors: healthy lifestyles (physical activity, nutrition, sleep habits, appropriate use of new technologies), family, social, school support networks, etc. ■ Promoting respect and reducing related stigma towards vulnerable and social minority groups and individuals with mental illness; building adolescents' empathy and tolerance towards what is 'different' and diversity. ■ Raising awareness among members of the education and health community about the importance behind students' and end-users' language use as well as the language used with them. Involving the media by disseminating information via networks made up of mental health professionals and counselors, parents' associations, end-users, etc. to eliminate any type of stigma.
Prevention, mental health promotion	■ Developing universal prevention programmes aimed at promoting mental health, emotional wellbeing and healthy lifestyles (e.g., physical activity, nutrition, sleep habits), as well as encouraging peer-to-peer respect and tolerance. ■ Developing programmes aimed at preventing victimization or any other kind of interpersonal violence.
Detection, screening	To promote early detection in young people and effective, efficient and evidence-based psychotherapy interventions and best practices: ■ Providing a repository of assessment and intervention instruments to improve early detection and scientifically supported interventions aimed at increasing transparency and reducing professional intrusion (unqualified practice). ■ Developing and implementing early detection selective and indicated prevention protocols and evidence-based psychotherapy interventions in schools and health interventions designed to treat mental disorders, (cyber)victimization, self-harm, and suicidal ideation and behavior in adolescents by specialist mental health professionals. ■ Assessing the potential role of interdisciplinary approaches (e.g., ITCs, epigenetics, language analysis) in early detection and the development of psychotherapy interventions. ■ Developing promotion, early detection and treatment programmes that adhere to the Convention on the Rights of the Child.

Country, year (reference)	Spain, 2018 [129]
Treatment	To develop an efficient network to improve early detection, early intervention and the best treatment for emotional and mental health problems in youth: ■ Developing interventions aimed at reducing all associated stigmas, whether directed at vulnerable or social minority groups, the mental disorder itself, or any other type.
Coordination	
Care pathways, integrated care/health in all policies	■ Greater collaboration is needed from involved actors: mental health and other discipline researchers and professionals as well as the youth themselves, their families and policymakers
Infrastructure, resources	To increase the budget for preventing and treating mental health problems and promoting mental health and emotional well-being: ■ Providing schools, health systems and social services with the knowledge and resources to identify and treat adolescents exhibiting emotional problems or those at risk of developing them, paying particular attention to vulnerable and minority groups and addressing the specific needs of adolescents. ■ Promoting the development and implementation of mental health psychotherapy interventions in adolescents and schools, as well as psychoeducational programmes that emphasize interdisciplinary and inclusive approaches instead of medicalisation as the only and/or priority alternative. ■ Increasing the budget for developing educational and social policies aimed at preventing inequality in youth with emotional problems.
Implementation strategy, process	■ Undertaking social and educational policies and increasing efforts to implement them more effectively so as to address inequalities among youth with emotional problems or those at psychosocial risk. ■ Implementing policies that make health and emotional well-being more easily accessible to young people (mental health literacy, inclusion in school curricula, online assessment and treatment).
Data acquisition, research	To increase the budget for research into mental health and emotional well-being: ■ Encouraging funding from public and private bodies and institutions to research and offer emotional health prevention programmes in schools and health clinics, including the early identification of emotional problems, (cyber)victimization, self-harm and suicide. ■ Increasing funding to bridge the gap between mental and physical health, taking into account not only healthcare needs and the burden of disease, but also the prevalence and severity of emotional disorders in youth. ■ Encouraging collaboration among teams to conduct multi-centre trials using rigorous designs across different contexts (primary healthcare, schools, etc.).
Additional characteristics	
Digitalisation for management and documentation	■ Employing language analysis and developing decision-support computer systems to help professionals detect adolescent emotional problems early on.
Digitalisation for telehealth, detection and intervention	■ Addressing ICT use and abuse among adolescents, given that much social interaction takes place online where different mental health problems are channeled (depression, anxiety, etc.).
Vulnerable patient groups (e.g. Transcultural care)	Particular interest paid to those associated with, or part of, minority groups at potential psychosocial risk: ■ This group can include persons with disabilities, women, children, ethnic minorities, people with mental illness, people living with the human immunodeficiency virus (HIV) and/or have developed AIDS, migrant workers, refugees, individuals with sexual diversity and/or a different gender identity, persons imprisoned for committing a crime, among other minorities. ■ Vulnerable and social minority groups have a greater risk of suffering from mental health problems or disorders given their disadvantaged situation as opposed to other predominant groups or the social majority
Transitional psychiatry	■ Helping people with emotional problems and those at risk of developing them transition from adolescence to adulthood.
Conclusion	
Conclusion of the document	Thanks to the efforts made by members, partners and other users of the PROEM network, a mental health problem in adolescents and gaps on how to tackle it in both a health and educational setting have been observed. These shortcomings manifest themselves as limited resources, training and available health literacy programmes; a lack of measures to detect at-risk individuals early on and scientifically supported psychotherapy interventions; and an inefficient healthcare network when it comes to making referrals. The PROEM network calls for mental health to be promoted in all adolescents and those in contact with this group; for symptoms to be detected early; and for intervention on incidence of mental disorders to be prioritized, establishing synergy among adolescents, adults and education professionals by promoting interdisciplinary approaches and synergies. In order to remedy these gaps, the message being sent out is that it is necessary to build mental health literacy; take on more mental health specialists in schools; provide training for education and primary healthcare professionals; increase the budget for mental health policy implementation; develop a more efficient health network; and encourage research that works towards identifying the risk factors, promoting positive mental health and developing efficient and effective interventions. The actions set out in this report seek to engage all stakeholders and lead to the formation of interdisciplinary working groups tasked with carrying out the measures proposed.

Country, year (reference)	Spain, 2018 [129]
Additional relevant document(s)	
Title of the document(s)	■ Youth Strategy 2020 (*Estrategia juventud 2020*), 2014: http://www.injuve.es/sites/default/files/2015/43/publicaciones/Estrategias%202020%20web%20C.pdf ■ Mental Health Strategy of the Spanish National Health System 2009-2013, 2012: https://www.sanidad.gob.es/organizacion/sns/planCalidadSNS/docs/saludmental/MentalHealthStrategySpanishNationalHS.pdf ■ Childhood and Adolescent Mental Health Care Program *(Programa de Atención a la Salud Mental de la Infancia y la Adolescencia – Programa de Salud Mental),* 2010: https://www.consaludmental.org/publicaciones/Programatencionsaludmentalinfancia.pdf

Abbreviations: NA – not available, NR – not reported

Norway

Table A-10: Main characteristics of the included CAMH models/strategies from Norway

