HTA Austria
Austrian Institute for
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GmbH

Transition from Child and Adolescent to Adult Mental Health Services

Analysis of International Models and Recommendations for Action for Austria

Final report

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List of abbreviations

ADHD.....Attention Deficit and Hyperactivity Disorder
AGREE II .....Appraisal of Guidelines for Research & Evaluation II
AMHS .....Adult Mental Health Services
BMSGPK .....Federal Ministry of Social Affairs, Health, Care and Consumer Protection *(German: Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz)*
CALD.....Culturally and Linguistically Diverse
CAMHS .....Child and Adolescent Mental Health Services
CETR .....Care, Education and Treatment Reviews
CPA .....Care Programme Approach
EP .....Adult Psychiatry *(German: Erwachsenenpsychiatrie)*
GBD .....Global Burden of Disease Study
HBSC .....School-aged Children Study
HDI .....Human Development Index
KJP .....Child and Adolescent Psychiatry *(German: Kinder- und Jugendpsychiatrie)*
MHAT study.....Mental Health in Austrian Teenagers
MHS .....Mental Health Services
MT.....Managed Transition
OECD .....Organisation for Economic Co-operation and Development
RCT.....Randomised Controlled Trial
RQ .....Research Question
SAGES .....Salzburg Health Fund *(German: Salzburger Gesundheitsfonds)*
SMI.....Severe Mental Illness
SUD.....Substance Use Disorders
TRAM .....Transition Readiness and Appropriateness Measure
TRAQ.....Transition Readiness Assessment Questionnaire
TROM.....Transition-Related Outcome Measure
UNICEF .....United Nations Children's Fund
UK.....United Kingdom
WHO.....World Health Organization
YLD.....Years Lived with Disability
YP .....Young People

Abstract

Background

The transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) is a critical phase, often characterised by care discontinuities and high dropout rates. Approximately 45% of CAMHS patients require ongoing care, but only a small proportion receive further regular treatment, and only 4.4% experience an optimal transition, which involves adequate planning, effective collaboration, and information sharing between teams, as well as continuity of care after transfer. Key barriers include rigid age limits, poor coordination and a lack of protocols. In 2018, for example, only two out of 28 European countries reported having formal guidelines in place. Similarly, a pilot study in Austria from 2018 demonstrated that 98.8% of the professionals rated the transition system as inadequate, emphasising the necessity of standardised protocols, interprofessional collaboration, and legal regulations.

transition from CAMHS to AMHS is marked by care gaps and high drop-outs

2 of 28 European countries with transition guidelines (2018) – 98.8% of experts in Austria rate transitional care as inadequate

Methods

This project systematically analysed international models and policies of transitional psychiatry, focusing on structural organisation, key characteristics, implementation approaches, and resource allocation. We carried out a multistep review to analyse international models and strategies. A structured document search was undertaken to identify guidelines, frameworks, and policy documents related to transitions in mental health. Quality appraisal was performed using an adapted version of the AGREE II instrument. Data were extracted using a combined deductive-inductive framework and synthesised using narrative analysis. Furthermore, expert consultations were conducted to provide additional information and to address missing data. Guiding starting points for the further development of transitional psychiatry in Austria were derived from the international findings, which were then validated and contextualised in further national expert consultations.

project aim: to analyse and compare international transitional psychiatry models and strategies

multi-stage review process with structured document search, deductive and inductive data analysis, quality assessment, narrative synthesis and expert consultations

Results

International models converge around several key principles: developmentally appropriate and individualised transitions, collaborative planning across sectors, flexible age limits, shared protocols, transition coordinators, and structured follow-up. Person-centred approaches, including psychoeducation, youth and parents/carers involvement, and digital tools, are emphasised to promote autonomy and reduce disengagement. Effective governance requires clearly defined roles, interdisciplinary cooperation and integrated documentation. However, implementation is hindered by workforce shortages, restrictive eligibility criteria, and financing structures that do not support transitional activities.

several internationally recognised best-practice transition principles vs. several hindering factors for implementation

Reviewing indication-specific transition models reaffirmed the general principles of high-quality transition and highlighted unique vulnerabilities and structural barriers. These include limited capacity and expertise for adult services for specific indications, misaligned eligibility criteria, reduced support intensity after transfer, the need to address stigma and medication adherence, and the need for tailored psychoeducation and awareness-raising.

further indication-specific vulnerabilities and structural obstacles identified

Austrian experts identified additional structural barriers: limited workforce capacity, fragmented reimbursement systems, and the absence of transition-specific services in the national health services catalogue (Leistungskatalog). Proposed solutions include interdisciplinary "transition boards," dual registration systems, dedicated transition budgets, reform of training regulations, and increased investment in research and evaluation.

structural barriers in Austria, such as limited workforce capacity and fragmented reimbursement systems

Overall, both international and Austrian perspectives emphasise the need to move from reactive, age-based transitions to proactive, structured, youth-centred processes. Sustainable improvement will require systemic alignment across clinical practice, education, funding and research.

proactive, structured and youth-centred process

Discussion

Despite the emerging consensus, systematic evaluations remain scarce, methodological rigour is limited, and key issues such as sustainability, resources, and cross-sectoral integration are insufficiently addressed. Divergences persist regarding the timing and intensity of planning, the background of transition coordinators, and the organisation of services.

evaluation, resources and implementation are rarely addressed and discrepancies in some topics

However, the results provide a basis for developing transitional psychiatry in Austria to better meet the needs of young people and align with existing system structures.

results provide a foundation for further development

In Austria, transitional psychiatry is still in its early stages, with recent legislative steps, such as raising the CAMHS age limit, constrained by staffing and infrastructure deficits. Sustainable implementation will require dedicated resources, sectoral restructuring, workforce development, and robust evaluation of both health and psychosocial outcomes.

Austria: early stages of transitional psychiatry – sustainable implementation required

Conclusion

International models provide guidance, but there is no single universally applicable model. The findings provided in this report provide an evidence-based foundation for further developments of Austria's transitional psychiatry, adapted to the local context.

evidence-based foundation for further developments, adapted to local context

Zusammenfassung

Hintergrund und Projektziele

Übergang von KJP zur EP von Versorgungslücken gekennzeichnet

Der Übergang von der Kinder- und Jugendpsychiatrie (KJP) zur Erwachsenenpsychiatrie (EP) ist eine sensible Phase, die häufig durch Versorgungsunterbrechungen gekennzeichnet ist. Empirische Arbeiten deuten auf hohe Abbruchquoten, ungedeckten Bedarf, unzureichende sektorübergreifende Koordinierung und lange Wartezeiten hin. Obwohl etwa 45 % der KJP-Patient:innen eine weitere Behandlung in der EP benötigen, ist der Übergang nur selten gut organisiert. Weniger als ein Drittel erhält eine weitere regelmäßige Behandlung und nur 4,4 % erfahren eine optimale Transition mit angemessener Planung, effektiver Zusammenarbeit und Informationsaustausch zwischen Teams sowie Kontinuität der Behandlung nach dem Transfer. Zu den Haupthindernissen gehören starre Altersgrenzen (in der Regel 18 Jahre), ein Mangel an Transitionsprotokollen und Kommunikation zwischen den Diensten sowie begrenzte personelle und strukturelle Ressourcen.

45 % Patient:innen haben weiteren Behandlungsbedarf, aber < als ein Drittel erhält regelmäßige Anschlussversorgung

inkonsequente Umsetzung: nur 2 von 28 europäischen Ländern mit Transitionsleitlinien (Stand 2018)

Eine randomisierte kontrollierte Studie (RCT) über die klinische Wirksamkeit und Kosteneffizienz eines Managed-Transition-Modells in acht europäischen Ländern im Rahmen des MILESTONE-Projekts konnte eine Verbesserung der Betreuungsqualität aufzeigen. Es fehlen jedoch langfristige Daten und allgemein anwendbare Erkenntnisse. Außerdem hat das MILESTONE-Projekt gezeigt, dass die Umsetzung von Transitionsstrategien uneinheitlich ist. Eine Untersuchung von 28 Ländern ergab, dass im Jahr 2018 nur zwei von ihnen – Dänemark und das Vereinigte Königreich – über nationale oder regionale Leitlinien verfügten. Ähnlich wurde in einer Pilotstudie in Österreich aus dem Jahr 2018 aufgezeigt, dass 98,8 % der Fachleute die Transitionsversorgung als unzureichend bewerteten. Dies unterstreicht den Bedarf an standardisierten Strategien und Modellen.

auch in Österreich laut Mehrheit der Fachleute Versorgungsdefizite

Projektziel: Analyse internationaler Modelle der Transitionspsychiatrie hinsichtlich Struktur, Umsetzung und Ressourcen

Das Projektziel bestand darin, internationale Modelle und Strategien der Transitionspsychiatrie systematisch hinsichtlich ihrer Unterschiede und Gemeinsamkeiten in Bezug auf ihre Merkmale, ihre strukturelle Organisation, ihre Umsetzungsstrategien und ihre Ressourcenverteilung zu analysieren und zu vergleichen. Darüber hinaus sollten förderliche und hinderliche Faktoren für eine erfolgreiche Implementierung und Umsetzung ermittelt werden. Auf Basis dieser Analyse wurden erste Anknüpfungspunkte für die Weiterentwicklung der Transitionspsychiatrie in Österreich abgeleitet.

Methoden

mehrstufiges methodisches Design

Zur Beantwortung der Forschungsfragen wurde ein mehrstufiges methodisches Design angewendet, bestehend aus strukturierter manueller Literatursuche, Dokumentenanalyse und Expert:innenkonsultationen. Zur Identifizierung von internationaler und nationaler Literatur wurde, neben dem Referenzland Österreich, in sieben ausgewählten Ländern – Australien, Belgien, Dänemark, Deutschland, den Niederlanden, der Schweiz und dem Vereinigten Königreich – eine strukturierte Literatursuche durchgeführt. Die Auswahl der Länder erfolgte auf Basis eines hohen Human Development Index (HDI ≥ 0,926), einer strukturellen Ähnlichkeit mit dem Bismarck-orientierten Gesundheitssystem Österreichs oder einer Vorreiterposition im Hinblick auf Strategien der Transitionspsychiatrie. Zusätzlich wurden internationale Organisationen (WHO, OECD, UNICEF) einbezogen, um länderübergrei-

strukturierte Handsuche, Dokumentenanalyse und Konsultationen mit Expert:innen

fende Leitlinien und Empfehlungen zu erfassen. Eingeschlossen wurden nationale oder transnationale Dokumente (z. B. Strategiepapiere, Versorgungsmodelle, Leitlinien) zur Transition von der KJP in die EP. Die Dokumente mussten durch staatliche oder gesundheitsbezogene Institutionen veröffentlicht worden sein und in deutscher oder englischer Sprache verfügbar sein oder maschinell übersetzt werden können. Zusätzlich mussten sich aus den Dokumenten relevante Charakteristika der Transition extrahieren lassen. Die Recherche erfolgte mittels strukturierter Suchsyntax.

strukturierte Literaturrecherche in 7 Ländern und internationalen Organisationen

Für die Analyse internationaler Modelle wurden insgesamt 98 relevante Dokumente identifiziert. Die auf Basis vorab definierter Ein- und Ausschlusskriterien 13 final eingeschlossenen Dokumente wurden mithilfe eines vordefinierten Kategoriensystems auf standardisierte Weise extrahiert. Die Extraktion wurde von einer Reviewerin vorgenommen und von einer zweiten Reviewerin überprüft. Die Datenanalyse erfolgte nach einem induktiv-deduktiven Prinzip, wobei vordefinierte Kategorien mit neuen, inhaltlich emergenten Themen kombiniert wurden. Die Ergebnisse wurden narrativ zusammengefasst und durch vergleichende Tabellen und grafische Visualisierungen ergänzt.

strukturierte Analyse und narrative Synthese

Einschluss von psychischen Erkrankungen anhand Inklusionskriterien

Für krankheitsspezifische Versorgungskonzepte wurden nur jene psychiatrischen Erkrankungen für die Literatursuche berücksichtigt, die mindestens zwei der folgenden Kriterien erfüllten: hohes Drop-out-Risiko oder geringe Überweisungswahrscheinlichkeit an die EP sowie hohe Prävalenz im Jugendalter und typischer Erkrankungsbeginn in der Adoleszenz. Dadurch ergab sich ein Einschluss von ADHS, Angststörungen, Depressionen, Essstörungen, Substanzmissbrauchsstörungen und Verhaltensstörungen. Von 26 identifizierten Dokumenten wurden sieben final eingeschlossen. Allerdings wurde bei der Literaturrecherche nur für drei der sechs Indikationsgruppen geeignete Evidenz zum Thema Transition gefunden.

narrative Synthese

Konsultationen mit Expert:innen

Ergänzend wurden neun internationale Expert:innen aus sechs Ländern konsultiert, um zentrale Inhalte zu ergänzen und Datenlücken zu schließen.

Qualitätsbewertung anhand adaptierter Version von AGREE II

Eine strukturierte Qualitätsbewertung aller eingeschlossenen Dokumente wurde anhand einer adaptierten Version des AGREE-II-Instruments durchgeführt.

Ableitung von Ausgangspunkten für Ö. basierend auf internationaler Evidenz und Validierung durch nationale Expert:innen

Für den anschließenden Österreich-Fokus war ein formaler Modellvergleich aufgrund des Fehlens eines nationalen Rahmenplans nicht möglich. Stattdessen wurden auf Basis der internationalen Evidenz mögliche Ausgangspunkte für Österreich zur Weiterentwicklung der Transitionspsychiatrie abgeleitet. Zur Validierung und Kontextualisierung der Ergebnisse wurden insgesamt vier nationale Expert:innen konsultiert.

Resultate

hohe Prävalenz von psychischen Erkrankungen bei Kindern und Jugendlichen

Epidemiologische Daten verdeutlichen die erhebliche psychische Belastung von Jugendlichen. Laut GBD-Studie 2019 leiden etwa 14 % der 15- bis 19-Jährigen an mindestens einer diagnostizierbaren psychischen Störung, während die österreichische MHAT-Studie 2017 eine Punkt- und Lebenszeitprävalenz von 23,93 % bzw. 35,82 % für jegliche psychiatrische Störung aufzeigte. Diese Zahlen unterstreichen die dringende Notwendigkeit strukturierter Transitionsprozesse.

2 Hauptmodelle, allerdings keines universal anwendbar – maßgeschneiderte Umsetzung notwendig

In der Praxis dominieren zwei Hauptmodelle: (1) Koordinationsmodelle, die die Übergabe zwischen der KJP und der EP stärken, und (2) jugendspezifische Dienste, die neue, altersgerechte Betreuung außerhalb der traditionellen Strukturen anbieten. Allerdings erfüllt kein Modell alle Bedürfnisse. Beide Modelle erfordern eine maßgeschneiderte Umsetzung zusammen mit einer systemischen Koordinierung und Bereitstellung von Ressourcen.

international wachsender Konsens über die wichtigsten Prinzipien einer wirksamen Transitionsversorgung

Internationale Leitlinien und Rahmenwerke spiegeln einen wachsenden Konsens über die wichtigsten Merkmale einer wirksamen Transitionsversorgung wider. Dazu gehören die frühzeitige Erkennung des Transitionsbedarfs, entwicklungsabhängige, flexible Altersgrenzen, sektorübergreifende Koordinierung, integrierte Betreuungplanung und Transitionskoordinator:innen sowie strukturierte Protokolle, gemeinsame Dokumentation und partizipativ gestaltete Modelle. Durch die Integration von Primärversorgung, Schulen und gemeindenahen Unterstützungsangeboten kann sichergestellt werden, dass die Transition über die klinischen Dienste hinaus in das breitere Umfeld der jungen Menschen eingebettet ist.

Barrieren durch Mangel an Fachkräften, strukturelle Unterschiede und limitierte Services

Zu den Haupthindernissen für die strukturierte Umsetzung und Implementierung gehören Personalmangel, isolierte Kooperationen, unflexible Altersgrenzen sowie unzureichende Erwachsenendienste oder -kompetenzen für bestimmte Indikationen.

schrittweise Implementierung und rechtliche und finanzielle Harmonisierung

Um die Nachhaltigkeit zu gewährleisten, wird eine schrittweise Implementierungsstrategie empfohlen, die durch die Einbeziehung von allen Interessengruppen unterstützt wird. Als entscheidende strukturelle Voraussetzungen werden die rechtliche und finanzielle Harmonisierung sowie klar definierte Zuständigkeiten und altersübergreifende Qualifikationen genannt.

Evaluationen mit Indikatoren auf individueller-, Service- und Systemebene

Evaluationen sollten die individuelle Ebene und die Dienstleistungs- und Systemebene umfassen. Kombinierte qualitative und quantitative Ansätze, externe Evaluierungen und regelmäßige Feedbackschleifen unterstützen zudem iterative Verbesserungen.

Indikations-spezifische Modelle legen Fokus besonders auf Entstigmatisierung, Sensibilisierung, und Psychoedukation

Die aus indikationsspezifischen Quellen gewonnenen Erkenntnisse untermauerten die allgemeinen Kernprinzipien einer qualitativ hochwertigen Transition, wobei sie insbesondere einen stärkeren Fokus auf Entstigmatisierung, Sensibilisierung und Psychoedukation legen. Darüber hinaus konnten gleichzeitig besondere Schwachstellen hervorgehoben werden. Dazu gehören begrenzte Kapazitäten und Fachkenntnisse für Erwachsenenangebote bei Aufmerksamkeitsdefizit-/Hyperaktivitätsstörung, Essstörungen und Substanzmissbrauch, uneinheitliche Aufnahmekriterien und eine geringere Unterstützungsintensität nach dem Transfer in die Erwachsenenversorgung.

Transitionspsychiatrie in Österreich noch in frühem Stadium

Darüber hinaus zeigen die Ergebnisse, dass die Transitionspsychiatrie in Österreich sich noch in einem frühen Stadium der strategischen Entwicklung und koordinierten Umsetzung befindet. Zwar gibt es Pilotprojekte und lokale Initiativen, doch es fehlt an einem umfassenden nationalen Rahmen.

österreichische Expert:innen empfehlen frühzeitige, gemeindenahe und kontinuierliche Transitionsprozesse sowie interdisziplinäre Zusammenarbeit, und Weiterbildungen

Österreichische Expert:innen stimmen den international anerkannten Grundsätzen für eine effektive Transitionspsychiatrie grundsätzlich zu. Um die mit unstrukturierten Transitionen verbundenen Risiken zu verringern, empfehlen Expert:innen eine frühzeitige Einbindung, Psychoedukation sowie gemeindenahe Dienste in Form von Tageskliniken. Zur Stärkung der Zusammenarbeit und der beruflichen Attraktivität wurden interdisziplinäre „Transitionsboards" sowie gemeinsame akademische Ausbildungsprogramme vorgeschlagen. Darüber hinaus haben Expert:innen anhaltende Hindernisse für die Umsetzung in Österreich festgestellt. So kann die seit 2024 bestehende

Möglichkeit KJP Patient:innen über das 18. Lebensjahr hinaus zu behandeln, weitgehend aufgrund begrenzter personeller Ressourcen nicht umgesetzt werden. Der Übergang wird oft informell gehandhabt, mit fragmentierter Finanzierung sowie nicht erstattungsfähigen Transitionsaktivitäten im Rahmen des aktuellen Leistungskatalogs. Darüber hinaus wurden eine nachhaltige Versorgungsforschung und eine gezielte Finanzierung, um die Evaluierung evidenzbasierter Prozesse zu unterstützen, gefordert.

Barrieren in Österreich: begrenzte personelle und infrastrukturelle Ressourcen, fragmentierte Finanzierung, wenig nachhaltige Versorgungsforschung

Diskussion

International lassen sich zwei Hauptmodelle für den Übergang unterscheiden und die Resultate zeigen eine Reihe von wiederkehrenden Prinzipien für eine qualitativ hochwertige Transition. Diese Prinzipien stehen im Einklang mit internationalen Rahmenwerken. Zudem wurden krankheitsspezifische Hindernisse, wie z. B. begrenzte Fachkenntnisse der Erwachsenenbetreuung in Bezug auf Aufmerksamkeitsdefizit-/Hyperaktivitätsstörung, Ess- und Substanzmissbrauchsstörungen sowie anhaltende Stigmatisierung und nicht aneinander angepasste Zugangskriterien aufgedeckt.

wiederkehrende Prinzipien als Grundlage für Transitionsstrategie

In den Ergebnissen wurden Evaluierung, Nachhaltigkeit der Ressourcen und Implementierung nur selten thematisiert. Außerdem gab es Diskrepanzen, vor allem in den Bereichen Zeitpunkt und Intensität der Übergangsplanung, Hintergrund der Transitionskoordinator:innen sowie strukturelle Organisation der Dienste.

Evaluierung, Ressourcen und Implementierung selten thematisiert und themenbezogene Diskrepanzen

Die Qualitätsbewertung ergab methodische Schwächen, und es gibt nur begrenzte systematische Evaluierungen und Langzeitdaten, sodass die Ergebnisse eher als Anhaltspunkte, denn als streng evidenzbasierte Richtlinien zu verstehen sind.

methodische Schwächen in Qualitätsbewertung aufgezeigt

Die Ergebnisse bieten zusammengenommen eine Grundlage für Überlegungen, wie die Transitionspsychiatrie in Österreich weiterentwickelt werden könnte, um besser auf die Bedürfnisse junger Menschen und die bestehenden Systemstrukturen abgestimmt zu sein.

Grundlage für mögliche Weiterentwicklung in Österreich

Die Transitionspsychiatrie in Österreich ist noch in einem frühen Stadium der strategischen Entwicklung und koordinierten Umsetzung. In Zukunft sollte die Entwicklung einer nationalen Strategie kooperativ erfolgen und Grundsätze der öffentlichen Gesundheit wie Partizipation, Empowerment, Prävention, frühzeitige Intervention und Stigmatisierungsabbau einbeziehen. Auch wenn die hier identifizierten Modelle als Grundlage für Österreich dienen können, sind die Abstimmung mit bestehenden Rahmenwerken für die Gesundheit von Kindern und Jugendlichen sowie die Anpassung an den österreichischen Kontext dennoch von entscheidender Bedeutung. Eine nachhaltige Umsetzung erfordert eine sektorale Umstrukturierung, zweckgebundene Finanzmittel, die Aus- und Weiterbildung von Fachkräften und eine intensive Zusammenarbeit zwischen Gesundheits-, Bildungs- und Sozialdiensten. Die kürzlich erfolgte Anhebung der Altersgrenze für CAMHS über 18 Jahre hinaus ist ein wichtiger Schritt in die richtige Richtung, verdeutlicht jedoch die Grenzen gesetzgeberischer Änderungen ohne ausreichende personelle und finanzielle Ressourcen.

Abstimmung mit bestehenden Rahmenwerken und Anpassung an nationalen Kontext

Notwendigkeit von ausreichendem Personal und finanziellen Mitteln

strenge Evaluierungen mit langfristigen Daten sowie Prävalenz von problematischen Transitionen erforderlich

Transition muss zudem im Rahmen von neuen Versorgungsmodellen untersucht werden

Um die gesundheitsökonomischen Argumente für strukturierte Transitionsmodelle zu untermauern, sind strenge Evaluierungen erforderlich, die langfristige gesundheitliche und psychosoziale Ergebnisse berücksichtigen. Darüber hinaus fehlen in Österreich zuverlässige Daten darüber, wie viele junge Menschen direkt von problematischen Transitionen betroffen sind. Diese Lücke zu schließen ist für gezielte politische Maßnahmen unerlässlich. Schließlich sollten künftige Forschungsarbeiten Transitionen innerhalb neu entstehender Versorgungsmodelle in Österreich untersuchen, wie beispielsweise Home Treatment. Darüber hinaus wirft die Priorisierung in Österreich digitaler und gemeindenaher Versorgung gegenüber stationärer Behandlung neue Fragen für die Transitionspsychiatrie auf, wie beispielsweise die Unterstützung der Kontinuität bei digitalen Konsultationen.

Limitationen

vorsichtige Interpretation der Ergebnisse aufgrund diverser methodischer und konzeptioneller Einschränkungen

Bei der Interpretation der Ergebnisse dieses Berichts sollten mehrere methodische und konzeptionelle Einschränkungen berücksichtigt werden. Die Literaturrecherche war zwar umfangreich, aber nicht systematisch. Sie konzentrierte sich hauptsächlich auf graue Literatur, was das Risiko einer unvollständigen Suche erhöht. Die Datenverfügbarkeit zwischen den ausgewählten Ländern war sehr unterschiedlich, was zu potenziellen Ungleichgewichten in der vergleichenden Analyse führte. Zudem wurden einige relevante Dokumente aufgrund ihres unspezifischen Fokus ausgeschlossen. Expert:innenkonsultationen repräsentieren zudem möglicherweise nicht alle Perspektiven vollständig. Außerdem wurden in allen Ländern Lücken in der Dokumentation festgestellt, vor allem in den Bereichen Finanzierung, personelle Ressourcen und Evaluierung.

Schlussfolgerung

Evidenzbasis für an Kontext angepasste Entwicklung der Transitionspsychiatrie

Zwar bieten internationale Modelle Leitprinzipien für die Transitionspsychiatrie, jedoch gibt es kein universal anwendbares Modell. Dennoch können die in diesem Bericht beschriebenen Best-Practice-Grundsätze als Evidenzbasis für eine kontextspezifische Entwicklung der Transitionspsychiatrie herangezogen werden. Die Entwicklung einer nationalen Strategie, die in Rahmenwerke für die psychische Gesundheit von Jugendlichen eingebettet ist und durch spezielle Ressourcen unterstützt wird, wird von entscheidender Bedeutung sein. Zu den größten Herausforderungen in Österreich gehören begrenzte Personalkapazitäten, fragmentierte Strukturen und Finanzierung. Die Ergebnisse sollen eine Wissensbasis darstellen und die strategische Planung für ein kohärenteres, integratives und nachhaltiges System der psychischen Transitionsversorgung für junge Menschen unterstützen.

1 Introduction

1.1 Background

Übergang zum Erwachsenenalter ist der Zeitraum, in dem die meisten Psychopathologien auftreten

psychische Erkrankungen als Ursache für 45 % der Krankheitslast bei 10- bis 24-Jährigen

In adolescent development, the transition phase refers to the developmental period between the ages of 15 and 25, thus marking the transition from childhood to young adulthood [1]. Adolescence and young adulthood represent critical developmental periods, during which most psychopathologies occur [2]. On one hand, massive changes are happening in the neuronal systems [3]. On the other hand, the transition phase is usually characterised by important life changes for young people (YP), such as those related to education, relationships and life circumstances [4]. In fact, mental health accounts for 45% of the total burden of disease in people aged ten to 24 and is the leading cause of disability in this age group [5]. Epidemiological data consistently demonstrate high prevalence rates of depression, anxiety disorders, attention deficit hyperactivity disorders (ADHD), and substance use disorders (SUD) in this age group [6, 7].

Übergang vom Kindesalter zum jungen Erwachsenenalter ist ein vielschichtiger, aktiver Prozess

Transition ist abgeschlossen, wenn Individuum erfolgreich in Erwachsenenversorgung integriert ist und dort funktioniert

The transition in healthcare is described as a 'multifaceted, active process that attends to the medical, psychosocial, and educational/vocational needs of adolescents as they move from the child-focused to the adult-focused healthcare system' [8]. This definition was originally formulated for pediatric chronic somatic care and later applied by analogy to transitions from child and adolescent to adult mental health care services. The understanding of transitions in healthcare has evolved from a narrow focus on administrative handovers between paediatric and adult services to a broader developmental process, with emphasis on preparing and empowering YP and shared responsibility between paediatric and adult teams [9]. It is important to distinguish between transfer, which refers to the moment when a young person moves into adult care, and transition, which encompasses the entire continuum of support [9]. Transition is not complete at the point of transfer but only once the young person is successfully integrated and functioning within the adult care system. Accordingly, transition should not be understood as a single time point, marked by reaching a specific age, but rather as a developmentally appropriate process [9]. The transition can occur at various service levels, including inpatient and outpatient settings within hospital departments and clinics, as well as private practice with general practitioners (GPs) and specialists [10].

Transitionspsychiatrie ist das gemeinsame Arbeitsfeld von Kinder- und Jugend- (KJP) sowie Erwachsenenpsychiatrie (EP)

notwendiger Wechsel von der KJP zur EP mit ca. 18 Jahren führt häufig zu Diskontinuität in der Versorgung

…

Transitional psychiatry is a joint area of child and adolescent psychiatry and adult psychiatry that provides YP with an appropriate framework for navigating the developmental tasks associated with adulthood [11]. The distinction between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS) is deeply rooted in European psychiatric care and tradition [12, 13]. Although there is no clear international consensus on where one ends and the other begins [14], the switch between them becomes necessary for many YP usually on their 18th birthday [12, 13]. However, important development processes, such as grey and white matter cortical pruning, ongoing white matter tract development, and the later maturation of prefrontal regulatory areas compared to the nucleus accumbens and the amygdala, continue into the mid-to-late twenties. These processes have significant effects on executive functioning, attention control, and emotion regulation [15]. Furthermore, mental disorders frequently result in developmental delays [16],

which could indicate that these young individuals often have not yet attained adult maturity. Consequently, this developmental transition into adulthood requires expertise from both CAMHS and AMHS [10, 17]. This is also the reason why many models have sought to ease the transition by extending the CAMHS boundary beyond the age of 18 [18, 19].

… neurobiologische Entwicklung und exekutive Funktionen reifen auch nach Erreichen des 18. Lebensjahres weiter

Although transitional psychiatry research commonly frames the population as youth engaged with CAMHS at the transition boundary to adult services, it is essential to acknowledge the substantial cohort of adolescents and emerging adults who develop first-onset or previously unrecognised mental health needs during this developmental window. Many of these individuals do not have prior contact with CAMHS and/or a diagnosis. Many modern service models (e.g., Forward Thinking Birmingham [18], Norfolk Youth Service [20], or Headspace Centres in Australia [21]) have been explicitly designed to improve early access and prevent disengagement for this second group.

Ausweitung der Zielpopulation auf Jugendliche und junge Erwachsene, die noch nie KJP-Dienste in Anspruch genommen haben, aber in dieser Zeit neue oder bisher nicht erkannte Bedürfnisse entwickeln

In addition, YP are sometimes unprepared when confronted with the approaches to care of AMHS, which are considered demanding, patient-centred, and diagnosis-oriented, while CAMHS is described as relationship-oriented, development-promoting, and milieu-accommodating [22]. Alongside this situational transition, those affected are also confronted with a developmental transition [23], with many of them placing lower priority on the transition in healthcare compared to other aspects of this transitional period, such as education, work, housing, relationships, and leisure [24].

Jugendliche sind manchmal unvorbereitet, wenn sie mit den Arbeitsmethoden der EP konfrontiert werden

Findings from the British TRACK study (2010) revealed significant fragmentation of care during the transition phase. Of 154 individuals that crossed the transition boundary, only 90 (58%) were formally referred to AMHS, while 64 (42%) were potential referrals but did not complete the transition [25]. From the 64 potential referrals, 52 (One-Third of the whole study population) were not referred due to various reasons, although the vast majority (42 individuals; 80.8%) still required ongoing psychiatric care. Even among those formally referred, only 49 (59%) participated in regular AMHS treatment. Overall, the findings suggest that a significant proportion of YP who require ongoing mental health support after CAMHS do not successfully transition to or receive adequate care in AMHS [25]. This means that, for most YP, the transition was poorly planned, performed, and experienced [25]. Furthermore, a systematic review (2019) found that only one-quarter (24%) of YP transitioned from CAMHS to AMHS, and 42% were not even referred to AMHS, despite still being categorised as needing care [26]. Similarly, a more recent study (2021) from the United Kingdom (UK) reported that less than 20% of YP were referred to AMHS [27]. Another study (2013) from Spain demonstrated that 56% of patients discontinued care immediately before the potential transfer to AMHS [28].

etwa 45 % der Patient:innen benötigen Weiterbehandlung in der Erwachsenenversorgung

großer Anteil wird trotz Bedarf nicht überwiesen und nur wenige erhalten regelmäßige anschließende Versorgung

Übergang oft schlecht geplant, durchgeführt und erlebt

Additionally, the TRACK study showed that, among those who transitioned to AMHS, only four out of 90 (4.4%) experienced an optimal transition, defined as adequate transition planning, good information sharing and collaboration between teams, and continuity of care after transition [25]. So, merely transferring to AMHS is far from a successful transition.

nur 4,4 % erleben optimalen Übergang

Furthermore, data from the 2022–2023 National Survey of Children's Health in the United States demonstrated that 82% of children did not receive services to prepare for the transition into adult care [29], and 78% of clinicians did not discuss the shift with adult professionals [30].

82 % ohne Vorbereitung auf Transition in die Erwachsenenversorgung

bestimmte Erkrankungen erfordern besondere Aufmerksamkeit

Diagnose und Dringlichkeit als Hauptprädiktoren für Transition in die Erwachsenenversorgung

Numerous studies have highlighted both diagnosis-specific and systemic challenges for various mental health conditions, e.g. behavioural disorders, indicating that such disorders may require particular or heightened attention in the transition process [25, 28, 31, 32]. The risk of dropout increases inversely with the length of contact with CAMHS and is higher for individuals not receiving any pharmacological treatment and for those without a formal diagnosis in their medical history [28]. In addition, people with less severe disorders have a higher risk of drop-out before transition [28]. Therefore, YP with severe and persistent mental health disorders, those with comorbidities, or YP on medication or who have been hospitalised are more likely to be referred to or predicted to transition to AMHS [25, 32]. Similarly, YP who have a higher need for immediate treatment or a higher degree of urgency are more likely to transition into AMHS [31]. The Irish IMPACT study in 2019 [33] also showed that the dominating factors associated with transfer to adult services relate to diagnosis, with those with a risk assessment and psychotic disorders being more likely to be referred to AMHS.

negative Konsequenzen mangelhafter Transitionen für Gesundheit, Soziales, Familie und wirtschaftlicher Teilhabe

Consequences of poor transition can lead to increased emergency admissions [34] and hospitalisations [35], reduced quality of life [35], poor treatment adherence [36], and a general deterioration in health [36, 37]. Additionally, experiencing a negative transition of care can contribute to the burden and distress of both the caregiver and the family [36]. Generally, untreated or inadequately treated mental health disorders are linked to loss of productivity, unemployment, absenteeism, homelessness, involvement with the criminal justice system, reduced quality of life, and a general decline in health and other physical health conditions [38]. There are additional significant financial burdens to consider when transitioning YP from CAMHS to AMHS. For example, when YP move to AMHS, they are more likely to be uninsured because they are frequently unemployed [39]. All of this could limit YP's access to Mental Health Services (MHS). Furthermore, these circumstances appear to occur at an age when YP are generally less inclined to utilise many health services [39].

