World Health Organization

European Region

Quality standards for child and youth mental health services

For use in specialized community or outpatient care across the WHO European Region

Abstract:

The quality standards for child and youth mental health services were developed in response to requests from the WHO pan-European Mental Health Coalition and WHO Member States for a standardised approach to quality assessment, measurement and improvement for child and youth community/outpatient mental health care across the WHO European Region. The standards outline an aspirational but achievable definition of high-quality care and provide a basis to assess and identify areas for improvement for the quality of specialised child and youth mental health services. The journey to implement the quality standards across the WHO European Region will require joint learning, commitment and action between all key stakeholders.

Keywords:

MENTAL HEALTH, CHILD, YOUTH, QUALITY OF HEALTH CARE

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Corrigendum

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On page 20, under "1. Measuring evidence-based treatment principles":

1. the line "These would require adaptation to evidence-based recommendations for children and youth mental health services but are below for inspiration" has been added to re-emphasize this point;
2. "prescribed lithium" has been changed to "evidence-based treatment" to avoid any misunderstanding.

These corrections were incorporated into the electronic file on 7th April 2025.

Contents

Foreword

Mental health and wellbeing are the foundation of our children's ability to learn, thrive, and contribute meaningfully to society. It is therefore imperative that children and young people have the best quality mental health care available to them.

Yet, most children and young people across the WHO European Region – straddling Europe and Central Asia - are not receiving the mental health care they need. Added to this is an unprecedent strain relating to escalating conflicts, climate anxiety, challenges posed by digital and social media, and stubborn social inequities. The result is declining mental wellbeing among children and adolescents, with girls and those from less affluent families being most affected. Most alarming is that suicide remains one of the leading causes of death, if not *the* leading cause, in this demographic.

Quite simply, improving the quality of child and youth mental health care is an investment in our present and our future. This was our primary aim in creating these quality standards: to provide countries with a comprehensive vision of what high quality care should look like. We co-created these standards with partners and stakeholders from across the Region, especially those who have used child and youth mental health services. They offer a foundation for countries to build services that children and young people can easily access, that empower them to make informed decisions, that include family/caregivers and link with the community, and that treat them with the respect and dignity to which they are entitled. Importantly, high-quality services should be provided by an adequate and competent workforce who are supported to do their jobs to the best of their ability. Of course, such services must be prepared to adapt based on the latest data, to continually improve with the evolving needs of the population.

These quality standards can be adapted and used by all countries regardless of their individual contexts and policies. They can spark innovation and complement wider quality improvement activities that countries are already undertaking.

But better mental health care is only part of the picture – we must also ensure that our children and young people have access to services and support to improve their well-being and prevent ill health in the first place. This requires commitment and engagement from multiple sectors, including education, social welfare, finance and justice, to name but a few. We must face the threats of non-communicable diseases and climate change. We must consider how to address the challenges and opportunities posed by megatrends such as population ageing and capitalize on the growing digital infrastructure within our health systems. Not least, we must address the scourge of violence against girls and women, a key challenge that also encompasses boys and men, significantly impacting mental health and well-being.

Our children and young people deserve a future of good mental health, complementing optimal physical health. Attaining WHO's vision of Health for All hinges upon a holistic view of health – with a foundation set at the very outset of life.

Dr Hans Henri P. Kluge
Regional Director
WHO Regional Office for Europe

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Definitions

Adolescent	is an individual aged between 10 and 19 years.
Caregiver	refers to any parent, family member, legal guardian or individual who has a defined caring role for the child or young person.
Child	is used to describe an individual aged 0 to 18 years.
Cocreate	is used to describe a process where the child, young person or caregiver meaningfully participates as an equal in a process to make a decision or create a product.
Diverse developmental trajectories	is used to describe the wide variety of different developmental journeys, including those experienced by people with autism spectrum disorder, attention deficit hyperactivity disorder, other delays and those without delays in meeting developmental milestones.
Developmental delays or disabilities	is used to describe children who are delayed in meeting developmental milestones, including social and communication, and who may or may not have received a formal diagnosis (of autism spectrum disorder, for example).
Mental health	is a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.
Mental health condition	is a broad term covering mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning or risk of self-harm.
Quality indicator	describes a numerical measure that indicates the quality of a specified aspect.
Quality improvement initiative	describes the action of any person working to implement iterative, measurable changes to improve the quality of a defined area or aspect.
Quality standard	is a statement outlining an aspect of high-quality care provision.
Quality theme	is a broad area or domain of high-quality care provision.
Peer support	refers to the help and assistance that people with lived experience (for example, of having a mental health condition or of being a caregiver for someone with a mental health condition) can provide to one another.
Risk of harm	is used to describe any perceived potential risk of severe harm or abuse (physical, emotional, sexual, financial, online, other) either from the person themselves (self-harm) or from other people.
Young people	refers to people between the ages of 15 and 24 years old.
Youth	refers to individuals between the ages of 15 and 24 years old

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Background

Globally, child and youth mental health is a priority. One in seven adolescents experiences a mental disorder *(1)*; three of the top 10 causes of disability adjusted life years for adolescents aged 10 to 24 years are mental health-related (self-harm, depression and anxiety) *(2)*; and suicide was the fourth leading cause of death in 15 to 29-year-olds *(2)*. Evidence suggests that the burden of mental disorders for children and adolescents has increased over the past 30 years (1990–2019), particularly for anxiety, depression and eating disorders *(3)*.

Despite these alarming statistics, most children and young people requiring support do not receive it; and for those who do seek help, the quality of services and their effectiveness is variable. Challenges to high-quality child and youth mental health care in community/outpatient settings across the WHO European Region include long waiting times to access care, services that are not child or youth-friendly, and lack of training and regulation of providers. Not receiving timely and high-quality mental health care during this pivotal life stage can have negative ongoing consequences for the individual throughout their lives, impacting their families and wider communities *(4)*.

Quality of mental health care is defined as “a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice” *(5)*. High-quality health services should be effective, safe, people-centred, timely, equitable, integrated and efficient *(6)*.

Globally, there have been some advances to improve the quality of mental health care. For example, quality standards and indicators have been developed and implemented in a few countries and services, quality improvement methods have been applied to mental health, and networks that focus on quality improvement in mental health care have been set up. However, these actions have only been observed in a limited number of countries globally and have rarely been applied in a systematic way or to child and youth mental health care.