Country, year (reference)	Norway, NR [130]
Title of the model/strategy	National guideline for health promotion and preventive work in the child and youth health centres and school health service, 0 – 20 years
Publisher	Norwegian Directorate of Health
Involved stakeholders	■ Norwegian Directorate of Health ■ Knowledge Centre for the Health Services ■ Patient advocacy groups and (non-governmental) organisations ■ Relevant trade unions, ministries and directorates ■ Norwegian Institute of Public Health ■ Public governors and county councils, ■ Centres of excellence ■ The Ombudsman for Children ■ Norwegian Directorate for Education and Training ■ Norwegian Directorate for Children, Youth and Family Affairs ■ Norwegien Institute of Public Health
Contracting entity/funding	Norwegian Directorate of Health
Language	English
Target users of the document	■ Staff at health centres, school health service and youth health centres ■ Political and administrative officials in local government ■ Educational institutions that train personnel for the services (colleges/universities) ■ Collaborating partners in local government, county councils and the specialist health service ■ Children, adolescents and their parents ■ Other relevant actors
Aim of the document	The guideline should clarify the authorities' requirements concerning the scope of the services and contribute to: ■ • good quality and professionally responsible operation ■ • holistic services ■ • proper prioritisation ■ • less unwanted variation ■ • equal services ■ • enable self-management and coping among parents, children and adolescents
Addressed age	0 – 20 years[37]
Key principles	Universal and low-threshold, needs-based and culturally sensitive, participatory, evidence-based, both – individual and population oriented, interdisciplinary, responsibly (good quality and be provided on time and to a sufficient scope).
Components	
Professions, workforce qualification and development	The staff in the services shall comprise: ■ Public health nurse, ■ Doctor

[37] Health centres 0-5 years, School health service 5-20 years

Country, year (reference)	Norway, NR [130]
Professions, workforce qualification and development *(continuation)*	The services should also have: ■ Physiotherapists The services may also have: ■ Psychologists, ■ Occupational therapists, ■ Other occupational groups with educational, social work, interdisciplinary or cross-cultural skills To ensure that the service has sufficient expertise, the management should: ■ assess competence requirements based on the service's tasks and the local population health profile ■ clarify resource requirements through training plans and a staff budget ■ establish and maintain a strategic competence plan
Involvement, user participation	User participation: ■ Health centres, the school health service and youth health centres shall ensure that children and adolescents are heard, get involved and enabled to exert influence in their dealings with the services, at individual and system level. ■ The services shall work to ensure that children and adolescents feel that their experiences and input are regarded as valid when decisions are to be made and new measures designed. ■ At individual level, user participation means listening to what children and adolescents say and asking for their input in matters that concern them. ■ At system level, user participation can mean that representatives of children and adolescents are involved in the design of the service.
Information, awareness raising activities	Through the systematic partnership with the school, the school health service should ascertain and plan the service's contribution to school-based health education, relevant topics for school-based health education, include: ■ Mental health ■ Sleep ■ Diet; see the recommendation Food and meals ■ Physical activity; ■ Puberty, the body, and sexual health; ■ Tobacco, alcohol and drugs; Violence and abuse; The school health service should offer all lower secondary school pupils a visit to a youth health centre (YHC): ■ Making adolescents specifically aware of the health centre's location, opening hours and the services that are provided there and elsewhere within the health service relating to physical and mental health ■ Supplementing other education concerning sexually transmitted infections (STIs) and the availability and use of contraceptives ■ Supplementing other education concerning how tests, physical examinations and other procedures are carried out in a specific setting Websites about mental health: ■ snakkommobbing.no (Blue Cross) ■ kirkens-sos.no (The Church's SOS in Norway) ■ sidetmedord.no (Mental health) ■ selvhjelp.no (Self-help Norway, the National Resource Center)
Prevention, mental health promotion	The Health Centre can offer universal, primary preventive parent education programmes to groups and/or individually to parents. The purpose is to promote the child's development and prevent mental problems in the child by strengthening the parents' parenting skills. The International Child Development Programme (ICDP) can be used for systematic parent education. ICDP is a universal health promoting and prevention programme directed at carers, generally the parents. The school health service should contribute to the schools' work relating to measures which promote a good psychosocial environment: ■ Promoting a good psychosocial environment at the school ■ Prevent unhappiness, bullying and mental health problems amongst children and adolescents through universal, group and individually oriented measures When necessary, the school health service should offer follow-up consultations to pupils. Divorce groups: The school health service can offer group counselling to support children and adolescents who experience divorce/break-ups between their parents ■ The school health service can offer group discussions/counselling for children and adolescents who experience divorce/break-ups between their parents. ■ The purpose of group measures should be to enhance the ability of group members to cope with the strains of everyday life and reduce negative consequences in the long term.

Country, year (reference)	Norway, NR [130]
Detection, screening	Health professionals shall, without being hampered by any obligation to maintain confidentiality, and at their own initiative, immediately notify the Child Welfare Service: ■ When there is reason to believe that a child is being abused at home or that a child is suffering other forms of neglect. ■ When a child has displayed persistent and serious behavioural difficulties. All children from 0–5 years of age should be offered regular consultations at health centres. Health centres for children from 0 to 5 years of age should follow a standardised programme of 14 consultations, including a home visit to new-born babies: ■ to ensure that parents can cope with and master their roles as parents to ensure good interaction between parent and child ■ to promote physical, mental and social development in babies and infants ■ to prevent and detect violence, abuse, and neglect ■ to detect physical and mental developmental anomalies at an early stage ■ to help the child receive necessary follow-up and instigate referrals when required The doctor's examination includes an assessment of psychological and behavioural development: ■ Assess social contact, temperament, and any self-regulating problems at an early age, and social skills, language development, capacity to concentrate and impulsivity. Partly undressed: The pupil should be partly undressed during the somatic part of the school-entry health consultation: ■ Be able to carry out an organ examination and observe skin surfaces which form part of the somatic examination ■ Be able to observe indications of violence, abuse and neglect The service is particularly well-placed to identify mental health problems and disorders and incipient abnormal development in children and adolescents in the following contexts: ■ During the school-entry health consultation ■ During the health consultation in the 8th grade ■ Through other targeted investigations ■ Through weighing and measuring ■ In connection with vaccination ■ When a child or adolescent contacts the service via drop-in ■ Through the collaboration with the school
Treatment	Medication management: ■ The health centre shall contribute to establishing routines for managing medications in kindergartens, schools and after-school programmes. This means that the health centre shall contribute to compiling routines on safe storage, administration and handout of medications in kindergartens, including routines for training personnel in kindergartens who assist children who require medication.
Coordination	
Care pathways, integrated care/health in all policies	■ Employees in health centres, the school health service and youth health centres must collaborate and cooperate to ensure high-quality and professionally responsible services. In many instances, it will also be necessary for the service to draw on other competencies in addition to regular staff. For example, the service shall have procedures for cooperation with GPs, the dental service and other municipal services. ■ The municipal coordinating unit is a key collaboration partner for health centres, the school health service and youth health centres to ensure holistic and coordinated services. Written co-operation procedures shall be established for assessment and follow-up of children who require an individual plan or long-term services. ■ Health centres, the school health service and youth health centres shall collaborate with the municipal Child Welfare Service. When necessary, the services should also collaborate with the Norwegian Directorate for Children, Youth and Family Affairs. ■ Managers of enterprises should ensure that procedures and regular collaboration meetings are established, both on a system and an individual level, which ensure that children and adolescents are identified as early as possible and receive the necessary follow-up. ■ Health centres, the school health service and youth health centres shall have procedures in place for collaboration with GPs of children and adolescents to ensure transparent distribution of responsibilities and tasks and good understanding of role. It is the municipality's responsibility to ensure that the services are able to collaborate. Collaboration with individual GPs must be based on consent of the child/adolescent and/or their parents. The name of the GP of the child/adolescent shall be specified in the patient's medical records. Where the municipality has appointed a psychologist, health centres, the school health service and youth health centres shall cooperate with the psychologist. If the municipality does not have a psychologist, the services should have a systematic collaboration with the specialist health service, especially the Child and Adolescent Psychiatric Outpatient Services (BUP). The specialist health service is obligated to provide the municipal health and care services with professional guidance.