1.2 Barriers to Effective Transitions

große Herausforderungen beim Übergang von der KJP zur EP

As demonstrated, the transition from CAMHS to AMHS often results in high drop-out rates and disruption of care for YP due to significant barriers. Such abrupt treatment ends are often referred to as "transition cliffs" [40]. Both international research and Austrian national studies highlight the challenges and emphasise the urgent need for structured models in transitional psychiatry.

drop-out-Faktoren: mangelnde Problemwahrnehmung, Stigma, Autonomiewunsch sowie strukturelle Hürden, Wartezeiten, Unzufriedenheit und wiederholte Anamnesen

In the literature, several reasons for dropping out during adolescence are described. Key challenges are the severity and chronicity of disorders [23], failure to recognise own mental health problems, lack of motivation, the stigma associated with psychiatric treatment and preference for self-management [23, 28]. Dissatisfaction with services can also play a role – if adolescents perceive treatment as ineffective, they may choose to discontinue care [13, 23, 28, 41]. Structural challenges within the transition process itself exacerbate these issues. Long waiting times, poor organisation of transition pathways, and difficulties in establishing a trusting relationship with new providers in AMHS create significant obstacles for YP [13, 23, 41]. Adolescents are furthermore often required to repeat their medical history multiple times, which

can be frustrating and discouraging [23, 41]. Additionally, many YP receive treatment initially because their parents seek help on their behalf [23]. As parental involvement decreases, those who lack personal awareness of their mental health needs may disengage from care altogether [23]. Controversially, another reason is the desire for parental non-involvement [41].

zentrale Anliegen sind Verlust von Beziehungskontinuität, fehlende Aufklärung und Einbindung und Sorgen über Versorgungslücken

Another qualitative study explored the experiences of YP transitioning from CAMHS to AMHS [42]. The results demonstrated that YP's main concerns centred on the loss of continuity in their relationship with CAMHS providers. Other key themes included a lack of information and involvement in planning, confusion over roles and responsibilities, and worries about potential gaps in MHS after the transition [42]. The need for an individualised approach that allows for flexible timing of transitions, collaboration, and engagement was highlighted by young patients [43].

familiäre Widerstände können Transitionen zudem erschweren

Family barriers may include resistance to change, challenges in switching providers since the previous provider is a familiar and trusted figure, the belief that the previous practitioner is the most knowledgeable doctor, or overprotectiveness that makes it difficult to let the young person take control [9]. Furthermore, during the transition, the lack of coordination, information, and support (including funding) to access equipment and supplies, such as essential medical supplies, can result in delays in receiving equipment that YP used to receive routinely, which can be frustrating for families [44].

Fachkräfte des Gesundheitswesens stehen ebenfalls vor professionellen, strukturellen und systemischen Hürden, wie mangelnde Schulungen, starre Systeme und fehlende Expertise und Kooperationen

Healthcare professionals responsible for managing transitions also face significant challenges. The child and adolescent care team may be overly protective, failing to encourage self-management sufficiently or adequately educate the patient and family about the specific condition, and the adult care team may not be trained to engage with YP, may not involve the family enough, or may expect the patient to achieve autonomy too soon [9]. Key issues between the services encompass ineffective communication between CAMHS and AMHS [45], insufficient transitional training and education in adolescent and young adult health for clinicians [9], unclear responsibilities due to the frequent absence of standardised transition protocols, service fragmentation [45], and the lack of specific services to which patients could be referred [13]. Inflexible policies, structures, and entrenched cultures were also cited as barriers, as was funding [46]. Legal, logistical, and clinical differences, time and resource constraints, and a lack of understanding of the different services prevent the services from working together, contributing to referrals not being made despite an ongoing need for care [47].

Defizite auch in Österreich: 98,8 % sehen Versorgung als unzureichend, nur 16,3 % verfügen über Transitionsprotokolle

Numerous studies from various Western healthcare systems show problems with the process in terms of preparation, coordination, communication, and regulation [13, 48-52]. Similarly, a pilot study about transition processes in Austrian psychiatry from 2018 [41] revealed significant deficits. 98.8% of the professionals surveyed rated the system as inadequate, and only 16.3% stated that their workplace had a structured transition protocol from CAMHS to AMHS. To date, this study remains the most recent and only one on this topic.

1.3 Findings from Transitional Psychiatry Evaluations

wenige Evaluierungen der Transitionspsychiatrie

Evaluations of transitional psychiatry models are scarce [26, 53]; to date, only one randomised controlled trial (RCT) with short follow-up has been conducted.

MILESTONE: EU-weite RCT zeigt, dass geplante, informationsgestützte Transition Wirksamkeit und Kosten-Effizienz steigert

The MILESTONE project is the sole RCT-based evaluation of a transition in mental healthcare. The study assessed clinical effectiveness and cost-effectiveness of the Managed Transition (MT) model across eight European countries [54]. MT is a multi-component intervention in which YP and their caregivers are closely involved in preparing for the transition from one service to another, with intensive information sharing and adaptation of services to maintain therapeutic continuity. The model included CAMHS training, systematic identification of YP approaching the upper age limit, a structured assessment and feedback. The results showed improved mental health and wellbeing, and benefits manifested more swiftly than with standard care. It was also deemed cost-effective, costing €17-€65 per patient for direct implementation and €22-€176 per clinician for training [54].

Youth Transition Project zeigte kürzere Übergangszeiten und bessere Einbindung in die Versorgung für 60 %, doch Wartezeiten, Ausschlüsse und Systembarrieren blieben Herausforderungen

Similarly, the Youth Transition Project adopted a shared management model when transitioning from CAMHS to AMHS [31]. The goal was to develop individualised transitional care plans that promote coordination and continuity of care. While this model demonstrated reduced transition times and improved service engagement for 60% of referred patients, it still left 40% of YP on waiting lists or without care. Mental health status and a higher level of urgency were directly related to AMHS utilisation. YP with behavioural disorders, however, tended to stay on the waiting list, and those who cancelled services exhibited more pronounced antisocial behaviours and anxiety disorders. The project also revealed systemic barriers to coordinating services. Different agency mandates allowed service providers to refuse or delay referrals based on eligibility criteria [31].

Forward Thinking Birmingham als Modell zur Ausweitung der KJP-Versorgung verbesserte Zugang, benötigte aber erhebliche Ressourcen

The Forward Thinking Birmingham model represents a whole-system approach to youth mental health, aiming to integrate services across sectors for 0–25-year-olds and their families through early intervention, collaborative care, capacity building, and the provision of evidence-based treatment and community services [18]. The results of an evaluation indicated that the model improved access to MHS for all ages; however, it faced significant workforce shortages, infrastructure gaps, incompatible data management systems and concerns regarding the skill mix and the service's capacity to meet demand. YP reported negative experiences with repeated changes in staff, resulting in delays and a feeling of being 'passed around' the system [18].

Norfolk Youth Service (14–25) zeigte 68 % mehr Überweisungen, jedoch Rückgang bei Annahmequote

mehr Überweisungen bei knappen Ressourcen führen zu Ausschlüssen und möglicher neuer Zugangsschwelle

Another example is the Norfolk Youth Service in the UK [20], which aimed to create a non-stigmatising, recovery-focused mental health service for 14 to 25-year-olds. The aim was to provide a stepped service for the mental health of YP that is tailored to individual needs, emphasising that people should not remain in the service longer than necessary, and allowing for flexible re-referrals to the service. The intervention successfully increased referrals by 68%, likely due to improved awareness and accessibility. Also, the average number of contacts per referral decreased. However, the proportion of referrals accepted has decreased. This may be due, at least in part, to the increased number of referrals clashing with the limited capacity of services – a consequence of increasing access to services while resources remain limited [55]. However, there is a possibility that such new service models may create a new service boundary [54, 55].

Evidenzlage unzureichend, um eindeutige Schlussfolgerungen über Wirksamkeit zu ziehen

Overall, the available evaluations show that structured, coordinated, youth-centred transition models can improve access, engagement, and continuity. However, they also reveal systemic barriers, like workforce constraints and limited scalability. Significant resources are required; if capacity is not met, patients may still face service refusal and disengagement. Furthermore, some commissioners feel that the 'transition' issues are merely being delayed until age 25 [44]. Due to the scarcity of rigorous long-term evaluations, the evidence base is insufficient to draw firm conclusions about the effectiveness of these models.

1.4 Policy Context of Transitional Psychiatry

Transitionspsychiatrie fragmentiert

nur zwei von 28 Ländern mit nationalen Strategien laut MILESTONE-Erhebung (Stand 2018)

Despite the high burden of psychiatric disorders in YP and the well-documented risks associated with poorly managed transitions from CAMHS to AMHS, transitional psychiatry remains fragmented. The MILESTONE survey of 28 countries found that only two countries, Denmark and the UK, had national and/or regional strategies or guidelines for transitional psychiatry at the time of the survey [13]. To our knowledge, this review remains the most comprehensive and current survey on the state of transition in mental health service policies across several countries. Similarly, a WHO report from 2018 on the situation of child and adolescent health in Europe indicated that only half of the member states had some guidance in place for the transition from CAMHS to AMHS [56].

in Österreich fehlende Standards und strukturelle Lücken

Initiativen basieren vielfach auf Eigeninitiativen

In Austria, as in many other countries, the lack of standardised transition protocols, workforce shortages, and structural misalignment between CAMHS and AMHS result in gaps in care [10]. Various concepts are being employed in Austria to bridge this care gap. Starting in autumn 2025, Gesundheit Österreich GmbH will compile a detailed overview of transitional psychiatric services in Austria. In Vienna, for example, two transition units are operated by the adult psychiatry department, whereas in Tyrol, a day clinic is run in cooperation between CAMHS and AMHS [10]. However, these efforts are mainly based on own initiatives, and there are no standardised concepts throughout Austria. In addition, the University Hospital Tulln has established an interdisciplinary research centre for transitional psychiatry [57].

dringender Bedarf an strukturierten Protokollen und gesicherten Ressourcen für die Transition von der KJP zur EP

With the implementation of the healthcare reform 'Zielsteuerung Gesundheit' [58] and the 'Children's and Youth Health Strategy 2024' [59], the importance of transitional psychiatry has been formally recognised. There is, therefore, an urgent need for structured strategies to guide this transition process, in order to enhance the psychiatric care of individuals in the transition phase and, simultaneously, secure the necessary resources to meet the increased demands in transition from CAMHS to AMHS.

1.5 Project Aim and Research Questions

Projektziel: systematische Analyse internationaler Modelle der Transitionspsychiatrie

The aim of this project is to systematically analyse and compare international strategies and models addressing transitional psychiatry for differences and similarities in structural processes, characteristics, implementation strategies, and resource allocation, as well as to identify factors that promote and hinder successful implementation. Based on this analysis, the project aims to assess their relevance for Austria and derive starting points for further development of transitional psychiatry in Austria. By addressing these critical gaps, this research supports Austria's national mental health policy objectives and contributes to the development of transitional psychiatric services.

Relevanz für Österreich ableiten und Startpunkte für Weiterentwicklung formulieren

Schaffung einer Wissensbasis für die Entscheidungsfindung

The aim of this study is ***not*** to develop a detailed implementation plan or carry out an impact analysis for specific interventions or a budget-impact analysis. Instead, the study will focus on structural comparisons and provide a knowledge base for decision-making.

3 Forschungsfragen

Gemeinsamkeiten und Unterschiede internationaler Strategien und Modelle zur Transitionspsychiatrie,

indikations-spezifische Herausforderungen,

und Analyse der österreichischen Versorgung

To achieve the aim of the project, the following research questions (RQ) will be addressed:

- **RQ1**: What international and cross-national strategies and models of transitional psychiatry exist, and what are their similarities and differences?
- **RQ2:** What are the particular challenges and considerations for transitioning young adults with specific mental health conditions?
- **RQ3**: How does Austria's current approach to transitional psychiatry compare with international models? What recommendations can be derived to harmonise Austria's transitional psychiatry with these models and strategies?

Struktur folgt Fluss von internationaler Evidenz zu nationaler Anwendung

To address these research questions, the project combined a structured literature review with expert consultations. International sources were analysed and synthesised to identify common principles and implementation aspects (hindering and enabling factors). Building on this synthesis, starting points for further development of transitional psychiatry in Austria were derived and validated through additional national expert consultations. The structure follows a flow from international evidence to national application, supporting the report's overarching goal of providing an evidence-informed basis for strengthening transitional psychiatry in Austria.

2 Methods

To identify and analyse international models of transition from CAMHS to AMHS, a structured multistage approach was adopted. The design consisted of three main phases: document search and data extraction of international models and strategies in transitional psychiatry (RQ1 & RQ2), analysis and derivation of starting points for Austria (RQ3), and expert consultations to validate findings and gain additional insights.

3 Phasen: Dokumentenanalyse, Expert:innenbefragung, Ausgangspunkte für Österreich

The following sections describe the methods used to answer the three RQs:

2.1 Methods for Research Question 1 and 2: International and Indication-Specific Models and Strategies

Country and Cross-National Institutions Selection

This study focused on two groups of countries: (1) early-adopting countries with structured guidance in the field of transitional psychiatry, as outlined in the European MILESTONE study [13] and the WHO report (2022) about transforming mental health [60]. In addition, (2) countries with a healthcare system comparable to Austria, which share the Austrian model of social health insurance and face similar governance and workforce challenges (Bismarck-like health care systems, for further information see [61]). Finally, a population threshold of ≥ 5 million was applied to ensure comparability in terms of healthcare system scale and service demand, and a Human Development Index (HDI) equal to or higher than Austria (≥ 0.926, 2022 [62]) was necessary to ensure comparability of health system capacity, workforce availability, and overall socio-economic conditions. Ultimately, seven countries were included in the analysis. The complete inclusion and exclusion criteria used for the country selection are listed in Table 2-1.

Kriterien für Länderauswahl:

2 Ländergruppen im Fokus: Vorreiterländer und Gesundheitssysteme mit Ähnlichkeit zu Österreich

Einschlusskriterien: ≥5 Mio. Einwohner:innen; HDI ≥ 0,926

Table 2-1: Inclusion and Exclusion Criteria for Country Selection

Criteria	Inclusion	Exclusion
1. Established/Early Adopted Strategies or Models for Transitional Psychiatry	Countries with national policies/strategies on transitional psychiatry according to MILESTONE [13] or WHO report [60]	Countries without structured policies or transition frameworks
2. Healthcare System Similarity	Bismarck-based health systems	Countries with highly centralised or heterogeneous health systems (unless adopted a transition policy at an early stage (see criteria 1))
3. Research and Documentation	Countries with accessible data or published reports	Countries with limited or unavailable data or policy documentation
4. Population Size	Countries with a population over 5 million	Countries with a population under 5 million
5. Geography	European countries	Non-European countries, unless they provide robust policy insights and were early adopting countries (e.g., Australia)
6. Human Development Index	Countries with an HDI equal to or higher than Austria's (≥ 0.926, 2022 [62])	Countries with an HDI below 0.926

Abbreviations: HDI … Human Development Index; WHO … World Health Organization.

Finally, we included the following countries for analysis (see Figure 2-1): **Australia (AU), Belgium (BL), Denmark (DK), Germany (DE), the Netherlands (NL), Switzerland (CH), and the United Kingdom (UK).**

7 Länder inkludiert: AU, BE, CH, DE, DK, NL, UK

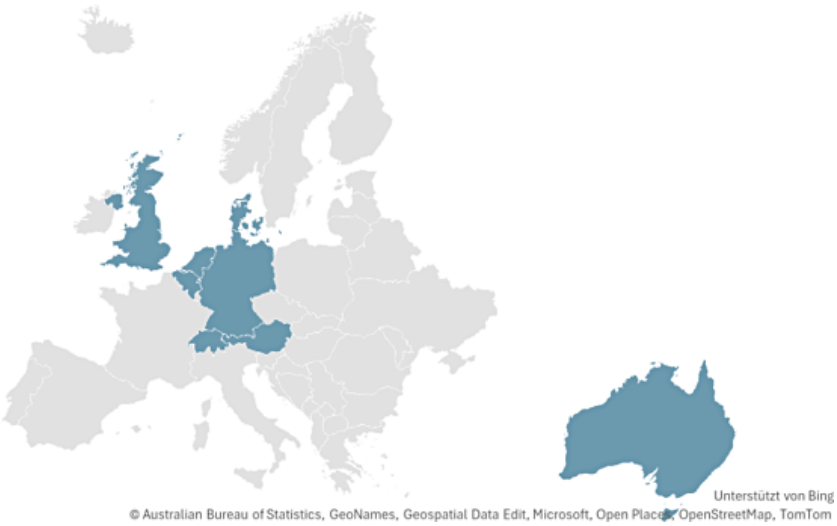


Figure 2-1: Country Selection for Analysis

The countries were selected due to their high HDI, their structural similarity to Austria's Bismarckian health system, which ensures policy relevance and their early introduction of structured strategies in transitional psychiatry, providing long-standing, well-documented examples of transitional care in mental health. These factors make them relevant comparison countries and ensure that the study results are applicable and informative for the development of transitional psychiatry in Austria.

relevanter Ländervergleich für die informierte Weiterentwicklung der Transitionspsychiatrie in Österreich

In addition to analysing national models, we included cross-national organisations and frameworks to provide a broader perspective on transitional psychiatry. These bodies influence guidelines and policy recommendations, making them relevant sources for evaluating international policies. The cross-national organisations included were the World Health Organization (WHO, the United Nations Children's Fund (UNICEF) and the Organisation for Economic Co-operation and Development (OECD) due to their central role in shaping global (youth) mental health policies.

WHO, OECD und UNICEF länderübergreifend inkludiert

Austria is used as the reference country in this review, as the analysis and resulting starting points are specifically tailored to the Austrian context (the project was initiated at the request of Austrian decision makers at the federal and state level, including the Federal Ministry of Social Affairs, Health, Care and Consumer Protection (Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz BMSGPK) and the Salzburg Health Fund (Salzburger Gesundheitsfonds SAGES), to support the development of transitional psychiatry in Austria).

Österreich als Referenzland

Selection of Specific Mental Health Conditions (RQ2)

genauere Analyse bestimmter Konditionen

Although the overall report adopts a transdiagnostic perspective, RQ2 complements this by zooming in on specific conditions to explore insights that may inform broader transition principles.

Kriterien für den Einschluss von psychischen Erkrankungen:

In light of the broad spectrum of mental health conditions requiring transitional support, we recognise the importance of considering additional diagnoses beyond those included in the analysis. However, for methodological and feasibility reasons, the literature search was limited to conditions that met predefined inclusion criteria. These criteria were developed to ensure focus and feasibility in addressing the research question, rather than to imply a prioritisation of certain disorders over others. This focus allowed the identification of condition-specific challenges and mechanisms that may otherwise remain obscured in broader, transdiagnostic analyses.

The selection of disorders for RQ2 was guided by their empirical relevance to the transition context and by quantitative indicators from the Global Burden of Disease (GBD) Study [7]. To ensure transparency and consistency, inclusion was based on three predefined criteria:

1. **High Dropout Rates or Low Referrals to AMHS**:
   The disorder is associated with elevated dropout rates or low referral likelihood during the transfer from CAMHS to AMHS. Evidence indicates that young people with anxiety or conduct disorders, ADHD, borderline intellectual functioning, autism spectrum disorder, or emerging personality disorders are particularly likely to disengage from care, whereas those with psychosis or severe mental illness are more consistently transferred [25, 28, 31, 32].

   (1) hohe Drop-out-Raten oder geringe AMHS-Zuweisung

2. **High Burden of Disease or Prevalence in Adolescents (15–19):**
   Disorders ranking among the four highest conditions in either years lived with disability (YLDs) or prevalence in the GBD Study [7].

   (2) hohe Krankheitslast oder Prävalenz bei 15- bis 19-Jährigen laut GBD-Study

3. **Emerging or Occurring Disorders during Late Adolescence:**
   The condition exhibits a steep increase in prevalence from early to late adolescence, indicating that it peaks during the transition phase, as per data from the GBD Study [7].

   (3) Erkrankungen mit steigender Prävalenz in der späteren Adoleszenz

Finally, conditions were included if they met at least two of the above criteria:

Inklusionskriterium: Erfüllung von mindestens 2 der 3 Auswahlkriterien

Table 2-2: Evaluation of Inclusion for Mental Health Conditions

Condition	Key Criteria	Inclusion in Literature Search
Anxiety Disorders	■ High dropout rates [28] ■ Low chances of being referred to or accepted by AMHS [25, 31, 32] ■ High burden of disease (YLD)/prevalence rates [7] ■ Disorders emerging/occurring in late adolescence [7]	✓
Autism Spectrum Disorder	■ Low chances of being referred to or accepted by AMHS [25, 32]	✗
Attention Deficit Hyperactivity Disorder	■ Low chances of being referred to or accepted by AMHS [25, 31, 32] ■ High burden of disease (YLD)/prevalence rates [7]	✓
Bipolar Disorder	■ Disorders emerging/occurring in late adolescence [7]	✗
Conduct Disorder	■ Low chances of being referred to or accepted by AMHS [25, 32] ■ High burden of disease (YLD)/prevalence rates [7]	✓
Depressive Disorders	■ High dropout rates [28] ■ High burden of disease (YLD)/prevalence rates [7] ■ Disorders emerging/occurring in late adolescence [7]	✓

Condition	Key Criteria	Inclusion in Literature Search
Eating Disorders	■ Low chances of being referred to AMHS [25] ■ Disorders emerging/occurring in late adolescence [7]	✓
Substance Use Disorders	■ High burden of disease (YLD)/prevalence rates [7] ■ Disorders emerging/occurring in late adolescence [7]	✓
Schizophrenia	■ NA	✗

Explanation:
Inclusion in Analysis: Conditions were selected if at least two predefined criteria were met: ✓… included; ✗… not included.
Abbreviations: NA … not applicable.

6 psychische Erkrankungen in Literatursuche einbezogen

Therefore, we focused on **Attention Deficit and Hyperactivity Disorder, Anxiety Disorders, Conduct Disorder, Depressive Disorders, Eating Disorders and Substance Use Disorders** for the literature search.

Hintergrundinformationen aus GBD-Studie

Background information on the selected inclusion criteria and the underlying epidemiological data from the GBD study is provided in Appendix 1. The appendix also details the operational thresholds and decision rules used to determine inclusion.

Schaffung eines breiteren Rahmens

Although RQ2 focused on specific conditions, its insights were subsequently synthesised with the broader findings from RQ1 to establish a wider framework that emphasises transition principles across diagnostic categories.

Search Strategy

strukturierte Literatursuche nach Strategien/Modellen zur Transitionspsychiatrie:

A structured hand search was conducted from February 13th to March 10th, 2025, to identify relevant strategies, policies, guidelines, and models of transitional psychiatry in the following databases and websites of the included countries and the reference country, Austria:

Datenbankrecherche, Handsuche und Rückwärtssuche

- TRIP database (https://www.tripdatabase.com/),
- Guidelines International Network (https://guidelines.ebmportal.com/),
- Google/Google Scholar,
- WHO MiNDbank (https://extranet.who.int/mindbank/),
- Youth Wiki – Europe's Encyclopedia of National Youth Policies (https://national-policies.eacea.ec.europa.eu/youthwiki),
- National websites of ministries of health, public health institutions, and guidelines,
- Websites of cross-national bodies (WHO, UNICEF, OECD).

strukturierte Handsuche anstelle systematischen Literatursuche da nationale Strategien und Dienstleistungsmodelle überwiegend als graue Literatur verfügbar sind

In line with the policy-oriented objectives of this report, we conducted an extensive, structured hand search rather than a systematic review of the peer-reviewed literature in biomedical and psychology databases. This approach was selected because national strategies, policies, and service models in transitional psychiatry are rarely published in scientific journals and are mainly accessible as grey literature, such as ministerial reports, guidelines, or strategy papers. The selected databases and websites were therefore considered the most appropriate and comprehensive sources to capture current policy frameworks and models across countries.

Rückwärtssuche

In addition, a backward-search was conducted to review the reference lists of all identified studies and identify further potentially relevant studies.

strukturierte Suchsyntax mit Schlüsselbegriffen, Synonymen und booleschen Operatoren zur gezielten Literatursuche

A search syntax was developed for keyword searches, focusing on key concepts (e.g., transition, adolescents, MHS) combined with the respective country and relevant keywords, such as guidelines, action plans, models, strategies, etc. Each area of the key concepts also included synonyms. In addition to brainstorming, these were determined through German-English dictionaries and by reviewing other relevant literature. Boolean operators and truncations (*) were used to create the search strings.

erste 100 Treffer nach Relevanz geprüft

In those databases where many hits were found, the first 100 results were checked for relevance by title and/or abstract (if available) screening, as sorted mainly by relevance. Additionally, in the Google and Google Scholar searches, the first 100 search results were reviewed for eligible publications to ensure that more recent publications were identified. This is due to the fact that the number of citations is the most heavily weighted factor in Google Scholar's ranking algorithm, making it more suitable for searching standard literature than for new and recent research [63].

The complete search protocol is outlined in Appendix 2.

Literature Selection

insgesamt 98 relevante Quellen nach Deduplizierung

First, the search hits were checked for relevance based on their title and abstract (if available). All search results (RQ1 = 92, RQ2 = 30) were then collected in Excel. After removing 24 duplicates, the final sample comprised 98 documents for full-text screening.

Screening mit unabhängiger Zweitprüfung und Konsensverfahren bei Unstimmigkeiten

The identified literature was then screened for eligibility and thematic relevance based on the predefined inclusion and exclusion criteria. The first reviewer (RS) screened all full-text documents for inclusion or exclusion. The second reviewer (YH) independently assessed a random 20% subsample of the full texts. Since there was complete agreement for this subsample, the remaining decisions made by the first reviewer were accepted. Any disagreements between reviewers or uncertainty regarding inclusion were resolved through discussion and consensus. If consensus could not be reached, a third reviewer (RJ) was consulted; this was necessary in two cases. The original articles were saved in an EndNote library. The results of the full-text review were managed independently and separately in an XLSX file by both reviewers.

diverse Ein- und Ausschlusskriterien für Dokumenteninklusion (z. B. Modellart, Inhalte, Sprache, Zeitraum etc.)

Documents were included if they presented national or transnational transitional psychiatry strategies or models and were published by government bodies, public health institutions, or international health organisations. We included national documents that described a strategy or model of care specific to the transition of CAMHS to AMHS. In cases where no specific document was available for a country, we included a general strategy or model for transition between health services that had a subchapter for transition between CAMHS and AMHS (e.g., DK). In the case of RQ2, we included a general disorder guideline if there was a subchapter specific to the transition from child to adult services (e.g., AU). Only documents that explicitly covered aspects such as structural organisation, service integration, implementation strategies, and resource allocation were included to ensure applicability. Additionally, documents had to be available in English, German, or a language that can be translated into one of these languages to ensure accessibility. If a country did not have a relevant document available in German or English, we used the automated translation tool DeepL (www.deepl.com) for document translation. Documents were excluded if they focused solely on regional mod-

els, where national models existed, or lacked a clearly defined policy framework. The full inclusion and exclusion criteria are presented in Table 2-3.

Table 2-3: Inclusion and Exclusion Criteria for Document Selection

Criteria	Inclusion	Exclusion
1. Type of Model	National or transnational strategies and models for transitional psychiatry published by government bodies, health organisations, or academic institutions	Regional strategies or models (if national models exist), informal or unofficial policies
2. Scope of Transition	Transition from child and adolescent mental health services to adult mental health services	Policies addressing transitions in other sectors (e.g., school-to-work) or policies limited to children (<18) or adults only (>25)
3. Publication Language	Policies available in English, German, or national languages (if no official translation exists, neural machine translation will be applied)	Policies published only in languages where neural machine translation using DeepL (www.deepl.com) is not feasible for technical interpretation
4. Publication Period	No restriction – all historical and current policies are included if still applicable	Policies explicitly marked as outdated or replaced
5. Model Characteristics	Models must describe relevant characteristics (e.g. age range, target groups, treatment approaches)	Policies that fail to specify key characteristics

regionale Modelle nur bei fehlenden nationalen Modellen berücksichtigt

This study prioritised national models where they were available. However, in cases where national frameworks were absent or insufficient information was provided, regional models were considered to prevent data gaps. These models were identified through an unstructured hand search, and the same inclusion criteria as for national models were applied to maintain consistency in the analysis.

Data Extraction

Datenextraktion in standardisierter XLSX-Tabelle anhand vordefiniertem Kategoriensystem

The data from the included studies were extracted into an XLSX data sheet that was tailored explicitly for this report to ensure a systematic comparison of key characteristics across the identified models. The data extraction sheet was piloted on two randomly selected references and revised accordingly. One researcher (RS) extracted the data from the included articles, and the second researcher (YH) verified them. Any divergence between the authors was resolved through discussion and consensus. The extracted data for each country were then categorised according to the dimensions listed in Table 2-4 and Table 2-5. The complete data extraction protocol is outlined in Appendix 5.

Table 2-4: Predefined Categories for Data Extraction (RQ1)

Categories	Extracted Data Points
Basic Model Information	Country, year, type of policy, governing body
Scope and Target Population	Stakeholder involvement, target user, setting, eligibility, age ranges, vulnerable populations
Service Integration and Coordination	Referral and transition process, integration between CAMHS and AMHS, continuity of care
Treatment Approach	Provided services, care pathways, therapeutic model, participation
Workforce, Training and Infrastructure Requirements	Defined responsibilities, multidisciplinary involvement, specific training and qualification requirements, collaboration strategies, workforce retention and sustainability strategies, infrastructure resources

Categories	Extracted Data Points
Implementation and Governance	Implementation process, evaluation, governance, key enablers and hindering factors
Costs and Resource Allocation	Funding source and cost estimation, economic evaluation
Evaluation and Effectiveness	Quality indicators, evaluation methods, timeframe

Abbreviations: AMHS … adult mental health services; CAMHS … children and adult mental health services.

Table 2-5: Predefined Categories for Data Extraction (RQ2)

Categories	Extracted Data Points
Basic Model Information	What is the basic information of this model (e.g., country, year of implementation, type of policy, governing body)?
Scope and Target Population	What is the aim and target population of this model?
Transition Approach	How is the transition managed for this condition?
Transition Challenges	What makes the transition challenging for this condition?
Additional Recommendations	Are there any other points to consider? Do gaps still exist?

Thematic Analysis and Data Synthesis

FF1: deduktive und induktive Kategorienbildung zur inhaltlichen Analyse der Modelle

To answer RQ1, an inductive and deductive coding framework was applied for analysis. The deductive approach was based on a pre-selected set of categories (see section on data extraction), while the inductive approach allowed new, emerging themes to be captured from the dataset. Initially, relevant sections of the extracted documents were assigned to the initial categories. These categories were then further refined and adapted throughout the data extraction process to ensure detailed coverage of relevant aspects. The final category system is presented in Appendix 6. Although the analytical process combined inductive and deductive elements, it did not follow a qualitative content analysis; instead, it applied a structured framework for categorising and synthesising model characteristics across countries.

narrative Synthese ergänzt durch Datenvisualisierung

länderübergreifende Vergleiche, um gemeinsame Elemente und Bereiche mit Unterschieden zu ermitteln und Merkmale hervorzuheben, die mit höherwertigen Transitionsprozessen verbunden sind

The final synthesis involved comparing the main categories across countries to highlight key trends and differences. Following a visual comparison of the data extracted from the included documents and expert consultations, such as comparative tables or dot matrix charts indicating the presence or absence of certain categories, a narrative synthesis approach was employed to summarise the data. The category system provided the framework for cross-country comparisons to identify both shared elements and areas of divergence. The analysis aimed to highlight features commonly associated with higher-quality transition processes, including structured planning, coordinated referral pathways, continuity, and youth participation. Where the data was not consistent enough to allow a structured comparison, a descriptive summary of the key points was undertaken instead. In the results tables, findings from written sources and expert consultations are presented together without typographical distinction to ensure readability and synthesis at a glance.

FF2: Scoping-Ansatz und narrative Synthese

To answer RQ2, a scoping approach was applied, focusing on mapping existing policies, guidelines, and service adaptations for the selected conditions. The findings were presented as a narrative synthesis, rather than a direct comparative analysis. One author (RS) developed the thematic narrative synthesis based on the extracted data. The preliminary findings of the synthesis were subsequently reviewed and discussed with the second researcher (YH). Although the synthesis was not conducted independently by both reviewers, regular team discussions and consensus-based revisions were performed.

For each thematic category, the type and number of contributing sources were documented to assess the breadth and provenance of the evidence base. At the end of each results subsection, a brief synthesis summarises the composition of the evidence base and the relative content coverage. These summaries are descriptive and intended to illustrate the extent and diversity of available information, rather than to quantify the quality or certainty of the evidence.

kurze Synthese über die Zusammensetzung der Evidenzbasis am Ende eines jeden Resultate Unterkapitels

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

keine Erhebung, ob Empfehlungen bereits implementiert sind

Quality Appraisal

An adapted version of the Appraisal of Guidelines for Research & Evaluation II (AGREE II) instrument was used to evaluate the quality of the included documents outlining transitional psychiatry models and policies. AGREE II comprises 23 key elements divided into six domains: Scope and Purpose, Stakeholder Involvement, Rigour of Development, Clarity of Presentation, Applicability, and Editorial Independence. Each element is assessed using a 7-point scale (1–7), with higher scores reflecting better quality.

Qualitätsbewertung mittels adaptierter AGREE-II-Checkliste

For the purposes of this study, we adopted an 11-item appraisal scheme, adapted from Reinsperger et al. (2022) [64] and Jeindl et al. (2022) [65]. This enabled a structured evaluation of formal guidelines and other policy-relevant documents, including position papers, reports, and frameworks. Although the AGREE II instrument recommends using all 23 items across its six domains, a modified version was used in this review. This was due to the heterogeneity of documents included, which comprised formal clinical guidelines, as well as position papers, strategy reports, and other policy-relevant frameworks. Due to the broader range of documents, certain AGREE II items were not applicable to all sources.

11 Items aus AGREE-II angewendet

Eleven selected AGREE II items were used for this project to assess the quality and scope of the identified policy documents, spanning over five key AGREE II domains:

- Domain 1: Scope and Purpose
  (clarity of objectives and intended audience),
  - Item 1: The overall objectives are clearly stated.
  - Item 3: The intended audience is clearly defined.
- Domain 2: Stakeholder Involvement (representation of relevant professions, user involvement, and definition of target users),
  - Item 4: The development group includes representatives from all relevant professional sectors.
  - Item 5: The views and preferences of the target audience have been considered.
  - Item 6: The target users of the document are explicitly defined.
- Domain 3: Rigour of Development (use of systematic evidence and explicit links to recommendations),
  - Item 7: Systematic methods have been employed to search for evidence.
  - Item 12: There is a clear connection between recommendations and evidence.