Hence there remains an urgent and increasing need to strengthen the quality of child and youth mental health services, to better support the mental health and future of our children and young people across the WHO European Region and beyond.

Reasons for developing quality standards for child and youth community mental health services

At the first meeting of the WHO pan-European Mental Health Coalition in May 2022 *(7)*, improving the quality of mental health care for children, adolescents and young people was highlighted as a key priority, with requests for tools to measure and standardize child and youth mental health care across the Region (including requests from Member States). This priority is aligned with the objectives under the *WHO European framework for action on mental health (8)* and the Programme on Quality of Child and Adolescent Mental Health Care, which is hosted by the WHO Athens Office on Quality of Care and Patient Safety, in collaboration with the WHO European Mental Health Flagship, and supported by the Government of the Hellenic Republic.

Consultations across the WHO European Region have highlighted some common challenges to high quality community/outpatient mental health care for children and young people:

- gaps in care provision during transitions (including those between different levels of care, e.g. tertiary to secondary; the transition from child and adolescent to adult services; and between different health and other sector services);
- inconsistent quality of care across providers, services and areas;
- long waiting times to receive mental health support;
- inconsistent training and regulation of mental health providers;
- services that are not “youth friendly” in terms of location, opening hours and inclusivity;
- lack of regulation of mental health information in online spaces;

- services that are not set up to meet the needs of people with complex needs;
- limitations in good quality data, research and knowledge translation; and
- lack of a "culture of quality".

These common challenges confirm the need for an approach that standardises and improves care quality across the WHO European Region for child and youth mental health, and hence the WHO European Quality Standards for Child and Youth Mental Health Care. See Box 1 for aims and scope of these quality standards. Table 1 shows a summary of the standards.

Box 1.

Aims and scope of the quality standards for child and youth mental health services and implementation resources

- To create standards and implementation resources that are relevant and useful.
- The contents should be evidence-based, cocreated with a variety of stakeholders and set aspirational but achievable levels of performance that are feasible to implement and can be linked to other WHO resources and tools.
- The standards are aimed at services providing specialised mental health care to children and youth in outpatient/community settings (e.g. primary health-care services which regularly see children and adolescents with distress; secondary outpatient care; mental health services provided in educational facilities).
- To offer ministries, government agencies, service providers, decision-makers and managers a framework under which to improve the quality of child, adolescent and youth mental health services.

Table 1. Summary of standards

QUALITY THEME 1 **Participation and empowerment**

- **Quality standard 1.1** Service facilities, location and design are planned and implemented with the active participation of users (children, young people, families, caregivers).
- **Quality standard 1.2** The service empowers children, young people and their caregivers to make informed decisions about their care and to independently improve their mental health and quality of life.

QUALITY THEME 2 **Rights and safety**

- **Quality standard 2.1** Children, young people, caregivers and staff are treated with dignity and respect, their rights are upheld and they are protected from abuse and harm.
- **Quality standard 2.2** Care provided is safe and does not cause harm.
- **Quality standard 2.3** The service provides equitable access and promotes inclusion for all children, young people and their families/caregivers free of discrimination based on their gender, ethnicity, religion, ability, culture or sexuality.

QUALITY THEME 3 **Family and community engagement**

- **Quality standard 3.1** The service includes caregivers/families directly in the provision of care when agreed and appropriate.
- **Quality standard 3.2** The service develops effective working relationships with key local organizations and the community to meet the holistic needs of children, young people and their caregivers.

QUALITY THEME 4 **Smooth transitions**

- **Quality standard 4.1** The service ensures referrals and transitions to other services are smooth, co-created with children, young people and caregivers, and allow for good continuity of care, particularly for those who may be at risk of harm.

QUALITY THEME 5 **Timely support**

- **Quality standard 5.1** The service provides assessment and intervention for children, young people and their families/caregivers in an early and timely manner.

QUALITY THEME 6 **Developmentally appropriate and evidence-based**

- **Quality standard 6.1** The service is able to assess, diagnose and provide a range of evidence-based interventions for children and young people with mental health conditions and diverse developmental trajectories.
- **Quality standard 6.2** The service has the capability to adapt the method of providing care, including via digital means, taking into consideration the developmental stage, ability, needs and preferences of the child, young person and their family.

QUALITY THEME 7 **Competent and appropriate workforce**

- **Quality standard 7.1** Staff are competent and supported to develop and maintain a strong therapeutic relationship with children, young people and their caregivers and to provide high-quality care.
- **Quality standard 7.2** The service has sufficient staff and the appropriate skill mix to provide high-quality care.

QUALITY THEME 8 **Quality improvement and data collection**

- **Quality standard 8.1** A culture of continuous quality improvement exists through effective governance and activities to monitor, evaluate and respond to the quality of the service.
- **Quality standard 8.2** The service has adequate resources to enable data collection, analysis and reporting.

How to use this resource

This resource sets out quality themes and standards based on shared definitions of high-quality care for outpatient/community settings providing specialised child and youth mental health support. To develop this resource, consideration was given to the perspectives of children, young people, caregivers and providers, previous national quality standards, published and unpublished literature, and consultations across the WHO European Region. Example quality indicators that have previously been used to measure related quality standards or themes are included for inspiration and adaptation.

This resource does not aim to provide guidance on national or service-level governance, but instead provides indicative areas to be included in these processes. It is expected that the implementation of the standards, including which quality indicators will be used to assess each standard, will be adapted based on the context. Quality standards should be used as part of a wider approach to improving health-care quality that is iterative and refined over time. Once quality standards have been defined, they can be assessed to prioritize areas for quality improvement. Quality assessment can either be done by staff within the service or by an external auditor, and should always be undertaken with an ethos of improvement and support. Quality improvement initiatives targeted at specific areas can be designed, implemented and assessed, allowing for redefinition and reprioritization of focus areas for quality improvement (Fig. 1).

Fig 1. Quality improvement cycle

Many different initiatives exist to improve the quality of health-care services, some of which are summarised in Table 2.