Country, year (reference)	Norway, NR [130]
Care pathways, integrated care/health in all policies *(continuation)*	**Health centres 0-5 years:** The health centre shall have a systematic collaboration with kindergartens in the municipality: ■ Combined, the health centres and kindergartens have detailed knowledge of the child population and are familiar with children in the municipality. The health centre should therefore collaborate with the kindergartens in the municipality at a organisational level. ■ The health centre can collaborate with the kindergartens at individual level for children who require additional follow-up. It is the responsibility of each municipality to evaluate the need for collaboration at individual level. Family centres (Familiens hus): ■ Several municipalities have established family centres. Services often include the local health centre, including maternity care, "drop-in play group", the preventive educational and psychological councelling service and, ideally, the municipal Child Welfare Services. The model is based on the principles of early intervention and "one door access" for coordinated help and is well-suited to capturing children and families with special needs for support and follow-up. The purpose of the collaboration is that families are met by a well-integrated chain of measures. Educational and Psychological Counselling Service (PPT): ■ PPT is the municipality's advisory and expertise centre for issues relating to children and upbringing. PPT provides advice on well-being, the learning environment and adapted education. Health centres can refer a child directly to PPT after the parents have given their consent. Children who do not attend – The health centre should have routines to follow up parents and children who: ■ do not attend agreed health consultations ■ repeatedly cancel or change agreed appointments **School health service, 5-20 years:** The school health service should have a systematic partnership with schools: ■ The school health service should work in systematic partnership with schools to facilitate a sound physical and psychosocial environment for pupils. ■ If no partnership with the school is in place, the school health service should take the initiative for establishing one. ■ The school health service should be involved in efforts by schools to plan school-wide, group-based and individualised interventions. Education: The school health service shall contribute to education in groups or forms at the discretion of the individual school: The school health service should provide targeted follow-up to children and adolescents with mental health problems and disorders. When necessary, the child/adolescent should be referred for further follow-up by e.g. a GP or the mental health service in the municipality: ■ The school health service should work with the Educational and Psychological Counselling Service (PPT) as and when necessary. The school health service should refer pupils to other relevant bodies when necessary. Such bodies could for example include: ■ Drug and alcohol consultants in the municipality ■ GPs ■ Psychologists or low-threshold mental health services in the municipality
Infrastructure, resources	The services in health centres, the school health service and youth health centres shall be free of charge. Children, adolescents and their parents shall be able to attend without an appointment or referral (drop-in). ■ Opening hours that are suitable for the target group and the objective of the service. ■ The services are free. ■ Universal design to accommodate for pushchairs and wheelchairs and such. ■ Appropriate competence among employees. ■ Children, adolescents and parents can make contact without an appointment or referral,
Implementation strategy, process	The municipality has an overall responsibility for health centres, the school health service and youth health centres and is obligated to plan, implement and correct the enterprise. Responsibility rests with the executive leader of the municipality, in the final instance with the municipal council. The manager of the health centres and school health service in the municipality has in most cases been delegated this responsibility and is responsible for ensuring that the service fulfils the requirements of the management system. Even if responsibility has been delegated, the municipality's executive management are responsible for ensuring that the health centres and school health service fulfil the requirements of the management system.

Country, year (reference)	Norway, NR [130]
Data acquisition, research	In key areas, there is a lack of evidence-based knowledge about the natural progression of health conditions and perceived health complaints and factors linked to health and health disorders, as well as the positive and potentially adverse effects of interventions. Nearly all children and adolescents in Norway participate in the systematic follow-up provided by the health centres and school health service. The conditions are therefore optimal for obtaining such knowledge through research. Research can be conducted in many ways and cover many aspects. For example, satisfaction amongst users of the services, relatives, practitioners and collaboration partners in kindergartens, schools and the Child Welfare Service; the prevalence of various health problems; and the effects of different measures and programmes. Research into factors linked to health, the occurrence of natural progression of health and perceived health issues, and the effects of specific measures, will be particularly valuable if the research is conducted based on how the service is performed over time through longitudinal and/or randomised controlled studies.
Additional characteristics	
Digitalisation for management and documentation	NR
Digitalisation for telehealth, detection and intervention	Children, adolescents and their parents shall be able to attend without an appointment or referral (drop-in), either via attendance in person (drop-in), by phone/SMS and/or through other digital solutions.
Vulnerable patient groups (e.g. Transcultural care)	Adapted services: the centres and services should provide suited to the users' circumstances and needs: ■ Taking into account linguistic and cultural differences in the indigenous Sami and immigrant population ■ Taking into consideration social differences in health and users' needs regardless of educational background, financial situation and class affiliation. ■ That the service is suited to children and adolescents with physical and/or mental disabilities. ■ That the service adjusts time spent in consultations based on individual needs. Particularly, consideration must be given to spend extra time when using a qualified interpreter.
Transitional psychiatry	Youth health centres should themselves assess whether there is a need for a lower age limit for use of the service. Health centre services should apply to adolescents up to the age of 20. In some municipalities, it may be desirable to expand the services provided to cover young adults up to 25 years of age. This could for example apply in: ■ Major towns and cities ■ Municipalities with university colleges, colleges or other study centres ■ Municipalities which for other reasons have a lot of immigrant youths It is up the municipality itself to assess whether it wishes to expand the services it provides to young adults over 20 years of age.
Conclusion	
Conclusion of the document	NR
Additional relevant document(s)	
Title of the document(s)	■ The National Plan for Children and Young People's Mental Health for the Period 2019-2024 ("*Opptrappingsplan for barn og unges psykiske helse (2019–2024)*"), 2019: https://www.regjeringen.no/no/dokumenter/prop.-121-s-20182019/id2652917/?ch=1 ■ The National Programme for Public Health ("*Program for folkehelsearbeid i kommunene*"), 2018: https://www.helsedirektoratet.no/tema/folkehelsearbeid-i-kommunen/program-for-folkehelsearbeid-i-kommunene ■ The Norwegian Government's strategy for young people's health 2016 – 2021 ("*Regjeringen lanserer ungdomshelsestrategi 2016-2021*"), 2016: https://www.regjeringen.no/no/dokumentarkiv/regjeringen-solberg/aktuelt-regjeringen-solberg/hod/pressemeldinger/2016pm/regjeringen-lanserer-ungdomshelsestrategi/id2503977/