- Domain 4: Clarity of Presentation (visibility of key recommendations and identification of implementation barriers and resource implications), and
  - Item 17: Key recommendations can be easily identified.
  - Item 18: The document identifies facilitators and barriers to implementation.
  - Item 20: The potential resource implications of implementation are addressed.
- Domain 5: Applicability (inclusion of monitoring and evaluation criteria).
  - Item 21: The document includes monitoring and/or audit criteria.

unabhängige Qualitätsbewertung durch 2 Reviewer:innen

The quality assessment was conducted by both reviewers (RS and YH) independently. In accordance with AGREE II guidance, domain scores were not aggregated into a single overall quality score. Instead, quality within each domain was measured by summing the individual item scores provided by both reviewers and then scaling the total score as a percentage of the maximum possible score for that domain. The results of the quality assessment of the included documents are presented in Appendix Section 4.

To extract and appraise the data, supplementary materials, including the Annexe, the complete guidelines, and the associated implementation strategies, were reviewed.

Expert consultation

zusätzlich Konsultation mit 9 nationalen Expert:innen aus 6 Ländern zur Ergänzung und Schließung von Datenlücken

Experts from the countries included were selected through purposive sampling to complement the literature search and fill potential data gaps. They were invited to participate in semi-structured written or oral consultations. A total of 37 experts were contacted (see Figure 2-2). Of these, twelve responded, and ten agreed to participate, although two had to cancel after initially accepting. Ultimately, we consulted eight experts from six countries – AU, BL, CH, DE, the NL, and the UK – who contributed either through oral interviews (n=7) or written questionnaires (n=1).

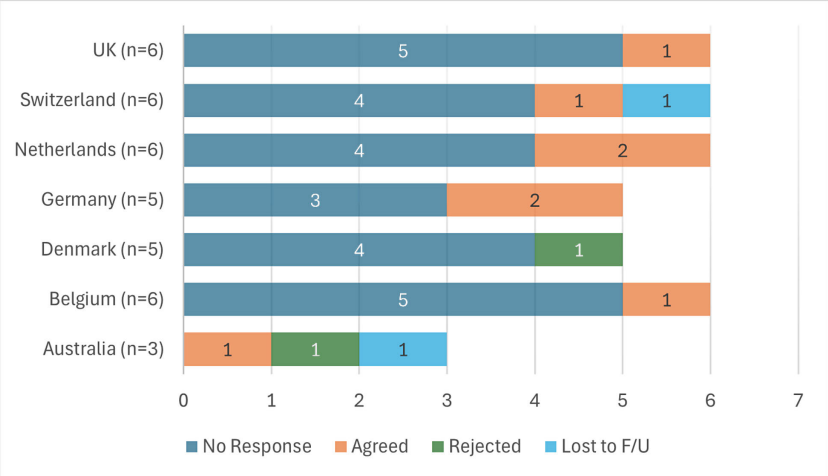


Figure 2-2: Overview of Expert Consultation by Country

breite, multidisziplinäre Perspektive

The experts were selected to ensure a broad, multidisciplinary perspective that encompasses research, clinical expertise, health policy, and service development. Our panel comprised clinicians (two specialists in adult psychiatry, as well as three child and adolescent psychiatrists), researchers, and policymakers with extensive experience in transitional psychiatry, including the development of young adult inpatient units, the creation of national mental health strategies, and pioneering research projects such as MILESTONE. The sample furthermore consisted of slightly over 60% female participants.

Kliniker:innen, Forscher:innen und politische Entscheidungsträger:innen mit umfassender Erfahrung

Fragebogen zu 7 Themenfeldern: Organisation, Versorgungskontinuität, Evaluation, Arbeitskräfte, Kosten, Umsetzung, Empfehlungen

For the expert consultation, we developed a questionnaire covering the following thematic areas: (1) General information on the organisation of transitional psychiatry in each country, (2) best or good practice models, continuity of care, disorder specifics, and patient and family involvement, (3) evaluation procedures and indicators, (4) workforce sustainability, (5) implementation, (6) cost estimates, and (7) recommendations for national strategies. The full expert questionnaire is available in Appendix 7.

Konsultationen zwischen April und Juli 2025

Antworten in strukturierten Fragebogen zusammengefasst eingefügt

The expert consultations took place between April and July 2025 via Zoom or Microsoft Teams and lasted 30–60 minutes each. The consultations were recorded with the respective expert's consent for internal documentation purposes and were subsequently deleted after the relevant information had been extracted. The consultations were transcribed, and the insights gathered during these consultations were clustered into themes and systematically compiled into a structured narrative summary of responses. This summary was subsequently sent to each expert for optional verification to ensure the accuracy of the collated data.

2.2 Methods for Research Question 3: Austrian System Analysis and Guiding Starting Points

Literature Search

Identifizierung österreichischer Dokumente gemäß Suchstrategie von FF1 und FF2

A structured hand search was conducted to collect relevant documents that provide an overview of the Austrian psychiatric transition landscape, following the same strategy as in section 2.1, "Search Strategy". No eligible records were identified through the TRIP Database, the Guidelines International Network (GIN), the WHO Mindbank, or Youth Wiki. One relevant document was retrieved via Google Scholar. The majority of the included Austrian documents (n=4) were sourced from national websites, specifically those of health ministries and public health institutions. Additionally, one document was identified through backward citation searching.

Development of Starting Points for Austria

Analysestrategie aufgrund fehlenden nationalen Modells für die Übergangspsychiatrie in Österreich abgeändert …

The initial methodological approach involved structured data extraction and expert consultation, followed by a structured policy mapping that systematically compared Austria's current national framework with the key policy dimensions identified through the analysis of international documents (RQ1). However, Austria currently lacks a dedicated national framework that explicitly defines standards for transitional psychiatry; as such, no formal model comparison was suitable. In light of this, the analytical strategy was modified. Based on the international evidence synthesised under RQ1, preliminary

"starting points for further development of transitional psychiatry in Austria" were created and organised according to the key policy dimensions identified in RQ1 and RQ2. These starting points were then presented to Austrian experts for validation and contextualization.

… vorläufige Empfehlungen auf Basis internationaler Evidenz

Due to the varying national approaches to transitioning from CAMHS to AMHS and the limited availability of comparative effectiveness data, this report refrains from making prescriptive recommendations. Although cross-national syntheses have identified recurring principles, the evidence base remains insufficient to justify favouring certain models over others. Furthermore, potential conflicts of interest among experts, combined with the context-dependent specifics of health system structures, require a cautious approach when drawing normative conclusions. To maintain methodological rigour and policy relevance without overstepping the available evidence, the project used international evidence to establish guiding starting points for Austrian stakeholders, enabling informed decision-making and context-specific adaptations rather than one-size-fits-all solutions. The starting points were derived by identifying recurring themes and reported implementation challenges across international documents, as well as expert consultations with international and national stakeholders. Particular attention was given to the transferability of strategies to the Austrian setting, guided by insights from national experts.

Ableitung von Startpunkten für Österreich statt one-size-fits-all Lösungen

Identifizierung wiederkehrender Themen und berichteter Herausforderungen mit besonderem Augenmerk auf Erkenntnisse der nationalen Expert:innen

Expert consultation

In addition to the international consultation, a second round of expert input was conducted between late June and July 2025 via Zoom and Microsoft Teams for approximately 60 minutes each. Austrian experts were identified through purposive sampling, including policymakers, clinicians, and researchers. This national consultation aimed to critically reflect on the feasibility and relevance of the proposed measures in the Austrian healthcare context.

Konsultationen mit nationalen Expert:innen

A total of seven experts were contacted in Austria. Three responded, all of whom agreed to participate in the study. Although these responses were formally counted as three, two of the experts were involved in one participating organisation, effectively resulting in four individual contributions. The sample consisted of ¾ female participants from two federal states, Vienna and Lower Austria. One expert preferred to complete the questionnaire in written form, the rest participated orally. The sample was multidisciplinary in nature, comprising one senior specialist in psychiatry, neurology and psychotherapeutic medicine, two transition coordinators, and one researcher in the field of transitional psychiatry. Expertise is, therefore, imparted through clinical leadership, practical implementation of transition programmes, and academic work in this field.

4 Expert:innen teilgenommen

multidisziplinäres Teilnehmer:innensample

Expertise durch klinische Anwendung, praktische Implementierung und akademische Forschung

The consultations and written questionnaires covered six thematic areas: (A) general areas of international consensus, (B) models of transitional psychiatry, (C) sustainability of the workforce, (D) facilitators and barriers to implementation, (E) costs and resource allocation, (F) evaluation and effectiveness.

mündliche und schriftliche Konsultationen zu 6 Themenbereichen

The consultations were transcribed, narratively summarised, and the collected summaries were clustered with a focus on areas of convergence, concerns regarding feasibility, and context-specific implementation conditions. The results were then used to refine the Austria-specific starting points. The complete questionnaire is available in Appendix 7.

Validierung und Priorisierung der Empfehlungen im österreichischen Kontext

3 Results

In the following sections, the results of the respective RQs will be presented.

Präsentation der Ergebnisse

3.1 International Approaches to Transitional Psychiatry

Synthese organisiert nach thematischen Kategorien

This chapter presents the key findings for RQ1, organised into the six overarching categories: (1) service integration and coordination, (2) treatment approaches, (3) workforce, training, and infrastructure requirements, (4) implementation and governance, (5) costs and resource allocation, and (6) evaluation and effectiveness. The chapter draws on international sources, as well as expert consultations, to identify key structures and hindering factors.

Flussdiagramm

Although this review did not follow a systematic protocol, a PRISMA-style flow diagram [66] (see Figure 3-1) was used to improve transparency in reporting the number of records identified, screened, and included from the structured hand search.

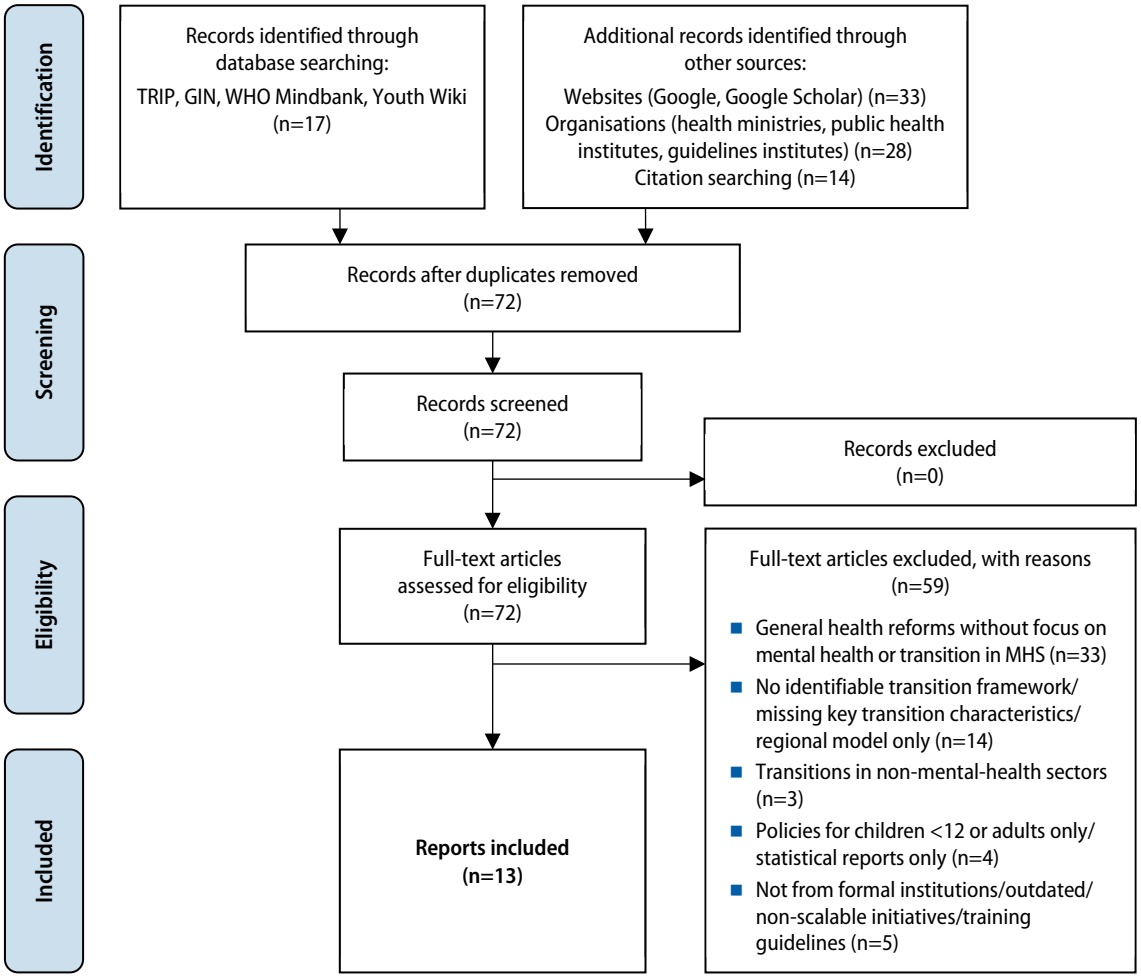


Figure 3-1: Flow of Literature Identification, Screening, and Inclusion for RQ1. Adapted from [66].

13 Dokumente in die endgültige Analyse einbezogen

Out of 72 screened documents, 13 were included for final analysis (see Table 3-1. The UK led with six included documents. AU (three included documents), CH, DE, DK, and the NL (one document each) also contributed relevant literature. In contrast, no eligible documents were found for BL or cross-national organisations (OECD, UNICEF, WHO).

Ausweitung auf regionale Modelle in Belgien und Australien

für Belgien keine geeigneten Dokumente identifiziert

Upon reviewing the available national policy and strategy documents, we found that in AU and BL, even though national mental health frameworks discussed transitions for YP, neither provided a structured national transition model for YP transitioning from CAMHS to AMHS. Given this absence, we have extended our approach to regional models in those two countries. However, none of the regional documents met the inclusion criteria for BL. Although some policy-level discussions recognise the importance of continuity of care for child and adolescent psychiatric patients, these documents lack an operational framework that defines transition criteria, coordination mechanisms, or implementation guidelines.

potenzielle Gründe für Mangel an nationalen Dokumenten

To investigate why these countries lack national transition models, we consulted experts from each country during the data collection process. In AU, for example, one national expert indicated that Headspace is widely regarded as the country's primary response to transitional care needs, which may explain why separate, formal transition frameworks are absent. In contrast, the complex and decentralised nature of BL's healthcare system was identified by a Belgian expert as a significant obstacle to creating national transition strategies. MHS are organised at the provincial level, and the country's linguistic and regional divisions further complicate policy implementation. Similar issues have been reported in CH, where MHS are managed by the cantons, and there is no unified national strategy for transitional psychiatry. In all these cases, the decentralised governance structure seems to obstruct the development and implementation of nationwide transition guidances.

Table 3-1: Included Documents per Country for Analysis (RQ1)

Country	Title	Document Aim	Publishing Body/Institution	Year	Type of Document	Language	Reference
AU – Australia	Supporting young people during transition to adult mental health services	Outline responsibilities of NSW specialist mental health services to ensure continuity of care and safety are maintained during the period of service transition	NSW Health – Ministry of Health	2023	Guideline	English	[67]
	Transition of care for young people receiving mental health services	Provide guidance and recommendations to support effective transitional care planning for young people in mental health services	Queensland Health	2021	Guideline	English	[68]
	South australian youth mental health system of care operational guidelines	Implement a state-wide youth mental health system of care for 16–24-year-olds	Government of South Australia. SA Health	2014	Guideline	English	[69]
DK – Denmark	Anbefalinger for transition fra børne- og ungeområdet til voksenområdet i sygehusregi	Ensure well-organised transition pathways for young people with chronic or long-term conditions	Danish Health Authority	2020	Recommendation	Danish	[70]
DE – Germany	Richtlinie des Gemeinsamen Bundesausschusses über die berufsgruppenübergreifende, koordinierte und strukturierte Versorgung insbesondere für schwer psychisch kranke Kinder und Jugendliche mit komplexem psychiatrischen oder psycho-therapeutischen Behandlungsbedarf (KJ-KSVPsych-RL)	Regulate interprofessional, coordinated, and structured care, especially for severely mentally ill children and adolescents	Gemeinsamer Bundesausschuss (G-BA)	2024	Guideline	German	[71]
NL – Netherlands	Jongeren in transitie van kinderzorg naar volwassenenzorg	Better organisation and content of transition care for young people	Federation of Medical Specialists	2022	Quality Standard	Dutch	[72]
CH – Switzerland	Stationäre und tagesklinische Angebote der psychia-trischen Gesundheitsversorgung an der Schnittstelle des Jugend- und Erwachsenenalters in der Schweiz	Overview and evaluation of inpatient and day clinic offers at the interface of youth and adult psychiatry in Switzerland	Zürcher Hochschule für Angewandte Wissenschaften	2020	Government Report	German	[73]
UK – United Kingdom	Transition from children's to adults' services. Quality Standard	Define measurable standards for effective transition from children's to adults' services	National Institute for Health and Care Excellence (NICE)	2023	Quality Standard	English	[74]
	Delivering better outcomes for children and young adults – new service models and better transitions across mental health	Identify challenges and propose service models to improve transitions from CAMHS to AMHS	Royal College of Psychiatrists	2022	Position Statement	English	[75]
	Meeting the needs of young adults within models of mental health care	Describe new models for young adult mental health care, and identify challenges and principles for service design	National Collaboration Centre for Mental Health	2022	Service Planning and Development	English	[76]
	Transitions from adolescent secure to adult secure inpatient services	Give clear guidance for the positive transition of young people from adolescent secure inpatient units to adult secure inpatient units	NHS England and NHS Improvement	2020	Practice Guidance	English	[77]
	Transition from children's to adults' services for young people using health or social care services	Support effective and person-centred transitions from children's to adult's health and social care services	National Institute for Health and Care Excellence (NICE)	2016	Guideline	English	[78]
	Planning mental health services for young adults – improving transition: A resource for health and social care commissioners	Support health and social care commissioners to plan and commission improved transition from CAMHS to AMHS	National Mental Health Development Unit (NMHDU)	2011	Commissioning Resource Guide	English	[79]

Abbreviations: AMHS … adult mental health services; CAMHS … children and adult mental health services; NSW … New South Wales; SA … South Australia.

3.1.1 Synthesis

2 komplementäre Datenquellen: (1) strukturierte Analyse von schriftlichen Dokumenten und (2) Expert:innen-befragungen

This chapter presents the results of the study, obtained through two complementary data sources: (1) analysis of written documents identified via a structured literature review and (2) expert consultations conducted aimed at providing context and enriching the evidence base. The results are organised by thematic categories, including the deductive framework based on predefined categories, as well as the additional inductive categories that emerged during the data review. The full data extraction table in Appendix 5 provides detailed source attribution to enable full traceability for all reported items. As shown in Table 3-1, the national findings are based on the following documents: AU [67-69], CH [73], DE [71], DK [70], the NL [72], and the UK [74-79], supplemented by insights from expert consultations.

narrative Darstellung der Ergebnisse, geordnet nach thematischen Kategorien

2 Hauptmodelle der psychischen Transitionsversorgung: das Modell der Koordinierung der Transition und das Modell der jugend-spezifischen Services

Two main models of transitional mental healthcare can be identified across the included countries: the coordination of transition model (e.g., the UK) and the specific care for youth model (e.g., Headspace in AU and DK). The UK approach emphasises strengthening collaboration between existing CAMHS and AMHS without altering their structures. It aims to ensure continuity of care through coordinated protocols and joint responsibility across services. In contrast, the youth-specific service model introduces dedicated youth MHS for individuals typically aged 16 to 24 (sometimes up to 30). This model expands access by tailoring services to the specific developmental and psychosocial needs of YP.

allgemeingültige Transitionsprinzipien

Regardless of the applied model, the following results present general characteristics of transition that apply to all models.:

Stakeholder Involvement in Policy Development

breite Einbindung von Fachakteur:innen bei der Gestaltung von transitionsbezogenen Maßnahmen und Praktiken

The literature review revealed that service providers, professional organisations, and researchers consistently participated in the design of transition-related policies and practices across all countries. Most documents also included government stakeholders, and to a lesser extent, patient and user representatives (AU, NL, UK). Non-governmental organisations and advocacy groups were less represented overall.

Table 3-2: Point Matrix of Stakeholder Involvement in Policy Development Across Included Countries

	Governmental Actors	Service Providers/Professional Associations/Researcher	Patient/Service User Representatives	NGOs/Advocacy Groups
Australia	●	●	●	●
Belgium	NA	NA	NA	NA
Denmark	●	●	○	○
Germany	○	●	●	○
Netherlands	●	●	●	○
Switzerland	●	●	○	○
United Kingdom	●	●	●	●

Explanation: Points indicate the involvement in policy formulation processes.
Empty circles mean that no evidence of involvement was found in the reviewed documents.
Abbreviations: NA … not applicable.
Sources: National documents (see Table 3-1); full details in Appendix 5 (Data Extraction Table).

Target Users of Policy

Adressat:innen meist Fachpersonal

Documents from AU, CH and the UK were aimed at policymakers, commissioners, local authorities and users of public health services. YP and their families were furthermore targeted by DE and the UK. Some documents did not specify individual target groups but appeared to assume broad applicability across all audiences. The UK addressed all four target groups: clinical providers, policymakers, YP and families, and broader system actors. Overall, the documents were primarily intended for clinicians and professionals in the fields of mental health and social care.

Table 3-3: Point Matrix of Target Users in Policies Across Included Countries

	Clinical Providers/Mental Health or Social Care Professionals	Policymakers/ Commissioners	Local Authorities/ Public Health	Young People/ Families
Australia	●	○	●	○
Belgium	NA	NA	NA	NA
Denmark	●	○	○	○
Germany	●	○	○	●
Netherlands	●	○	○	○
Switzerland	●	●	○	○
United Kingdom	●	●	●	●

Explanation: Points indicate whether each group is targeted or mentioned in the policy documents. Empty circles mean that no evidence of targeting was found in the reviewed documents.

Abbreviations: NA … not applicable.

Sources: National documents (see Table 3-1); full details in Appendix 5 (Data Extraction Table).

Setting

Versorgungssetting meist stationär und ambulant

All the reviewed countries describe transitional mental healthcare in inpatient and/or outpatient settings. Several countries (AU, DE, UK) describe multisectoral settings that involve health, social care, education, and specialist services. The NL describes the setting as 'joint transition clinics' in a document, which directly bridges CAMHS and AMHS. In contrast, documents from countries such as CH and DK outline hospital- or inpatient-based settings.

Table 3-4: Point Matrix of Service Settings Addressed in Transitional Psychiatry Policies Across Included Countries

	Inpatient/ Hospital-Based Care	Outpatient/ Ambulatory Care	Community-Based Services	Joint Clinics	Multisectoral (e.g., rehabilitation, education, social care, home care)
Australia	●	●	●	○	●
Belgium	NA	NA	NA	NA	NA
Denmark	●	○	○	○	○
Germany	●	●	○	○	●
Netherlands	○	●	○	●	○
Switzerland	●	○	○	○	○
United Kingdom	●	●	○	○	●

Explanation: Points indicate whether the setting is mentioned as context for the policy. Empty circles mean that no evidence of involvement was found in the reviewed documents.

Abbreviations: NA … not applicable.

Sources: National documents (see Table 3-1); full details in Appendix 5 (Data Extraction Table).

Eligibility

thematischer Fokus der Strategien/Modelle (z. B. psychische oder somatische Erkrankungen etc.)

A specific focus was placed on mental health conditions in AU and DE. This provides guidance aimed at young people transitioning within psychiatric care systems. In contrast, documents from DK and the NL take a broader approach to chronic conditions, addressing both physical and mental health needs. The UK is unique in having guidelines that integrate general health and social care.

Table 3-5: Point Matrix of Eligibility Focus in Transitional Psychiatry Policies Across Included Countries

	Mental Health Conditions	Chronic Conditions (Somatic and/or Psychological)	General Health or Social Care
Australia	●	○	○
Belgium	NA	NA	NA
Denmark	○	●	○
Germany	●	○	○
Netherlands	○	●	○
Switzerland	●	○	○
United Kingdom	●	○	●

Explanation: Points indicate which domain is covered in the policy documents.
Empty circles mean that no evidence of focus was found in the reviewed documents.

Abbreviations: NA … not applicable.

Sources: National documents (see Table 3-1); full details in Appendix 5 (Data Extraction Table).

Age Range

in allen Ländern flexible Obergrenzen der Altersspanne über 18 hinaus

Some documents suggest that they adopt a broader life-course approach, integrating transition planning into a wider continuity of care strategy (DE, UK). The age range starts in all countries between the ages of twelve and 16. Some documents (AU, DK, NL) start at 12–13 years old, and others (AU, CH, UK) focus on the later adolescent stage at approximately 16 years. Notably, the ages associated with transitions extend beyond 18 in all reviewed countries, either through formal policies or flexibility based on individual circumstances. This acknowledges that developmental maturity varies and that strict age thresholds may not be suitable for all YP.

Table 3-6: Point Matrix of Age Ranges Addressed in Transitional Psychiatry Policies across Included Countries

	Life-course approach (starts from zero)	Early adolescence (starts from 12–13 years)	Later adolescence (16–17)	Transition beyond age 18	Flexible/no defined age ranges
Australia	○	●	●	●	●
Belgium	NA	NA	NA	NA	NA
Denmark	○	●	○	●	○
Germany	●	○	○	●	○
Netherlands	○	●	○	●	○
Switzerland	○	○	●	●	○
United Kingdom	●	○	●	●	○

Explanation: Points indicate whether the setting is mentioned as a context for the applicability of a policy.
Empty circles mean that no evidence of focus was found in the reviewed documents.

Abbreviations: NA … not applicable.

Sources: National documents (see Table 3-1); full details in Appendix 5 (Data Extraction Table).

Vulnerable and High-Risk Population

vulnerable und gefährdete Populationen: junge Menschen in benachteiligten Situationen und junge Personen mit chronischen Krankheiten, geistigen Behinderungen, neurodegenerativen Erkrankungen oder Begleiterkrankungen

Documents from various countries highlight the specific challenges faced by vulnerable youth populations during the transition from CAMHS to AMHS. These groups include YP in disadvantaged situations, such as those in out-of-home or foster care, or those under state protection. They also encompass YP who are homeless or lack residency status. Furthermore, young offenders and those living in remote or rural areas face particular barriers to access. Cultural and linguistic minorities, including refugees, culturally and linguistically diverse (CALD) populations, and Aboriginal and Torres Strait Islander youth, are also recognised as requiring culturally sensitive and inclusive approaches. Likewise, LGBTIQ+ youth frequently encounter discrimination and may need additional psychosocial support.

Health-related vulnerabilities affect YP with chronic disorders, intellectual disabilities, or neurodevelopmental conditions, as well as those with physical and psychological comorbidities (many transitions at once). Those particularly at risk are YP who are diagnosed with a chronic or long-term condition for the first time between the ages of 16 and 17. YP in special education, those with low health literacy, or those requiring adapted communication formats are also at risk. Transitions sometimes involve healthcare services, as well as municipal and social systems. This is particularly true when a condition necessitates intensive social interventions in conjunction with medical treatment. This is notably relevant for YP with a history of trauma, abuse, or substance use.

Service Integration and Coordination

Referral and Transition Process

Timing of Transition

Schwerpunkt auf Früherkennung, frühe Planung und Vorbereitung

All of the countries examined endorse early and individualised planning as a cornerstone of successful transitional care. Most systems (AU, CH, DE, NL, DK, UK) begin planning six to twelve months in advance. Furthermore, the countries highlight the need for early identification, planning and preparation. Identification and planning can begin as early as 13 or 14 years of age in some cases (DK, UK), with an extended transition period of several years, depending on the young person's pace. The use of the Transition Readiness Assessment Questionnaire (TRAQ) is recommended (AU).

Transitionen nicht nur altersabhängig, sondern auch von klinischen Erfordernissen und Entwicklungsreife

Transitions are not only age-triggered but also guided by clinical need (severity, complexity of condition, and degree of risk), as well as developmental readiness, cultural identity, education, employment, family and caregiver support, housing, community environment, availability of services, and access (UK, AU). Flexibility includes the option for YP to remain in CAMHS beyond the age of 18, or to move to AMHS prior to 18, when appropriate. Similarly, CH and DK promote flexibility through an elastic age limit (21–25 years). YP over 18 who present with a mental health problem for the first time should ideally be given the choice, where possible, of receiving care from a youth service for people up to the age of 25 or an adult service (UK). That the transfers should only take place at a relatively stable point in terms of emotional well-being and disorder was also emphasised (AU, DE, UK).

Coordination Mechanism

individuelle Übergangspläne, interprofessionelle Zusammenarbeit und sektorübergreifende Abstimmung

In AU, coordination mechanisms highlight the exchange of concise and relevant information, service matching, and integrated planning that involves YP, their parents, peers, and medical and psychosocial teams. Additionally, the importance of summaries from CAMHS, which provide medical and other relevant information, was highlighted (DK). Interprofessional case discussions, joint consultations, and individual transition plans are widely recognised as coordination mechanisms in the countries. The UK furthermore recommends flexible, person-centred transition protocols. These plans must be tailored to individual needs, incorporate built-in decision-making flexibility, link to existing care plans, and be coordinated across services.

Preparation and Support Actions

Vorbereitung auf die Transition durch ausreichend Planung und gemeinsame Zielsetzung

The intensity and scope of preparation for transition through support structures vary across countries. AUs approach focuses on risk-informed preparation, including reviewing care plans, conducting risk assessments, establishing crisis management protocols and creating safety plans. DK endorses a holistic assessment of both maturity and disorder stage. This model is unique in its use of health literacy tools, such as questionnaires designed to support dialogue, to foster informed decision-making and engagement. In the NL, preparation focuses on joint decision-making and offers materials and tools for transition care, as well as evaluative tools to guide YP and their families through the process. In the UK, preparation involves joint meetings and assessments by both services, with goal-setting across various life domains (e.g., employment, housing, and education), and consideration of personal, procedural, and relational safety needs. The UK also includes an evaluation of self-confidence, self-management, and transition readiness.

Table 3-7: Comparative Overview of Referral and Transition Processes in Transitional Psychiatry Policies Across Included Countries

	Timing of Transition	Coordination Mechanisms	Preparation and Support Actions
Australia	Early identification; planning ≥6 months prior; emotional stability as trigger; assessment of developmental, psychosocial, and health needs; use of TRAQ; focus on education, housing, medication, and communication needs	Clear protocols; stakeholder identification; relevant information sharing; selection of appropriate service	Care plan review; intervention review; safety and crisis plans; risk assessment
Belgium	NR	NR	NR
Denmark	Transition at age 18–20; planning 6–12 months prior; early planning from age 12–14 in some cases; multi-year structured process paced by young person	Joint planning with YP, parents, peers, and adult services; sharing of medical summary and key information	Holistic readiness and maturity check; transition only during stable illness phase; use of dialogue-oriented HL questionnaire
Germany	Early, structured planning, based on the development and disorder stage, together with the patient and caregivers	Interprofessional case discussions	NR
Netherlands	Early intervention	Joint consultation, individual transition plans; institutional policies and strategies	Joint selection of materials and tools; evaluation tools; transition coaches; integrated care systems
Switzerland	Early planning; flexible upper age limit (21–25)	NR	NR

	Timing of Transition	Coordination Mechanisms	Preparation and Support Actions
United Kingdom	Flexible models based on needs (0–25); adolescent services up to 25 or transition earlier; choice for YP entering late in youth/adult services; early identification; early and flexible pathway planning; planning ≥6 months prior (in some cases from age 13–14); focus on education, employment, housing, identification of support or carers; timing at emotional stability; involvement of all relevant parties (incl. GP, carers)	Clear protocols; person-centred plans; use of local service maps to support transition; shared decision-making; coordination by both services; agreement by YP and carers	Joint assessments; goal setting; self-management assessment; consideration of all domains (education, employment, inclusion, health, housing); procedural and relational safety needs

Abbreviations: AMHS … adult mental health services; CAMHS … child and adolescent mental health services; HL … health literacy; TRAQ … transition readiness assessment questionnaire; YP … young people; NR … not reported.
Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

The body of evidence regarding service integration and coordination was broad, informed by all included documents (guidelines, quality standards, practice guidance, policy recommendations, government reports, position statements, resource guidance, and service planning), and further supplemented by inputs from three expert consultations.

Evidenzbasis: alle inkludierten Dokumente, ergänzt durch 3 Expert:innen-konsultationen

Integration between CAMHS and AMHS

Transition Coordination Roles

A key element of all systems is the existence of a designated transition coordinator to oversee the process. This position could alleviate some of the administrative burden of managing transitions from clinicians, allowing them to focus on patients' mental health needs. In most countries, this function is embedded within existing care structures and is often assigned to medical staff, such as doctors or nurses. In DE, however, it is recommended that it be assigned to a non-medical person. The NL and the UK emphasise tailoring the coordinator's role to the developmental needs and abilities of each young person, sometimes involving professionals with whom they already have a relationship. YP could also be involved in selecting their coordinator, as suggested by documents from the NL and the UK. The coordinator's main tasks include planning and coordinating the transition process, communicating with different services, representing the patient's interests, and monitoring and implementing the process. They should be the primary point of contact and support, accompanying patients and their families throughout the transition process for at least six months before and after the transfer. Furthermore, they should act as a link between the young person and the professionals involved, arranging appointments (including GP appointments) and assisting with navigating services, as documented in UK reports.

designierte Koordinator:innen als zentrale Ansprechperson und Unterstützung bei Planung, Kommunikation und Navigation

Joint Working Mechanisms

Several countries highlight the importance of structured collaboration and formal cooperation agreements that outline shared responsibilities and the organisation of transitional care pathways for information exchange and continuity. Most countries (AU, DK, DE, NL, CH and UK) recommend using structured jointly commissioned transition plans between CAMHS and AMHS, based on guiding principles and service-level agreements with agreed-upon transition protocols. The need for regular discussions to ensure patient-centred planning and coordination was endorsed (DE). The UK recommends

gemeinsame Versorgungsprotokolle, Fallkonferenzen und abgestimmte Übergabepläne zwischen KJP und EP

that parallel planning, which should start months before handover, should include joint assessments, face-to-face meetings between lead professionals, planning the timing of the handover, appointing a new lead carer or care coordinator, and ensuring the availability of services, including crisis and on-call services. The Danish model highlights continuity of care through providers, i.e. ensuring that the same clinician provides care until the patient reaches the age of 24. Other strategies included shared documentation, as well as feedback mechanisms, shared digital infrastructure, and routine joint reviews of systems and processes to support collective responsibility. Intersectoral collaboration, particularly with schools, social services and educational counsellors, was also endorsed.