Table 2. Examples of quality improvement activities

Category	Example interventions
System environment	Registration and licensing of mental health professionals and mental health facilities
	Clinical governance to improve management, accountability and provision of quality mental health care, e.g. clinical audit; service user involvement; continuing professional development; clinical effectiveness research and development; use of information systems and clinical governance committees
	Public reporting and comparative benchmarking, e.g. through regular quality reports shared with payers, service users, the general public and staff in the service to improve transparency and accountability
	Training and supervision of the workforce to develop competencies in the provision of child and youth mental health services and quality improvement
Reducing harm	Regulation of medicine to ensure quality assured, safe and effective medicines are used to eliminate substandard and falsified medicines and overuse of medication
	Inspection of institutions providing mental health care for minimum safety standards
	Adverse event reporting and critical incident review mechanisms
Improvement in clinical care	Clinical pathways and protocols to guide evidence-based care
	Clinical decision support tools to support evidence-based decision-making
	Collaborative and team-based improvement cycles in a formalised manner to strengthen the quality of a particular topic
Patient, family, children and young people, and community engagement	Experience and feedback mechanisms, e.g. through surveys, patient-reported experience measures, patient-reported outcome measures

Note: adapted from *Delivering quality health services: a global imperative for universal health coverage (9).*

How the standards were developed

In global health, there is no consensus on methods to develop quality of care indicators or standards *(10)*. Without a standardized approach to rely on, WHO developed methods in collaboration with a steering group and adapted methods used previously to develop quality standards and indicators. The methods aimed to prioritize inputs from a wide range of stakeholders, including children and young people, their caregivers and service providers. It is anticipated that the standards will be a living document that will be reviewed and updated over time. Please see Fig. 2 for methods used to develop the standards.

Fig 2. Methods used to develop the quality standards

Step 1 to define high-quality care in child and youth mental health services (September 2022–May 2024)

a. Scoping review of existing national and international quality standards for child, adolescent and youth mental health care – from published peer-reviewed research, health ministry websites, international organisations.

b. Consultations with the pan-European Mental Health Coalition and other networks to find any unpublished quality standards for child and youth mental health care.

c. Systematic literature review into peer-reviewed published literature looking at feedback on child and youth mental health care from the perspectives of users (children and young people and their caregivers) and providers in the WHO European Region.

d. Survey conducted across the WHO European Region to understand definitions of high- and low-quality child and youth mental health care from the perspectives of users (children and young people and their caregivers), service providers and the general public.

e. Focus group discussions and consultations to gain insight into how high-quality care is defined and understood by service users and providers.

Step 2 iterative draft and update based on initial consultations (November 2022–April 2024)

a. Using the data collected from Step 1, initial sets of quality standards were drafted, presented to a series of small stakeholder groups for consultation and updated in an iterative manner.

b. The draft quality standards were then updated based on the accumulated feedback, resulting in an initial set of quality standards.

Step 3 wider consultation on an initial set of quality standards for child and youth mental health services (June–November 2024)

a. The initial quality standards were sent for wider consultation (selected group of providers and users, and wider public consultation).

b. Feedback was reviewed by the core writing team and the standards were updated.

Step 4 initial pilot of preliminary quality standards for child and youth mental health services (September–December 2024)

An initial pilot was conducted to understand challenges, barriers and enablers to implementation of the quality standards, as well as the overall acceptability and feasibility of the quality standards across four sites.

Step 5 launch of quality standards for child and youth mental health services (March 2025)

The quality standards for child and youth mental health care

QUALITY THEME 1
Participation and empowerment

Quality standard 1.1

Service facilities, location and design are planned and implemented with the active participation of users (children, young people and their families or caregivers).

Rationale

Children, young people and their families or caregivers are the experts of their experience, and children have the right to participate in decisions that affect them *(11)*. User perspectives are essential to understand the quality of care provided and to develop innovative and acceptable solutions to improve quality of care. Young people have consistently stated that they would like their voice to be heard and for services to be in a location and delivered in a way that makes them easy to access. To ensure that services are user-friendly, they need to be coproduced with users.

Intent

High-quality care is codesigned and implemented with active participation from users (children, young people and caregivers) to centre the care around their needs and preferences. Active participation includes involvement in the design of the mental health service such as opening times, location of services, referral systems and staff recruitment, as well as in the delivery of care (e.g. cocreation of communication materials).

Example activities to meet the standard

- Gathering feedback from children, young people and their caregivers on their experience of the service, e.g. through suggestion boxes, discharge questionnaires, satisfaction surveys, focus groups and complaint mechanisms, and for users to be aware of these methods. Suggestions are then acted upon.
- A youth advisory group that regularly meets and provides meaningful input into service development, e.g. at review meetings.
- A formal policy or strategy exists to involve children, young people and caregivers with lived experience in the design and delivery of care.

Inspiration: quality indicators to measure standard 1.1

The quality indicators below could potentially be used/adapted to measure standard 1.1.

1. **Measuring "What matters to me" (Scottish Government)** ***(12)***
   "Percentage of replies for people with mental health problem who agree with statement 'People took account of the things that mattered to me' in health and social care experience survey."
2. **Measuring formal consumer participation arrangements**
   To measure the outcome "Embedded lived experience", the Mental Health Commission of New South Wales (NSW) in Australia tracks the following indicator with the aim to see it increase over time *(13)*:

   "The percentage of specialised mental health service organisations that have a consumer participation arrangement in place (i.e. a formal consumer participation policy or consumer representation arrangement)".

Quality standard 1.2

The service empowers children, young people and their caregivers to make informed decisions about their care and to independently improve their mental health and quality of life.

Rationale

There was strong and consistent feedback from children, young people, their families and service providers that a high-quality service allows service users to have choice and agency in all aspects of their mental health care. Young people emphasized the need to be treated as individuals and the importance of their identity in recovery.

Intent

Children, young people and their caregivers are provided with enough information to make informed decisions about their own care (including informed consent and confidentiality) and are supported to make these decisions. They are provided with information to understand the diagnosis and treatment options including any benefits or potential risks associated with each option. They are provided with the knowledge and skills to identify, understand and self-manage symptoms, as well as to work towards improved mental health and quality of life.

Example activities to meet the standard

- Care, treatment and discharge plans are co-created with children, young people and caregivers, and based on their wishes and goals.
- Regular review of care plans (including medication) is undertaken to understand how the treatment is progressing and any unwanted effects or side-effects.
- All children, young people and caregivers who are referred to the service are given information to allow them to understand what the service offers, waiting times, self-help resources, what to do if they are dissatisfied with the care provided and what to do if they need urgent support while waiting.
- All children, young people and families have access to a youth advocate.
- Psychoeducation materials and sessions are provided to all children, young people and caregivers.
- There is a mechanism in place for children, young people and their families to have a say over their assigned clinician without any negative impact on their treatment.
- Children, young people and families are included in the process – and provided with copies of any correspondence or reports written about them.