Abbreviations: NA – not available, NR – not reported

United Kingdom

Table A-11: Main characteristics of the included CAMH models/strategies from United Kingdom

Country, year (reference)	United Kingdom, 2015 [131]
Title of the model/strategy	Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing
Publisher	National Health Service England, Department of Health
Involved stakeholders	■ NHS England ■ Local Government, Department of Health ■ Psychiatrists ■ Public Health Liverpool ■ Children's Commissioner for England ■ Children & Young Peoples Mental Health Coalition ■ Programmes Local Government Association ■ Children, Young People & Transition to Adulthood, NHS England ■ British Association for Counselling & Psychotherapy ■ Mental Health Service Alliance ■ NHS Confederation ■ Psychiatrists ■ Paediatricians ■ Teachers ■ Service Directors ■ Royal College of Nursing ■ Counselling Psychology ■ British Psychological Society ■ Council for disabled children ■ Ministerial advisory group for mental health users & carers ■ Social media communication experts ■ Youth justice board ■ Health education England
Contracting entity/Funding	National Health Service England, Department of Health
Language	English
Target users of the document	■ Children and young people (open letter) ■ Parents ■ Carers ■ Parliament ■ Policy, investment, commissioning, regulation, training and inspection ■ Accounting officers ■ Ministers
Aim of the document	To consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.
Addressed age	Children and young people (age not specified).
Key principles	Promoting resilience, prevention and early intervention; improving access to effective support, a system without tiers; care for the most vulnerable; accountability and transparency; developing the workforce.
Components	
Professions, workforce qualification and development	Developing the workforce: ■ Targeting the training of health and social care professionals and their continuous professional development to create a workforce with the appropriate skills, knowledge and values to deliver the full range of evidence-based treatments ■ Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT) to commission a sector body to produce a framework of core content for ITT which would include child and adolescent development. ■ By continuing investment in commissioning capability and development through the national mental health commissioning capability development programme. ■ Extending the CYP IAPT curricula and training programmes to train staff to meet the needs of children and young people who are currently not supported by the existing programmes.

Country, year (reference)	United Kingdom, 2015 [131]
Professions, workforce qualification and development *(continuation)*	■ Building on the success of the CYP IAPT transformation programme by rolling it out to the rest of the country and extending competencies based on the programme's principles to the mental wellbeing workforce, as well as providing training for staff in schools. ■ Developing a comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix. ■ Improving the skills of staff working with children and young people with mental health problems by working with the professional bodies, NHS England, PHE and HEE, to ensure that staff are more aware of the impact that trauma has on mental health and on the wider use of appropriate evidence-based interventions. ■ Piloting the roll-out of teams specialising in supporting vulnerable children and young people such as those who are looked after and adopted, possibly on a sub-regional basis, and rolling these out if successful.
Involvement, user participation	■ The Taskforce firmly believes that the best mental health care and support must involve children, young people and those who care for them in making choices about what they regard as key priorities, so that evidence-based treatments are provided that meet their goals and address their priorities. These need to be offered in ways they find acceptable, accessible and useful.
Information, awareness raising activities	■ Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal.
Prevention, mental health promotion	Promoting resilience, prevention and early intervention ■ Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots. ■ Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools. ■ Building on the success of the existing anti-stigma campaign led by Time to Change, and approaches piloted in 2014/15, to promote a broader national conversation about, and raise awareness of mental health issues for children and young people.
Prevention, mental health promotion *(continuation)*	■ Enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.
Detection, screening	■ Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour.
Treatment	Improving access to effective support – a system without tiers ■ Extending use of peer support networks for young people and parents based on comprehensive evaluation of what works, when and how. ■ Ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented.
Coordination	
Care pathways, integrated care/health in all policies	■ Moving away from the current tiered system of mental health services to investigate other models of integrated service delivery based on existing best practice. ■ Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector. ■ Improving communications and referrals, for example, local mental health commissioners and providers should consider assigning a named point of contact in specialist children and young people's mental health services for schools and GP practices; and schools should consider assigning a named lead on mental health issues. ■ Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools. ■ Strengthening the links between children's mental health and learning disabilities services and services for children and young people with special educational needs and disabilities (SEND). ■ Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care. ■ Improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools, single points of access and one-stop-shop services, as a key part of any universal local offer. ■ Putting in place a comprehensive set of access and waiting time standards that bring the same rigour to mental health as is seen in physical health services. ■ Making sure that children, young people or their parents who do not attend appointments are not discharged from services. Instead, their reasons for not attending should be actively followed up and they should be offered further support to help them to engage. This can apply to all children and young people. ■ Having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services with aligned or pooled budgets by developing a single integrated plan for child mental health services in each area, supported by a strong Joint Strategic Needs Assessment.