Information Sharing Processes

strukturierter Informationsaustausch und persönliche Übergabedossiers mit medizinischen, sozialen und krankheits- und behandlungsspezifischen Daten

In terms of information-sharing, AU emphasises structured inter-agency communication that includes a clear and accessible plan, risk assessment, and regular updates. The UK recommends a personal transition folder containing medical, social, and psychosocial data, which is created months before transfer. This folder should include profile, health status, educational and social care needs, preferences for parent and carer involvement, emergency care plans, history of unplanned admissions, strengths, achievements, and goals. Additionally, written information about what to expect from services and the support available should be easily accessible to YP and carers, including details about available benefits and financial support (UK).

Service Alignment Strategies

„Warm Handovers" mit gemeinsamen Treffen mit dem aufnehmenden Team vor Transfer, parallele Planung und stufenweise Übergänge

Service alignment is pursued through structured 'warm handovers', where transition planning includes joint meetings with the receiving adult team prior to the transfer taking place. This should be along with written materials about the new treatment centre (DK). The number of meetings varies from at least one in DE to annual consultations with all parties involved in the NL. In the UK, service alignment is recommended through parallel planning and graded transitions, where CAMHS and AMHS participate in preparation simultaneously several months before the anticipated transfer. During this time, multiple joint appointments are arranged where YP meet key members of the adult team. Discussions should cover what is working well in the transition planning and what can be improved, the young person's clinical needs, psychological status, social and personal circumstances, caring responsibilities, educational and vocational needs, cognitive abilities and communication needs. The UK also recommends a phased transition of therapy, including attending individual and/or group psychological therapy sessions, as well as integrated pathways that comprise joint meetings, training and education opportunities, and the development and implementation of a coordinated care plan. Furthermore, the NL highlights that CAMHS and AMHS need to sensitise professionals to the problem of the different cultures of adult and child/adolescent psychiatry, to avoid a 'culture shock' for YP. The UK, furthermore, proposes Integrated Care Systems, and CH and DK propose institutionally integrated structures where CAMHS and AMHS services could be managed under the same umbrella or department.

Table 3-8: Comparative Overview of Integration Mechanisms Between CAMHS and AMHS Across Included Countries

	Transition Coordination Roles	Joint Working Mechanisms	Information Sharing Processes	Service Alignment Strategies	Other
Australia	Designated transition coordinator; involvement of all partners in care planning and delivery	Joint working teams; joint planning; collaboration	Structured planning; accessible documentation; regular and timely documented exchange; risk assessment; referral information; joint communication	'Warm handovers'; introduction to adult service	NR
Belgium	Designated liaison (referee person) to allocate resources, accompany patients and families through the process	NR	NR	NR	Shared outpatient settings, where possible
Denmark	Contact persons/ coordinators to manage roles, coordinate transition planning, act as point of contact	Cross-department collaboration; continuity with same doctor/nurse until age 24	NR	Prior meetings/visits; written handover about new treatment centre	NR
Germany	Non-medical coordinator to oversee implementation, ensure treatment continuity, continuous exchange of information	Structured cross-sector collaboration; regular discussions; intersectoral collaboration	NR	At least one joint case discussion between referring and receiving doctor	NR
Netherlands	Transition coordinator (healthcare provider) supports and supervises process, acts as advocate, builds trust, draws up plan, coordinates services	Individual transition planning	Structured information-sharing	Annual consultations with all parties to prepare and sensitise professionals; reduce "culture shock" for YP	NR
Switzerland	Clinical case manager, monitors severe cases, screens risk, coordinates planning and treatment, long-term case management	Joint transition planning; shared protocols; integrated working; agreed mission statement	Shared plans; joint documentation; information-sharing	NR	Psychiatric clinics managing both CAMHS and AMHS may operate shared adolescent section under one management
United Kingdom	'Named worker'/transition coordinator, coordinates transition, takes away administrative burden, supports handover, arranges appointments (incl. GP), helps navigate services, supports family, provides advice for minimum of 6 months before and after transfer (healthcare provider with meaningful relationship with YP)	Parallel planning ≥3 months prior; face-to-face meetings between professionals; information on existing and available services, including crisis or out-of-hours services; jointly review systems and practices to identify needed changes	Shared transition folder with personal and medical data, education, preferences, risks, treatment needs, legal rights, expectations; adult provider information	Staff introduction; graded transitions (multiple visits, meeting key members of adult team, phased transition of therapy, e.g. via attendance in individual and/or group psychological therapy sessions); focus on goal setting, self-management support; planning across education, employment, health, and housing, procedural and relational safety	Development of integrated care systems; joint clinics; cross-CAMHS/ AMHS staffing

Abbreviations: AMHS … adult mental health services; CAMHS … child and adolescent mental health services; GP … general practitioner; YP … young people; NR … not reported.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Evidenzbasis und spiegelt Kombination aus dokumentenbasierten und expert:innenbasierten Beiträgen wider

The evidence base for integration between CAMHS and AMHS comprised all thirteen included documents (guidelines, quality standards, practice guidance, policy recommendations, government reports, position statements, resource guidance and service planning), as well as content from four expert consultations. The evidence base is, therefore, extensive and cohesive, reflecting a combination of document-based and expert-based input.

Continuity of Care

Parallel Care During Transition

parallele Betreuung vor Transfer, für frühzeitige Einbindung und Zusammenarbeit mit dem aufnehmenden Team

AU supports parallel care for three to six months before transfer, emphasising the early involvement and collaboration of the receiving team. A similar approach is taken in DK, where an overlap between paediatric and adult care is emphasised. Even if responsibility can be transferred midway through the process, both parties should be involved in the transition for a while. According to the perspective of a German expert, 'track models' offer a possible effective approach, whereby the same professional continues to provide care in all settings, regardless of institutional affiliation.

Post-Transition Follow-Up

offener Wiedereintritt in KJP sowie begleitende Nachsorge durch regelmäßige Folgegespräche

Anwesenheit der vorherigen Fachkraft für die ersten Termine in Erwachsenenversorgung

AU recommends open re-entry to CAMHS, as well as continued post-transfer care coordination. Maintaining some level of post-transition communication with the referring service is also seen as key to system responsiveness. DK recommends that YP have several follow-up meetings with the same counsellor immediately after transition. The focus should shift towards self-management and health literacy, including education on understanding the disorder and making healthy lifestyle choices. Similarly, the NL recommends at least one evaluation meeting with the same practitioner in the first year after transfer, where possible, and further periodic consultations are encouraged. DE supports ongoing monitoring through regular assessments of treatment goals and outcomes. The UK also specifies that the same practitioner should be present for at least the first AMHS appointments after transfer, and that a plan review meeting should be held at least once a year. Additionally, joint pre- and post-transfer Care Programme Approach (CPA) meetings should be held, alongside Care, Education and Treatment Reviews (CETR), beginning up to six months before the transition and continuing afterwards.

therapeutische Wirkung von Monitoring, Unterstützung und strukturiertem Kontakt

One expert from the NL endorsed during the consultation the importance of follow-up monitoring. According to the expert, the MILESTONE project showed that around half of adolescents may experience resolution of symptoms without requiring further care. However, simply receiving care, even without intensive treatment or visible improvement, can help stabilise mental health and prevent deterioration. The therapeutic effect of monitoring, support and structured contact can be particularly valuable during this developmental period. This is particularly relevant for conditions with a high potential for relapse, such as eating disorders, where symptoms may improve only to re-emerge shortly after recovery. Similarly, prodromal symptoms of severe mental illnesses (SMI) such as schizophrenia require ongoing observation to detect early warning signs. In such cases, continuity of care acts as a buffer against escalation. Conversely, service discontinuities or long waiting periods can aggravate symptoms and disrupt recovery trajectories.

Disengagement and Re-entry Strategies

Nachverfolgung versäumter Termine und strukturierte Reintegration, wenn notwendig

It is recommended that adult services follow up on missed appointments and, if necessary, involve other professionals, such as GPs, school nurses, or youth workers (NL, UK). A referral can be made to the transition coordinator or CAMHS services. Guidance must be provided on supporting reintegration and identifying alternative support and involvement opportunities (e.g., self-help groups). There is a strong emphasis on shared responsibility for monitoring, where GPs are given guidance on what to monitor and when to refer back. In AU, CH, DE, and DK, no structured reintegration procedures are reported.

Table 3-9: Comparative Overview of Continuity of Care Strategies Across Included Countries

	Parallel Care During Transition	Post-Transition Follow-Up	Disengagement and Re-entry Strategies	Other
Australia	Parallel care for 3–6 months; receiving care team engaged pre-transition; joint involvement of CAMHS/ AMHS, YP and family	Post-transition contact with CAMHS; continued care with open re-entry	NR	NR
Belgium	NR	NR	NR	NR
Denmark	Joint transition phase between CAMHS and AMHS (e.g., shared outpatient services); transfer of responsibility during process	Multiple follow-up sessions with same counsellors; immediate post-transition meeting, focus on self-management, lifestyle and disorder education	NR	NR
Germany	Track models; same practitioner continuity across settings	Regular treatment and goal assessment; individual and group therapy for YP for inpatient and outpatient continuity	NR	Early detection centres for psychologist/specialist; appointments as support for inpatient admission if needed
Netherlands	NR	At least one evaluation within first year with same practitioner; periodic consultation and monitoring; regular monitoring (being in care) might help prevent symptoms from worsening, even if no visible improvement	GP or other providers coordinate re-referral if YP misses appointments; clear guidance on monitoring, and referral to adult care	NR
Switzerland	NR	NR	NR	NR
United Kingdom	NR	Annual plan review; six-month post-transition contact; continuity with same practitioner for first two attended appointments; CPA and CETR meetings pre- and post-transition; joint case meetings	Adult services initiate contact after missed appointments; re-engagement efforts; GP or child/adult service involvement; assessment of readiness to re-refer if further support required	NR

Abbreviations: AMHS … adult mental health services; CAMHS … child and adolescent mental health services; CETR … care, education and treatment review; YP … young people, CPA … care programme approach; GP … general practitioner; NR … not reported.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Evidenzbasis gut vertreten in schriftlichen Quellen, mit Expert:innenbeiträgen, für kontextuelle Details

Evidence on continuity of care was drawn from all included written sources (guidelines, quality standards, practice guidance, policy recommendations, government reports, position statements, resource guidance and service planning), as well as three expert consultations. The topic is well-represented across written sources, with expert input providing contextual detail.

Treatment Approach

Provided Services

Psychoeducation/Empowerment

Psychoedukation und Empowerment zur Förderung von Autonomie, und Selbstmanagement

All countries integrate psychoeducation and empowerment to varying degrees and in different forms. Most emphasise self-management skills, decision-making skills, and autonomy, as well as how to deal with the differences between CAMHS and AMHS. DK also focuses on patient rights, confidentiality, and informed consent. The NL emphasises the importance of providing clear, oral and written information about adult care services, including a description of the transition process, counselling options, and the differences between child and adult care. The UK recommends the use of advocacy tools and welcome packs (provision of written information) to provide high-quality information about AMHS in various media and languages.

Clinical Assessment/Treatment

individualisierte Versorgungsansätze

AU recommends developmental and psychosocial assessments, trauma-informed care, and coordination and navigation of care. DE emphasises the need for individualised treatment goals as part of a detailed treatment plan that includes medication and early warning systems. It also integrates crisis prevention and planning. DK emphasises 'youth hours' and 'youth pathways', focusing particularly on the needs of YP and minimising contact with much younger patients or adults.

Peer Support/Mentoring

Peer-Mentoring zur Unterstützung der Betroffenen

je nach Erkrankung leichtere oder schwerere Integration in peerbasierte Settings

Peer mentoring is recognised as a valuable form of support and an effective means of exchanging experiences, and is recommended in several countries (AU, DK, NL, UK). Furthermore, the UK recommends it for various areas, including education, employment, housing, health, and social inclusion. As highlighted by one expert from DE, YPs with affective disorders, such as anxiety and depression, as well as emerging personality or maturation disorders, often respond well to peer-based settings; they tend to engage quickly in group environments and benefit from shared experiences. In contrast, YP with conditions such as schizophrenia or psychotic disorders often struggle to integrate into peer-oriented care structures, as their symptoms may limit their social engagement.

Use of Digital Tools

digitale Technologien, um Jugendliche zu motivieren und Betreuung zu unterstützen

Digital technologies are recommended to engage YP where appropriate (or for YP who move as an opportunity to stay in the same service). These include referral to online support services, online consultations and the use of evidence-based apps or other devices as either an adjunct to therapy or as a tool to facilitate therapeutic outcomes (AU, DK, DE, NL, UK). Furthermore, digital tools should be used as alternatives to meet written and verbal communication needs, providing age- and literacy-level appropriate, jargon-free information materials and communication tools (e.g., social media) (AU, UK). Mobile treatment for clinical case management, which serves a relational, supportive, and coordinating function to continuously accompany the transition phase and span interfaces between CAMHS and AMHS, was also recommended (CH).

Table 3-10: Comparative Overview of Treatment Approaches Across Included Countries

	Psychoeducation/ Empowerment	Clinical Assessment/ Treatment	Peer support/ Mentoring	Use of Digital Tools
Australia	Education on service delivery differences, skills development, self-determination, self-management; psychoeducation for YP, families, and carers	Coordination and navigation of care; assessment of mental state, safety, and risk; psychiatric review; therapy and trauma-informed care tailored to developmental and psychosocial needs	Peer support; group-based interventions	Digital tools for age and literacy level appropriate communication (e.g., social media) with accessible, jargon-free information materials; online support services such as use of evidence-based apps, as adjunct to therapy
Belgium	NR	NR	NR	NR
Denmark	Empowerment sessions; disorder education (resilience, independence, coping with disorder); rights; confidentiality; consent; psychosocial support	'Youth hours', 'youth tracks'; support for autonomy, communication with professionals	Group programmes or consultations with peers to share experiences	Digital tools for communication and counselling
Germany	Psychoeducation; training; counselling	Individualised treatment plans, including therapy goals, medication needs, crisis planning	Peer support valued by patients with anxiety/ depressive disorders and personality/maturational disorders; underrepresentation in conditions such as schizophrenia due to integration challenges	Use of media and digital applications to supplement care
Netherlands	Education on self-management; shared decision-making; self-confidence; verbal/written information on adult services (process and care differences); psychosocial care; transition preparation	NR	Peer mentoring, coaching	E-health support tools
Switzerland	NR	Treatment-integrated clinical school support	NR	Mobile treatment for clinical case management, relationship and coordination support, continuous coverage across CAMHS and AMHS
United Kingdom	Advocacy; multilingual high-quality information; education on service use; promotion of autonomy, decision-making; welcome packs	Transition coordination meetings; life domain planning (e.g., education, housing, wellbeing)	Peer support, coaching, mentoring; support across education, community, health, and independent living	Mobile technology for online consultations; information-sharing via social media

Abbreviations: AMHS … adult mental health services; CAMHS … child and adolescent mental health services; NR … not reported.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Care Pathway

Phased Integrated Care Pathways

Most countries recommend phased, integrated care pathways that include structured preparation, transfer, and follow-up stages to ensure continuity of care. These models highlight early planning, personal handovers, and collaboration across services.

stufenweise, integrierte Betreuungspfade, inklusive Vorbereitung, Übergabe und Nachbereitung

Individualised Planning

entwicklungsgerechte, personalisierte Übergangsplanung

Where reported, countries emphasise developmentally appropriate, personalised transition planning, often co-produced with the young person. The focus lies on tailoring pathways to meet individual mental health needs, readiness, and autonomy. AU and DE, furthermore, explicitly highlight the importance of avoiding multiple simultaneous transitions (e.g., school, housing).

Table 3-11: Comparative Overview of Care Pathways for Transitional Psychiatry Across Included Countries

	Phased Integrated Care Pathways	Individualised Planning	Other
Australia	Review of care; personal handover; contact with family and providers; clear referral pathways; support pre-, during, and post-transfer	Developmentally appropriate, peer-driven, individualised plans	Avoidance of multiple simultaneous transitions
Belgium	NR	NR	NR
Denmark	Early transition, transfer, follow-up phases	NR	NR
Germany	Structured, phased treatment plan	NR	NR
Netherlands	NR	NR	NR
Switzerland	NR	NR	NR
United Kingdom	Integrated care pathways; clear access pathways across services; significant relationship building; strong communication; collaborative working	Personalised, developmentally appropriate pathways based on mental state	NR

Abbreviations: NR … not reported.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Therapeutic Model

patient:innenzentrierte entwicklungs- und jugendgerechte Versorgung

Nearly all countries endorse person-centred principles to align care with individual preferences and to foster shared decision-making. AU incorporates this alongside cultural sensitivity. The UK also mentions the importance of non-stigmatising and youth-friendly care. The UK integrates developmental needs into person-centred and age-adapted, youth-led and strengths-based care, which emphasise empowerment and engagement. AU and DK adopt a recovery-oriented framework, and AU additionally adds a layer of trauma sensitivity. AU is the only country that explicitly references trauma-informed practice in multiple sources.

Table 3-12: Point Matrix of Therapeutic Models Referenced in Policies Across Included Countries

	Patient-Centred Care (Developmentally and Youth-Appropriate/Culturally Sensitive)	Recovery-Oriented Care	Trauma-Informed Care
Australia	●	●	●
Belgium	NA	NA	NA
Denmark	○	●	○
Germany	●	○	○
Netherlands	●	○	○
Switzerland	●	○	○
United Kingdom	●	○	○

Explanation: Points indicate whether and which therapeutic model was referenced in the policy.
Empty circles mean that no reference was found in the reviewed documents.

Abbreviations: NA … not applicable.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Participation

Shared Decision-Making Mechanisms

aktive und umfassende Partizipation junger Personen an Entscheidungen und Plänen

Most countries recommend the active and full participation of YP in decisions and plans related to transition, with AU and the UK applying co-production principles to encompass service design and evaluation. The UK's recommendations prioritise the principle of co-production, as this provides the appropriate context for effectively implementing the other principles.

Family Involvement

aktive Einbeziehung der Familie, angepasst an der jungen Person

Across countries, family and caregiver involvement in planning and decision-making is encouraged, but it is usually adapted and customised to the young person's age, development, and preferences.

Support, Training, and Feedback

strukturierte Unterstützung und Bildungsmöglichkeiten für junge Menschen und Familien

Several countries recommend structured support and training opportunities for YP and their families, such as groups, events, and feedback loops (AU, DK, UK). DK recommends a 'split-visits' approach. This involves separate and joint conversations with YP and their parents, to prepare them for meetings with the healthcare provider alone. The UK also recommends separate care conversations for YP and carers to raise concerns and questions. After the transition, it is advised to continuously evaluate if the support provided is adequate and appropriate.

Table 3-13: Comparative Overview of Participation Strategies Across Included Countries

	Shared Decision-Making Mechanisms	Family Involvement	Support, Training, and Feedback
Australia	Full involvement in care planning, service design, evaluation; co-production; tool development; decision-making	Age-appropriate, culturally sensitive involvement; involved in care planning	Feedback opportunities
Belgium	NR	NR	NR
Denmark	NR	Active inclusion; partner involved post-transition	individual and joint sessions, e.g., 'Split Visits'; family training; group events; post-transition support review
Germany	NR	Age- and development-appropriate involvement of relevant persons from social environment	NR
Netherlands	YP leads care decisions	Parental role adjusted over time; agreement on individual transition plan	NR
Switzerland	Involvement as early as possible	Customised involvement based on family relationship and patient preference	NR
United Kingdom	Full, equal involvement at all stages; co-production in care, design, evaluation; CPA and CETR participation	Ongoing family involvement, based on YP preferences	Feedback mechanisms; separate sessions for YP and carers

Abbreviations: CETR … care, education and treatment review; CPA … care programme approach; YP … young people; NR … not reported.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Evidenzbasis basiert auf weniger Inhalt als die vorangegangenen Kategorien

The evidence regarding treatment approaches was informed by all thirteen documents (guidelines, quality standards, practice guidance, policy recommendations, government reports, position statements, resource guidance and service planning) and two expert consultations. However, it is generally based on less content than the preceding categories.

Workforce, Training and Infrastructure Requirements

Defined Responsibilities

1 Person im Team für delegierte Koordinierung

Most countries do not explicitly define strategies about who is responsible for what in ensuring a smooth transfer between CAMHS and AMHS. Only DE and the NL mention role-based delegation. DE assigns responsibility to a reference doctor or psychotherapist with delegated coordination to a non-medical staff member, and the NL formalised clearly defined responsibilities, with a transition coordinator coordinating roles.

Multidisciplinary Involvement

breite multidisziplinäre Integration von Disziplinen in Teams

Countries with formalised transition frameworks (e.g., AU, UK) have broader stakeholder inclusion, including, apart from CAMHS and AMHS teams, transition coordinators, families, nurses, primary care providers, social workers, peer workers, education/vocational providers, the voluntary sector, and other agencies such as those involved in substance use or justice sectors, or other providers like physiotherapists or dietitians. In contrast, others focus primarily on medical and direct care staff.

Table 3-14: Point Matrix of Multidisciplinary Involvement Across Included Countries

	CAMHS and AMHS Teams	Nurses and Other Clinical Staff	Transition Coordinator/ Case Manager	Primary Care	Social Work	Other Relevant Services	Educational/ Vocational Providers	Peer Worker	Family/Carers/ Significant others
Australia	●	●	●	●	●	●	●	●	●
Belgium	NA	NA	NA	NA	NA	NA	NA	NA	NA
Denmark	●	●	●	○	●	●	●	○	●
Germany	●	○	●	○	●	●	○	○	●
Netherlands	●	○	●	●	○	○	●	○	●
Switzerland	●	○	●		●	○	●	○	
United Kingdom	●	●	●	●	●	●	●	●	●

Explanation: Points indicate whether and which disciplines are mentioned as part of the transitional care workforce. Empty circles mean that no evidence of involvement was found in the reviewed documents.

Abbreviations: NA … not applicable.

Sources: National documents (see Table 3-1) and expert consultations; full details in Appendix 5 (Data Extraction Table).

Training and Qualification Requirements

Bedarf an altersübergreifender Kompetenz

interdisziplinäre Schulungen und/oder Zusatzqualifikationen

Professionals with cross-cutting competencies in child, adolescent, and adult mental health are required. Several sources recommend the need for training in developmental and person-centred practices, as well as training across age ranges, to engage with the unique needs of priority populations and understand age-appropriate options and flexibility. To support cross-sector collaboration and foster a shared understanding of transitional needs, it was recommended that joint interdisciplinary training be provided to professionals from CAMHS and AMHS. Such training aims to establish a common knowledge base, foster interprofessional communication and encourage flexible, age-appropriate responses. Proposals included additional qualifications and postgraduate programmes in transitional psychiatry. Notably, the proposals involved training child and adolescent psychiatrists to work with YP up to the age of 25, as well as equipping adult psychiatrists with the necessary skills to engage with adolescents. Suggested formats for specialised postgraduate ed-

ucation included master's programmes and additional qualifications in transitional psychiatry. One expert recommended reciprocal placements, such as child and adolescent psychiatrists completing one-year rotations in adult psychiatry and vice versa, to foster early familiarity with patient needs across different age groups. Other training methods encompassed shadowing, reflective case-based learning, and structured engagement with YP's perspectives.

Anforderungen an Koordinator:innen – medizinischer Hintergrund oder Berufserfahrung

Furthermore, it was mentioned that training is necessary for professionals responsible for coordinating transitions. Recommendations varied from requiring formal clinical qualifications to ensuring a minimum of two years of relevant experience. Some countries specify that transition coordinators should possess a medical background.

Schulungsbedarf für alle beteiligten Berufsgruppen

Training and support needs were also highlighted for professionals across services to enable them to identify emerging mental health issues and provide appropriate care. Training needs were also mentioned for peer workers and mentors.

Workforce Retention and Sustainability Strategies

Personalbindung und Rollenoptimierung

In light of staff shortages in the workforce, the sustainability of transitional psychiatry services depends on strategic staff retention and optimising roles. Key factors supporting retention, according to experts, include meaningful work, recognition, appropriate remuneration, and engaging roles, particularly in youth-focused care.

Verringerung der Abhängigkeit von Fachdiensten durch bedarfsgerechte Versorgung und Stärkung des interprofessionellen Vertrauens

According to experts, promising models emphasise needs-based care rather than diagnosis-driven approaches, promoting community-based interventions and reducing reliance on specialist services. Strengthening interprofessional trust and referral acceptance (e.g., CAMHS professionals should avoid unnecessary referrals, and AMHS should take GP or CAMHS referrals seriously and prioritise them) was identified by an expert as crucial for the sustainable delivery of care, especially between CAMHS, AMHS, and GPs.

finanzielle Anreize

Financial incentives, such as relocation bonuses, time-bound commitment payments, and housing support, were also mentioned as effective in addressing regional workforce shortages.

Aufgabenteilung über Berufsgruppen hinweg

Sharing tasks across professional groups – for example, involving nurses, social workers, and occupational therapists alongside psychiatrists and psychotherapists – was highlighted by one expert as a way to optimise resources and maintain quality. Clear role definitions and professional boundaries are essential, as tasks must remain within the areas of expertise of the respective professional groups to ensure quality and safety.

Infrastructure Resources

jugendfreundliche Infrastruktur

Transitional care requires supportive infrastructure and accessible digital tools. For infrastructure, there is a need for youth-friendly physical environments. Recommendations include creating dedicated waiting areas with age-appropriate information materials and spaces for private use. Key components further include integrated clinical documentation systems and shared information platforms, as well as digital resources such as e-learning modules, flowcharts and video materials.

digitale Werkzeuge, integrierte Dokumentationssysteme

Evidenzbasis mit starkem Rückgriff auf Expert:innenperspektiven

Evidence for workforce, training, and infrastructure requirements was derived from ten documents (guidelines, quality standards, policy recommendations, government reports, position statements, resource guidance, and service plan-

ning) and six expert consultations. Compared to other themes, the proportion of expert input was higher. The evidence base is therefore mixed, combining document-based input with a strong reliance on expert perspectives.

Implementation and Governance

Implementation Strategies and Lifespan Approaches

schrittweise Implementierung

A phased implementation roll-out was recommended (AU, DK). Effective implementation requires promoting transition psychiatry care at a national level as part of high-quality, person-centred services. Key strategies include securing recognition from health authorities, mobilising role models, and engaging YP and their families through schools and associations. Recommended measures include appointing transition leads, updating digital infrastructure (Information and Communications Technology/Electronic Health Record Systems), incorporating standards for transition services into training programmes across medical and paramedical disciplines, enabling joint consultations, integrating the quality standard into local protocols and care pathways, and providing institutional support for extended consultation times and interprofessional meetings (e.g., double consultations by both child and adolescent and adult provider). Toolkits, peer support structures, and the visible dissemination of standards (e.g., on institutional websites) will also help increase uptake. Continuous feedback from working groups, families, and youth councils is also recommended.

diverse Empfehlungen, um Implementierung zu fördern

Berücksichtigung der Lebensspannen- und Lebensverlaufsperspektive

Early investment in child and family services through prevention and early intervention, as well as parenting support and early family services, is considered vital by experts for reducing long-term demand on mental health systems. Adult services are also encouraged to consider the needs of their patients' children in order to improve intergenerational outcomes. Additionally, experts endorsed the importance of adopting a lifespan approach.

Governance

gemeinsame Governance und Abstimmung interner Strategien

Governance responsibilities should be shared across partner organisations and should explicitly include YP and their carers. Each participating entity should align its internal strategies and key performance indicators with the overarching system goals. To ensure seamless information flow and minimise discrepancies in care cultures across sectors, cross-organisational governance mechanisms are recommended.

Key Enablers

starke Führung, Einbeziehung von Interessengruppen und Koproduktionsprozesse zur Förderung einer erfolgreichen Umsetzung

The practical implementation of transitional psychiatry models is supported by strong leadership, stakeholder engagement and co-production processes that encourage buy-in. The establishment of local transition forums, comprising representatives from CAMHS, AMHS, the voluntary sector, and service users, was mentioned as a means of jointly reviewing, monitoring, and improving transition protocols, as well as providing an arena for debate and service development. Joint Strategic Needs Assessments and a shared language across services were also considered beneficial tools for aligning service delivery with population needs.

klare Ressourcenbereitstellung und Rechtsrahmen notwendig

Favourable structural conditions include adequate resource availability, such as infrastructure, staffing and financial resources, as well as clear legal and regulatory frameworks. As adult units are often not designed to meet the legal conditions and requirements of minors (e.g., supervisory duties), expand-

ing the framework of legal possibilities is necessary. Financial incentives, such as specific remuneration for cross-service consultations, were also recommended to initiate and support collaboration. Furthermore, seen as beneficial were binding quality standards that align with international guidelines, along with users being aware of the quality standard and feeling competent to apply it.

klare Kommunikation und Dissemination

Additional facilitators included strategic communication and the dissemination of clear and actionable recommendations. Data-driven planning and commissioning, informed by population health, were advised to help implement models aligned with local needs.

Früherkennung und frühe Intervention sowie Einbeziehung von Haus- und Kinderärzt:innen

Considering the entire care journey, personalised care models and care navigation support were considered vital for helping YP access the right services. Emphasis was placed on early detection and intervention, which can prevent the need for specialist care, prevent severe illness and reduce treatment costs. Primary practitioners and paediatricians should be involved in early detection and informed about transition services to choose appropriate care pathways directly (e.g., adult treatment instead of CAMHS for older adolescents).

Konzeptstudie zu Kriterien und Qualitätsstandards für die Errichtung einer Transitionsstation

A German expert involved in this consultation shared a detailed concept paper outlining the criteria and quality standards for establishing a transitional psychiatry unit in DE, established by the Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie and the Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde [80]. Several parameters define the structural quality of such a unit. The recommended maximum number of beds is 18, and a dedicated crisis intervention protocol must be in place that complies with international child rights standards, particularly avoiding the joint admission of minors and adults under coercive circumstances. The unit should be jointly managed by both CAMHS and AMHS, ideally under a binding cooperation agreement between both services. Shared medical leadership is encouraged, although ultimate responsibility may rest with the clinical department to which the unit is structurally assigned. The unit must provide access to education and vocational programmes through schools or training institutions connected to the hospital. Regarding staffing, the document recommends a multidisciplinary team composed of professionals from both CAMHS and AMHS. Staffing levels should comply with the standards for youth psychiatric care (PPP-Richtlinie KJ2/KJ3), regardless of the patient's age, and without resulting in reduced staffing in other services. Medical, psychological, and nursing personnel must be drawn from both disciplines, and specialist psychiatric care must be jointly provided by board-certified physicians in both CAMHS and AMHS [80].

strukturierte Übergabe mit paralleler Behandlung

In the outpatient setting, the framework calls for structured handovers from CAMHS to AMHS practitioners, with parallel treatment provided by both for a minimum of six months in complex cases. The model also emphasises the need to prepare families for the transition and provide closely timed appointments after the transition to ensure continuity and prevent treatment dropout [80].

Hindering Factors

Fachkräftemangel, sektorale und finanzielle Trennungen und fehlende Standardisierung behindern koordinierte Transitionen

Numerous structural and systemic barriers hamper the effective realisation of transitional psychiatry models. The most notable include a shortage of specialist personnel, especially in rural and underserved regions, high vacancy levels, lengthy waiting times, and overwhelmed professionals. An ageing workforce, high staff turnover, housing shortages, and the perception of poor working conditions in healthcare environments worsen these challenges. Further obstacles include limited inpatient capacity in CAMHS, insufficient adult service programmes for specific indications and fragmented service delivery. Sectoral and financial divisions between CAMHS and AMHS, such as differing billing systems and funding responsibilities, also complicate coordination. The absence of formal implementation strategies leads to variability and a lack of standardisation across local systems. Finally, low health literacy also impedes service navigation and continuity of care.

Diagnoseunsicherheit im Adoleszenzalter und mangelnde Versorgungsintegration

At the service level, achieving an accurate diagnosis during adolescence can be challenging and often results in delays or inappropriate referrals. Poor integration between services, long waiting lists, limited continuity and inadequate care coordination across regions (e.g., if a YP moves) further hinder transition pathways.

Evidenzbasis überwiegend konsultationsbasiert

The body of evidence regarding implementation and governance consisted of ten documentary sources (guidelines, quality standards, policy recommendations, government reports, position statements, and resource guidance), as well as several expert consultations. The written evidence is limited in scope, with experts providing most contextual and practical insights. The evidence base is therefore predominantly consultation-driven.

Costs and Resource Allocation

Funding

klare, nachhaltige Finanzierungsstrukturen erforderlich

Clear, sustainable funding mechanisms are required for implementation. An expert highlighted that current age-segregated financing structures should shift towards family-centred models that support coordination across life stages. Reimbursement might require adjusted tariffs, bundled payments, and adapted contractual agreements between health insurers, municipalities, and care providers. Compensation mechanisms should also account for the intensive coordination required across the health, education, and social sectors.

Budgeteinschränkungen besonders in Erwachsenenversorgung

Notably, a German expert emphasised that adult psychiatric care budgets are considered inadequate and should, at the very least, be equivalent to those for child and adolescent psychiatry.

Economic Evaluation

erste Kostenschätzungen aus den Niederlanden – €6.500 pro Patient:in

Evidence from the NL provides an initial understanding of the direct healthcare costs associated with structured transition care. A budget impact analysis of depression treatment estimated additional costs of €6,507 per patient. This includes activities such as joint consultations, coordination, and warm handovers, but excludes expenses for medication and productivity loss. Within the set of interventions calculated, the transition coordinator is the intervention with the highest cost. Expanding this type of care nationwide would require an estimated investment of over €880 million over five years.

Koordinationsstelle als teuerste Maßnahme

Nutzen für die öffentliche Gesundheit führt langfristig zu Einsparungen

The direct costs of transition care are relatively easy to quantify; however, the potential indirect benefits, such as the possibilities for reduced treatment interruptions, fewer hospitalisations, lower risks of suicide and improved educational and occupational outcomes, are more challenging to measure and monetise but are expected to generate significant long-term savings and public health benefits. There are also expected effects on savings through a reduction in costly treatment interruptions caused by inadequate care.

Economic Feasibility

Bedeutung von Früherkennung und Kontinuität der Versorgung für langfristige Senkung der Gesundheitskosten

Although incentives may appear costly in the short term, they are more economical in the long term. The importance of early detection and continuity of care in reducing long-term costs is widely recognised. As an expert highlighted, promising cost-benefit projections from AU, the UK, and the United States suggest a reduced incidence of SMI, improved educational and vocational integration, shorter hospital stays, and fewer high-intensity treatments. Although formal economic evaluations are still limited, experts emphasise that investment in structured transition care is likely to yield improved outcomes and a substantial return on investment for society.

Evidenzbasis stammt in erster Linie aus Konsultationsbeiträgen

Evidence on costs and resource allocation was derived from four documents (including one quality standard containing a budget-impact analysis [72], a government report, a position statement and service planning) and five expert consultations. Written sources, therefore, provide only partial information, and most findings rely on expert input. The evidence base is therefore narrow and primarily derived from consultation input.