Inspiration: quality indicators to measure standard 1.2

The quality indicators below could potentially be used/adapted to measure standard 1.2.

1. **Measuring the prevalence of codeveloped treatment plans**
   Norway's national quality indicator system *(14)* includes an indicator to measure participation in treatment plans based on the national clinical records system for children and adolescents:

   "The proportion of patients…who, together with a therapist, have drawn up a treatment plan in mental health care for children and young people".

2. **Measuring mental health information provided to users**
   In Italy, indicators exist to measure the quality of mental health care delivered to patients with schizophrenia and related disorders *(15, 16)*. Two of these relate to patient information for adults and have potential to be adapted for this standard:

   "Patients treated with psychoeducation (at least one session)"

   "Mean number of psychoeducation sessions (per year, in patients with at least one session)".

QUALITY THEME 2
Rights and safety

Quality standard 2.1

Children, young people, their families and caregivers, and staff are treated with dignity and respect, their rights are upheld and they are protected from abuse and harm.

Rationale

The United Nations Convention on the Rights of the Child *(11)* states that children and adolescents have the right to be protected from violence and abuse and to a safe environment. Children, adolescents and young people with mental health needs may be at additional risk of experiencing violence and abuse, either from those around them (e.g. domestic violence *(17)*) or through self-harming. In addition, children and young people have the right to be treated with dignity and respect and to a safe environment, in both digital and physical settings. Services providing mental health care for children, young people and their families must adhere to these principles.

Intent

Services ensure that a thorough risk assessment is conducted for every child and young person accessing mental health care and that any reports of potential harm or abuse (both from the individual to others or self, and to the self from others) are acted upon to keep the individual safe in physical and online settings. Children, young people and families should be treated with respect and feel listened to, understood and accepted. They should also understand their rights regarding consent, mental health legislation, how to access advocacy services and a second opinion, how to view their medical records and how to provide feedback on the quality of the service. Staff should be protected from abuse and harm in the workplace.

Example activities to meet the standard

- Coproduce risk assessment and management plans that consider risk to self, risk to others and risk from others, and ensure they are followed and updated regularly with the child, young person and/or family.
- Staff act in line with local protocols on child protection and reports of potential harm, including referral to other teams where appropriate and a focal point dedicated to child protection and safeguarding.
- Guidelines for gathering informed consent are clear and followed, including consent to treatment and to communicate with other individuals/agencies in the provision of care, and this is effectively documented and communicated to children, young people and caregivers.
- Protocols about how to assess capacity for informed consent exist and are followed, and are in line with national and international legislation.
- When children or young people are not able to provide informed consent (due to age or capacity), their views are sought and taken into consideration as much as possible.
- Services have and follow appropriate privacy and confidentiality guidelines, including for mental health services delivered through digital means.
- Procedures are in place to allow staff to raise concerns and action to be taken when staff feel their rights are not upheld (staff associations, focal point).

Inspiration: measuring standard 2.1

The quality indicators below could potentially be used/adapted to measure standard 2.1.

1. **Measuring respectfulness of service**
   To measure the outcome, "A high-quality, evidence-based system of care", the Mental Health Commission of New South Wales in Australia measures the respectfulness of a service *(18)*:

   "Proportion of NSW [New South Wales] consumers who rated a positive experience, with the service showing respect".

2. **Measuring assessment of suicidal risk**
   Q-bup, an overall quality register for child and youth psychiatric care in Sweden *(19)*, provides quality indicators for child and adolescent mental health. The indicator below could be adapted to measure the service protecting users from self-harm/suicide:

   "Proportion of patients who received a structured suicide risk assessment".

Quality standard 2.2

Care provided is safe and does not cause harm.

Rationale

Patient safety is a core element of high-quality health care. For children, young people and families accessing mental health services, it is important that they do not come to any harm as a result of the care received. Potential safety issues for children, young people and caregivers accessing mental health care include overuse and misuse of medication, abuse or harm from others (including in the provision of care) and within the service space (e.g. structurally unsound buildings). Whilst safety is important for all children, young people and caregivers accessing care, there are groups who may be more at risk of unsafe practices, such as those with developmental delays and disabilities.

Intent

Efforts are made to reduce side-effects, misuse and overuse of medication, particularly for children and young people with developmental delays and disabilities. It is important to ensure no harm results from interactions with service providers, including in the delivery of psychological therapy. Lastly, the service space must be safe and a clear feedback mechanism must exist to report any experiences of unsafe care.

Example activities to meet the standard

- Safe use of medication is audited regularly (e.g. every year).
- The physical health and effects of medication on children and young people are monitored by the service regularly and acted upon, ensuring the safety and well-being of the individual.
- Non-pharmacological treatment options are available to avoid the unnecessary use of medication.
- Staff are equipped with the skills to accurately assess, diagnose and follow evidence-based treatment protocols for children and adolescents.
- Providing accurate information to users, in an easy-to-understand manner, about medication side-effects, therapeutic alternatives, monitoring and what to do in case there is a concern about medication.
- Professionalisation, accreditation and regular supervision of staff to ensure they have sufficient training and competencies and provide safe care.
- Activities to increase the safety of the clinical space include monitoring entrances and exits, clinic rooms that allow for privacy, an alarm system that is easily accessible for service users and staff, ensuring sufficient staff are present to respond to any incidents, the service is securely separated from adult services, and the space is tidy and free of hazards.
- Emergency medical equipment (e.g. for resuscitation) and fire safety equipment (e.g. extinguishers) are easily accessible and staff are regularly trained in their use.
- There is a clear feedback and action mechanism in case the young person or family receive care that is not safe.

Inspiration: measuring standard 2.2

The quality indicators below could potentially be used/ adapted to measure standard 2.2.

1. **Measuring the use of antipsychotic medication to manage behaviour that challenges in people with autism**
   To measure the quality statement, "Autistic people with behaviour that challenges are not offered antipsychotic medication for the behaviour unless it is being considered because psychosocial or other interventions are insufficient or cannot be delivered because of the severity of the behaviour", the United Kingdom National Institute for Health and Care Excellence proposes the two following indicators *(20)*:

   "Evidence of local arrangements to monitor the use of antipsychotic medication in autistic people with behaviour that challenges" (structure); and

   "The proportion of autistic people with behaviour that challenges having antipsychotic medication for the treatment of their behaviour that challenges in whom psychosocial interventions are insufficient or cannot be delivered because of the severity of the behaviour" (process).