Country, year (reference)	United Kingdom, 2015 [131]
Care pathways, integrated care/health in all policies *(continuation)*	■ Health and Wellbeing Boards ensuring that both the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies address the mental and physical health needs of children, young people and their families, effectively and comprehensively. ■ By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge.
Infrastructure, resources	■ Legislating to ensure no young person under the age of 18 is detained in a police cell as a place of safety ■ Making the investment of those who commission children and young people's mental health services fully transparent.
Implementation strategy, process	■ We can start by doing what we know works, indeed already is working in some areas of the country, but is not being applied consistently. The second step is to deliver the commitments already made and the initiatives already started that give us the fundamental building blocks that will help justify securing the third element. With better data, transparency and accountability, the value of investment in mental wellbeing and care for child and young people can, and we believe will, be demonstrated and justified. A cycle of virtue can be created where, for each taxpayer's pound invested, the benefit for the individual and society can be realised with confidence. In the meantime, there are targeted opportunities if resources can be identified through re-prioritisation and/or on an 'invest to save' basis. ■ And, of course, any local area can make a decision to re-prioritise its resources in favour of child mental health on the basis of existing national and local evidence of need and efficacy.
Data acquisition, research	■ The Department of Health fulfilling its commitment to complete a prevalence survey for children and young people's mental health and wellbeing, and working with partner organisations to implement the Child and Adolescent Mental Health Services dataset within the currently defined timeframe. ■ Developing and implementing a detailed and transparent set of measures covering access, waiting times and outcomes to allow benchmarking of local services at national level, in line with the vision set out in Achieving Better Access to Mental Health Services by 2020. ■ Monitoring access and wait measurement against pathway standards – linked to outcome measures and the delivery of NICE-concordant treatment at every step.
Additional characteristics	
Digitalisation for management and documentation	NR
Digitalisation for telehealth, detection and intervention	■ Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme (an accreditation awarded to good practice) in order to guide young people and their parents in respect of the quality of the different offers.
Vulnerable patient groups (e.g. Transcultural care)	Care for the most vulnerable ■ Commissioners and providers across education, health, social care and youth justice sectors working together to develop appropriate and bespoke care pathways that incorporate models of effective, evidence-based interventions for vulnerable children and young people, ensuring that those with protected characteristics such as learning disabilities are not turned away. ■ Making multi-agency teams available with flexible acceptance criteria for referrals concerning vulnerable children and young people. These should not be based only on clinical diagnosis, but on the presenting needs of the child or young person and the level of professional or family concern. ■ Mental health assessments should include sensitive enquiry about the possibility of neglect, violence and abuse, including child sexual abuse or exploitation and, for those aged 16 and above, routine enquiry, so that every young person is asked about violence and abuse. ■ Ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to appropriate evidence-based services. Those who are found to be more symptomatic who are suffering from a mental health disorder should be referred to a specialist mental health service. ■ Specialist services for children and young people's mental health should be actively represented on Multi-Agency Safeguarding Hubs to identify those at high risk who would benefit from referral at an earlier stage. ■ For the most vulnerable young people with multiple and complex needs, strengthening the lead professional approach to co-ordinate support and services to prevent them falling between services. ■ Improving the care of children and young people who are most excluded from society, such as those involved in gangs, those who are homeless or sexually exploited, looked-after children and/or those in contact with the youth justice system, by embedding mental health practitioners in services or teams working with them.
Transitional psychiatry	■ Promoting implementation of best practice in transition, including ending arbitrary cut-off dates based on a particular age. ■ The Taskforce does not wish to be prescriptive about the age of transition, but does recognise that transition at 18 will often not be appropriate. We recommend flexibility around age boundaries, in which transition is based on individual circumstances rather than absolute age, with joint working and shared practice between services to promote continuity of care.

Country, year (reference)	United Kingdom, 2015 [131]
Conclusion	
Conclusion of the document	The work of the Taskforce has revealed great potential to meet the desire for children and young people to have better support and care for their mental health. The economic argument and evidence for effective interventions make a strong case for putting national energy and effort into supporting the expectations that have emerged. We have described a vision for our country in which child mental health and wellbeing is everybody's business, where our collective resilience and mental strength is regarded as an asset to the nation in the same way as we prize our levels of attainment, creativity and innovation. These have been set out clearly in the report and are illustrated by the additional money already identified for eating disorder services from April this year. The work of the Taskforce has reconfirmed that we are by no means alone in the international community in grappling with how to give our children and young people a better start, to keep them safe and to help their mental health and resilience. It would be a hallmark of our progress if by 2020 we could truly say that England is leading the world in improving the outcomes for children and young people with mental health problems. We know that it is possible. But it will only happen if we decide with resolve and determination to place such a goal at the heart of the economic and social vision for our nation.
Additional relevant document(s)	
Title of the document(s)	■ Cross-Government Suicide Prevention Workplan, 2019: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf ■ The Five Year Forward View for Mental Health, 2016: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf ■ Counselling in schools: a blueprint for the future, 2016: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497825/Counselling_in_schools.pdf

Abbreviations: NA – not available, NR – not reported

Quality assessment of the included documents

Table A-12: Quality assessment of the included documents

Quality Assessment Check	AU, 2022 [120]	AU, 2021 [121]	AU, 2013 [122]	CH, 2020 [123]	CH, 2016 [124]	CH, 2016 [125]	CH, 2015 [126]	CZ, 2020 [127]	DE, 2021 [128]	ES, 2018 [129]	NO, NR [130]	UK, 2015 [131]
Domain 1: Scope and Purpose												
1. The overall objective(s) of the guideline [document] is (are) specifically described.	7	7	7	7	7	4	5	7	7	7	7	7
2. The health question(s) covered by the guideline is (are) specifically described.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3. The population (patients, public, etc.) to whom the guideline [document] is meant to apply is specifically described.	7	6	7	6	5	5	5	6	6	6	7	6
Domain 2: Stakeholder Involvement												
4. The guideline [document] development group includes individuals from all the relevant professional groups.	7	7	6	7	7	7	7	6	7	7	7	7
5. The views and preferences of the target population (patients, public, etc.) have been sought.	7	7	7	5	3	3	3	3	6	7	7	6
6. The target users of the guideline [document] are clearly defined.	4	4	4	4	5	4	4	4	7	7	7	7
Domain 3: Rigour of Development												
7. Systematic methods were used to search for evidence.	1	1	1	1	1	1	1	1	1	1	3	1
8. The criteria for selecting the evidence are clearly described.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9. The strengths and limitations of the body of evidence are clearly described.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
10. The methods for formulating the recommendations are clearly described.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
12. There is an explicit link between the recommendations and the supporting evidence.	4	7	4	3	7	3	5	6	3	4	7	5
13. The guideline has been externally reviewed by experts prior to its publication.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
14. A procedure for updating the guideline is provided.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Domain 4: Clarity of Presentation												
15. The recommendations are specific and unambiguous.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
16. The different options for management of the condition or health issue are clearly presented.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
17. Key recommendations are easily identifiable.	6	7	6	5	7	5	6	6	7	7	7	7

Quality Assessment Check	AU, 2022 [120]	AU, 2021 [121]	AU, 2013 [122]	CH, 2020 [123]	CH, 2016 [124]	CH, 2016 [125]	CH, 2015 [126]	CZ, 2020 [127]	DE, 2021 [128]	ES, 2018 [129]	NO, NR [130]	UK, 2015 [131]
Domain 5: Applicability												
18. The guideline [document] describes facilitators and barriers to its application.	5	6	4	5	7	5	6	6	6	5	7	7
19. The guideline provides advice and/or tools on how the recommendations can be put into practice.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
20. The potential resource implications of applying the recommendations have been considered.	5	6	4	6	7	6	6	7	7	6	7	7
21. The guideline [document] presents monitoring and/or auditing criteria.	7	7	6	5	7	5	5	6	7	6	7	6
Domain 6: Editorial Independence												
22. The views of the funding body have not influenced the content of the guideline.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
23. Competing interests of guideline development group members have been recorded and addressed.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Overall quality of this guideline/document (1 – lowest possible quality, 7 – highest possible quality)	**60 of 77 (78%)**	**65 of 77 (84%)**	**56 of 77 (73%)**	**54 of 77 (70%)**	**63 of 77 (82%)**	**48 of 77 (62%)**	**53 of 77 (69%)**	**58 of 77 (75%)**	**64 of 77 (83%)**	**63 of 77 (82%)**	**73 of 77 (95%)**	**66 of 77 (86%)**