Evaluation and Effectiveness

Quality Indicators

multidimensionale Indikatoren auf klinischer, Dienstleistungs- und Systemebene für Wirksamkeitsbewertung erforderlich

To assess the effectiveness of transitional psychiatry services, multidimensional indicators are necessary at clinical, service, and system levels. Key metrics for processes and continuity include the proportion of YP who start transition planning at age 13 or 14, if they have a designated care coordinator, the number of joint planning meetings they attend, indicators of continuity of care (such as the absence of care gaps and completed handovers), the proportion who met an adult service practitioner before transfer, those who had a meeting in the past twelve months to review transition planning, and satisfaction with the transfer. Post-transfer engagement is measured through metrics such as attendance at adult service appointments, missed visits and follow-up rates after missed visits, age upon discharge, and crisis episodes within the first year after discharge.

Indikatoren auf klinischer und psychosozialer Ebene

Clinical and psychosocial outcomes include health status indicators (e.g., disease control and frequency of unplanned hospitalisations or emergency visits), as well as broader functioning metrics such as quality of life, education, employment, and adherence. Parental involvement and outcomes, as well as health literacy, are also considered relevant.

Indikatoren auf System- und Politikebene

System- and policy-level indicators assess whether transition care objectives are being met. These include structural quality (e.g., availability of equipment and trained staff), visibility of transition in education and policy, and observed changes in care delivery. Evaluation should also identify barriers, unintended effects, and areas for improvement.

Evaluation Methods

Evaluation mit quantitativen und qualitativen Methoden

Selbstlerntools für iterative Verbesserungen

An Australian report recommended the use of both quantitative and qualitative methods. These include patient experience surveys, mirror meetings, interviews with YP and their families, and routine data from health records. For a thorough evaluation, research designs that include comparison groups and external evaluations are encouraged to reduce bias. Additionally, long-term cost-effectiveness studies were advised, as the benefits may not be immediately apparent but could result in lower costs over the long term. A Belgian expert recommended the Quebec Self-Learning Tool to provide regular feedback, allowing for adaptive improvements.

Timeframe

regelmäßige Evaluationen und kontinuierliches Monitoring empfohlen

Evaluation is recommended at various times in reports, with both short-term and long-term review cycles. Comprehensive evaluations should be scheduled to take place at regular intervals (e.g. annually (AU) or every three to five years after implementation (DE, NL)). Individual transition programmes are also expected to incorporate continuous monitoring, including periodic treatment reviews every six (DE) to twelve (AU) months after transfer.

Evaluationsziele auf Patient:innen- und Systemebene

Indikatoren dynamisch anpassen

The primary objectives of the evaluation should include recognising the strengths of YP, promoting engagement with new services, addressing service gaps, evaluating adherence to guidelines, identifying the need for workforce training, and enhancing data sharing. For example, a Belgian expert involved in the consultations explained that a retrospective analysis uncovered unexpected referral patterns (e.g., from schools and GPs rather than child psychiatrists), prompting reflection on models of continuity of care. Furthermore, indicator frameworks should be dynamic and reviewed periodically to ensure continued relevance.

begrenzter Umfang der Evidenzbasis

The body of evidence on evaluation and effectiveness was informed by nine documentary sources (guidelines, quality standards, policy recommendations, government reports, position statements, resource guidance and service planning) and four expert consultations. However, most sources discussed the evaluation conceptually, and the available content was limited in scope.

3.1.2 Quality Appraisal (AGREE II)

Domänen 1 und 4 erhielten in allen Ländern durchweg hohe Bewertungen

Domäne 3 wies die niedrigsten Durchschnittswerte auf

The results of the quality appraisal of the included documents are visualised in Figure 3-2. Overall, Domain 1 (Scope and Purpose) has the highest median and the narrowest interquartile range, showing high scores and low variability across documents. Domain 4 (Clarity of Presentation) also has high scores and a relatively small spread. Domain 5 (Applicability) also performed relatively well in several settings. Domain 2 (Stakeholder Involvement) showed some lower values and greater variability, with many documents lacking evidence of participatory development processes. In contrast, Domain 3 (Rigour of Development) showed considerable variation and had the lowest median scores. This reflects the limited use of systematic methods when developing recommendations, particularly in non-guideline documents. Country-specific distributions are presented in Appendix 4.3.

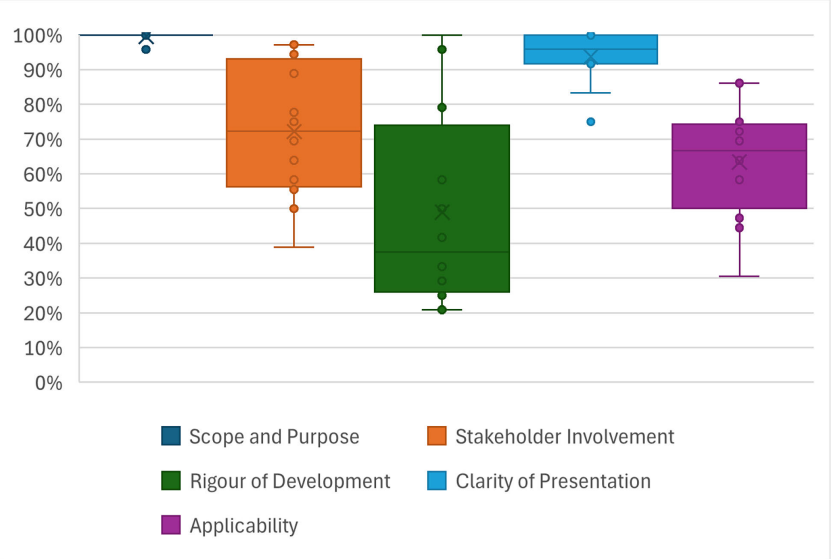


Figure 3-2: Quality Appraisal of Studies Included in RQ1 Across Five Domains (Box Plot)

Qualität der einbezogenen Dokumente insgesamt mäßig bis hoch

Overall, the structural quality of the documents included was moderate to high, particularly in terms of clarity and defined scope. Deficiencies were evident in the use of systematic methods and participatory design. This might be explainable by the inclusion of formal guidelines, as well as other policy-relevant texts, which must be considered when interpreting the results.

3.2 Indication-Specific Models and Strategies

Evidenz zu Transitionen für nur 3 der 6 inkludierten Indikationsgruppen gefunden

Although six indication groups were defined a priori for inclusion in this review, the literature search identified eligible transition-related evidence for only three of these, despite comprehensive search and screening procedures (see Appendix 2.2). Consequently, this chapter presents the results of the analysis of transitional psychiatry models and strategies across three of the included mental health conditions: ADHD, depression, and conduct disorder.

The number of records identified, screened, and included from the structured hand search are presented in Figure 3-3.

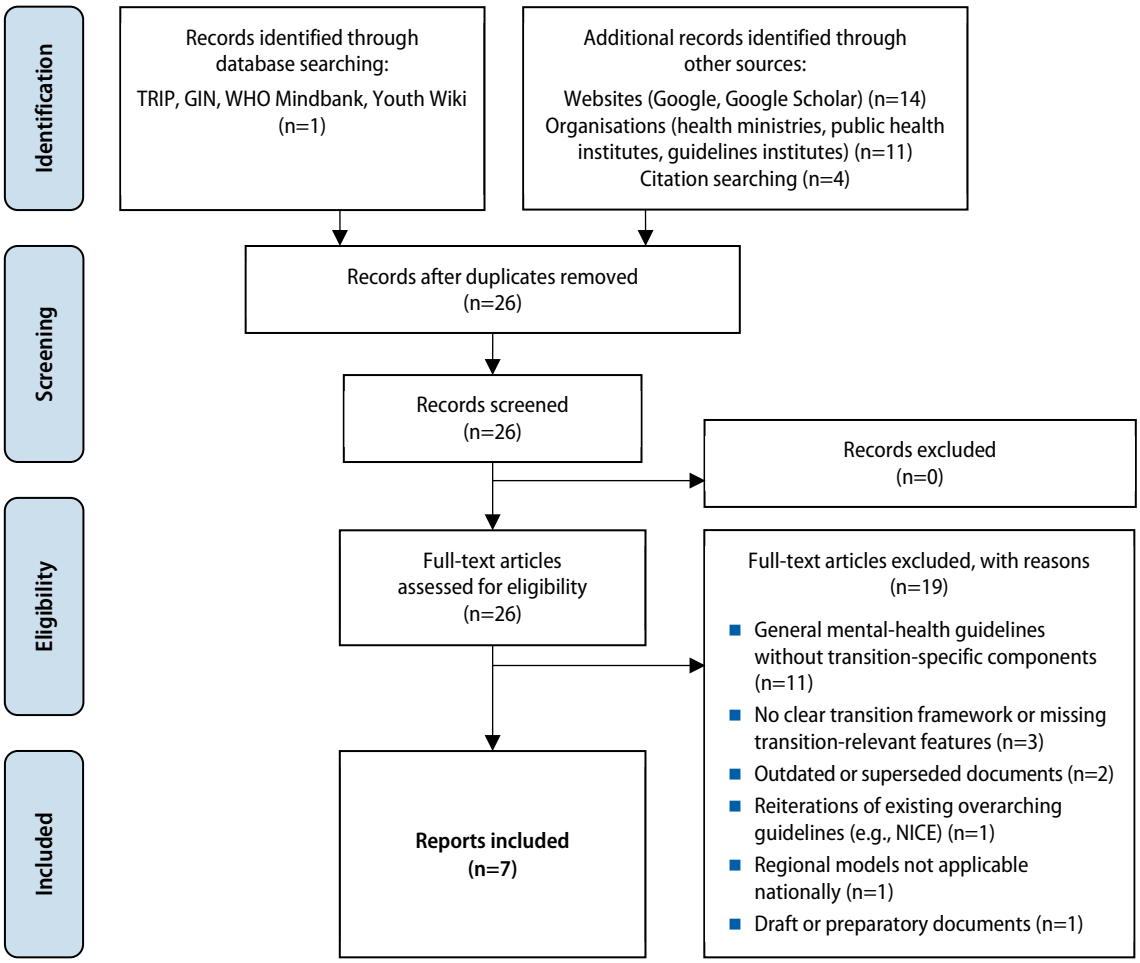


Figure 3-3: Flow of Literature Identification, Screening, and Inclusion for RQ2. Adapted from [66].

7 Dokumente in die endgültige Analyse einbezogen

Out of 26 documents screened for RQ2, seven documents were included in the final analysis (see Table 3-15). The UK contributed with five documents to the majority of the included documents; other countries with one document each were AU and the NL.

Table 3-15: Included Documents per Country for Analysis (RQ2)

Indication	Country	Title	Document Aim	Publishing Body/Institution	Year	Type of Document	Language	Reference
ADHD	AU – Australia	Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder	Provide evidence-based clinical practice recommendations for ADHD in Australia	Australian ADHD Professionals Association (aadpa)	2022	Guideline	English	[81]
	UK – United Kingdom	Attention deficit hyperactivity disorder: diagnosis and management	Diagnosis and management of ADHD in children, young people and adults	National Institute for Health and Care Excellence (NICE)	2019	Guideline	English	[82]
	UK – United Kingdom	Bridging the gap: optimising transition from child to adult mental healthcare	Explore reasons for suboptimal transition and development of roadmap for improvements	European Brain Council, GAMIAN-Europe	2017	Expert Policy Paper	English	[83]
	UK – United Kingdom	Recommendations for the transition of patients with ADHD from child to adult healthcare services: a consensus statement from the UK adult ADHD network	Formulate recommendations for effective transition of patients with ADHD from child to adult healthcare services	National Institute for Health and Care Excellence (NICE)	2016	Guideline	English	[84]
Depression	NL – Netherlands	Achtergronddocument Transitietool depressieve-stemmingsstoornissen	Support professionals in counselling young people with depressive mood disorder during the transition from youth to adult mental health care	Kenniscentrum Kinder- en Jeugdpsychiatrie	2019	Background Document	Dutch	[85]
	UK – United Kingdom	Depression in children and young people: identification and management	Identification and management of depression in children and young people aged five to 18	National Institute for Health and Care Excellence (NICE)	2019	Guideline	English	[86]
Conduct Disorder	UK – United Kingdom	Antisocial behaviour and conduct disorders in children and young people: recognition and management	Recognition and management of antisocial behaviour and conduct disorders in children and young people	National Institute for Health and Care Excellence (NICE)	2017	Guideline	English	[87]

Abbreviations: ADHD … attention deficit hyperactivity disorder.

3.2.1 Synthesis

narrativer Syntheseansatz zur Zusammenfassung der Daten

As in the results chapter for RQ1, a narrative synthesis approach was used to summarise the data. In this case, the focus was not on comparing countries but on examining specific conditions more closely. Therefore, a descriptive summary of the main points is presented. The full data extraction table, along with detailed source attributions, can be found in Appendix 5.

Analyse der Dokumente, gefolgt von Analyse von Konsultationen mit Expert:innen

Consistent with the study's overall methodology, this chapter draws on two complementary data sources: (1) a structured review of written documents and (2) expert consultations. This chapter first presents the analysis of written documents, followed by the analysis of expert consultations.

Transitionsmodelle sollen auf entwicklungsbedingten Bedürfnissen statt Pathologien basieren

The findings are interpreted within the focused scope; however, the broader principle remains that transitional care should be guided by developmental and contextual needs rather than by pathology and should therefore adopt transdiagnostic models. This focus was applied solely to identify disease-specific challenges and mechanisms that might be less apparent in broader, transdiagnostic documents.

viele Dokumente verweisen oder stützen sich auf übergreifende NICE-Leitlinie

Most of the literature on indication-specific transition planning referenced or was based on the overarching NICE guidelines, particularly the 2016 guideline on transition from children's to adult services in health and social services [77]. As this guideline was already part of the analysis from RQ1, our synthesis for RQ2, therefore, only included additional disorder-specific insights.

Part I: Structured Findings from the Literature

ADHD

4 Dokumente untersuchten die Transition bei ADHS

A total of four documents explored the transition in ADHD, three from the UK [82-84] and one from AU [81]. The transition approach largely aligns with the results from RQ1, yielding only a few additional insights.

Mangel an spezialisierten ADHS-Diensten und Fachwissen über ADHS bei Erwachsenen

Primärversorgung als erster Ansprechpartner für die Nachsorge

gründliches re-assessment nach dem Transfer

The most notable insight was the recommendation that children's services should not discharge patients until adult services have formally accepted them, as there are limited adult services, insufficient professional training, and a lack of expertise in adult ADHD. Furthermore, it should be clear what happens if AMHS is unable to accept the referral. The general practitioner (GP) was often recommended as the primary contact for follow-up, with specific guidance on monitoring medication and assessing risk. Furthermore, the reassessment after transition should cover personal, educational, occupational, and social functioning, as well as an evaluation of any coexisting conditions, especially drug misuse, personality disorders, emotional issues, and learning difficulties.

Adhärenzprobleme und Stigma

altersübergreifende Aufklärung, Schulungen, Sensibilisierungs-kampagnen

Secondly, since ongoing issues include medication adherence and stigma, interventions should focus on building skills that enhance autonomy, self-regulation, social functioning, and reduce stigma. Proposed solutions include accessible age-appropriate information resources to aid self-management (also for parents/carers, as the role change from 'passive recipient of care' to active self-management' and relationship-building skills may not be feasible for a person with ADHD depending on level of impairment), training for both specialist and non-specialist professionals, and public awareness campaigns targeting ADHD recognition and treatment (for the public, parents, and schools).

Overall, the evidence base on ADHD was primarily guideline-driven and supplemented by one policy paper, offering a coherent description of transition-related recommendations.

hauptsächlich klinische Leitlinien als Ergebnis Basis

Depression

Two guidelines – one from the UK [86] and one from the NL [85] – addressed transitions in depressive disorders.

2 Dokumente analysierten Depressionen

An additional insight from the Dutch guideline was the recommendation to use a 'treatment passport', which contains symptoms and details of the approach used, as well as a personalised transition letter written by the YP themselves. This letter should outline what the new practitioner needs to know about them. Furthermore, emphasis was placed on the continuation of prior treatment and the utilisation of existing documented information. Both measures aim to prevent unnecessary repetition of diagnostics and interviews in adult services.

„Behandlungspass" mit persönlichen Übergabebriefen

kein Neuanfang mit Diagnostik und Interviews

Additionally, the Dutch Patient Federation emphasised shared decision-making, encouraging YP to ask three core questions: (1) What are my options? (2) What are the pros and cons? (3) What does this mean for me?

3 Fragen zur Förderung von partizipativer Entscheidungsfindung

The evidence on depressive disorders was derived from one background document and one clinical guideline, with the background document providing the majority of relevant content.

1 Hintergrunddokument und 1 klinische Leitlinie als Ergebnis Basis

Conduct Disorders

Only one guideline, from the UK [87], addressed transition in conduct disorders.

1 Dokument inkludiert

Little additional indication-specific information was offered, but the guidelines underscored access barriers and the emotional burden of transition, particularly for marginalised populations.

Zugangshindernisse und emotionaler Stress

A single clinical guideline informed the evidence on conduct disorders. Accordingly, the evidence base for this condition is narrow.

1 klinische Leitlinie als Ergebnis Basis

Part II: Expert Consultation Findings

The following findings are based on expert consultation guided by indication-specific questions (see consultation guide in Appendix 7). These questions were formulated broad and open and were not restricted to particular conditions. As such, the findings presented here reflect the issues and conditions that experts considered most relevant when asked to comment on indication-specific aspects of transition. Although many of the insights provided are of a general nature and may be transferable across conditions, this section reports them in the indication-specific framing that was posed to the experts. The synthesis presented in this chapter reflects the combined findings of all participants.

zusammengefasste Ergebnisse der Konsultationen mit Expert:innen

As reported in Chapter 3.1.1, two main models of transitional mental healthcare can be identified across the included countries: the coordination of transition model (e.g., in the UK) and the specific care for youth model (e.g., Headspace in AU and DK). However, as experts highlight, neither model universally meets the needs of all YP. A distinction must be made based on clinical presentation and service history. YP with neurodevelopmental disorders – such as intellectual disability, ADHD, or autism, with or without co-occur-

keines der Hauptmodelle der Transitionsversorgung wird Bedürfnissen aller jungen Menschen gerecht …

ring anxiety or depression – often experience long-term engagement with CAMHS. For this group, the coordination model may be more appropriate, as it preserves established care relationships and prioritises seamless transitions without requiring structural reforms. Conversely, YP who first seek help during adolescence for emerging or escalating symptoms, which may indicate SMI such as bipolar disorder or schizophrenia, often present atypically and are no longer eligible for CAMHS. For these individuals, the developmentally tailored youth-specific service model can address a significant service gap, as these YP require rapid access to specialised, age-appropriate care that neither traditional CAMHS nor AMHS is well equipped to provide.

… Unterscheidung auf Grundlage des klinischen Erscheinungsbildes und bisherigen Versorgung

One expert from DE furthermore strongly emphasised the need to prioritise early intervention for YP with SMI. If left unsupported, this group is at high risk of becoming the "chronic patients of tomorrow". SMI in YP can include psychotic disorders, severe affective disorders such as major depression or bipolar disorder, and SUDs. This highlights the need for providing early, tailored interventions to prevent long-term functional decline. However, as one expert from the UK highlighted, a significant barrier lies in the misalignment between CAMHS and AMHS eligibility criteria. While AMHS access is usually restricted to individuals with formally diagnosed conditions such as schizophrenia, bipolar disorder, anorexia or personality disorders, CAMHS tends to take a needs-based approach and is reluctant to make specific diagnoses during adolescence (especially personality disorder diagnoses), due to concerns about developmental appropriateness and stigma. This discrepancy creates a gap in care. Without a formal diagnosis, young people may be denied access to adult mental health services, even when their needs are significant. In some cases, as the expert explained, professionals often diagnose personality disorders at age 18 to provide access to adult services. This controversial workaround reflects deeper systemic tensions.

Notwendigkeit früher Intervention bei jungen Menschen mit schweren psychischen Erkrankungen, aufgrund Chronifizierungsrisiko

Zugang zu EP durch formal diagnostizierte schwere Erkrankungen, während KJP spezifische Diagnosen teils verzögert, aufgrund Bedenken hinsichtlich Entwicklung und Stigmatisierung

Another factor highlighted in the expert consultations is the notable gaps in adult services for neurodevelopmental disorders like autism and ADHD, leading YP to fall through the cracks. Also, more attention is needed for severe SUDs, as these conditions are often not included in the existing services, as endorsed by one Swiss expert.

Lücken in Erwachsenenversorgung für spezifische Erkrankungen

A further challenge arises for adolescents with disrupted social development, such as those from unstable family environments, youth welfare institutions or residential care, who are primarily patients with high-risk profiles, such as those exhibiting severe self-harming behaviour, displaying emotionally unstable traits or experiencing repeated acute crises, as explained by one of the experts. These individuals often require intensive, sustained child and adolescent psychiatric support, particularly as inpatients. However, their transition to adult services is often characterised by a significant reduction in available support, due to lower staff-to-patient ratios and stricter admission criteria in the adult sector, as highlighted by two experts.

Transition zu Erwachsenenversorgung durch Verringerung von Verhältnis zwischen Personal und Patient und strengere Aufnahmekriterien gekennzeichnet

3.2.2 Quality Appraisal (AGREE II)

Dokumente erzielten hohe Werte in den Domänen 1 und 4, Domäne 3 wies die größten Schwankungen auf

The results of the quality appraisal for the documents included in RQ2 are visualised in Figure 3-4. Across all countries, documents consistently scored highly in Domains 1 and 4, indicating clearly defined aims and relevant target populations. Domain 4 (clarity of presentation) has the highest median and the narrowest interquartile range, showing consistently high scores and low variability across documents. Domain 1 (scope and purpose) also performs well, with high scores and a relatively small spread, though it has a couple of lower outliers. Domain 5 (applicability) is moderately strong but exhibits some lower values and greater variability. Similarly, Domain 2 (stakeholder involvement) was generally well addressed; however, some documents lacked transparent descriptions of how the views of service users or professionals had been incorporated into the process. Domain 3 (rigour of development) shows the greatest variation and the lowest minimum score, indicating significant differences in quality. Country-specific distributions are presented in Appendix 4.3.

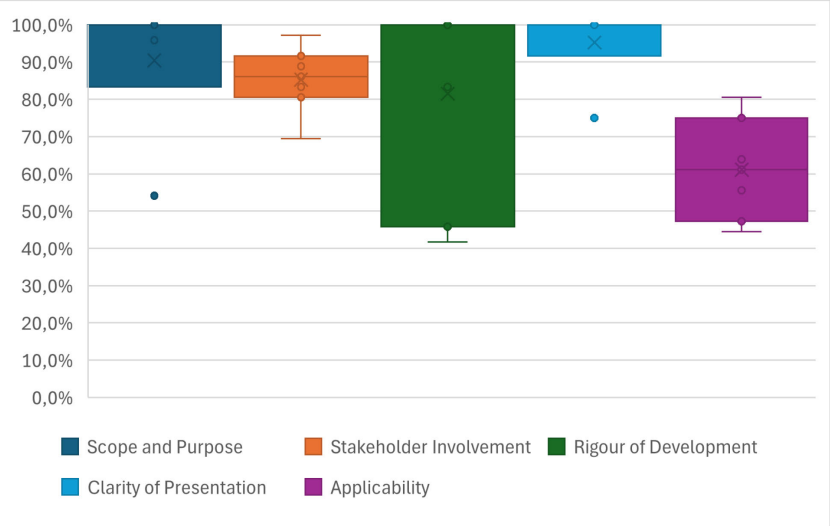


Figure 3-4: Quality Appraisal of Studies Included in RQ2 Across Five Domains (Box Plot)

Dokumente schnitten in Domänen 1, 2 und 4 besser ab als in 3 und 5

Overall, these findings indicate that presentation clarity and defined scope are often prioritised, but many documents lack methodological transparency and implementation planning. Again, it is important to emphasise that the document set included formal guidelines, as well as other policy-relevant texts, which must be taken into account when interpreting the results.

3.3 Transitional Psychiatry in Austria

Prävalenz psychischer Erkrankungen, Ausrichtung der Transitionspsychiatrie in Österreich

This chapter begins with an overview of mental health epidemiology. It then examines the alignment of transitional psychiatry in Austria with international models and strategies (Chapter 3.1), identifying national documents that reference the importance of transition-specific approaches and integrating insights from expert consultations to assess national potentials and hindering factors for advancing transitional psychiatry in Austria.

3.3.1 Epidemiology of Adolescent Mental Health

durchschnittliche Prävalenz von mindestens 1 diagnostizierbaren psychischen Erkrankung bei Kindern und Jugendlichen (15–19 Jahre) 14 % (351 von 2.516 Millionen Personen in dieser Altersgruppe)

The GBD Study 2019 [7] estimated that the mean prevalence of at least one diagnosable mental disorder among children and adolescents aged 15–19 years was 13.96%. This translates to 351 million out of 2.516 billion people in this age group worldwide. In this age group, the highest prevalence was recorded for anxiety disorders, with 4.34% (109 million), followed by depressive disorders (2.69%) and ADHD (2.26%) [7]. A European systematic review [6] of the prevalence of mental disorders in children and adolescents came to similar conclusions. The study identified a pooled prevalence rate for mental disorders among children and adolescents aged five to 18 in Europe of 15.5%. Again, anxiety disorders accounted for the highest pooled prevalence rate (7.9%), followed by ADHD (2.9%), oppositional defiant disorder (ODD) (1.9%), and depressive disorders (1.7%) [6].

österreichische Jugendliche: Punkt- und Lebenszeitprävalenz 23,93 % bzw. 35,82 % für jegliche psychiatrische Erkrankung

höchste Prävalenzrate für Angststörungen, gefolgt von ADHS und depressiven Störungen

In Austria, the situation seems even more alarming. The MHAT study (Mental Health in Austrian Teenagers) 2017 [88] is the most recent epidemiological study to investigate mental health disorders in Austrian adolescents. The study included 3,477 teenagers aged ten to 18, with just over 50% of participants being female. The findings showed a point prevalence of 23.93% and a lifetime prevalence of 35.82% for any psychiatric disorder. The highest prevalence rate was found for any anxiety disorder, with a point prevalence of 10.07 and a lifetime prevalence of 15.58. This was followed by ADHD, with rates of 4.04 and 5.23, any depressive disorder at 2.85 and 6.19, and any eating disorder at 1.56 and 3.73. Considering gender differences, the study found that neurodevelopmental disorders like ADHD were three times more prevalent in males than in females (15.4% and 5.2%), internalising disorders such as anxiety disorders were twice as prevalent in females (19.53% vs. 9.52%), and eating disorders were eight times higher in females than in males (5.47% vs. 0.64%). In addition, over 40% of individuals within each diagnostic category met the criteria for another diagnostic category during their lifetime, most frequently depressive disorders and anxiety disorders [88].

Verschlechterung des emotionalen Wohlbefindens mit zunehmendem Alter

In addition, the WHO's Health Behaviour in School-aged Children (HBSC) study, conducted in 2021 and 2022 [89], assessed the mental health of Austrian schoolchildren aged ten to 21. As part of this study, the prevalence of frequent symptoms (occurring several times a week) was measured. Irritability or bad mood had the highest prevalence at 34.8%, followed by difficulty falling asleep at 27.9%, nervousness at 27.0%, concerns about the future at 23.2%, depression at 21.6%, and anxiety at 19.6%. Moreover, the emotional well-being of YP was assessed. The results showed an evident deterioration in emotional well-being with increasing age, particularly in the female cohort [89].

Schätzung: im Jahr 2024 62.874 (13,96 % von 450.385) Jugendliche in Österreich mit psychischer Erkrankung, wovon fast die Hälfte eine fortlaufende Behandlung in der Erwachsenenversorgung benötigen könnte

According to Statistik Austria, 450,385 people aged between 15 and 19 lived in Austria in 2024 [90]. Applying the GBD prevalence rate (13.96%) to this population, we can estimate that 62,874 adolescents in Austria had a mental disorder in 2024. However, as the MHAT study [88] suggests higher prevalence rates in Austria, this estimate may be conservative. It is important to note that the MHAT study includes individuals aged ten to 18 years, which limits its direct relevance to the late adolescent age group, specifically those aged 15 to 19 years. As a result, the GBD prevalence estimate is the best reference for this calculation. According to expert consultations in Austria, CAMHS clinicians estimate that approximately 45% of the patients require ongoing treatment in AMHS [41]. Applying this to the number of adolescents with a potential mental disorder, we estimated, based on the latest prevalence data (62,874), that approximately 28,300 individuals aged 15–19 may require ongoing mental health care in adult services at some point.

ADHS mit Prävalenz von 5–8 % häufigste neuropsychiatrische Störung im Kindes- und Jugendalter

Barrieren für Transition aufgrund mangelnden Verständnisses für ADHS im Erwachsenenalter und uneinheitlicher Leistungserbringung

In relation to specific disorders, ADHD is, with a prevalence of 5–8% [91, 92], considered one of the most common neuropsychiatric disorders of childhood and adolescence. However, it is increasingly recognised that the disorder persists into adulthood in a significant proportion of patients (known as "adult ADHD") [93]. Around 15% of children with ADHD continue to exhibit all the symptoms of the disorder in adulthood, and a further 50% experience impairing symptoms, although they change over time [91]. The heterogeneity of symptoms is at least partly the reason why ADHD was not recognised as a mental disorder in adulthood for a long time [93]. It is estimated that the prevalence is up to 3% [91, 93, 94], and of these, a third require treatment [91]. However, adult ADHD service provision is inconsistent [95], creating a significant barrier to the transition in ADHD, together with a poor understanding of long-term ADHD [96].

Angststörungen mit Lebenszeitprävalenz bis zu 30 % häufigste psychische Erkrankung im Kindes-, Jugend- und Erwachsenenalter

With a lifetime prevalence of up to 30% [97, 98], anxiety disorders are the most common mental disorders in childhood, adolescence and adulthood. Anxiety disorders and depression often occur sequentially or comorbidly or are concomitant or secondary disorders of other mental disorders [97, 99]. The transition phase plays a crucial role here, as 50% of all anxiety disorders occur by the age of 13, and almost all anxiety disorders manifest for the first time by the age of 25 [97]. Untreated or inadequately managed anxiety disorders during adolescence have been demonstrated to result in poor adjustment in the workplace, strained family relationships, diminished life satisfaction, inadequate coping skills, chronic stress, and substance abuse, dependency, and anxiety in adulthood [100].

Verhaltensstörungen betreffen erheblichen Teil der Kinder und Jugendlichen weltweit und sind gekennzeichnet durch schweres asoziales und aggressives Verhalten

Conduct disorder affects a significant proportion of children and adolescents worldwide. Meta-analytic data suggest an overall prevalence of conduct disorder of 8%, with rates ranging from 7% in females to 11% in males [101]. Conduct disorder is marked by severe antisocial and aggressive behaviour. It often concomitantly manifests with ADHD and neurocognitive impairments and frequently results in the development of antisocial personality disorder in adulthood [102]. Furthermore, about one in four young people diagnosed with conduct disorder will later go on to develop antisocial personality disorder as adults [103].

Essstörungen dauern häufig bis ins Erwachsenenalter an …

Eating disorders are also among the most common mental disorders in adolescence and young adulthood, with an onset usually between the ages of 14 and 19 [104]. The overall proportion of children and adolescents with disordered eating is estimated to be 22.36%, with girls being more affected [105]. Furthermore, the incidence rate is increasing among YP under 15. It is unclear

… hohe Mortalitätsraten und hohes Suizidrisiko

frühzeitige Identifizierung und Intervention erschwert durch Abwesenheit von Krankheitsgefühl und vorsätzlicher Verdeckung der Symptome

whether this is because of earlier detection or an earlier age of onset [106]. Additionally, global prevalence rates increased dramatically from 3.4% to 7.8% between 2000 and 2018 [107]. In patients with anorexia nervosa, the all-cause mortality risk is 4.5 times higher, with suicide accounting for 13.9% of deaths and a tenfold increased risk compared to the general population [108]. Because eating disorders are chronic and often go unnoticed, especially initially, early detection and reducing the duration of untreated illness are crucial [104]. A particularly insidious aspect of eating disorders is the deliberate concealment behaviours that significantly complicate early detection and intervention. Research demonstrates that concealment of disordered eating is common, using methods like faking eating, hiding food, avoiding eating with others, wearing baggy clothes to hide body shape, and falsifying weight measurements [109]. Moreover, a wide range of somatic secondary disorders can develop, particularly in cases of severe anorexia nervosa [104].

Substanzmissbrauchsstörungen etablieren sich oft im Jugendalter und können zu chronischen Störungen mit hohen Rückfallpotenzial werden

Anstieg Hospitalisierungsraten bei gleichzeitig sinkendem Durchschnittsalter des Erstkonsums (bzw. Erkrankungsbeginns)

fragmentierte Angebote zur Behandlung von Substanzmissbrauchstörungen

Substance abuse is one of the most common mental disorders in the emerging adulthood period [110]. As the prefrontal cortex of adolescents is still developing, this results in diminished impulse control and heightened sensation-seeking behaviour, making adolescents especially vulnerable to the adverse health consequences of alcohol consumption [111]. A pattern of abuse or dependence often becomes established during adolescence and can develop into a chronic mental disorder with a high potential for relapse. Progression often involves a steady increase in the intensity of use and a shift towards "harder" substances [110]. In Belgium, hospitalisation rates for acute alcohol intoxication among adolescents reached 31 per 10,000 inhabitants aged 10–17 years, with the minimum age of admission decreasing from 12.6 years in 2015 to 11.1 years in 2021 [111]. Furthermore, among adults hospitalised for substance use disorders, 70% also carried concurrent mental health diagnoses such as mood, psychotic, or anxiety disorders [112]. Substance abuse can lead to considerable damage to health, reduced life expectancy and social disintegration [110]. Additionally, there is a lack of appropriate services for YP with SUDs, such as a lack of youth-specific care facilities, a lack of beds for qualified withdrawal treatment for YP and a lack of medical rehabilitation facilities [110].

3.3.2 Alignment with International Models

in Österreich derzeit kein nationales Dokument, das explizit Standards für die Transitionspsychiatrie beschreibt – daher kein Dokument inkludiert

Unlike the other countries included in this analysis, Austria currently lacks a specific national framework, guideline or policy document that explicitly describes standards or protocols for transitional psychiatry. Therefore, no formal model was considered for inclusion according to the inclusion criteria. However, several national strategies and plans in related areas (e.g. child and adolescent health, mental health reform and health targets) acknowledge the importance of transition and continuity of care for YP with mental health needs (see Table 3-16). They also recognise challenges such as care disruption, a lack of coordination between children's and adult services, and inadequate support for YP with chronic or complex mental health needs. However, these references remain general and lack clear implementation steps.