2. **Measuring the safety of medication provided**
   To measure the standard, "Applying the basic principle of producing the minimum possible harm with the prescription of antipsychotics, achieving the maximum benefit" in adults diagnosed with depression, bipolar disorder or schizophrenia, the following indicator was proposed for use in Spain, which could potentially be adapted for use in children and adolescents:

   "Proportion of patients that receive the pharmacological with a gradual introduction of [name of recommended medication] when these symptoms are present" (21).

3. **Measuring information on medication provided to users**
   In a project in Italy (15, 16), quality indicators have been proposed to measure psychoeducation, something that could be adapted for use with appropriate information for children and adolescents and their caregivers:

   "Patients treated with medication psychoeducation (at least one session)"; and

   "Mean number of psychoeducation sessions including evidence-based information on medication (per year, in patients with at least one session)".

Quality standard 2.3

The service provides equitable access and promotes inclusion for all children, young people and their families/caregivers free of discrimination based on their gender, ethnicity, religion, ability, culture or sexuality.

Rationale

Equitable access to health care is a core component of WHO's vision for universal health coverage. This is particularly important for child and youth mental health, where difficulties accessing care are widely reported by caregivers and young people, particularly for those from ethnic minority and disadvantaged backgrounds and with language barriers. An element of high-quality care is equitable access for all individuals who need the service.

Intent

All children, young people and caregivers requiring mental health support are able to access the care they need regardless of their background or personal characteristics. This includes those who may have additional needs, such as children, young people or caregivers with diverse developmental trajectories, complex presentations or comorbidities, or who speak a different language. In cases where an individual's presentation does not fit into the service mandate, efforts are made to refer the individual to a service where they can access the mental health support needed.

Example activities to meet the standard

- The service collects and reviews data about the children, young people and families who use it and those who miss appointments. This data is compared with local population statistics and action is taken to address any inequities of access where identified.
- Individuals from underrepresented communities are included in the codesign of services (see Quality standard 1.1) in order to make the service more accessible and responsive to their needs.
- If someone does not attend an appointment or assessment, the team actively follows up with the individual. In cases where they are unable to engage the individual, a team decision is made based on need, risk and consent about how to proceed (e.g. reach out to referrer or the community around the young person in case potential risk is identified).
- The service provides children, young people and their families with information that is culturally appropriate and sensitive (e.g. images that reflect the community).
- Professional interpreters are available for those who need them and members of the family are not relied upon for this purpose.
- The service environment allows easy access for all people; for instance, hoists and handrails are available, there is access to low-stimulation areas for "quiet time" and materials are available that are designed for people living with hearing or vision loss.
- There is regular training to reduce stigma and discrimination for all working in the service.

Inspiration: measuring standard 2.3

The quality indicators below could potentially be used/adapted to measure standard 2.3.

1. **Measuring equity of access**
   The following indicators, proposed by the United Kingdom's Royal College of Psychiatrists' Quality Network for Community CAMHS [Child and Adolescent Mental Health Services] *(22)* to measure the standard statement "Measures are taken to ensure equity of access" could be adapted:

   "The service reviews data at least annually about the young people who use it. Data are compared with local population statistics and action is taken to address any inequalities of access where identified"; and

   "Data on missed appointments are reviewed monthly. This is done at a service level to identify where engagement difficulties may exist".

2. **Measuring equitable care**
   The following indicators, used by the Scottish Government to measure equitable care *(12)*, could be used:

   "% of people with severe and enduring mental illness and/or learning disability who have had an annual health check within previous 12 months";

   "% of under 18 psychiatric admissions admitted out with NHS [National Health Service] specialist CAMH [child and adolescent mental health] wards"; and

   "% of caseload with an active anticipatory care plan".

3. **Measuring equitable care for specific groups**
   Equitable access is measured by disaggregated data for specific groups by the Australian Government Productivity Commission *(23)*. The selected community group is a community that may have challenges accessing services (e.g. in Australia people residing in low socio-economic areas or remote locations, or Aboriginal and Torres Strait Islander Australians). Results for this indicator should be interpreted with caution as variation could be due to variations in access or other issues such as the prevalence of mental illness:

   "The proportion of the population in a selected community group using the service, compared to the proportion of the population outside the selected community group".

QUALITY THEME 3
Family and community engagement

Quality standard 3.1

The service includes caregivers/families directly in the provision of care when agreed and appropriate.

Rationale

For a holistic and consistent approach to supporting mental health, services need to engage with the day-to-day system around the child, young person or family, when agreed, appropriate and safe. Caregivers have stated that high-quality care is that which involves them directly in the delivery of care to the child or young person (e.g. decision-making, self-management strategies), equips them with the skills to provide support to the child or young person and provides them with emotional support where needed. Young people emphasized that high-quality care listens to their preferences about when the service communicates with their caregivers and systems around them.

Intent

When agreed with the child and/or young person, and appropriate and safe to do so, caregivers/families are involved in mental health care provision. This includes offering caregivers time to discuss their concerns and provide relevant information for the assessment, giving them information on how to support the child/young person, and involving them in decisions around care (treatment, discharge plans). The service should offer support and interventions for caregivers/families where appropriate, including access to peer support, educational training programmes, family therapy and stress management strategies where needed.

Example activities to meet the standard

- Each caregiver receives an information pack specifically adapted for caregivers, including, for example, key staff members in the team, who to contact in an emergency, community support organizations and self-help materials.
- A protocol exists and is implemented for gathering informed consent from young people and caregivers for communicating with other services.
- Siblings are provided with clear information about the child/young person's needs, particularly for those with diverse developmental trajectories.

Inspiration: measuring standard 3.1

The quality indicators below could potentially be used/adapted to measure standard 3.1.

1. **Measuring whether carers feel supported**
   To measure "Person-centered care", the Scottish Government *(12)* used the mental health quality indicator below:

   "Percentage of carers for people with mental health problems who feel supported to continue in their caring role".

2. **Measuring whether carers feel involved in the care**
   To measure "Family and carer involvement in treatment and care", the Mental Health Commission of New South Wales in Australia *(24)* tracks the following indicator, with the aim to see it increasing over time:

   "The proportion of carers of people using NSW [New South Wales] mental health care services who reported that a) their personal values, beliefs and circumstances were taken into consideration and b) they were involved in decisions affecting their family member, partner or friend".