Abbreviations: AU – Australia; CH – Switzerland; CZ – Czechia; DE – Germany; ES – Spain; NA – not applicable; NO – Norway; NR – not reported; UK – United Kingdom

Indicators in child and adolescent mental health care

Table A-13: List of indicators clustered according to Peitz et al. [24]

Indicator	Description	Source
Mental Health Resources		
School Readiness	Assessment of readiness for school in pupils, which covers cognitive functioning, communication (ability to understand and to use spoken language) and development	[151, 155]
Engagement with learning	Assessment of different aspects of learning participation, e.g. school attendance, students liking school, how many young people can reach a certain level of education and show good skills in certain school subjects	[151-153, 155]
Classmate support	Percentage of young people who agree that their classmates are kind and helpful	[152, 158]
Children and adolescents with a positive connection with their parent or guardian	Percentage of young people who say they can talk to their parents/guardians and feel understood	[151, 157]
Positive self-esteem	Percentage of students who report positive self-esteem, based on self-reporting that they usually felt good about themselves	[149]
Pro-social behaviour	Percentage of pupils with a "normal" score on the pro-social scale of the Strengths and Difficulties Questionnaire (SDQ)	[151, 152]
Healthy Lifestyle	Percentage of children and adolescents meeting or not exceeding national recommendations in the relevant categories (e.g. diet, physical activity, sleep)	[151, 152]
Spirituality	Assessment of spirituality	[151]
Emotional intelligence	Assessment of emotional intelligence	[151]
Relationships with other children and adolescents	Percentage of pupils who have close friends (and/or romantic relationships) and find it easy to talk to friends	[151, 152]
Acceptance by peers	Percentage of pupils who strongly agree or agree that other pupils accept them as they are	[151]
Educational environment	Assessment of the educational environment aspects from pupils (e.g. treatment by teachers, relationship with teachers, school ethos)	[151, 152]
Play and free time	Assessment of play behaviour (e.g. encouragement, access to imaginative, spontaneous play, time) and percentage of pupils who felt that they were able to do the things that they wanted to do in their free time	[151]
Neighbourhood satisfaction	Percentage of pupils who feel safe, experience social support and trust from people in their living environment	[151, 152]
Participation of children and adolescents	Percentage of children and adolescents who participate in clubs, groups, organisations and politics	[151, 152]
Sense of agency and respect of children's rights	Assessment of whether children and young people believe that they can make a positive difference in the world and feel their rights are respected by others	[151, 152]
Physical environment	Evaluation of the physical environment of children and adolescents (e.g. house conditions, overcrowding, free time places)	[151, 153]
Mental Health Risks		
Sexual health	Pregnancies (registered births and stillbirths combined with notifications of abortions) in children and young people in the past year and percentage of pupils who reported having had sexual intercourse (using a condom)	[151]
Children in need	The number of children identified as 'in need' due to misconduct or certain situations e.g. abuse, neglect, family stress or parent disability or illness	[152, 155]

Indicator	Description	Source
Repeat child protection cases	The number of children who became the subject of a child protection plan for a second or subsequent time during the year expressed as a percentage of all new child protection cases during the year	[155]
Children subject to a child protection plan	The number of children who were subject of a child protection plan	[151, 155]
Children in care	The number of children who started to bee looked after and children in care in a specific time frame	[151, 155]
Looked children whose emotional wellbeing is a cause of concern	Proportion of looked after children in the area who are affected by poor emotional wellbeing (measured with e.g. the Strengths and Difficulties (SDG) Questionnaire)	[155]
Children leaving care	The number of children who ceased to be looked after by local authorities during the year	[155]
Family homelessness	Households eligible for assistance, are unintentionally homeless and in priority need	[151, 155]
Risky behaviours	Percentage of 15 year olds who responded to a number of questions and reported having undertaken at least three unhealthy/illegal behaviours	[155]
Long-term illness, disability or medical condition	Percentage of children and adolescents who have a long-standing physical condition or disability and percentage of children and adolescents who are limited in their daily activities as a result	[151, 152, 155]
School exclusion	The rate of school suspensions	[150-153, 155]
Pupil absence	Percentage of half days missed by pupils due to overall absence	[155]
Learning disability	Number of school pupils identified as having specific, moderate, severe, profound or multiple learning disabilities	[155]
Experience with bullying (incl. cyberbullying)	The percentage of children and adolescents who were bullied/cyberbullied and percentage of children who bullied another person in the past couple of months	[151, 152, 155]
Alcohol consumption	The percentage of adolescents of regular drinkers and their alcohol consumption (e.g. evaluation by using the CAGE questionnaire)	[151, 155]
Smoking	Percentage of 15 years olds and their cigarette consumption	[155]
Drug consumption	Percentage of 12 years olds and their drug consumption	[153, 155]
Entrants to the youth justice system	Proportion of 10-17 year olds receiving a (first) referral	[155]
Developmentally vulnerable children	Estimated Prevalence of developmentally vulnerable children	[153]
Sadness	Percentage of pupils who felt sad quite often, very often or always in the last week	[151]
Family relations and structure	Assessment of different aspects that evaluate the family situation and structure (e.g. divorce rates, lone parent family, treatment by parents, parental discord or children and adolescents caring for a family member)	[151, 152]
Parental health and healthy living	Assessment of different aspects that evaluate parental healthy living (e.g. physical activity, maternal smoking/drug consumption in pregnancy, parental drug consumption)	[151, 152]
Parental mental health problems	Assessment of parental mental wellbeing and mental health (e.g. common mental health problems, postnatal depression)	[151, 152]
Peer relationship problems	Percentage of children and adolescents with a 'borderline' or 'abnormal' score on the peer relationship problems scale of the Strengths and Difficulties Questionnaire (SDQ)	[151, 152]
Pressure (e.g. in school, life) and stress	Assessment of whether children and young people feel pressure (e.g. pressure of school work, pressure to fit in, time pressure) and stress (experience of tree or more stressful life events)	[151, 152]
Feeling lonely	Percentage of pupils who felt lonely in the last week	[151, 152]