Table 3-16: Austrian Documents Referencing the Importance of Transition Psychiatry

Document Title	Year	Type of Document	Publisher	Context	Content	Strategies and Actions	Reference
Kinder- und Jugendgesundheitsstrategie	2025	Strategy Paper	Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK)	Optimisation of healthcare structures for children and young people	Part of Goal 21: "Schnittstellenmanagement" (nationwide interface management)	Development of standardised processes, involvement of all relevant professions, improvement of structures and cooperation, integration into training and continuing education, resource provision, case management positions, and evaluation indicators	[59]
Modell für einen verbesserten Zugang zur psychosozialen Versorgung für Kinder und Jugendliche	2023	Report	Gesundheit Österreich GmbH	Conceptual model for improving access to psychosocial services	Transition recognised as a problem area	Extend age boundaries and improve planning and organisation of transitions	[113]
Pandemie und psychische Gesundheit von Kindern, Jugendlichen und jungen Erwachsenen mit chronischen und seltenen Erkrankungen	2022	Position Paper	Österreichische Liga für Kinder- und Jugendgesundheit	Recommendations for care to strengthen the mental health of children and adolescents and their families	Part of Recommendation 5: "Regulated Transitions to Adulthood and the Labour Market to Adult Healthcare"	Closer involvement of relevant professional groups in transition processes, inclusion of transitions in professional training, provision of time and financial resources for transition services, creation of dedicated case management roles, and more substantial involvement of patient/self-help groups	[114]
Integrierte psychosoziale Versorgung von Kindern und Jugendlichen	2016	Report	Gesundheit Österreich GmbH	Overview of existing challenges in the psychosocial care structures for child and adolescent health in Austria	Identifies the need for better coordination at transition points and proposes standards for cooperation	Development of concepts and agreements, and monthly coordination meetings	[115]

thematische Prioritätensetzung ohne systematische Umsetzung

Austria's current approach can best be described as thematic prioritisation without systemic implementation. Although there is evidence of awareness in high-level strategy documents, the absence of dedicated service models, coordination protocols or transition-specific funding mechanisms limits the provision of transitional care with consistent quality. Austria appears to be setting the agenda, presenting a timely opportunity for structured development.

3.3.3 Expert Consultations: Expert Input and Implementation Insights

General Characteristics of Successful Transition

Konsens mit international anerkannten Grundsätzen für erfolgreiche Transitionspsychiatrie

The analysis of the interviews reveals a consensus with the internationally recognised principles of successful transition in mental health. Transition is not viewed as a single event, but as an ongoing process that accompanies development. Support is often required until young adulthood (ages 25–30), particularly for individuals with neurodevelopmental disorders such as ADHD or autism, as emphasised by one expert. Furthermore, transitions should not coincide with other significant life events, such as changing schools or moving from home. In Austria, an amendment to the medical training regulations took effect in May 2024, allowing child and adolescent psychiatrists to continue treating patients beyond the age of legal majority (18) [116].

strukturierte und formalisierte Kooperationsprozesse zwischen KJP und EP

Several experts furthermore highlighted that structured and formalised cooperation processes between CAMHS and AMHS are fundamental. The idea of a 'transition board,' analogous to tumour boards, was described, in which clinical psychology, dietology, social work, and other professional groups regularly discuss cases alongside CAMHS and AMHS.

"easy start" in die Transition und stabile Entwicklungsumgebung

Lücken in Betreuung während des Übergangs erhöhen das Risiko von Explorationsverhalten, wie Drogenkonsum

The concept of an "easy start", i.e., an early and low-threshold entry into transition planning, supplemented by psychoeducation and the acquisition of self-management skills, is central, as endorsed by the experts. Furthermore, the importance of a stable development environment in which YP can develop the skills they need to lead an independent life (e.g. education, career, partnership, separation from parents) was emphasised. These life tasks can only be mastered if structural gaps in the transition between CAMHS and AMHS are avoided. One expert repeatedly mentioned that gaps in care during the transition lead to treatment dropouts and increase the risk of exploratory behaviour, substance use and polytoxicomania. Accordingly, maintaining continuity is also important in terms of prevention. In this context, long waiting times were explicitly warned against as they can cause mental disorders to become chronic and disrupt long-term developmental processes. Therefore, access to transitional services must be swift and targeted. In particular, community-based care structures such as acute day clinics and outpatient transitional facilities were proposed by the expert.

Schaffung von Bewusstsein und Sichtbarkeit

Almost all experts highlighted the need for creating awareness and visibility to establish the transition issue as a shared responsibility between services, and to ensure that YP with high support needs gain access to care.

standortunabhängiges Case Management

A key obstacle, endorsed by one of the experts, is the mobility of YP, which makes coordinated handovers and joint case management more challenging. Location-independent case management could address this issue, enabling the best possible use of existing services while at the same time conserving resources and ensuring continuity of care.

bisherige Initiativen beruhen hauptsächlich auf individuellen Bemühungen ohne formale Anerkennung

Despite the consensus on content, there is a lack of structural integration into the healthcare system in Austria. As two of the experts described, most of the initiatives to date are based on individual efforts, the sustainability of which depends, therefore, heavily on personal commitment and institutional resources. Many of these activities take place without formal recognition in the "Leistungskatalog" (catalogue of reimbursed procedures), which makes them neither billable nor plannable. They also highlighted that the absence of a legal framework for billing transitional activities is particularly problematic. Therefore, the need for national frameworks, clinical standards, and quality-assured process tools (e.g., checklists and cooperation protocols) was emphasised.

unzureichende Finanzierung der Versorgungsforschung

Finally, one of the experts pointed out the inadequate funding of health services research. Ongoing healthcare research is crucial for reviewing, monitoring, and assessing the application and implementation of measures. The expert stressed that, in this complex field, there is no single correct approach; instead, all measures must be customised to the individual and the region. Only with adequate research funding can objective, independent data be obtained and financial incentives be supported. Therefore, improved research funding is a fundamental requirement.

Sustainability of the Workforce

fehlende Ressourcen erschweren Umsetzung von Transitionsprinzipien

Ensuring personnel sustainability remains a major challenge. The absence of existing resources in local inpatient and outpatient sectors, for example, hampers the implementation of the 2024 amendment, which allows treatment over 18, as highlighted by one of the experts.

flexiblere Modelle des Ausbildungsschlüssels notwendig

One of the experts points out a structural bottleneck in the "Ausbildungsschlüssel" (trainee-to-supervisor ratio), particularly in small departments. With the upcoming wave of retirements and the shortage of junior staff, this ratio risks compromising the delivery of care. It was therefore suggested that this ratio be increased or abolished, or that flexible models be introduced – for example, allowing one supervisor to oversee two or three trainees (e.g., 1:2 or 1:3).

gemeinsame Ausbildungsformate für berufsgruppenübergreifendes Verständnis von Transition

Between the experts, there was agreement that both specialist areas (e.g., medical focus in AMHS and educational focus in CAMHS) are essential for transitional psychiatry. It was therefore proposed that joint university training formats be established, such as master's programmes or university courses that bring together doctors, psychologists, and psychotherapists from both fields. This would promote a shared, cross-professional understanding of transition. Additionally, one of the experts described the professional integration of different disciplines as a means of making the profession more attractive (e.g., new combinations of specialities).

Aufwertung des Berufsbildes

All experts also reinforced the value of upgrading the profession. A positive work environment, respectful communication, and realistic goals were frequently identified as essential. The formation of interdisciplinary teams with clear, shared objectives was also regarded as crucial for motivation, a sense of belonging, and stability.

Legal and financial framework

Herausforderungen bei der Abrechnung sowohl bei Krankenkassen als auch innerhalb der Organisationen

During the consultations, the experts highlighted several billing challenges and sectoral competence limits. For example, in many federal states, it is currently necessary to submit individual applications to the health insurance provider for treating patients over 18 years of age in CAMHS, as these services cannot be formally billed, as one expert observed. Conversely, experts described how adult services are often unable to bill for services provided to CAMHS patients. Proposed solutions include using dual registration to manage patients in both CAMHS and AMHS simultaneously or establishing an independent transition budget that covers joint case discussions, parallel treatment phases, and coordination activities between the services. Additionally, one of the experts reported that the higher support needs of complex cases, such as patients with multiple comorbidities or high utilisation of psychiatric services ("heavy users"), are not sufficiently considered in the current system. Therefore, a differentiated remuneration system for complex care needs and diagnostic optimisation for intensive care users is seen as necessary to use resources more efficiently.

unzureichender freier Zugang zu psychiatrischen Dienstleistungen

Moreover, as reported by one of the experts, free access to all types of mental health care is insufficient overall. For some services (e.g. psychotherapy), public funding often covers only a proportion of the treatment costs, and services free of charge are often associated with extremely long waiting times.

Evaluation and Effectiveness

unzureichende institutionelle Verankerung und Finanzierung von Evaluierungen in Österreich

The need for a systematic evaluation was emphasised. At the same time, the consultations revealed that institutional anchoring and funding in Austria are currently inadequate. According to one expert, a central obstacle is the lack of a legal obligation to evaluate health-related initiatives, combined with a lack of central responsibilities, e.g., at the level of health insurance funds. Lastly, the importance of independent research structures was endorsed.

Evaluation sollte patient:innenzentriert sein und sowohl subjektive Erfahrungen als auch objektivierbare Lernprozesse widerspiegeln

As mentioned by two experts, a sustainable evaluation should be patient-centred, reflecting both subjective experiences and objectifiable learning processes. Combined formats that include workshops and standardised questionnaires, along with parent feedback and external assessments, allow for a thorough evaluation of transition quality. Knowledge transfer is particularly relevant; the goal is to assess what patients absorb, retain, and apply in their daily lives. Key result areas include disorder-specific knowledge, medication knowledge, self-management and health literacy.

Further identified topics

Schule als besonders geeignetes Setting für frühzeitige Identifizierung und Monitoring

Prevention is a key cross-cutting issue in sustainable transitional psychiatry. In two consultations, the school was identified as a particularly suitable setting – both for recognising problems and mental disorders early on, as well as for initiating, supporting, and monitoring appropriate treatment from an early stage, and for destigmatising and maintaining ongoing support relationships. According to experts, deliberately expanding clinical-psychological expertise within the school service, ideally through permanently employed psychologists, could help ensure continuity and coordination, making them central links in the transition system.

gezielter Ausbau der klinisch-psychologischen Expertise im Schuldienst wünschenswert

3.3.4 Starting Points for Further Development for Austria

erste Schritte für die Weiterentwicklung der Transitionspsychiatrie in Österreich

This chapter sets out initial steps for the further development of transitional psychiatry in Austria, informed by international evidence and the insights of international and national experts. While the starting points themselves are presented here in a condensed form, the underlying arguments and evidence that informed them can be found in the previous result chapters. The first section highlights system-level considerations concerning governance, workforce, financing, and evaluation, and the second section outlines a process-level framework of established and emerging principles that describe how transitions can be structured in practice.

System-Level Recommendations for Strengthening Transitional Psychiatry

System Level Foundation

Adoleszenz als kritischer Zeitraum für Auftreten psychischer Erkrankungen

Adolescence is a critical period for the onset of mental health disorders. As shown in the previous chapters, epidemiological data highlight the high prevalence of conditions such as ADHD, anxiety, conduct disorder, depression, eating disorders and substance misuse [6, 7, 88, 91, 94, 97, 98, 101, 104, 105].

psychische Erkrankungen unterscheiden sich von anderen Krankheiten, die für Transition unmittelbar relevant sind;

können im Vergleich zu anderen Erkrankungen besondere Aufmerksamkeit erfordern

Notably, the transition in mental health appears to be even more problematic than in physical care: age of onset is often clustered around adolescence and early adulthood [97, 104]; trajectories are often fluctuating and relapsing [93, 104, 110]; there is high multimorbidity (including substance use) [100, 102, 104, 110, 112]; diagnostic uncertainty is frequent before the age of 18 [117]; developmental delays can blunt 'readiness' [16]; and there is heightened vulnerability to stigma and disengagement [118, 119] (cf. results chapter 3.2). Furthermore, many of these disorders persist into adulthood [92, 102, 104, 110], emphasising the need for providing continuous, age-appropriate care during this transition. These features mean that mental health conditions may require special attention compared to other conditions, and at a minimum, an overarching transition framework as a baseline architecture for all transitions would require a dedicated mental health addendum. It may even be advisable to develop a specific transition guidance for mental health to ensure that the distinct clinical and developmental needs of this group are adequately addressed.

Grundsätze für Transition überschneiden sich

besonders vulnerable Gruppen benötigen kultursensible und diskriminierungsfreie Transitionsstrategien

However, it is not necessarily required to develop separate guidance for each mental health condition. The findings from RQ1 and RQ2 show that the principles of transition often overlap across conditions. Evidence highlighted that the severity and complexity of the mental disorder, rather than the diagnostic category, should inform transitional planning. Nevertheless, it may be beneficial to provide tailored recommendations for specific vulnerable and high-risk groups. Factors that contribute to vulnerability include indication-specific vulnerabilities (see chapter 3.2), disability, migration status, socio-economic disadvantage, trauma exposure, multi-morbidity, involvement in child protection or justice system and minority group membership.

Develop Dedicated Transition Guidance for Mental Health.

Given the specific developmental and clinical needs in mental health care, it may be appropriate to either prepare a standalone mental health transition guidance or, at a minimum, include a dedicated mental health addendum within broader transition frameworks. Tailored recommendations should be provided for vulnerable and high-risk groups.

kohärenter Rahmen, der Förderung der psychischen Gesundheit, Prävention und Versorgung integriert

It is recommended that a systematic, phased roll-out of transition models be implemented, supported by long-term resource planning and a lifespan approach that integrates prevention, early intervention, and family support. This aims to decrease future demand for MHS, mitigating long-term morbidity and preventing chronic disorder trajectories.

Embed Transition Models Within a Lifespan-Oriented Policy Framework.

Developing transition models within a broader lifespan-oriented framework that emphasises prevention, early intervention, and family involvement may help ensure continuity of care and reduce later service demands.

Begleitung im Alltag durch Fachpersonen in Schule und Beruf sowie in Primärversorgung

Additionally, it is important to involve primary care providers and non-clinical cooperation partners in the transition process. Although the degree of cross-sector integration varied throughout the analysis, there is an evident trend towards embedding transition within a broader care infrastructure, spanning health, education, and social services.

Ensure Multisectoral Involvement in Framework Development.

Involving stakeholders across various sectors, such as social services, education, and youth advocacy, in policy development may help ensure that mental health transition guidance is context-sensitive and effectively embedded within existing care structures.

Improve the Role of Primary Care and the Education and Employment Sector for Youth Mental Health.

Improving the responsiveness of primary care settings and the education and employment sectors may aid early identification and earlier detection and support for YP with emerging mental health concerns.

Furthermore, with appropriate guidance, primary care providers or school-based professionals can assist in monitoring stability and medication and recognising risks and the need for additional support.

klare Kommunikation und Dissemination

Furthermore, it is crucial to support transitional care through targeted communication strategies and accessible, action-oriented guidance. This may improve professionals' awareness of transition standards and their ability to apply them consistently across service settings.

Promote Communication and Dissemination for Shared Understanding.

Strategic communication and dissemination of clear, actionable recommendations, along with efforts to ensure professionals feel informed and capable of applying transition standards, could help foster greater alignment.

Finanzierungs- und Abrechnungslandschaft für Transitionspsychiatrie fragmentiert und verwaltungsaufwändig

National experts described the financing and billing landscape for transitional psychiatry as fragmented and administratively burdensome. Treatment beyond the age of 18 often requires separate, case-by-case approval, and adult services are frequently unable to bill for adolescents formally assigned to CAMHS. Additionally, transitional activities lack formal recognition in the national service catalogue of reimbursed procedures ("Leistungskatalog"), which means they are neither billable nor scalable. To improve coordination and planning, experts have proposed solutions such as dual registration and a dedicated transition budget. There may be a need to adapt reimbursement

models and contractual agreements among insurers, healthcare providers, and municipalities.

Zugangshindernisse, da Erstattungssätze oft nicht Behandlungskosten decken

Additionally, the amount reimbursed by statutory health insurers often covers only a fraction of actual treatment costs, forcing many patients to rely on publicly funded services. However, waiting times for these services are long, creating significant access barriers at a time when continuity and timeliness of care are most critical.

Improve Financial and Structural Conditions for Transitional Psychiatry.

Optimising reimbursement processes and reviewing contractual arrangements may enable more planned and scalable transitional care across sectors.

Address Access Limitations in Public Mental Health Services.

Assessing and addressing access barriers in psychiatric service availability and reimbursement models could help reduce delays in care.

Versorgungslücken für bestimmte Diagnosen

serviceübergreifende Qualifikationen für die Arbeit mit 14–25-Jährigen

Importantly, adequate resourcing, infrastructure, and workforce development, along with additional training, are required to realise structural changes. National and international experts have identified significant service gaps in adult services for specific diagnostic groups, including autism, ADHD, eating disorders, and SUD, and a lack of expertise for certain conditions in adults (e.g., ADHD). Furthermore, to strengthen inter-service collaboration, the findings suggest that structured and evidence-based training in transition skills should be made mandatory in both basic and ongoing medical training. This could, for example, include master's or postgraduate programmes. Additionally, cross-age qualifications, whereby CAMHS professionals are trained to work with YP up to 25, and AMHS professionals are equipped to support younger adolescents, are considered vital.

mehr Nachhaltigkeit durch Förderung der Attraktivität von Arbeitsplätzen und reformierten Personalschlüsseln

Workforce sustainability, too, emerged as a critical concern. Experts emphasised the need to increase the attractiveness of the profession by enhancing professional recognition, offering appropriate remuneration, and creating meaningful roles. Furthermore, the current *Ausbildungsschlüssel* – the legally prescribed trainee-to-supervisor ratio – was viewed as particularly limiting. Experts called for reform of this ratio to enable more responsive workforce planning. Finally, maintaining an equivalent standard of care within AMHS compared to CAMHS presents challenges due to disparities in staffing levels.

Support Service Availability and a Trained Workforce Across Diagnostic Groups.

Broadly reviewing and strengthening the availability of services and workforce expertise for YP with different mental health conditions can support continuity of care.

Support Cross-Age Competencies.

Developing postgraduate certificates, master's programmes or training requirements across disciplines that equip CAMHS professionals to support YP up to age 25, and AMHS professionals to work with younger adolescents, may help promote developmentally appropriate care across services.

Improve Workforce Sustainability.

Measures to improve role attractiveness, professional development, and cross-service collaboration may support long-term workforce sustainability in transitional psychiatry.

Care Models and Access Pathways

zwei Hauptmodelle:

Koordinierung vs. jugendspezifische Dienste mit jeweiligen Vor- und Nachteilen

kein Modell entspricht Bedürfnissen aller Jugendlichen

In terms of service models, two dominant models of transition from CAMHS to AMHS have been identified across the included countries: the coordination of transition model and the specific care for youth model. The coordination model appears particularly suitable for YP, who have received long-term care in CAMHS. It focuses on bridging the gap between CAMHS and AMHS by strengthening collaboration and ensuring continuity of care, while leaving existing service structures intact. In contrast, the specific care for youth model, which is based on establishing additional services designed explicitly for YP, offers a more suitable approach for individuals who do not receive mental healthcare until they begin to experience symptoms during puberty or adolescence. These services aim to improve access to specialised care for YP. YP with clear diagnoses and a long history in CAMHS might be more effectively integrated into coordinated transitions. In contrast, those with emerging, complex, or undiagnosed conditions can receive better support through flexible, youth-specific services. Consequently, flexibility in service allocation is crucial. Transitional services must facilitate the adaptation of services to the individual based on their clinical presentation, stage of disorder, and psychosocial needs.

Abkehr von starren Altersgrenzen – Zeitpunkt am Entwicklungsstand und „Transition Readiness" ausgerichtet

An area where the frameworks converge is in their adoption of flexible transition age ranges. This signals a shift away from rigid age boundaries and towards personalised trajectories. Many strategies suggest providing support well into the mid-20s, when it is both clinically and developmentally appropriate. Developmental maturity is just as significant as diagnostic classification, as successful transitions rely heavily on a young person's readiness and ability to take on responsibility.

Reformen müssen gegen Beschränkungen in Ressourcen abgewogen werden

Structural solutions, such as extending CAMHS or AMHS age boundaries or introducing dedicated youth services (e.g., 13–25 models), may help improve continuity. However, such reforms must be carefully weighed against resource constraints and the risk of creating new transition points. A one-size-fits-all solution is unlikely to succeed.

Consider Incorporating Elements from Both Transitional Care Models to Meet the Diverse Needs of Young People.

The coordination model may be particularly relevant for individuals with a long history of engagement with CAMHS and ongoing mental health conditions. In contrast, youth-specific services may be more effective in supporting adolescents with emerging, unclear, or undiagnosed mental health issues. Given the variety of clinical presentations and developmental stages, it is advisable to adopt a flexible, needs-based approach to service design.

Diskrepanz zwischen Zugangskriterien von KJP und EP

However, a central challenge lies in the discrepancy between the access criteria for CAMHS and AMHS: AMHS requires a formal diagnosis for entry, while CAMHS often delays diagnoses, particularly for personality disorders, due to concerns about stigma and developmental appropriateness. Crucially, previous treatment in CAMHS should be recognised as a sign of vulnerability. Adult services ought to prioritise these individuals by ensuring they have optimised referral pathways and can bypass waiting lists.

Recognise CAMHS History as a Criterion for Priority in AMHS.

Previous engagement with CAMHS can serve as a valuable indicator when prioritising access to AMHS or regional adult care services. Mechanisms such as 'transitional priority tracks' could help ensure timely continuity of care for vulnerable YP.

jugendfreundliche Räume und zentrale Infrastruktur

Countries recommend ensuring youth-friendly spaces and central infrastructure to support engagement and effectively coordinate and deliver transitional care. Where co-location of services is not possible, formal cooperation agreements between CAMHS and AMHS are advised. Additionally, for YP who relocate for education or employment purposes, mechanisms for location-independent mobile case management (e.g., digital or virtual formats) can enable sustained care across regions.

Vereinbarungen zwischen räumlich und geografisch distanzierten Diensten

gemeinsame Dokumentation, Informationssysteme und digitale Tools

Furthermore, shared clinical documentation, information systems, and digital tools are recommended to promote consistency in care, engage YP, enhance communication between professionals and enable the use of a common language. Furthermore, it is important to use existing documented information whenever possible.

Strengthen Formalisation and Coordination between Geographically Separate Services.

Co-location, where feasible, or formal cooperation agreements between CAMHS and AMHS – particularly when services are geographically distant – may enable smoother transitions through real-time collaboration and direct handovers. Additionally, solutions such as mobile case management functions could aid continuity for geographically mobile youth.

Support Youth-Friendly Infrastructure.

Improving the accessibility and youth-appropriateness of physical care environments may support more developmentally responsive transitions across services.

Promote the Use of Shared Digital Tools and Data Records.

Expanding shared digital infrastructure across services could improve communication, documentation, and coordination during transitional care processes.

Evaluation and Continuous Research

Evaluierung erfordert mehrstufige Indikatoren

Evaluating transitional mental healthcare requires the use of multi-level indicators that span individual, service, and system domains. A combination of qualitative and quantitative methods applied at regular evaluation cycles could serve as an effective evaluation approach. Furthermore, external evaluations, comparison groups and cost-effectiveness studies are encouraged to reduce bias and support the validity of findings.

Kombination von qualitativen und quantitativen Methoden

laufendes Monitoring zur iterativen Verbesserung

Conducting ongoing monitoring of transition programmes is recommended for iterative improvement of services. This may include regular case discussions and reviews, as well as the use of monitoring tools (e.g., Quebec self-learning model) and structured documentation, such as patient records and feedback forms.

Embed Multi-Level Evaluation and Continuous System Learning.

Combining patient and staff feedback, as well as external evaluations, with individual-, service-, and system-level indicators, and implementing structured review cycles and learning models, can help improve services over time.

Entwicklung lokal angepasster Services muss durch solide Versorgungsforschung begleitet werden

Furthermore, the consultations revealed a critical gap in health services research. Favourable conditions for implementing transitional mental healthcare include data-informed planning and commissioning guided by population health needs and local service demand. However, a robust research infrastructure must guide the development of locally adapted practices. Therefore, improved and sustainable funding for health service research, as well as support for the evaluation and monitoring, is necessary.

Strengthen Health Services Research.

Enhancing the research infrastructure and securing sustainable support for the evaluation and monitoring of transitional care models may enable the development of context-sensitive, evidence-informed practices.

Addressing Stigma and Strengthening Autonomy

Sensibilisierung und Reduktion von Stigma

Finally, the findings underscore that, in addition to structural and procedural improvements, broader efforts to raise awareness and reduce stigma remain essential to improve access, engagement and continuity of care for YP with mental health needs.

Psychoedukation, Selbstmanagement, Therapietreue und gemeinsame Entscheidungsfindung

Evidence also emphasises psychoeducation and skills training to support self-management, medication adherence, and shared decision-making. These interventions should be directed at YP and, in cases where the condition has the potential to impede full participation (e.g., ADHD), they should also extend to parents or carers.

Strengthen Awareness and Reduce Stigma for Mental Health Conditions.

Developing targeted awareness campaigns and offering structured training for both specialist and non-specialist professionals (e.g., in education, primary care, or justice sectors) could help reduce stigma and promote earlier help-seeking for conditions such as ADHD, eating disorders, or SUD.

Promote Psychoeducation and Empowerment for YP and Families.

Providing structured psychoeducation and skills training to YP can strengthen self-management, medication adherence, and shared decision-making during the transition process.

Berücksichtigung von Perspektive junger Menschen

As a tangent, when contemplating potential starting points for reform, it is vital to consider the perspectives of YP, as their experiences and needs are essential to designing person-centred transitional care.

Principles and Processes of High-Quality Transition

wiederkehrende Grundsätze bewährter Praktiken

Although no single model can be universally applied due to variations in system structure, patient cohorts, and available resources, recurring best practice principles for successful transitions have been identified.

Grafik 5–1: Überblick über etablierte Grundsätze für qualitativ hochwertige transitionspsychiatrische Versorgung

Figure 3-5 presents an overview of established or emerging principles of best practice for transitional mental healthcare. This framework illustrates the core steps of the transition process alongside key cross-cutting themes, offering an overview of internationally recognised features of high-quality transitional care and illustrating what should be a shared international understanding of high-quality transition.

Transition als schrittweiser Prozess

proaktive Planung und Früherkennung

The evidence indicates that transition is not a single event, but a phased process that begins well before the handover and extends into post-transfer follow-up. Across the findings, there is consensus that proactive planning and early identification are essential. This process should ideally begin 6–18 months in advance and be guided by readiness assessments that consider both clinical stability and developmental maturity, rather than relying solely on age. Effective transition planning requires collaborative decision-making among services and joint care reviews.

strukturierte Koordinierung durch Koordinator:innen und Parallelphasen

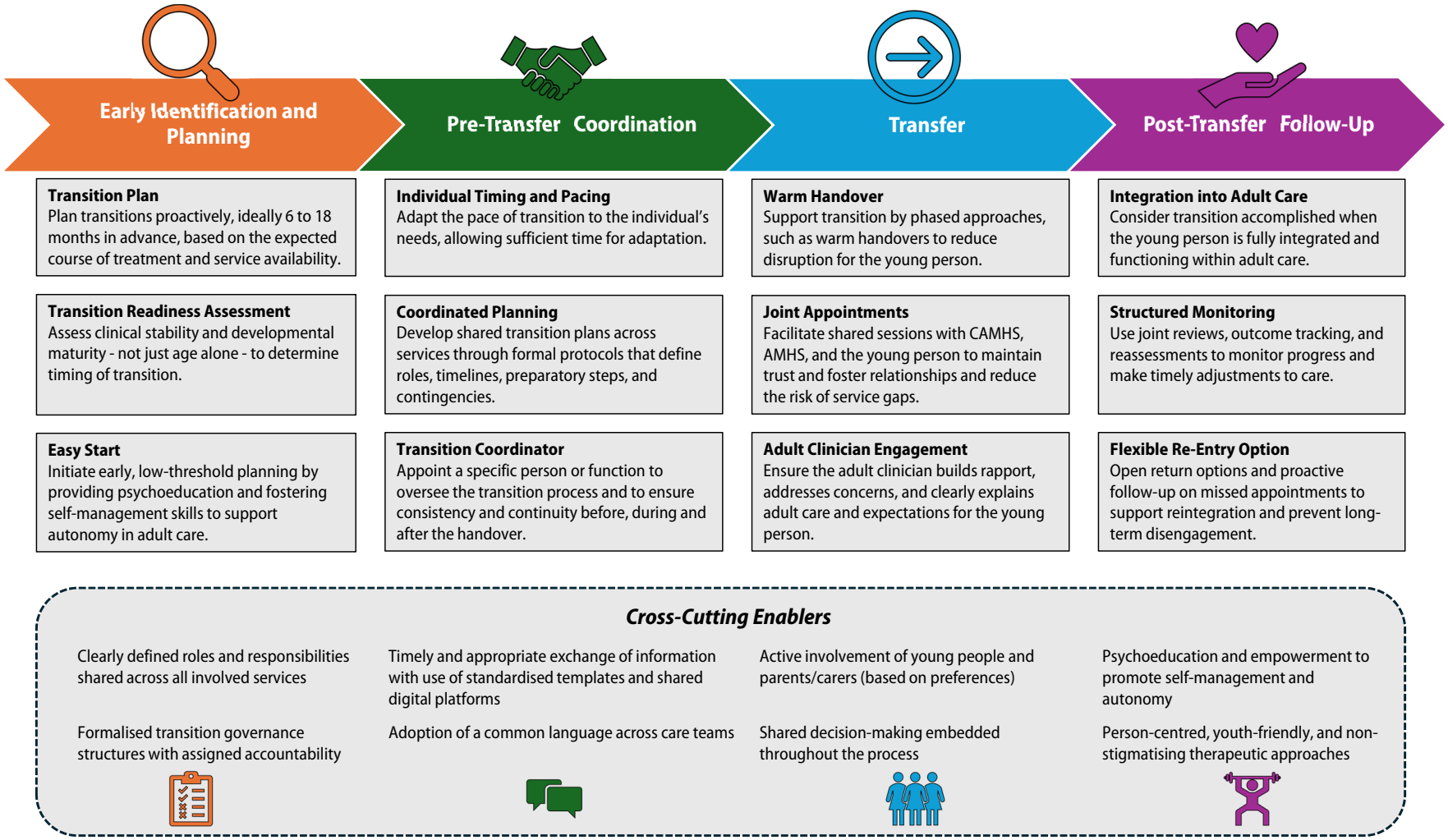
A recurring element is structured coordination across services, supported by formalised protocols that define responsibilities, timeframes, preparatory steps, and alternative pathways in case referrals are not accepted. The appointment of a transition coordinator is frequently highlighted as a way to safeguard continuity, as well as the joint involvement of CAMHS and AMHS during the transition phase.

strukturierte Nachsorge und Möglichkeit für Wiedereinstieg

The evidence also emphasises that transition does not end with transfer: ongoing monitoring, opportunities for re-entry, and mechanisms to support full integration into adult care are considered integral components of high-quality care. In particular, for conditions with high relapse rates, structured follow-up and open return pathways are considered critical safeguards.

bereichsübergreifende Faktoren unterstützend während allen Phasen

Finally, cross-cutting enablers are recognised as underpinning all phases. These include clearly defined responsibilities, shared digital tools, and systematic information exchange, as well as the active involvement of YP and carers in line with their preferences, and embedding shared decision-making and psychoeducation to strengthen autonomy.



Abbreviations: AMHS … adult mental health services; CAMHS … child and adolescent mental health services.

Figure 3-5: Overview of Established Best-Practice Principles for Transitional Mental Health Care.

4 Discussion

4.1 Reflections and Implications

Fokus auf Bereitstellung einer Wissensbasis zur Unterstützung einer evidenzbasierten Entscheidungsfindung in Österreich

The aim of this report was to systematically analyse and compare international models and strategies of transitional psychiatry. The goal was to identify structural characteristics, implementation practices and contextual factors that could inform and enhance Austria's approach to transitional psychiatry. The focus was on providing a knowledge base to support evidence-based decision-making in Austria.

2 wichtige Erkenntnisse: international unterschiedliche Modelle, aber wiederkehrenden Prinzipien

Two key insights emerged: first, that different transition models exist internationally, each with their own advantages and disadvantages; and second, that a set of recurring principles, such as transition planning, information sharing, continuity of care, the introduction of transition coordinators or case managers, and the active participation of YP, emerge across all contexts.

Erkenntnisse aus 20 Dokumenten und Konsultationen mit 13 Expert:innen

Across our three RQs, we synthesised insights from 20 documents and consultations with 13 experts from seven countries. The findings cover international approaches to transitional psychiatry, condition-specific challenges, and Austria's current structures. The quality appraisal of the included documents provides important context for interpreting these findings: most demonstrated strength in scope and purpose, clarity of presentation, and applicability, but weaknesses were evident in participatory development and methodological rigour. Limited use of systematic methods reduces confidence in whether recommendations reflect the best available evidence, and variability in applicability scores suggests that feasibility considerations are often underdeveloped. Importantly, the included materials span both formal guidelines and less structured policy texts, which must be taken into account when interpreting the results of the quality appraisal. As the overall results were of moderate to high quality, they should be understood as indicative of an international consensus rather than rigorously evidence-based directives.

Qualitätsbewertung: Stärken in Bezug auf Umfang und Zweck, und Klarheit der Darstellung; Defizite in Bezug auf die methodische Sorgfalt

Ergebnisse sollten als indikativ interpretiert werden

Konsens über Grundprinzipien für qualitativ hochwertige Transitionen

A strong consensus emerged across the evidence on core principles: early identification and planning, structured coordination, joint CAMHS–AMHS involvement at transfer, and mechanisms for continuity. Workforce training was repeatedly highlighted, with recognition that both child and adult providers lack preparation for managing the interface. Similarly, there was broad agreement on cross-cutting principles such as shared decision-making, psychoeducation, empowerment, self-management, autonomy, and participation.

Evaluierung, Ressourcen und Implementierung wurden weniger thematisiert

By contrast, some areas were addressed less consistently or were largely absent. Several guidelines and experts acknowledged the importance of evaluation and system learning, but there was limited detail on how to embed these practices in routine care. Likewise, the sustainability of personnel and resources, as well as the costs of implementing transition models, were seldom addressed. Additionally, although the degree of cross-sector integration varied throughout the analysis, there is an evident trend towards embedding transition within a broader care infrastructure, spanning health, education, and social services. However, few sources have considered how to systematically embed transitions within broader youth care.