Quality standard 3.2

The service develops effective working relationships with key local organizations and the community to meet the holistic needs of children, young people and their caregivers.

Rationale

An integrated and holistic approach is a core part of high-quality mental health care for children and young people. Service providers requested better coordination with health, social care and education systems as well as more structured and coordinated information flow between the systems. Children, young people and caregivers requested information about what type of support is available in other services.

Intent

A cross-sectoral approach is used to take action on mental health prevention, promotion and support, including engagement with a range of different local organisations. Informed consent for interorganisational collaboration should be discussed with children, young people and families in the intake procedure. Where informed consent is agreed, all organisations and individuals involved in the care of the child, young person and/or family should take a holistic and consistent approach together (e.g. working closely with school, other health services, social welfare, employers and others). A mapping exercise can identify key organisations working in the local area and wider collaborations can be set up (e.g. supervision and training for key schools in the area, referral pathways). Information on relevant key organizations and how to access them is provided to children, young people and caregivers.

Example activities to meet the standard

- Multiprofessional meetings are held with others involved with the child/young person in their care (e.g. teachers, social workers, community workers) to discuss the care plan, when agreed with the child, young person and family.
- Key day-to-day individuals (e.g. teachers, community workers) are provided with information and training on how to support the mental health of the child or young person, when agreed with the child, young person, and family.
- Mapping of relevant organisations in the local area (e.g. vocational services, education support, physical health services, social networks, cultural groups) is conducted, regularly updated and shared as appropriate with children, young people and their caregivers and is made available for everyone (e.g. online, printed leaflets).
- Comprehensive multisectoral mapping of care pathways is conducted and documented, and reviewed and updated periodically.
- When more than one organisation or professional is involved in the care of children, young people and their families, a “working together” agreement is cocreated which outlines roles and responsibilities.
- A care coordinator or key worker is assigned to each child/young person to support a smooth journey between the different services or organisations.
- Sectors work together to provide care, including prevention, promotion and early intervention for children and young people in community settings such as schools and community centres.
- Correspondence detailing the outcome of the assessment and how to support the child or young person are shared with the child or young person and individuals involved in their care, as appropriate and agreed with the child/young person/caregiver.

Inspiration: measuring standard 3.2

The quality indicators below could potentially be used/adapted to measure standard 3.2.

1. **Measuring coordination of care by health professionals**
   Care coordination is one way to ensure a smooth journey for users. The following indicator, used by the Mental Health Commission of New South Wales in Australia *(25)* to measure "People experience coordinated and integrated service responses" could be adapted to measure this standard:

   "The proportion of people in NSW [New South Wales] who experienced a health professional coordinating their care for more than 3 health professionals for the same condition in the last 12 months by mental health status".

QUALITY THEME 4
Smooth transitions

Quality standard 4.1

The service ensures referrals and transitions to other services are smooth, cocreated with children, young people and caregivers, and allow for good continuity of care, particularly for those who may be at risk of harm

Rationale

One of the most common challenges reported by service providers and users was in service transitions, including when referring into the service (e.g. from general practitioners, community services, self-referral), referrals within the service (e.g. between therapists) and when transitioning to other services (e.g. to higher levels of care, to adult services and discharge to primary health care). Young people reported that relationships with staff ended too abruptly, having to retell their personal stories was challenging and that care was fragmented when they transitioned to adult services. Caregivers requested more information and support during discharge and transitions. Smooth transitions are particularly important for those who may be at risk of harm to minimise any gap in care provision.

Intent

All referrals and transitions between services are smooth, planned in advance and cocreated with the child, young person and/or caregiver. Children, young people and caregivers do not experience gaps in care provision, are well informed about next steps and who to contact, and the need to retell stories is reduced as much as possible.

Example activities to meet the standard

- When being discharged from the service, a discharge plan is codeveloped with the child, young person and their caregivers, clearly outlining how the child or young person can reaccess the service if needed. This is communicated with all involved in the care of the child or young person.
- Transition meetings are held, where possible between the young person and all individuals involved in their care to ensure a smooth transition to other services.
- A clear transition plan, which includes an up-to-date care plan and risk assessment as well as details of key contact people, is cocreated with the child, young person and caregivers, and all agencies are involved when transferring to another service (e.g. to adult services, to a different geographical location, to a different level of care).
- Upcoming transitions are talked about and planned in advance and cocreated as much as possible with the child/young person and caregiver.

Inspiration: measuring standard 4.1

The quality indicators below could potentially be used/adapted to measure standard 4.1.

1. **Measuring community follow-up**
   Key performance indicators for Australia's public mental health services *(26)* use the following indicator to rate post-discharge community care:

   "Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community mental health service contact, in which the consumer participated, was recorded in the seven days following that separation".

The above indicator could be adapted; e.g. "The proportion of separations from the child and youth mental health service for which an adult mental health service contact, in which the consumer participated, was recorded in the [to be defined] days following that separation".

QUALITY THEME 5
Timely support

Quality standard 5.1

The service provides assessment and intervention for children, young people and their families/caregivers in an early and timely manner.

Rationale

Long waiting times for child and youth mental health care are a common challenge across the WHO European Region and are associated with adverse consequences *(27)*. Service providers have voiced frustration about not being able to provide timely care, and children, young people and their caregivers have said they want to be seen quickly. The evidence suggests that timely care is particularly important for this age group, as delaying intervention can lead to escalation of mental health conditions due to unmet needs and prolonged suffering, causing difficulties for the child or young person in accessing education or career opportunities, with ongoing negative consequences throughout their lives.

Intent

All children, young people and families requiring mental health support, including referral, assessment and treatment, can access it in a timely and early manner without significant delay.

Example activities to meet the standard

- For urgent and routine care, services to define a maximum time period between referral and assessment and first appointment within which children and young people should be seen, communicate this to staff and jointly develop methods to adhere to it.
- Service monitors the time between referral and assessment for children and young people referred to the service and develops accountability measures.
- Young people with urgent mental health needs receive a mental health assessment within a specified time period.
- Service establishes an individual or function to monitor and coordinate the flow of people into the service, allowing for prioritisation based on urgency/risk.
- Initiatives to reduce waiting list times, such as low intensity briefer interventions for those not requiring urgent care.
- To encourage early referrals, educate potential referrers (e.g. schools, caregivers, young people) about the service, groups of children and young people who may be at risk, and when to refer to the service.