Indicator	Description	Source
Discrimination and stigma	Assessment of discrimination and harassment, perception of attitude of adults, stigma towards children and young people (with disabilities and without)	[151-153]
Violence	Percentage of children and young people with experience in domestic abuse and neighbourhood violence	[151, 152]
Culture	Assessment of perception of looks, body image and other values important for children and adolescents	[151, 152]
Problematic social media usage	Mean score for pupils on the social media disorder scale	[152]
Mental Health Literacy		
Care seeking among adolescents with symptoms of depression and/or anxiety	Percentage of adolescents reporting symptoms of depression and/or anxiety reporting contact with health professional or counsellor for mental health care	[157]
Positive Mental Health		
Positive self-rated health and mental health	Percentage of students perceive their health and mental health in general to be good	[149, 151, 152]
Life satisfaction	Assessment of the life satisfaction of children and young people (e.g. by using the Warwick-Edinburgh Mental Wellbeing Scales "WEMWBS")	[149, 151, 152, 155, 158]
(Mental) wellbeing	Measurement of (mental) wellbeing from child and adolescents	[151, 152]
Happiness	Percentage of pupils who feel very happy with their life at present	[151]
Psychopathology		
Self-reported mental illness and substance use for youth	Number of children and adolescents who report mental illness and substance use	[150]
Common mental disorders	The estimated proportion of children and adolescents who have a common mental disorder	[150, 151, 155]
Mental disorders in children and young people	The estimated number of children and adolescents suffering from a mental illness (in total and divided according to different disorders e.g. depression, ADHA, emotional disorders, conduct disorders, hyperkinetic disorders, and eating disorders...)	[149-151, 153, 155, 157, 158]
Symptom load	Number and severity of symptoms of a mental disorder	[156]
Emotional and behavioural problems/symptoms	The estimated number of children and adolescents suffering from a emotional and behavioural disorder (in total and divided according to different disorders e.g. conduct problems, hyperactivity)	[149, 151-153, 155, 157]
Neonatal abstinence syndrome	Prevalence of babies with neonatal abstinence syndrome	[150]
Drug-related disorders	Hospitalised children and young people and under discharged in the past year for mental and behavioural disorders due to psychoactive substance use (general acute and psychiatric hospitals)	[151]
Eating disorders	Prevalence of eating disorders in children and young people aged 17 years and under	[151, 152]
Self-Harm and Suicidality		
Self-harm	Incidence rate of intentional self-harm (e.g. self-poisoning or self-injury) and hospitalism rate due to self-harm	[151, 152, 155]
Suicidal thoughts	Percentage of adolescents reporting suicidal thoughts in the last 2 weeks	[157]
Suicide and suicide attempts	Deaths from intentional self-harm or by events of undetermined intent and suicide attempts by children and adolescents	[149-151, 153, 157, 158]

Indicator	Description	Source
Supply and Utilization of Mental Health Care		
Admissions of children to child and adolescent acute inpatient units	Admissions of children to child and adolescent acute inpatient units as a percentage of the total number of admissions of children to mental health acute inpatient units	[154]
Child and adolescent community mental health (teams/services)	Number of child and adolescent existing CAMH (services/teams)	[154]
Child and adolescent day hospital (teams)	Number of existing day hospital (teams)	[154]
Number of paediatric liaison teams	Number of paediatric liaison teams	[154]
Population access to specialised clinical mental health care	The percentage of consumers who reside in the state/territory and received care from a state/territory specialised mental health service (including admitted patient mental health care services, ambulatory mental health care services and residential mental health care services)	[153]
Physicians' full-time equivalent allocation to mental healthcare for children and youth	Capacity of family physicians, paediatric physicians and psychiatrists who provide mental health services	[150]
Child/adolescent admission to child and adolescent mental health inpatient units	Number of admissions to child and adolescent inpatient units	[150, 154, 155]
Bed days used in child and adolescent acute inpatient units	Percentage of bed days used in CAMHs units as to total of bed days used	[154]
Length of stay for psychiatric hospitalisations	The average length of stay of in psychiatric inpatient units of children and youth	[150, 153]
Rate of readmission after a mental health and addictions-related hospital discharge	Number of children and adolescents readmitted to hospital due to addiction or mental health and due to a non-addiction or mental health related reason	[150, 153]
Rate of community and outpatient visits (mental health and addictions)	Number of children and adolescent visits to community and outpatient visits related to mental health and addiction	[150, 153, 155]
Treatment days per three month community mental health care period	The average number of community mental health treatment days per three-month period of ambulatory care provided by state/territory specialised community (also known as ambulatory) mental health service unit(s).	[153]
Child/adolescents referrals (incl. re-referred) received by mental health services	Number of child/adolescents referred to each CAMHs	[152, 154]
Child/adolescents referrals (incl. re-referred) accepted by mental health services	Number of child/adolescent accepted by each CAMHs	[153-155]
New (incl. re-referred) child/adolescent offered first appointment for the current month (seen and did not attend)	Number of new (including re-referred) children/young people who received a first appointment the current month and were seen or did not attend their first appointment	[154]
New (incl. re-referred) child/adolescent referrals seen in the current month	Number/percent of accepted referrals seen by CAMHs in the current month	[154]
(Teams) Number of active cases	The total number of cases currently active (in the team) at a given time point	[154]
Urgent referrals (incl. re-referrals) to child and adolescent mental health teams/units	Number of urgent referrals (incl. re-referrals) to child and adolescent mental health team/units	[150, 154]
Consultation appointments	The total number of Consultation appointments, clinic, home, hospital, school or other (incl. face-to-face and teleconsultations)	[150, 154]
Specific services	Number and distribution of specific services (e.g. for small children (infant psychiatry) or young people with addiction problems)	[150, 153]

Indicator	Description	Source
Children and youth were seen by a psychiatrist	Number of children and adolescents seen by a psychiatrist	[150]
Children and youth were treated for certain indications (e.g. mental health or addictions)	Treatment rates of children and adolescents for certain indications (e.g. mental health or addictions)	[150]
Youth in provincial correctional centres using mental health and addictions services	Number of youth in provincial correctional centres using mental health and addiction services	[150]
Emergency department visits (mental health and addictions)	Number of children and adolescents emergency department visits related to mental health and addiction and rate	[150]
Emergency department visits as first contact	Rate of children and youth seen in the emergency department for acute mental health, self-harm and addiction problems with no prior medical mental health care.	[150]
Children and adolescents returning to the emergency department for mental health and addiction within 30 days	Rate of 30-day repeat unscheduled emergency department visit after a mental health and addictions-related emergency department discharge for children and youth	[150]
Emergency department visits as first point of contact for that resulted in admission	The proportion of emergency department first-contact visits for mental health and addiction that resulted in an inpatient admission and the proportion discharged home.	[150]
Most common prescription mental health drugs	Annual incidence of the most common classes of prescription mental health drugs among children and youth	[149]
Treated prevalence of schizophrenia in children and youth	Number of children and youth treated for schizophrenia at inpatient or outpatient settings	[150]
Quality of care		
Children/adolescents admitted to adult mental health inpatient units	Number of children/adolescents admitted to adult mental health inpatient units	[154]
Number of cases closed/discharged by CAMHs	Number of cases closed/discharged by CAMHs	[154]
Change in mental health consumer's clinical outcomes	The proportion of episodes of care where either a significant improvement, significant deterioration or no significant change were identified between baseline and follow-up of completed outcome measures	[153]
Impact on consumers, families and others	The proportion of admissions to community care where the parent's assessment of the consumer's social impairment and distress is at approximately the 95th percentile compared with community norms	[153]
Post-discharge community mental health care	Examination whether children and youth were seen in an outpatient setting within one week following a mental health and addictions related hospital discharge	[150, 153]
Seclusion rate	The number of seclusion events per 1,000 patient days within public acute admitted patient specialised mental health service units	[153]
Measures restricting freedom	Proportion of children and adolescents with at least one measure restricting freedom (e.g. isolation, fixation, restraint and medication despite patient resistance)	[153, 156]
Involuntary treatment and involuntary patient days	Number of admitted patients with specialised mental health care days where the consumer has a mental health legal status of "involuntary"	[153]
Hospital admission as first contact for mental health and addictions for children and youth	Number of children and adolescents admission to hospital as first contact for mental health and addictions	[150]
Accepted referrals/re-referrals offered first appointment and seen within a given time point by child and adolescent community mental health teams	Percent to be seen for a first appointment within a given time point (e.g. 12 weeks or 12 months)	[154]