Bereiche, in denen die Ergebnisse keinen Konsens ergaben

Beyond these gaps, there were also areas where the documents and expert input revealed no consensus. Planning for the transition to AMHS usually begins six to twelve months prior to transfer. However, in some cases, identification and planning can begin as early as 13 or 14 years old, with extended transition periods lasting several years, depending on individual readiness. Furthermore, all models agree that developmental readiness and clinical need, not just age alone, should guide transitions. However, the scope and intensity of preparation varied. Models varied in their approaches to ensuring continuity. In the UK, continuity was suggested through parallel working periods. In Denmark, it was proposed to provide consistent care by the same clinician until the age of 24. However, these examples reflect different models of transition, either as a process of coordination or as the provision of youth-specific services. Furthermore, a transition coordinator was endorsed internationally, but the required background varied. The primary responsibilities assigned to the coordinator (such as transition as clinical handover versus a more comprehensive life-course process involving navigation and advocacy) may be the reason why some countries prefer coordinators with or without a medical background. Additionally, resource constraints likely influence this choice as well. Ultimately, recommendations agree that a dedicated professional should lead coordination. Structural integration also differed: CH and DK propose institutionally integrated CAMHS–AMHS services under one umbrella, in other contexts, location-independent case management and agreements between partners are promoted as alternatives.

Fokus auf Entstigmatisierung und Awareness Raising

Overall, findings from RQ2 reinforced the core principles of RQ1 but placed greater emphasis on indication-specific vulnerabilities. Most notably, they highlight limited adult service availability and insufficient adult-sector expertise for conditions such as ADHD, autism, eating disorders and SUD. The need for addressing stigma, medication adherence, and tailored psychoeducation was further illustrated. There is substantial evidence indicating that conditions such as SUDs and eating disorders are highly stigmatised [120, 121]; however, stigma is prevalent across all mental health conditions [122, 123]. Across conditions, structural barriers persisted, including misaligned eligibility criteria between CAMHS and AMHS, as well as reductions in support intensity following transfer to AMHS. The results thus reveal structural gaps that might be overlooked in overarching guidelines or strategies, underscoring the need to consider indication-specific care concepts in comprehensive transition models for mental health.

wenig Aufmerksamkeit für allgemeine System- und Implementierungs-bedingungen

Taken together, the evidence suggests that international consensus on what constitutes good transition practice is emerging. Still, less attention has been paid to the broader system-level and implementation conditions that ultimately determine whether these principles can be realised in practice.

Prior studies have reported similar findings, with broad agreement on key principles of transitional care.

kein Modell wird unterschiedlichen Bedürfnissen aller Jugendlichen gerecht

personenzentrierte Lösungen, integrierte Versorgung und Koordination erforderlich

Evidence indicates that no single model fully addresses the diverse needs of all YP:

- **Extending CAMHS to age 25** delays disruptive transitions but requires major capacity expansion for under-18 services [75].
- **Relying on AMHS for younger adults** fails to address developmental needs and risks excluding those who do not meet adult service thresholds [75].
- **Creating 14–25 youth hubs** arguably provides the most developmentally tailored care but also poses the greatest risk of creating a new

transition point and comes with high financial and operational costs [75, 124, 125].

- **Flexible boundaries based on developmental readiness** provide person-centred solutions but demand integrated pathways, extensive training, and cross-sector collaboration [75].

Modelle am besten in gemischten Formen umsetzen, auf lokale Bedürfnisse und Ressourcen zugeschnitten

Overall, these models are not mutually exclusive and may be best implemented in blended forms to fit local needs and resources. Ultimately, all of them require adequate resourcing, workforce development, and cross-sectoral alignment [75]. Similar to our results, the literature cautions against a one-size-fits-all model [46].

ermittelte Grundsätze für Transitionen weitgehend übereinstimmend mit bisheriger Literatur

The identified principles of international best-practice transition largely converge with findings from previous literature [25, 46, 75, 126-128]. Frameworks such as the four core components of effective transition [25], the "four Ps" (people, process, paper, place) [127] and co-produced transition programmes [46] reinforce the principles. All emphasise flexible and phased transitions, parallel working between CAMHS and AMHS, avoidance of transfers during crises, complete transfer of information, youth-friendly spaces, shared decision-making, and participation, among other key elements – suggesting a broad international consensus on the essential building blocks of high-quality transition. However, despite this convergence on principles, only very few evaluations provide rigorous evidence of their effectiveness [26, 53].

systematische, schrittweise Implementierung unterstützt durch langfristige Ressourcenplanung und Lebensspannen- und Lebensverlaufsperspektive

We found that a systematic, phased roll-out of transition models should be supported by long-term resource planning and a lifespan perspective. Such an approach integrates prevention, early intervention, and family support to decrease long-term demand for services and prevent chronic disorder trajectories, thereby reducing the impact on both YP and the health system [129]. These recommendations align with the 2022 Report on Child and Adolescent Mental Health Care [65], which similarly called for a coherent framework that links mental health promotion, prevention, and care.

Trend zur Einbettung von Transitionen in breitere Versorgungsinfrastruktur

Additionally, embedding transition within a broader care infrastructure, spanning health, education, and social services, is further supported by the literature. Involving stakeholders beyond clinical teams integrates mental health care into YP's wider support networks, enabling prevention, early detection, and timely referral, while at the same time reducing the risk of multiple concurrent transitions [22, 130].

Zusammenspiel mehrerer Schlüsselfaktoren: zeitliche, Stakeholder, und systemisch

Finally, similar to our results, the literature identified key factors influencing transition outcomes, spanning temporal aspects, stakeholder dynamics, and system-level conditions (see Figure 4-1) [128]. The interplay of these domains determines whether the experience is ultimately supportive or disruptive [128].

teilweise Instrumente für die Transition verfügbar (TRAM und TROM)

Tools to structure and evaluate transitions are increasingly available. The TRAM (Transition Readiness and Appropriateness Measure) and TROM (Transition-Related Outcome Measure) from the MILESTONE project can identify barriers, guide decision-making, tailor support, and evaluate outcomes [131]. Together, they represent promising approaches to structured assessment and outcome evaluation. However, YP often perceive questionnaires as disengaging and practitioner-centred [46]. Alternatives such as co-produced transition booklets, guiding preparation, tracking progress, and consolidating information may be more acceptable [46]. Cross-sector tools from other fields might also offer inspiration. For example, Austria's SUPA survivorship passport in paediatric oncology offers quickly accessible, personalised, digital

Instrumente aus anderen Disziplinen können Inspiration für die Transitionspsychiatrie sein

treatment summaries and tailored follow-up recommendations [132]. Adapted for mental health, such tools could strengthen continuity across services.

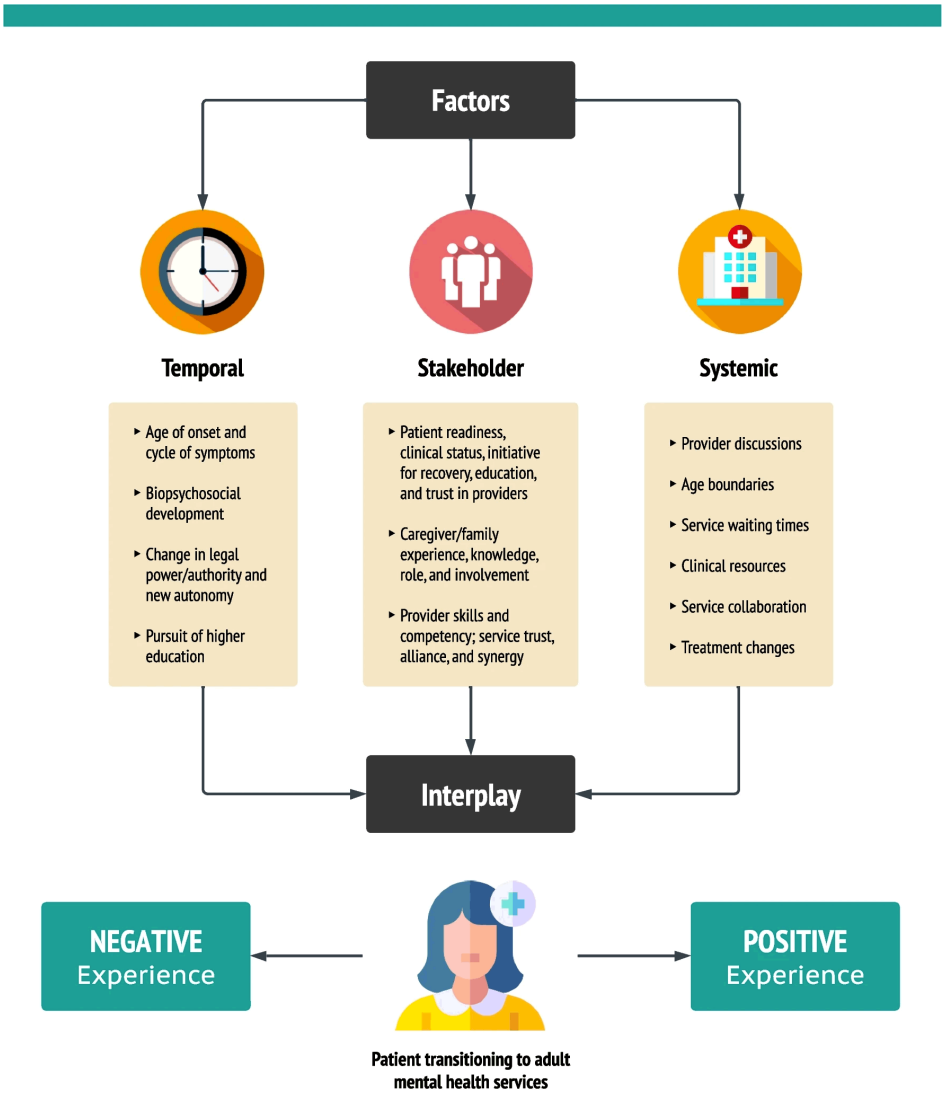


Figure 4-1: Key Factors Influencing the Transition from CAMHS to AMHS. Reproduced with permission from [128].

österreichische Curricula: wenig systematische Vorbereitung auf Schnittstellenmanagement von KJP und EP

At the same time, several implementation challenges remain. For example, to strengthen inter-service collaboration, the need for staff in paediatric and adult services to be trained and change attitudes towards each other's services is consistent with the literature [133]. Our findings suggest that training CAMHS professionals to work with young people up to 25, and training AMHS professionals to support younger adolescents, is essential. Although both Austrian curricula (psychiatry and psychotherapeutic medicine [134] and child and adolescent psychiatry and psychotherapeutic medicine [135]) touch on the other age group, neither provides systematic preparation for managing the interface between child and adolescent psychiatry and adult psychiatry. More explicit training on collaboration and transition processes could improve readiness, mutual understanding, and familiarity with the needs across age groups.

identifizierte strukturelle Hindernisse zudem in internationaler Literatur aufgezeigt

Additionally, structural issues identified in this report are consistently reported in the literature, including service fragmentation [45], a lack of appropriate referral options [13], as well as inflexible policies, entrenched cultures, insufficient funding, and legal, logistical, and clinical differences [46, 47, 75, 126].

Transitionen in der psychischen Versorgung tendenziell problematischer als in somatischer Versorgung, insbesondere durch Vulnerabilitätsfaktoren

Some guidelines address transition more broadly across chronic conditions, such as the German S3 guideline on transition from paediatrics to adult medicine [136]. Although the guideline outlines general principles, it does not contain specific recommendations for mental health. Importantly, the transition in mental health appears to be even more problematic than in physical care [47]. This is particularly true, given the fluctuating trajectories, multimorbidity, diagnostic uncertainty, developmental delays, and stigma. Furthermore, factors such as disability, migration status, socio-economic disadvantage, trauma exposure, multi-morbidity, child protection or justice involvement, and minority group membership exacerbate the risk of vulnerability. Previous reviews also highlight these groups as facing structural disadvantages and call for targeted strategies, including culturally and linguistically appropriate services, additional resources, and early prioritisation of complex cases via a lead professional model [65].

uneinheitliche Implementierung von Modellen

Several initiatives have identified key components of effective transition models; however, the systematic implementation of these models remains inconsistent.

in 75 % der europäischen Länder Übergang üblicherweise bei gesetzlicher Altersgrenze von 18 Jahren

praktische Umsetzung der Ausweitung der Altersgrenze für die KJP in Österreich durch Personalmangel eingeschränkt

In recent years, some efforts have been made to improve the transition between CAMHS and AMHS [60]. It is increasingly argued that service models should consider a more flexible approach, acknowledging developmental needs over rigid chronological thresholds [14]. Nevertheless, the legal definition of adulthood at 18 still often functions as a rigid treatment cut-off [10]. This is consistent with WHO findings that 75% of European countries use 18 as the usual age of transition [56]. Importantly, in 2024, Austria took an initial significant step by raising the CAMHS age limit beyond 18 [116], in line with international recommendations and the findings of this report to prevent abrupt discontinuity of care. However, limited staffing and infrastructure make it unlikely that the amendment will materialise. In many cases, CAMHS remain forced to prioritise care for minors, and adult services often lack adequate provision for specific diagnoses [137]. Therefore, legislative changes without adequate resources for implementation are not sufficient. Moreover, such reforms require effective dissemination so that practitioners across services are aware of the policy change.

Entwicklung und koordinierte Umsetzung der Transitionspsychiatrie in Österreich noch im Anfangsstadium

Our findings suggest that, although transitional psychiatry has garnered increasing international attention, its strategic development and coordinated implementation in Austria are still in preliminary stages. Although individual initiatives, pilot projects, and specialised centres exist, a detailed national strategy has yet to be established. In Austria, the transition process frequently relies on the motivation of individual professionals rather than on a systematic framework. Similarly, information and awareness are uneven; activities are predominantly project-oriented, lacking national visibility or sustainability.

neue Ansätze für die Struktur und die Finanzierung des Sektors erforderlich

Our analysis suggests that achieving sustainable transitional structures in Austria requires more than the adoption of principles; it also requires new approaches to the sector's structure and funding. Austrian experts favour embedding transitional psychiatry in modular care concepts, with binding standards for stronger cooperation, expanded training and research, and greater involvement of non-clinical partners such as social work and school psychology [22].

Umsetzung von Empfehlungen erschwert durch Zeit- und Ressourcenmangel, starre Systeme und Aufnahmekriterien der Erwachsenenversorgung

Developing a national strategy for transitional psychiatry in collaboration with YP, their families, and professionals would foster a shared vision and consensus on goals and principles. The strategy should build upon and be linked with existing mental health frameworks. Although Austria has a Child and Youth Health Strategy [59], it lacks specific transitional content. Moreover, a recent scientific report has highlighted the absence of a stand-alone national strategy for child and youth mental health [65]. However, successful implementation requires addressing challenges in child and adolescent psychiatric care. These include regional differences in access to services, poor coordination between sectors, and the need for expanded treatment options like home treatment and outreach approaches [65].

internationale Grundsätze sollten als Orientierung, nicht als direkt übertragbare Modelle betrachtet werden

erfolgreiche Umsetzung hängt von pragmatischer Anpassung an österreichische Gegebenheiten ab

The international models reviewed in this report offer valuable guidance for structuring age-appropriate, continuous, and collaborative mental health care. However, their transferability to the Austrian context is not without limitations. A major issue is the shortage and ageing of the psychiatric workforce. Nearly one-quarter of child and adolescent psychiatrists and over one-third of adult psychiatrists are expected to retire within five years [138]. Furthermore, demand for specialist publicly funded outpatient care is projected to exceed capacity by 10–25% by 2035 [139]. This shortage leads to long waiting times and barriers to access, with a median waiting time of 90 days in CAMHS and 37 days in AMHS (as of 2024), and a significant proportion of practices not accepting new patients [140]. Access is further restricted by fragmentation within the healthcare system. This fragmentation involves complex navigation across sectors, a lack of coordination, unclear patient pathways, an absence of holistic treatment approaches, a divide between urban and rural areas, and a strict separation between social care and healthcare services [141]. Consequently, the international principles in this report should be viewed as adaptive frameworks rather than directly transferable models. A successful implementation will require adaptation and tailoring to the Austrian context. The crucial point is that without political commitment and dedicated resources, a strategy runs the risk of remaining merely declaratory rather than impactful.

4.2 Limitations

keine systematische Literaturrecherche

Although the literature search was extensive and targeted, it was not conducted systematically. Instead, we employed a comprehensive manual search strategy, focusing on grey literature, including government websites, public health agencies, and international organisations. This approach was chosen based on the expectation that data on mental health strategies and models are often not published in peer-reviewed journals. However, this carries the risk of incomplete retrieval and the possibility that relevant documents may have been missed.

limitierte Länderauswahl; Unterschiede in Quantität und Qualität der Dokumente

Additionally, the selection of countries was limited to a defined set based on predefined inclusion criteria. Consequently, promising practices from non-included countries may have been overlooked. Furthermore, there was significant variation in the quantity and quality of publicly available documentation across different countries.

limitierte Übertragbarkeit

Another limitation is the inclusion of regional models, such as those from AU and BL, as they may not be applicable across all national contexts.

Exklusion von übergreifenden Dokumenten

We excluded documents that addressed general health rather than mental health, as well as those that focused on mental health without specifically considering adolescents. Although these exclusions were necessary to maintain a consistent focus, they may have resulted in important information being omitted.

Kategorisierung der gesammelten Daten mit Überlappungen

Another limitation is the difficulty of categorising the collected information. Although care was taken to assign data consistently, some thematic boundaries remained fluid, and alternative interpretations of certain data points are possible.

limitierte Konsultationen mit Expert:innen pro Land und pro Disziplin

Although the expert consultations contributed significantly to the contextualisation and interpretation of the findings, they also had limitations. In most cases, a maximum of two experts were consulted per country, and not all relevant professional groups were represented. In Austria, for instance, only four experts from three organisations took part, most of whom were from universities or large urban hospitals. This means that perspectives from smaller or rural facilities, which often face different structural challenges, may be underrepresented. Additionally, professional interests and institutional affiliations may have introduced biases, despite efforts to maintain balance through multidisciplinary sampling.

Bedarfsanalyse basierend auf Sekundärdaten

Regarding the Austrian prevalence data, the analysis was based on secondary data, including older prevalence estimates. As there is a lack of more recent epidemiological data on youth mental health in Austria, the findings should be interpreted with caution and understood as indicative rather than definitive.

Fehlen von schriftlichen Informationen in mehreren Schlüsselbereichen

Expert:innenkonsultationen für Kontextualisierung und Füllen von Datenlücken

Finally, the results presented in this report are predominantly informed by policy and guideline-based sources, complemented by expert consultations. For RQ1, all thirteen included documents provided a broad and cohesive foundation, particularly for topics such as service integration, integration between CAMHS and AMHS and continuity of care. In contrast, areas such as workforce sustainability, implementation and governance, costs, and evaluation methods were supported by fewer written sources and relied more heavily on expert insights, which may affect the robustness and transferability of the findings. For RQ2, the written evidence base consisted of seven documents, primarily clinical guidelines. ADHD was well-represented through multiple guidelines, depressive and conduct disorders, on the other hand, were informed by fewer or single sources. Across both research questions, the evidence is primarily descriptive and theoretical, with limited empirical or evaluative content. Expert consultations, therefore, played a crucial role in contextualising and supplementing gaps in the documentary base.

4.3 Future Research Directions

mehr Daten über aktuelle österreichische Landschaft nötig

While system-level differences may limit the applicability of some results of this report, they can serve as inspiration for national reforms and pilot projects. However, more data is needed on the current Austrian landscape. The national mapping of existing transitional services in Austria, which is planned by Gesundheit Österreich GmbH starting in autumn 2025, will provide a valuable opportunity to generate empirical data on current structures and practices.

Bedeutung reibungsloser Transitionen auch von internationalen Organisationen anerkannt

The critical importance of smooth transitions between CAMHS and AMHS, as well as the widespread risk of disruptions in care during this developmental period, have also been recognised by international organisations such as WHO and UNICEF [142, 143]. These global perspectives frame continuity of care as a core element of system strengthening. However, these calls remain largely aspirational, as evidence on implementation and long-term outcomes is scarce. A key implication is, therefore, the need for more rigorous and sustained evaluation of transitional psychiatry models. Current evidence is limited to a handful of observational studies and a single RCT (MILESTONE), with few long-term follow-ups. Future evaluations should systematically and in the long term assess symptom severity and functioning and outcomes directly relevant to YP's lives, including school and work participation, quality of life, and drop-out rates (see Results 3, "Evaluation and Effectiveness"). The measurement of school and work participation is of particular importance, as such outcomes can inform health economic considerations and strengthen arguments for investing in structured and evidence-informed transition models.

Notwendigkeit einer robusteren und nachhaltigeren Evaluierung der Modelle

Untersuchung der zugrunde liegenden Mechanismen, um Wirkungen zu erzielen

Research should also investigate the underlying mechanisms that allow transition models to achieve results, such as readiness, engagement, and self-management skills. This will help identify which components are most important for effective practice. A realist synthesis protocol has been published with this focus, examining what works for whom, under what circumstances, how, and why, for all YP transitioning to adult services [37]. Although the study is not specific to mental health, it is likely to generate insights that are at least partially applicable and relevant to transitional psychiatry, particularly in understanding the mechanisms and contextual factors that shape outcomes.

Prävalenzen über Abbrüche und Bedarf für strukturierte Transitionen im österreichischen Kontext fehlen

Future research should also try to quantify the number of YP in Austria who are affected by problematic transitions between CAMHS and AMHS. International data and prevalence studies such as GBD (2019) [7] and MHAT (2017) [88] demonstrate the high burden of mental disorders in adolescence, but systematic evidence on the scale of transition disruptions in the Austrian context is lacking. Such data would be essential for strengthening the evidence base for targeted policy responses.

Faktoren identifizieren, die ausschlaggebend sind, ob bewährte Praktiken in Routineversorgung übernommen werden können

In addition, there is a pressing need to examine the broader system- and implementation-level factors that determine whether best-practice principles can be translated into routine care. This should include strategies to strengthen cross-sectoral integration, particularly at the interfaces of health (with a focus on comorbidities), education, employment, and housing. Finally, linking transitional psychiatry research to established mental health policy indicators [65] could enhance comparability, facilitate monitoring, and embed transition outcomes in broader mental health performance frameworks.

Finally, future research should investigate transitions within newly emerging models of care in Austria. An example is home treatment, which has been increasingly implemented as an alternative to inpatient care [144]. Although its relevance is growing, little is known about how continuity is maintained when YP move, for instance, from a child and adolescent home treatment team to an adult team. This question is particularly relevant in Austria, where structured home treatment services for adults are not yet established [145]. This means that the transition to adult care is unclear and poses a risk of discontinuity. Similarly, the key principle of the recent health reform, "digital vor ambulant vor stationär" (digital before outpatient before inpatient) [146], warrants specific attention in transition research. By prioritising digital and community-based care over inpatient treatment, this principle raises new questions for transitional psychiatry, such as how to support continuity in digital consultations. Empirical studies are needed to assess how such reform principles can be operationalised in transitional care and if they effectively address existing discontinuities.

Transitionen sollten in neuen Versorgungsmodellen untersucht werden, wie digitale Konsultationen und Home-Treatment Settings

5 Conclusion

hohe Prävalenz und Kontinuität von psychischen Erkrankungen

Adolescence is a critical developmental phase during which many mental health conditions first emerge. Epidemiological data confirm the high prevalence of anxiety disorders, depression, ADHD, eating disorders and SUDs during this life stage. Many of these conditions persist into adulthood, highlighting the need for ongoing, coordinated and age-appropriate care. Transitional psychiatry, positioned at the intersection of CAMHS and AMHS, aims to fulfil this requirement by providing a structured framework to support YP as they navigate the psychological and social challenges of emerging adulthood.

Transitionspsychiatrie stellt Brücke zwischen KJP und EP dar

nicht genügend Evidenz, um ein einziges Transitionsmodell für universelle Anwendung zu befürworten

A key finding of this report is the identification of two dominant models of transitional psychiatry internationally: the coordination model, which aims to bridge existing services (e.g. through joint working and flexible protocols), and the youth-specific care model, which establishes separate services tailored to the needs of YP. Both models offer unique benefits, such as continuity for those with longstanding CAMHS involvement versus accessibility for those with emerging or undiagnosed needs; however, they also present specific challenges. Evidence suggests that hybrid and context-sensitive approaches that are adapted to local resources and population needs are most promising. This report's findings, therefore, do not advocate one-size-fits-all solutions, but instead emphasise the need for approaches that can be adapted to meet the developmental, clinical, and psychosocial needs of YP.

internationale Modelle bieten wiederkehrende Prinzipien und Best-Practice-Elemente einer hochwertigen Transitionsversorgung

In addition, this report synthesises a set of recurring principles and best practice elements of high-quality transitional care that emerge consistently across countries, including early preparation, shared decision making, flexible age limits, and sustained follow-up. These principles reflect a growing international consensus on what constitutes high-quality transition practice and should provide a common basis for developing or adapting transition care frameworks. However, despite a strong international consensus on the principles of good transition, evidence of effectiveness remains weak.

Reformen müssen vor Hintergrund bestehender Ressourcenknappheit bewertet werden

Entwicklung einer nationalen Strategie von wesentlicher Bedeutung

Austria has acknowledged the issue of transitions but relies on fragmented initiatives and motivated individuals instead of a coherent national framework. Reforms must be carefully evaluated in light of existing resource constraints. Developing a national strategy, embedded within youth mental health frameworks and supported by dedicated resources, will be essential. Sustainable improvement will require not only adoption of principles but also structural reforms in funding, workforce sustainability and development, cross-sectoral integration and health services research. Only then can transitional psychiatry deliver lasting benefits for YP.

vergleichende Wissensbasis als Grundlage für strategische Entscheidungen

Rather than offering an implementation blueprint, this report provides a knowledge base to inform strategic decision-making. Drawing on lessons from international experience, it identifies critical elements, contextual enablers, and systemic challenges relevant to Austria. The starting points outlined here aim to support the further development of transitional psychiatry in Austria.

References

[1] Rosenfeld R. G. and Nicodemus B. C. The transition from adolescence to adult life: physiology of the 'transition' phase and its evolutionary basis. Hormone Research. 2003;60(Suppl 1):74-77. DOI: 10.1159/000071230.

[2] Solmi M., Radua J., Olivola M., Croce E., Soardo L., Salazar de Pablo G., et al. Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. Molecular Psychiatry. 2022;27:281-295. Epub 20210602. DOI: 10.1038/s41380-021-01161-7.

[3] Paus T., Keshavan M. and Giedd J. N. Why do many psychiatric disorders emerge during adolescence? Nature Reviews Neuroscience. 2008;9(12):947-957. Epub 20081112. DOI: 10.1038/nrn2513.

[4] Tuomainen H. Commentary: State of transitional care for emerging adults – reflections on Anderson et al. The Journal of Child Psychology and Psychiatry. 2022;63(11). Epub 20220309. DOI: 10.1111/jcpp.13599.

[5] Gore F. M., Bloem P. J., Patton G. C., Ferguson J., Joseph V., Coffey C., et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. The Lancet. 2011;377(9783):2093-2102. Epub 20110607. DOI: 10.1016/S0140-6736(11)60512-6.

[6] Sacco R., Camilleri N., Eberhardt J., Umla-Runge K. and Newbury-Birch D. A systematic review and meta-analysis on the prevalence of mental disorders among children and adolescents in Europe. European Child & Adolescent Psychiatry. 2024;33(9):2877-2894. Epub 20221230. DOI: 10.1007/s00787-022-02131-2.

[7] Kieling C., Buchweitz C., Caye A., Silvani J., Ameis S. H., Brunoni A. R., et al. Worldwide Prevalence and Disability From Mental Disorders Across Childhood and Adolescence: Evidence From the Global Burden of Disease Study. JAMA Psychiatry. 2024;81(4):347-356. DOI: 10.1001/jamapsychiatry.2023.5051.

[8] Blum R. W., Garell D., Hodgman C. H., Jorissen T. W., Okinow N. A., Orr D. P., et al. Transition from child-centered to adult health-care systems for adolescents with chronic conditions. A position paper of the Society for Adolescent Medicine. Journal of Adolescent Health. 1993;14(7):570-576. DOI: 10.1016/1054-139x(93)90143-d.

[9] Moreno-Galdo A., Regne-Alegret M. C., Aceituno-Lopez M. A., Camprodon-Gomez M., Marti-Beltran S., Lara-Fernandez R., et al. Implementation of programmes for the transition of adolescents to adult care. Anales de Pediatrìa. 2023;99(6):422-430. Epub 20231127. DOI: 10.1016/j.anpede.2023.09.014.

[10] Trabi T., Purtscher-Penz K. and Plener P. The transition of psychiatric ill adolescents from child and adolescent psychiatric care to adult psychiatric care. neuropsychiatrie. 2023;37(1):26-32. Epub 20221121. Versorgung psychisch kranker Jugendlicher im Prozess der Transition vom Jugend- ins Erwachsenenalter. DOI: 10.1007/s40211-022-00441-0.

[11] Schrank B. Transitionspsychiatrie – ein Definitionsversuch mit Praxisbezug. psychopraxis neuropraxis. 2022;25(2):100-102. DOI: 10.1007/s00739-022-00788-7.

[12] Tuomainen H., Schulze U., Warwick J., Paul M., Dieleman G. C., Franic T., et al. Managing the link and strengthening transition from child to adult mental health Care in Europe (MILESTONE): background, rationale and methodology. BMC Psychiatry. 2018;18(167). Epub 20180604. DOI: 10.1186/s12888-018-1758-z.

[13] Signorini G., Singh S. P., Marsanic V. B., Dieleman G., Dodig-Curkovic K., Franic T., et al. The interface between child/adolescent and adult mental health services: results from a European 28-country survey. European Child & Adolescent Psychiatry. 2018;27(4):501-511. Epub 20180124. DOI: 10.1007/s00787-018-1112-5.

[14] Singh S. P. Transition of care from child to adult mental health services: the great divide. Current Opinion in Psychiatry. 2009;22(4):386-390. DOI: 10.1097/YCO.0b013e32832c9221.

[15] Chan V., Moore J., Derenne J. and Fuchs D. C. Transitional Age Youth and College Mental Health. Child and Adolescent Psychiatric Clinics of North America. 2019;28(3):363-375. Epub 20190410. DOI: 10.1016/j.chc.2019.02.008.

[16] Schlack R., Peerenboom N., Neuperdt L., Junker S. and Beyer A. K. The effects of mental health problems in childhood and adolescence in young adults: Results of the KiGGS cohort. Journal of Health Monitoring. 2021;6(4):3-19. Epub 20211208. DOI: 10.25646/8863.

[17] Thun-Hohenstein L. Care, provision of care and models of care in child and adolescent psychiatry in Austria. neuropsychiatrie. 2022;36(4):151-159. Epub 20221026. Versorgung und Versorgungskonzepte in der Kinder- und Jugendpsychiatrie. DOI: 10.1007/s40211-022-00435-y.

[18] Birchwood M. J., Street C., Singh S. P., Lamb C., Anderson Y., Warner-Gale F., et al. Impact and process evaluation of Forward Thinking Birmingham, the 0-25 Mental Health Service: Final Report. University of Warwick; University of Birmingham; GIFT (Great Involvement Future Thinking); CLAHRC-WM., 2018 [cited 18.03.2025]. Available from: https://wrap.warwick.ac.uk/id/eprint/100545/7/WRAP-impact-process-evaluation-report-Birchwood-2018.pdf.

[19] McGorry P., Bates T. and Birchwood M. Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK. The British Journal of Psychiatry. 2013;54:s30-35. DOI: 10.1192/bjp.bp.112.119214.

[20] Wilson J., Clarke T., Lower R., Ugochukwu U., Maxwell S., Hodgekins J., et al. Creating an innovative youth mental health service in the United Kingdom: The Norfolk Youth Service. Early Intervention in Psychiatry. 2018;12(4):740-746. Epub 20170804. DOI: 10.1111/eip.12452.

[21] Rickwood D., Paraskakis M., Quin D., Hobbs N., Ryall V., Trethowan J., et al. Australia's innovation in youth mental health care: The headspace centre model. Early Intervention in Psychiatry. 2019;13(1):159-166. Epub 20181012. DOI: 10.1111/eip.12740.

[22] Neumann M., Dürr A., Gonzalez-Martin A., Urban M., Manoharan N., Surikova V., et al. Mind the gap – Forderungen für eine verbesserte transitionspsychiatrische Versorgung aus Expert:innenperspektive. psychopraxis neuropraxis. 2024;27(4):245-250. DOI: 10.1007/s00739-024-01017-z.

[23] Hendrickx G., De Roeck V., Maras A., Dieleman G., Gerritsen S., Purper-Ouakil D., et al. Challenges during the transition from child and adolescent mental health services to adult mental health services. BJPsych Bulletin. 2020;44(4):163-168. DOI: 10.1192/bjb.2019.85.

[24] White P. H., Cooley W. C., Transitions Clinical Report Authoring Group and American Academy of Pediatrics A. A. o. F. P., American College of Physicians,. Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home. Pediatrics. 2019;143(2). DOI: 10.1542/peds.2018-3610.

[25] Singh S. P., Paul M., Ford T., Kramer T., Weaver T., McLaren S., et al. Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. The British Journal of Psychiatry. 2010;197(4):305-312. DOI: 10.1192/bjp.bp.109.075135.

[26] Appleton R., Connell C., Fairclough E., Tuomainen H. and Singh S. P. Outcomes of young people who reach the transition boundary of child and adolescent mental health services: a systematic review. European Child & Adolescent Psychiatry. 2019;28(11):1431-1446. Epub 20190308. DOI: 10.1007/s00787-019-01307-7.

[27] Saour T. Transition from child and adolescent mental health services to adult mental health services. BJPsych Open. 2021;7(S1):S347-S348. DOI: 10.1192/bjo.2021.910.

[28] Reneses B., Escudero A., Tur N., Aguera-Ortiz L., Moreno D. M., Saiz-Ruiz J., et al. The black hole of the transition process: dropout of care before transition age in adolescents. European Child & Adolescent Psychiatry. 2023;32:1285-1295. Epub 20220120. DOI: 10.1007/s00787-021-01939-8.

[29] Child and Adolescent Health Measurement Initiative. Transition to adult health care, age 12-17 years. 2023 [cited 26.02.2025]. Available from: https://www.childhealthdata.org/browse/survey/results?q=11152&r=1.

[30] Child and Adolescent Health Measurement Initiative. Discussed shift to providers who treat adults, age 12-17 years. 2023 [cited 26.02.2025]. Available from: https://www.childhealthdata.org/browse/survey/results?q=11157&r=1.

[31] Cappelli M., Davidson S., Racek J., Leon S., Vloet M., Tataryn K., et al. Transitioning Youth into Adult Mental Health and Addiction Services: An Outcomes Evaluation of the Youth Transition Project. The Journal of Behavioral Health Services & Research. 2016;43(4):597-610. DOI: 10.1007/s11414-014-9440-9.

[32] Singh S. P., Paul M., Ford T., Kramer T. and Weaver T. Transitions of care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK Study): a study of protocols in Greater London. BMC Health Services Research. 2008;8:135. Epub 20080623. DOI: 10.1186/1472-6963-8-135.