Inspiration: measuring standard 5.1

The quality indicators below could potentially be used/adapted to measure standard 5.1.

1. **Measuring waiting list times**
   Specific targets for waiting list times for children and adolescent mental health services have been set by the United Kingdom's Quality Network for Community CAMHS [Child and Adolescent Mental Health Services] *(22)*:

- an initial assessment/choice is offered within 6 weeks for 90% of non-urgent referrals;
- 90% of children and young people (and caregivers) wait no more than 6 weeks between assessment and treatment; and
- all young people should be seen within an 18-week waiting time target.

To measure these, specific guidance is given by the United Kingdom's Care Quality Commission *(28)*:

> *"… mean waiting times from referral to assessment and from referral to treatment (actual and target) for the last six months"; and*
>
> *"Check that the service is meeting the 18-week waiting time target for all other patient groups. No young person should wait more than this to start treatment, except in occasional and exceptional circumstances".*

A service could adapt these, deciding the desired minimum waiting-list times.

QUALITY THEME 6
Developmentally appropriate and evidence-based

Quality standard 6.1

The service is able to assess, diagnose and provide a range of evidence-based interventions for children and young people with mental health conditions and diverse developmental trajectories.

Rationale

Young people and caregivers emphasized the importance of receiving interventions likely to improve quality of life and functioning and reduce symptoms of mental health conditions. Evidence for what does and does not work for child and youth mental health treatment is growing. Interventions that have been shown to consistently reduce symptoms of mental health conditions for children and young people are those that have gone through rigorous scientific trials. Ideally the evidence has been collated through systematic literature reviews or meta-analyses.

Intent

Interventions provided by the service should follow international guidelines and be evidence-based to reduce symptoms of mental health conditions and improve quality of life and functioning for children, young people and their caregivers/families.

Example activities to meet the standard

- Assessments are standardized and cover mental health and medication, psychological and social needs, strengths and areas for development, risk of harm from self and others, desires for treatment and best available evidence-based measures. Interventions offered by the service are in line with evidence-based national or international guidelines for providing mental health care to children and adolescents.
- Interventions outlined in the treatment plan (including those offered by other agencies) are in line with evidence-based national or international guidelines for providing mental health care to children and adolescents.
- Guidelines for treatment that are aligned with international evidence-based guidelines exist and are followed.
- The service has adequately trained and supported staff to provide care in line with this standard.
- Routinely measuring clinical outcomes to monitor symptomatic and functional impact of support.

Inspiration: measuring standard 6.1

The quality indicators below could potentially be used/adapted to measure standard 6.1.

1. **Measuring evidence-based treatment principles**
   Inspiration can be taken from mental health condition specific treatment indicators based on evidence-based principles. Multiple treatment-specific indicators exist for adults; for example, in Sweden the national quality register for bipolar disorder (29) developed quality indicators based on evidence-based treatment principles (for adults). These would require adaptation to evidence-based recommendations for children and youth mental health services, but are presented below for inspiration:

- proportion of patients with bipolar type 1 who are prescribed [evidence-based treatment] (aiming for 70%);
- proportion of patients with relapse in affective relapse in the last 12 months (aiming for below 40%); and
- proportion of patients for whom a structured or semi-structed diagnostic instrument was used as support in the diagnostics (aiming for 50

2. **Measuring change in a person's clinical outcomes**
   To measure "A high-quality, evidence-based system of care", the Mental Health Commission of New South Wales in Australia *(30)* assesses the change in a person's clinical outcomes with the aim of seeing "an increase in the proportion of episodes of care ending in significant improvement after receiving care in the community or in hospital":

   "The proportion of mental health-related episodes of care provided by state and territory public mental health services where: significant improvement, significant deterioration, and no significant change was identified at two sets point in the person with lived experience of a mental health issue's care journey. For example, at admission (entering) and discharge from receiving (leaving) mental health services in a hospital, or from a community mental health service. Responses are collected by clinicians using HoNOS (Health of the Nation Outcomes Scale), a tool using 12 items (scales)".

3. **Measuring whether the service made a difference**
   To measure "A high-quality, evidence-based system of care", the Mental Health Commission of New South Wales in Australia *(30)* uses the following indicator:

   "Proportion of NSW [New South Wales] consumers who felt that the service is making a difference (excellent or very good)".

Quality standard 6.2

The service has the capability to adapt the method of providing care, including via digital means, taking into consideration the developmental stage, ability, needs and preferences of the child, young person and their family.

Rationale

Children and young people present with a variety of different abilities, needs, developmental stages and preferences. High-quality care is responsive to the needs of the individual. Young people emphasized the option to receive support online/through digital means as an alternative to face-to-face care.

Intent

All children, young people and caregivers receive individualised care that is easy to access and adapted based on development stage, needs and preferences.

Example activities to meet the standard

- Services delivering digital mental health care have appropriate patient safety, privacy, information and cyber security, and service continuity provisions in place.
- Information is communicated to children, young people and caregivers in a way that is easy to understand and avoids jargon. Written communication and use of pictures or social stories can be used to aid understanding.
- Creative methods may be used to adapt psychological therapies for children and young people.
- The availability of technologies such as electronic health records, video consultation platforms and patient portals to enable choice for online service provision.
- Communication preferences for care delivery are obtained from the young person and contribute to digital innovation designs and implementation.
- Clinical and technology protocols are in place to ensure online services are provided safely and securely.
- Digital information and training resources for young people and staff are available and easily accessible

Inspiration: measuring standard 6.2

No measurable quality indicators related to standard 6.2 were found in existing quality frameworks. However, some proposed indicators, which could be adapted, are shown below:

- proportion of patients/consumers receiving information on referral to a digital service (including approach, risks, benefits and intended impact of the model of care);
- proportion of services delivering a digital mental health solution; and
- proportion of services delivering a digital mental health solution with an accessible privacy policy on their website.

QUALITY THEME 7
Competent and appropriate workforce

Quality standard 7.1

Staff are competent and supported to develop and maintain a strong therapeutic relationship with children, young people and their caregivers and to provide high-quality care.