Indicator	Description	Source
Costs due to Mental Disorders		
Costs per acute mental health admitted patient day	Average cost of a patient day provided by state/territory acute admitted patient mental health care service units	[153]
Costs per community mental health treatment day	The average cost per community treatment day provided by state/territory specialised community (also known as ambulatory) mental health care service unit(s)	[153]
Costs for care and accommodation of vulnerable children and young people	The average costs for care and accommodation of children and young people (e.g. children in care, safeguarding children and young people's services, youth justice etc.; rate per 10,000 aged 0-17)	[155]
Burden of Disease and Mortality		
Functional limitations among adolescents with depression and/or anxiety	Percentage of adolescents reporting symptoms of depression anxiety, or functional limitations in daily activities/relationships (school/work, family, peers)	[157]
Needs, Unmet Needs and Barriers in Mental Health Care		
Special educational needs	The number of pupils identified as having special educational needs (in total and split in pupils identified as having social, emotional and mental health as their main need)	[150, 155]
Additional support needs	Pupils classified as having additional support needs	[151]
Wait time and total no. on waiting list for first appointment	The time elapsed from the point at which the referral is received by a member of a CAMHs team to the day the assessment takes place (raised with different time windows e.g. waiting at the end of the month or waiting from 3-6 months)	[150, 154]
General practitioner (GP) registered population with mental disorders aged 5-16	The estimate of the percentage of children aged 5-16 who have mental disorders (hyperkinetic disorder, eating disorder …) based on the age, sex and socio-economic classification of children registered to GP practices	[155]
Mental health service users on care programme approach	Number of people on care programme approach at the end of the reporting period as a proportion of all people in contact with mental health services	[155]
Unmet need for mental health care among adolescents with symptoms of depression and/or anxiety	Percentage of adolescents reporting symptoms of depression and/or anxiety, having no contact with health professionals or counsellors for mental health care	[157]
Sociodemographic variables with an impact on public mental health		
Positive and sustained destinations	Percentage of school leavers in positive and sustained destinations 9 months after leaving school	[151, 152]
General certificate of secondary education achieved for children in care	Assessment of how many young people living in care are able to reach a certain level of education	[155]
Children and adolescents in low income families	Percentage of children in low income families and/or living in poverty (absolute, relative and persistent poverty)	[151, 152, 155]
Income inequality	Gini coefficient for households with children aged 17 years and under	[151]
Equality analysis	Analysis of different indicators, e.g. deprivation, rurality, children with additional support needs and children looked after, where data allow	[151, 152]
Workless households	Percentage of children and young people aged 15 years and under who live in workless households	[151]
Free school meals	The percentage of pupils known to be eligible for and claiming free school meals	[155]
Unaccompanied Asylum Seeking Children looked after	The number of unaccompanied asylum seeking children looked after	[155]
16-17 year olds not in education, employment or training or whose activity is not known	Proportion of 16-17 year olds not in education, employment or training or whose activity is not known	[155]

Table A-14: Data sources of indicators

Country		Data source	Source
Canada	**1**	Yang J, Kurdyak P and A. G. Developing Indicators for the Child and Youth Mental Health System in Ontario. Healthc Q. 2016;19(3):6-9. DOI: 10.12927/hcq.2016.24865. https://www.ices.on.ca/Publications/Atlases-and-Reports/2017/MHASEF [cited 12.08.2022] https://www.ices.on.ca/Publications/Atlases-and-Reports/2015/Mental-Health-of-Children-and-Youth [cited 12.08.2022]	[150]
	2	https://www.childhealthindicatorsbc.ca/sites/default/files/CHBC-PHO%20CY%20Health%20Report%20Nov%202016%20-%20WEB.pdf [cited 12.08.2022]	[149]
Australia		https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/indicators/key-performance-indicators-for-australian-public-mental-health-services [cited 12.08.2022] https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan.pdf [cited 12.08.2022] https://meteor.aihw.gov.au/content/584825 [cited 12.08.2022] https://www.aihw.gov.au/getmedia/f9bb1a07-a43b-458a-9b73-64ef19d8aedd/Key-Performance-Indicators-for-Australian-Public-Mental-Health-Services-Third-Edition.pdf.aspx [cited 12.08.2022] Furhter document "Aspects of recovery for children and adolescents according to parents/carers" for download on the webpage: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/indicators/mental-health-indicator-library [cited 12.08.2022]	[153]
Scotland	**1**	https://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/HealthImprovement/Documents/Childrens%20and%20Young%20Persons%20Mental%20Health%20Full%20Scot PHO%20Report%20Dec%202013.pdf [cited 12.08.2022]	[151]
	2	Two Documents (Children And Young People Mental Health Indicator Set; Children And Young People Mental Health Indicator Rationeles) available under the following webpage: https://publichealthscotland.scot/publications/children-and-young-people-mental-health-indicator-resources/	[152]
Ireland		https://www.hse.ie/eng/services/publications/kpis/key-performance-indicators-acute-metadata-2022.html [cited 12.08.2022]	[154]
UK		Different webpages to choose from the website: https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh [cited 12.08.2022] Further Document "Indicator list CYPMH" for download on the given webpage: https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh [cited 12.08.2022]	[155]
Switzerland		https://www.anq.ch/wp-content/uploads/2019/08/ANQ_PSY_KJP_Manual_ab_2020.pdf [cited 12.08.2022]	[156]
UNICEF		Document for download can be found on: https://data.unicef.org/resources/adolescent-health-indicators/ [cited 12.08.2022]	[157]
WHO		https://gateway.euro.who.int/en/datasets/cah/#mental-health-and-well-being [cited 12.08.2022]	[158]

HTA Austria
Austrian Institute for
Health Technology Assessment
GmbH