[33] Leavey G., McGrellis S., Forbes T., Thampi A., Davidson G., Rosato M., et al. Improving mental health pathways and care for adolescents in transition to adult services (IMPACT): a retrospective case note review of social and clinical determinants of transition. Social Psychiatry and Psychiatric Epidemiology. 2019;54(8):955-963. Epub 20190306. DOI: 10.1007/s00127-019-01684-z.

[34] Jarvis S., Flemming K., Richardson G. and Fraser L. Adult healthcare is associated with more emergency healthcare for young people with life-limiting conditions. Pediatric Research. 2022;92(5):1458-1469. Epub 20220212. DOI: 10.1038/s41390-022-01975-3.

[35] Ryan J. M., Fortune J., Walsh A., Norris M., Kerr C., Hensey O., et al. Transition from child to adult health services for young people with cerebral palsy in Ireland: a mixed-methods study protocol. BMJ Open. 2020;10(12):e041425. Epub 20201222. DOI: 10.1136/bmjopen-2020-041425.

[36] Toulany A., Gorter J. W. and Harrison M. A call for action: Recommendations to improve transition to adult care for youth with complex health care needs. Paediatrics & Child Health. 2022;27(5):297-309. Epub 20220822. DOI: 10.1093/pch/pxac047.

[37] Sipanoun P., Aldiss S., Porter L., Morgan S., Powell E. and Gibson F. Transition of young people from children's into adults' services: what works for whom and in what circumstances – protocol for a realist synthesis. BMJ Open. 2024;14(1):e076649. Epub 20240104. DOI: 10.1136/bmjopen-2023-076649.

[38] Taylor H. L., Menachemi N., Gilbert A., Chaudhary J. and Blackburn J. Economic Burden Associated With Untreated Mental Illness in Indiana. JAMA Health Forum. 2023;4(10):e233535. Epub 20231006. DOI: 10.1001/jamahealthforum.2023.3535.

[39] Barr N. G., Longo C. J., Embrett M. G., Mulvale G. M., Nguyen T. and Randall G. E. The transition from youth to adult mental health services and the economic impact on youth and their families. Healthcare Management Forum. 2017;30(6):283-288. Epub 20171023. DOI: 10.1177/0840470417709579.

[40] Babajide A., Ortin A., Wei C., Mufson L. and Duarte C. S. Transition Cliffs for Young Adults with Anxiety and Depression: Is Integrated Mental Health Care a Solution? The Journal of Behavioral Health Services & Research. 2020;47(2):275-292. DOI: 10.1007/s11414-019-09670-8.

[41] Pollak E., Kapusta N. D., Diehm R., Plener P. L. and Skala K. Transitional and Adolescent Psychiatry in Austria: A Pilot Study on the Attitudes of Experts. Kinder- und Jugendpsychiatrie und Psychotherapie. 2018;46(4):325-335. Epub 20171204. Transitions- und Adoleszenzpsychiatrie in Osterreich: Eine Pilotuntersuchung zur Sicht von Expert(innen). DOI: 10.1024/1422-4917/a000559.

[42] Cleverley K., Lenters L. and McCann E. "Objectively terrifying": a qualitative study of youth's experiences of transitions out of child and adolescent mental health services at age 18. BMC Psychiatry. 2020;20(1):147. Epub 20200403. DOI: 10.1186/s12888-020-02516-0.

[43] Broad K. L., Sandhu V. K., Sunderji N. and Charach A. Youth experiences of transition from child mental health services to adult mental health services: a qualitative thematic synthesis. BMC Psychiatry. 2017;17(1):380. Epub 20171128. DOI: 10.1186/s12888-017-1538-1.

[44] Care Quality Commission. From the pond into the sea. Children's transition to adult health services. 2014 [cited 31.03.2025]. Available from: https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf.

[45] Hill A., Wilde S. and Tickle A. Review: Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS): a meta-synthesis of parental and professional perspectives. Child and Adolescent Mental Health. 2019;24(4):295-306. Epub 20190604. DOI: 10.1111/camh.12339.

[46] Dunn V. Young people, mental health practitioners and researchers co-produce a Transition Preparation Programme to improve outcomes and experience for young people leaving Child and Adolescent Mental Health Services (CAMHS). BMC Health Service Research. 2017;17(1):293. Epub 20170420. DOI: 10.1186/s12913-017-2221-4.

[47] Singh S. P. and Tuomainen H. Transition from child to adult mental health services: needs, barriers, experiences and new models of care. World Psychiatry. 2015;14(3):358-361. DOI: 10.1002/wps.20266.

[48] Gerritsen S. E., Dieleman G. C., Beltman M. A. C., Tangenbergh A. A. M., Maras A., van Amelsvoort T., et al. Transitional psychiatry in the Netherlands: Experiences and views of mental health professionals. Early Intervention in Psychiatry. 2020;14(6):684-690. Epub 20191120. DOI: 10.1111/eip.12890.

[49] Hovish K., Weaver T., Islam Z., Paul M. and Singh S. P. Transition experiences of mental health service users, parents, and professionals in the United Kingdom: a qualitative study. Psychiatric Rehabilitation Journal. 2012;35(3):251-257. DOI: 10.2975/35.3.2012.251.257.

[50] McNamara N., McNicholas F., Ford T., Paul M., Gavin B., Coyne I., et al. Transition from child and adolescent to adult mental health services in the Republic of Ireland: an investigation of process and operational practice. Early Intervention in Psychiatry. 2014;8(3):291-297. Epub 20130704. DOI: 10.1111/eip.12073.

[51] Paul M., Ford T., Kramer T., Islam Z., Harley K. and Singh S. P. Transfers and transitions between child and adult mental health services. The British Journal of Psychiatry. 2013;54:s36-40. DOI: 10.1192/bjp.bp.112.119198.

[52] Salgado J. Transition services in mental health – A suitable solution for young patients? A qualitative study of the opinions of adolescent and adult psychiatrists in Portugal. Health Care Transitions. 2024;2:100076. Epub 20241029. DOI: 10.1016/j.hctj.2024.100076.

[53] Cleverley K., Rowland E., Bennett K., Jeffs L. and Gore D. Identifying core components and indicators of successful transitions from child to adult mental health services: a scoping review. European Child & Adolescent Psychiatry. 2020;29(2):107-121. Epub 20181008. DOI: 10.1007/s00787-018-1213-1.

[54] Singh S. P., Tuomainen H., Bouliotis G., Canaway A., De Girolamo G., Dieleman G. C., et al. Effect of managed transition on mental health outcomes for young people at the child-adult mental health service boundary: a randomised clinical trial. Psychological Medicine. 2023;53(6):2193-2204. Epub 20211029. DOI: 10.1017/S0033291721003901.

[55] Maxwell S., Ugochukwu O., Clarke T., Gee B., Clarke E., Westgate H., et al. The effect of a youth mental health service model on access to secondary mental healthcare for young people aged 14-25 years. BJPsych Bulletin. 2019;43(1):27-31. Epub 20180921. DOI: 10.1192/bjb.2018.70.

[56] World Health Organization (WHO). Situation of child and adolescent health in Europe. 2018.

[57] Universitätsklinikum Tulln. Ausbau der Kinder- und Jugendpsychiatrie in Tulln um fast elf Millionen Euro. 2022 [cited 21.08.2025]. Available from: https://tulln.lknoe.at/universitaetsklinikum-tulln/pressemeldungen/newsdetail/ausbau-der-kinder-und-jugendpsychiatrie-in-tulln-um-fast-elf-millionen-euro.

[58] Bundesministerium für Soziales Gesundheit Pflege und Konsumentenschutz (BMSGPK). Zielsteuerung Gesundheit – Zielsteuerungsvertrag auf Bundesebene 2024 bis 2028. 2024 [cited 25.02.2025]. Available from: https://www.sozialministerium.at/Themen/Gesundheit/Gesundheitssystem/Gesundheitsreform-(Zielsteuerung-Gesundheit)/Zielsteuerungsvertrag-2024-bis-2028.html.

[59] Bundesministerium für Soziales Gesundheit Pflege und Konsumentenschutz (BMSGPK). Kinder- und Jugendgesundheitsstrategie. Aktualisierung 2024. Vienna: 2024 [cited 05.03.2025]. Available from: https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=846&attachmentName=Kinder_und_Jugendgesundheitsstrategie.pdf.

[60] World Health Organization (WHO). World mental health report: transforming mental health for all. Geneva: World Health Organization, 2022 [cited 10.02.2025]. Available from: https://iris.who.int/bitstream/handle/10665/356119/9789240049338-eng.pdf?sequence=1.

[61] Wallace L. S. A view of health care around the world. The Annals of Family Medicine. 2013;11(1):84. DOI: 10.1370/afm.1484.

[62] United Nations Development Programme (UNDP). Human Development Index (HDI). 2022.

[63] Beel J. G. B. Google Scholar's Ranking Algorithm: An Introductory Overview. In: Larsen B. and Leta J., editors. Proceedings of the 12th International Conference on Scientometrics and Informetrics (ISSI'09). Rio de Janeiro: International Society for Scientometrics and Informetrics; 2009. p. 230-241.

[64] Reinsperger I. and Paul J. Perinatal and infant mental health care models and pathways. A scoping review. Vienna: HTA Austria – Austrian Institute for Health Technology Assessment GmbH, 2022 Report No. AIHTA Project Report No.: 148 [cited 09.04.2025]. Available from: https://eprints.aihta.at/1420/1/HTA-Projektbericht_Nr.148.pdf.

[65] Jeindl R. and Hofer V. C. Child and adolescent mental health care models. A scoping review. Vienna: HTA Austria – Austrian Institute for Health Technology Assessment GmbH, 2022 Report No. AIHTA Project Report No.: 149 [cited 07.03.2025]. Available from: https://eprints.aihta.at/1418/1/HTA-Projektbericht_Nr.149.pdf.

[66] Page M. J., McKenzie J. E., Bossuyt P. M., Boutron I., Hoffmann T. C., Mulrow C. D., et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021;372:n71. Epub 20210329. DOI: 10.1136/bmj.n71.

[67] NSW Health. Supporting Young People During Transition to Adult Mental Health Services. 2018 [cited 03.04.2025]. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2018_022.pdf.

[68] Queensland Health. Transition of care for young people receiving mental health services. 2021 [cited 03.04.2025]. Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0020/151085/qh-gdl-365-5.pdf.

[69] Government of South Australia SA Health. South Australian Youth Mental Health System of Care Operational Guidelines. 2014 [cited 03.04.2025]. Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/054d5a0043a723e8bdb7fd8c4c8bcc49/YMHSOC_Operational_Guidelines_V7FINAL.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-054d5a0043a723e8bdb7fd8c4c8bcc49-onrQzUY.

[70] Sundhedsstyrelsen. Anbefalinger for transition fra børne- og ungeområdet til voksenområdet i sygehusregi. Copenhagen, Denmark: 2020 [cited 08.04.2025]. Available from: https://www.sst.dk/-/media/Udgivelser/2020/Transition-sygehusregi/Anbefalinger-for-transition-fra-boerne--og-ungeomraadet-til-voksenomraadet-i-sygehusregi.ashx?la=da&hash=06AC85998FAB7703246261F122DF9FA1A0D7525F.

[71] Gemeinsamer Bundesausschuss (G-BA). Richtlinie des Gemeinsamen Bundesausschusses über die berufsgruppenübergreifende, koordinierte und strukturierte Versorgung insbesondere für schwer psychisch kranke Kinder und Jugendliche mit komplexem psychiatrischen oder psychotherapeutischen Behandlungsbedarf (KJ-KSVPsych-RL). 2024 [cited 10.04.2025]. Available from: https://www.g-ba.de/downloads/62-492-3495/KJ-KSVPsych-RL_2024-03-21_iK-2024-07-09.pdf.

[72] Federatie Medisch Specialisten. Jongeren in transitie van kinderzorg naar volwassenenzorg. Utrecht, Netherlands: 2022 [cited 09.04.2025]. Available from: https://richtlijnendatabase.nl/richtlijn/kwaliteitsstandaard_-_jongeren_in_transitie_van_kinderzorg_naar_volwassenenzorg/startpagina_-_jongeren_in_transitie_van_kinderzorg_naar_volwassenenzorg.html.

[73] von Wyl A., Chew Howard E., Wade-Bohleber L., Passalacqua S., Schneebeli L., Haemmerle P., et al. Stationäre und tagesklinische Angebote der psychiatrischen Gesundheitsversorgung an der Schnittstelle des Jugend- und Erwachsenenalters in der Schweiz. Zurich, Switzerland: 2020 [cited 10.04.2025]. Available from: https://www.bag.admin.ch/dam/bag/de/dokumente/psychische-gesundheit/politische-auftraege/postulat-staehelin/stationaere-und-tagesklinische-angebote-der-psychiatrischen-versorgung.pdf.download.pdf/ZHAW_Bericht_Transitionspsychiatrie_final_D.pdf.

[74] National Institute for Health and Care Excellence (NICE). Transition from children's to adults' services. Quality Standard. 2023 [cited 11.04.2025]. Available from: https://www.nice.org.uk/guidance/qs140/resources/transition-from-childrens-to-adults-services-pdf-75545472790213.

[75] Dubicka B., Boland B., Lamb C., Lavis P., Vaidya G., Athanas E., et al. Delivering better outcomes for children and young adults – new service models and better transitions across mental health. 2022 [cited 11.04.2025]. Available from: https://www.rcpsych.ac.uk/docs/default-source/members/faculties/child-and-adolescent-psychiatry/child-and-adolescent-psychiatry-faculty-delivering-better-outcomes-for-children-and-young-adults.pdf?sfvrsn=2041138f_5.

[76] National Collaboration Centre for Mental Health. Meeting the needs of young adults within models of mental health care. 2022 [cited 11.04.2025]. Available from: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/nccmh-meeting-the-needs-of-young-adults-within-models-of-mental-health-care.pdf?sfvrsn=f05f18df_17.

[77] National Institute for Health and Care Excellence (NICE). Transition from children's to adults' services for young people using health or social care services. 2016 [cited 11.04.2025]. Available from: https://www.nice.org.uk/guidance/ng43/resources/transition-from-childrens-to-adults-services-for-young-people-using-health-or-social-care-services-pdf-1837451149765.

[78] NHS England and NHS Improvement. Transitions from adolescent secure to adult secure inpatient services: Practice guidance for all secure services. 2020 [cited 11.04.2025]. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/03/camhs-adult-secure-transition-practice-guidance.pdf.

[79] National CAMHS Support Service. Planning mental health services for young adults – improving transition: A resource for health and social care commissioners. 2011 [cited 11.04.2025]. Available from: https://www.choiceforum.org/docs/planmh.pdf.

[80] Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie Psychosomatik und Psychotherapie (dgppn). Kriterien („J") und Strukturmerkmale für die stationäre und ambulante Transitionspsychiatrie in Deutschland. 2021 [cited 22.04.2025].

[81] Australian ADHD Guideline Development Group. Australian EvidenceBased Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder (ADHD). Melbourne, Australia: 2022 [cited 07.04.2025]. Available from: https://adhdguideline.aadpa.com.au/.

[82] National Institute for Health and Care Excellence (NICE). Attention deficit hyperactivity disorder: diagnosis and management. 2019 [cited 15.04.2025]. Available from: https://www.nice.org.uk/guidance/ng87/resources/attention-deficit-hyperactivity-disorder-diagnosis-and-management-pdf-1837699732933.

[83] Asherson P., Bilbow A., Carr-Fanning K., Destrebecq F., Dom G., Galderisi S., et al. Bridging the gap: Optimising transition from child to adult mental healthcare. 2017 [cited 15.04.2025]. Available from: https://www.adhdfoundation.org.uk/wp-content/uploads/2022/03/Bridging-the-gap-Optimising-transition-from-child-to-adult-mental-heatlhcare.pdf.

[84] Young S., Adamou M., Asherson P., Coghill D., Colley B., Gudjonsson G., et al. Recommendations for the transition of patients with ADHD from child to adult healthcare services: a consensus statement from the UK adult ADHD network. BMC Psychiatry. 2016;16(1):301. Epub 20160826. DOI: 10.1186/s12888-016-1013-4.

[85] Kenniscentrum Kinder- en Jeugdpsychiatrie. Achtergronddocument Transitietool depressieve-stemmingsstoornissen. 2019 [cited 15.04.2025]. Available from: https://www.kenniscentrum-kjp.nl/wp-content/uploads/2019/12/Achtergronddocument-Checklist-transitie-in-zorg-voor-jongeren-met-een-depressie.pdf.

[86] National Institute for Health and Care Excellence (NICE). Depression in children and young people: identification and management. 2019 [cited 15.04.2025]. Available from: https://www.nice.org.uk/guidance/ng134/resources/depression-in-children-and-young-people-identification-and-management-pdf-66141719350981.

[87] National Institute for Health and Care Excellence (NICE). Antisocial behaviour and conduct disorders in children and young people: recognition and management. 2017 [cited 15.04.2025]. Available from: https://www.nice.org.uk/guidance/cg158/resources/antisocial-behaviour-and-conduct-disorders-in-children-and-young-people-recognition-and-management-pdf-35109638019781.

[88] Wagner G., Zeiler M., Waldherr K., Philipp J., Truttmann S., Dur W., et al. Mental health problems in Austrian adolescents: a nationwide, two-stage epidemiological study applying DSM-5 criteria. European Child & Adolescent Psychiatry. 2017;26(12):1483-1499. Epub 20170524. DOI: 10.1007/s00787-017-0999-6.

[89] Felder-Puig R., Teutsch F. and Winkler R. Psychische Gesundheit von österreichischen Jugendlichen. Ergebnisse des WHO-HBSC-Survey 2021/22. Vienna: BMSGPK, 2023 [cited 20.02.2025]. Available from: https://www.sozialministerium.at/Themen/Gesundheit/Kinder--und-Jugendgesundheit.html.

[90] Statistik Austria. Bevölkerung zu Jahresbeginn nach Alter, Geschlecht sowie österreichischer/ausländischer Staatsangehörigkeit seit 2002 (.ods). 2025 [cited 20.02.2025]. Available from: https://www.statistik.at/statistiken/bevoelkerung-und-soziales/bevoelkerung/bevoelkerungsstand/bevoelkerung-nach-alter/geschlecht.

[91] Banaschewski T., Roth-Sackenheim C., Berg G. and Reif A. Transition psychiatry: attention deficit/hyperactivity disorder. Zeitschrift für Kinder- und Jugendpsychiatrrie und Psychotherapie. 2020;48(6):425-428. Epub 20200907. Aufmerksamkeitsdefizit-Hyperaktivitatsstorung: Transitionspsychiatrie. DOI: 10.1024/1422-4917/a000756.

[92] Ayano G., Demelash S., Gizachew Y., Tsegay L. and Alati R. The global prevalence of attention deficit hyperactivity disorder in children and adolescents: An umbrella review of meta-analyses. Journal of Affective Disorders. 2023;339:860-866. Epub 20230724. DOI: 10.1016/j.jad.2023.07.071.

[93] Ginsberg Y., Quintero J., Anand E., Casillas M. and Upadhyaya H. P. Underdiagnosis of attention-deficit/hyperactivity disorder in adult patients: a review of the literature. The Primary Care Companion for CNS Disorders. 2014;16(3). Epub 20140612. DOI: 10.4088/PCC.13r01600.

[94] Ayano G., Tsegay L., Gizachew Y., Necho M., Yohannes K., Abraha M., et al. Prevalence of attention deficit hyperactivity disorder in adults: Umbrella review of evidence generated across the globe. Psychiatry Research. 2023;328:115449. Epub 20230909. DOI: 10.1016/j.psychres.2023.115449.

[95] Janssens A., Eke H., Price A., Newlove-Delgado T., Blake S., Ani C., et al. The transition from children's services to adult services for young people with attention deficit hyperactivity disorder: the CATCh-uS mixed-methods study. Health and Social Care Delivery Research. 2020;8(42). DOI: 10.3310/hsdr08420.

[96] Ford T. Transitional care for young adults with ADHD: transforming potential upheaval into smooth progression. Epidemiology and Psychiatric Sciences. 2020;29:e87. Epub 20200109. DOI: 10.1017/S2045796019000817.

[97] Kölch M. G., Romanos M., Roth-Sackenheim C. and Schramm E. Anxiety and Depression in Transition – Desiderata for Improved Care and Research: Results of the Joint Task Force Transition of DGPPN and DGKJP. Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie. 2020;48(6):429-433. Epub 20200703. Angst und Depression in der Transition – Desiderate fur eine verbesserte Versorgung und Forschung: Ergebnisse der gemeinsamen Task-Force Transition von DGPPN und DGKJP. DOI: 10.1024/1422-4917/a000739.

[98] Kessler R. C., Berglund P., Demler O., Jin R., Merikangas K. R. and Walters E. E. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry. 2005;62(6):593-602. DOI: 10.1001/archpsyc.62.6.593.

[99] Van Den Noortgate M., Morrens M., Van Hemert A. M., Schoevers R. A., Penninx B. and Giltay E. J. Unveiling Transitions in Disease States: Study of Depressive and Anxiety Symptom Networks over Time. Depression and Anxiety. 2024;2024:4393070. Epub 20240716. DOI: 10.1155/2024/4393070.

[100] Essau C. A., Lewinsohn P. M., Olaya B. and Seeley J. R. Anxiety disorders in adolescents and psychosocial outcomes at age 30. Journal of Affective Disorders. 2014;163:125-132. Epub 20140102. DOI: 10.1016/j.jad.2013.12.033.

[101] Mohammadi M. R., Salmanian M. and Keshavarzi Z. The Global Prevalence of Conduct Disorder: A Systematic Review and Meta-Analysis. Iranian Journal of Psychiatry. 2021;16(2):205-225. DOI: 10.18502/ijps.v16i2.5822.

[102] Fairchild G., Hawes D. J., Frick P. J., Copeland W. E., Odgers C. L., Franke B., et al. Conduct disorder. Nature Reviews Disease Primers. 2019;5(1):43. Epub 20190627. DOI: 10.1038/s41572-019-0095-y.

[103] Rubin D. H. Editorial: Evolving Understanding of Conduct Disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2020;59(2):225-226. Epub 20191213. DOI: 10.1016/j.jaac.2019.06.020.

[104] Voderholzer U., de Zwaan M., Lowe B., Schulze U. and Herpertz-Dahlmann B. Transition von Adoleszenten mit Essstörungen in das Erwachsenenalter: Das Positionspapier der Task-Force Transitionspsychiatrie der DGKJP und DGPPN. Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie. 2020;48(6):443-447. Epub 20200529. Transition von Adoleszenten mit Essstorungen in das Erwachsenenalter: Das Positionspapier der Task-Force Transitionspsychiatrie der DGKJP und DGPPN. DOI: 10.1024/1422-4917/a000727.

[105] Lopez-Gil J. F., Garcia-Hermoso A., Smith L., Firth J., Trott M., Mesas A. E., et al. Global Proportion of Disordered Eating in Children and Adolescents: A Systematic Review and Meta-analysis. JAMA Pediatrics. 2023;177(4):363-372. DOI: 10.1001/jamapediatrics.2022.5848.

[106] van Eeden A. E., van Hoeken D. and Hoek H. W. Incidence, prevalence and mortality of anorexia nervosa and bulimia nervosa. Current Opinion in Psychiatry. 2021;34(6):515-524. DOI: 10.1097/YCO.0000000000000739.

[107] Galmiche M., Dechelotte P., Lambert G. and Tavolacci M. P. Prevalence of eating disorders over the 2000-2018 period: a systematic literature review. The American Journal of Clinical Nutrition. 2019;109(5):1402-1413. DOI: 10.1093/ajcn/nqy342.

[108] Soeby M., Gribsholt S. B., Clausen L. and Richelsen B. Overall and cause-specific mortality in anorexia nervosa; impact of psychiatric comorbidity and sex in a 40-year follow-up study. International Journal of Eating Disorders. 2024;57(9):1842-1853. Epub 20240612. DOI: 10.1002/eat.24223.

[109] Vandereycken W. and Van Humbeeck I. Denial and concealment of eating disorders: a retrospective survey. European Eating Disorders Review. 2008;16(2):109-114. DOI: 10.1002/erv.857.

[110] Thomasius R., Arnaud N., Holtmann M. and Kiefer F. Substance-related disorders in adolescence and young adulthood. Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie. 2020;48(6):448-452. Epub 20200324. Substanzbezogene Storungen im Jugend- und jungen Erwachsenenalter. DOI: 10.1024/1422-4917/a000725.

[111] van Roozendaal H., Verhulst S., Glazemakers I., De Meulder F., Vander Auwera A., Bael A., et al. Characteristics of Adolescents Admitted with Acute Alcohol Intoxication: A Retrospective Multicentre Study in Antwerp, Belgium, in the Period 2015-2021. Children (Basel). 2023;10(8). Epub 20230812. DOI: 10.3390/children10081378.

[112] Canadian Institute for Health Information. Fewer young people being hospitalized for substance use, but overall rates still higher than before the pandemic. 2023 [cited 01.10.2025]. Available from: https://www.cihi.ca/en/news/fewer-young-people-being-hospitalized-for-substance-use-but-overall-rates-still-higher-than-before#:~:text=7%20in%2010%20children%20and%20youth%20hospitalized.

[113] Sagerschnig S., Grabenhofer-Eggerth A. and Kern D. Modell für einen verbesserten Zugang zur psychosozialen Versorgung für Kinder und Jugendliche. Vienna: Gesundheit Österreich GmbH, 2023 [cited 15.07.2025]. Available from: https://goeg.at/gesamthafte_loesung_kiju.

[114] Österreichische Liga für Kinder- und Jugendgesundheit. Pandemie und Psychische Gesundheit von Kindern, Jugendlichen und jungen Erwachsenen mit chronischen und seltenen Erkrankungen. Positionspapier. Vienna: 2022 [cited 15.07.2025]. Available from: https://www.kinderjugendgesundheit.at/site/assets/files/1236/liga_positionspapier_psyche_2022_last_web.pdf.

[115] Kern D. and Sagerschnig S. Integrierte psychosoziale Versorgung von Kindern und Jugendlichen. Vienna: Gesundheits Österreich GmbH, 2016 [cited 15.07.2025]. Available from: https://www.sozialministerium.gv.at/dam/jcr:09fb2747-fb26-4d81-a831-3b752f03947e/integrierte_psychosoziale_versorgung_von_kindern_und_jugendlichen_-_abschlussbericht%202016.pdf.

[116] Republik Österreich. Sonderfach Kinder-und Jugendpsychiatrie und Psychotherapeutische Medizin. BGBI. II; 2024.

[117] Reimherr J. P. and McClellan J. M. Diagnostic Challenges in Children and Adolescents With Psychotic Disorders. The Journal of Clinical Psychiatry. 2004;65.

[118] Austin L. J., Browne R. K., Carreiro M., Larson A. G., Khreizat I., DeJonckheere M., et al. "It Makes Them Want to Suffer in Silence Rather Than Risk Facing Ridicule": Youth Perspectives on Mental Health Stigma. Youth & Society. 2024;57(1):30-55. DOI: 10.1177/0044118x241237236.

[119] Song N., Hugh-Jones S., West R. M., Pickavance J. and Mir G. The effectiveness of anti-stigma interventions for reducing mental health stigma in young people: A systematic review and meta-analysis. Cambridge Prisms: Global Mental Health. 2023;10:e39. Epub 20230710. DOI: 10.1017/gmh.2023.34.

[120] Brelet L., Flaudias V., Desert M., Guillaume S., Llorca P. M. and Boirie Y. Stigmatization toward People with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder: A Scoping Review. Nutrients. 2021;13(8). Epub 20210818. DOI: 10.3390/nu13082834.

[121] El Hayek S., Foad W., de Filippis R., Ghosh A., Koukach N., Mahgoub Mohammed Khier A., et al. Stigma toward substance use disorders: a multinational perspective and call for action. Frontiers in Psychiatry. 2024;15:1295818. Epub 20240201. DOI: 10.3389/fpsyt.2024.1295818.

[122] Ahad A. A., Sanchez-Gonzalez M. and Junquera P. Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review. Cureus. 2023;15(5):e39549. Epub 20230526. DOI: 10.7759/cureus.39549.

[123] Crisp A. H., Gelder M. G., Rix S., Meltzer H. I. and Rowlands O. J. Stigmatisation of people with mental illnesses. The British Journal of Psychiatry. 2018;177:4-7. DOI: 10.1192/bjp.177.1.4.

[124] Banaschewski T. and Driessen M. Transition psychiatry – inpatient treatment. Fortschritte der Neurologie Psychiatrie. 2019;87(11):625-627. Epub 20191122. Transition – Stationare Behandlung. DOI: 10.1055/a-1028-6999.

[125] Schrank B. Transition Psychiatrie: learnings for psychiatry as a whole. Psychiatrie Praxis. 2023;50(8):401-403. Epub 20231116. Transitionspsychiatrie: eine Chance für die Psychiatrie als Ganzes. DOI: 10.1055/a-2176-4960.

[126] Kilicel D., De Crescenzo F., Barbe R., Edan A., Curtis L., Singh S., et al. Mapping Child and Adolescent Mental Health Services and the Interface During Transition to Adult Services in Six Swiss Cantons. Frontiers in Psychiatry. 2022;13:814147. Epub 20220509. DOI: 10.3389/fpsyt.2022.814147.

[127] McDonagh J. E. Transition of care: how should we do it? Paediatrics and Child Health. 2007;17(12):480-484. DOI: 10.1016/j.paed.2007.09.007.

[128] Ragnhildstveit A., Tuteja N., Seli P., Smart L., Uzun N., Bass L. C., et al. Transitions from child and adolescent to adult mental health services for eating disorders: an in-depth systematic review and development of a transition framework. Journal of Eating Disorders. 2024;12(1):36. Epub 20240307. DOI: 10.1186/s40337-024-00984-3.

[129] Health Services Safety Investigations Body. Investigation report: Transition from child and adolescent mental health services to adult mental health services. 2018 [cited 12.09.2025]. Available from: https://www.hssib.org.uk/patient-safety-investigations/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/investigation-report/pdf/.

[130] Singh S. P. M., Belling R., White S., Kramer T., Weaver T., Herts B., McLaren S., Ford T. Transition from CAMHS to adult mental health services (TRACK): a study of policies, process and user and carer perspective. University of Warwick, 2010 [cited 02.09.2025]. Available from: https://wrap.warwick.ac.uk/id/eprint/48972/1/3027551.pdf.

[131] Santosh P., Singh J., Adams L., Mastroianni M., Heaney N., Lievesley K., et al. Validation of the Transition Readiness and Appropriateness Measure (TRAM) for the Managing the Link and Strengthening Transition from Child to Adult Mental Healthcare in Europe (MILESTONE) study. BMJ Open. 2020;10(6):e033324. Epub 20200623. DOI: 10.1136/bmjopen-2019-033324.

[132] Rzepka A. The Survivorship Passport in Austria. OCG Journal – Das IT-Magazin der Österreichischen Computer Gesellschaft. 2024;49(03):28.

[133] Viner R. M. Transition of care from paediatric to adult services: one part of improved health services for adolescents. Archives of Disease in Childhood. 2008;93(2):160-163. Epub 20071017. DOI: 10.1136/adc.2006.103721.

[134] Österreichische Ärztekammer. Ausbildungsinhalte zum Sonderfach Psychiatrie und Psychotherapeutische Medizin. 2015.

[135] Österreichische Ärztekammer. Ausbildungsinhalte zum Sonderfach Kinder- und Jugendpsychiatrie und Psychotherapeutische Medizin. 2015.

[136] Gesellschaft für Transitionsmedizin. S3-Leitlinie: Transition von der Pädiatrie in die Erwachsenenmedizin. 2021 [cited 01.09.2025]. Available from: https://www.awmf.org/leitlinien/detail/ll/186-001.html.

[137] Neumann M., Dorfler S., Holzinger A. and Steiner-Hofbauer V. The amendment to Austria's medical training regulation permitting continued care by child and adolescent psychiatrists after reaching legal adulthood: a qualitative study on professional attitudes and clinical practice. neuropsychiatrie. 2025. Epub 20250530. Die Novelle der Arzteausbildungsordnung zur Weiterbehandlung durch Kinder- und Jugendpsychiater:innen uber die Volljahrigkeit hinaus: Eine qualitative Analyse von Einstellungen und klinischer Realitat. DOI: 10.1007/s40211-025-00527-5.

[138] VIENNA.AT. Psychische Gesundheit: Ärztekammer warnt vor Versorgungslücke. 2025 [cited 08.10.2025]. Available from: https://www.vienna.at/psychische-gesundheit-aerztekammer-warnt-vor-versorgungsluecke/9486038.

[139] Zech C. and Riedel M. Future gaps in the public provision of health services in Austria? A mixed-methods analysis for specialists in internal medicine. Human Resources for Health. 2025;23(1):41. Epub 20250813. DOI: 10.1186/s12960-025-01013-3.

[140] Ärztekammer Wien. Präsentation der großen Wiener Wartezeitenstudie 2024 [cited 08.10.2025]. Available from: https://www.aekwien.at/pressekonferenzen/-/asset_publisher/dwFaXtW3IYQX/content/pr%C3%A4sentation-der-gro%C3%9Fen-wiener-wartezeitenstudie.

[141] Schwarz T., Schmidt A. E., Bobek J. and Ladurner J. Barriers to accessing health care for people with chronic conditions: a qualitative interview study. BMC Health Services Research. 2022;22(1):1037. Epub 20220814. DOI: 10.1186/s12913-022-08426-z.

[142] World Health Organization (WHO). World mental health report: transforming mental health for all. Geneva: 2022 Report No. Licence: CC BY-NC-SA 3.0 IGO [cited 01.09.2025]. Available from: https://iris.who.int/bitstream/handle/10665/356119/9789240049338-eng.pdf?sequence=1.

[143] World Health Organization (WHO) and United Nations Children's Fund (UNICEF). Mental health of children and young people: service guidance. Geneva: 2024 Report No. icence: CC BY-NC-SA 3.0 IGO [cited 01.09.2025]. Available from: https://iris.who.int/bitstream/handle/10665/379114/9789240100374-eng.pdf?sequence=10.

[144] Wolf S. and Grössmann N. Home-Treatment in der Kinder- und Jugendpsychiatrie: Eine Analyse zur Wirksamkeit und möglichen Implementierung in Österreich. Vienna: 2020.

[145] Plener P. L. and Frottier P. M. [Assertive care as new treatment perspective for Austria]. neuropsychiatrie. 2022;36(4):188-191. Epub 20221107. Stationsersetzende Massnahmen: neue Versorgungsperspektive fur Osterreich. DOI: 10.1007/s40211-022-00446-9.

[146] Bundesministerium für Soziales Gesundheit Pflege und Konsumentenschutz (BMSGPK). eHealth-Strategie Österreich. Vienna: 2024.

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