Rationale

Service providers, caregivers and young people emphasised the importance of having staff who are adequately trained to communicate and work with children, young people and their families. Service providers asked for more training, resources and time to attend training. Caregivers stated that a high-quality service is one where staff can provide effective interventions, while young people said it was important that staff were friendly and approachable, and that young people should be able to develop a good relationship with them. It is also important that the emotional well-being of staff is supported, in addition to their skill development, as burnout can lead to more mistakes and lower quality of care.

Intent

Staff are well equipped to develop strong therapeutic relationships, be compassionate and provide appropriate evidence-based care for children, young people and their families. Staff should have access to professional development, training and supportive supervision, and be encouraged to look after their own emotional well-being.

Example activities to meet the standard

- The service ensures that staff develop annual professional development plans with their supervisor/manager which outline goals for skill development and ways to develop the required competencies. These plans are reviewed regularly and implemented as far as possible.
- The service develops a supervision framework and provides staff with access to regular supportive supervision (weekly or monthly), which allows for discussion of challenges in providing care and for skill development, and allows staff to receive emotional support as appropriate.
- The service provides regular training and guidance for staff on how to respond to challenging situations involving both clients and other staff (such as when a young person does not consent to involving caregivers), how to ensure rights are upheld, and how to assess, respond to and manage risk when a potential risk of harm is identified.
- Opportunities are provided for staff to take part in small-group case discussions and/or peer supervision. Team/service awaydays are offered to allow for team building, training and service development.
- Systems are in place to ensure staff are aware of their roles and responsibilities, have clearly documented job descriptions and scope of practice, and mechanisms exist for staff to report incidents/complaints/feedback safely and independently if necessary.

Inspiration: measuring standard 7.1

The quality indicators below could potentially be used/adapted to measure standard 7.1.

1. **Measuring whether health professionals listened and showed respect**
   To measure “A skilled capable and compassionate workforce”, the Mental Health Commission of New South Wales in Australia *(31)* uses the following indicator with the aim of seeing “an increase in the proportion of people who felt they were always listened to carefully and always shown respect when seeing a health professional”:

   “the proportion of people in NSW [New South Wales] aged 15 years and older who felt they were always listened to carefully and always shown respect when seeing a General Practitioner and Medical Specialist in the last 12 months”.

Quality standard 7.2

The service has sufficient staff and the appropriate skill mix to provide high-quality care.

Rationale

Shortages in staffing and resources in child and youth mental health care have been reported as a challenge across the WHO European Region. Providers stated that this results in them not being able to provide optimal care. Young people stated that high-quality care involves low staff turnover to allow for consistent staff members.

Intent

A service has adequate numbers of staff across a variety of different disciplines (e.g. social workers, psychologists, psychiatrists, nurses, occupational therapists) and resources to provide a range of holistic and evidence-based interventions.

Example activities to meet the standard

- Regularly (e.g. yearly) review the skill mix of staff members and compare this against evidence-based guidelines for children and young person mental health services, identifying gaps and recruiting to meet the needs of the service.
- The service has an agreed protocol to respond to low staffing levels, including what level equates to unsafe care, how the team can report concerns about staffing, how to access additional staff members and a contingency plan.
- Clear plans and processes are in place to ensure minimum staffing requirements are consistently met.
- Long-term staffing and retention plans are in place, aligned with broader sectoral plans.
- The use of well-trained and supported peer-support workers (family peer-support workers or young people).

Inspiration: measuring standard 7.2

The quality indicators below could potentially be used/adapted to measure standard 7.2.

1. **Measuring full-time equivalent staff employed in specialised mental health services by service setting**
   To measure “A skilled capable and compassionate workforce”, the Mental Health Commission of New South Wales in Australia *(32)* uses the following indicator with the aim of seeing “an increase in rate of FTE [full-time equivalent] staff employed in specialised mental health services in line with population growth, particularly community mental health services”.

   “Full-time equivalent staff employed in specialised mental health services per 100 000 population”.

A similar indicator is used by the WHO *Mental health atlas (33)*, to measure progress against the WHO Comprehensive Mental Health Action Plan 2013–2020. Whilst this is not strictly a quality indicator as there is no defined “ideal” staffing level, it could be possible to adapt the indicator in case a desired level of staffing was determined:

> *“Total number of [type of child and adolescent mental health specialist] per 100 000 population”.*

2. **Measuring mental health consumer and carer peer workers**
   To measure the outcome “Embedded lived experience”, the Mental Health Commission of New South Wales in Australia *(34)* tracks the following indicator with the aim of seeing “an increase in the rate of consumer and carer peer workers”:

   “the number of paid full-time equivalent (FTE) consumer and carer workers per 10 000 mental health care staff FTE, in specialised mental health services in NSW [New South Wales]”.

QUALITY THEME 8
Quality improvement and data collection

Quality standard 8.1

A culture of continuous quality improvement exists through effective governance and activities to monitor, evaluate and respond to the quality of the service.

Rationale

Reports of inconsistencies in the quality of care for child and youth mental health were reported by all stakeholders. Pockets of goodwill and innovation were reported, alongside a lack of structured approach to quality improvement including no definitions for high-quality care, methods to measure quality or training for providers in this space.

Intent

A systematic approach to quality improvement is taken, including quality improvement methods, practices, guidelines, protocols and guidance materials.

Example activities to meet the standard

- Routine use of clinical outcome measures, e.g. progress against user-defined goals at regular intervals which is then used to inform care.
- Clinical outcome data is reviewed on a regular basis, shared with the team and service users, and used to make improvements to the service.
- The service holds meetings on a regular basis with other agencies, young people and caregivers to review strengths and areas for quality improvement in the service, including the standards and themes set out in this document. The service then acts on these recommendations.
- Staff time dedicated to quality improvement exists, and an individual/team leads on initiatives for quality improvement within the service in collaboration with other staff.
- Critical incident reviews are held every time someone is harmed or makes a complaint within the service, and a supportive approach is used to problem-solve and to make a plan to minimize the risk of the incident recurring. Young people and their caregivers should be invited as appropriate.
- Regular audits take place and audit results are available for stakeholders, and learning points disseminated within the services and to relevant partner organisations.
- Training, coaching and capacity-building initiatives are undertaken to build capacity of staff and managers to conduct/lead quality improvement initiatives.
- Introduction of incentives for high-quality care provision, e.g payment by results for following treatment guidelines, initiatives to reward units ("gold star") or nominating an individual as a "quality champion".

Inspiration: measuring standard 8.1

No measurable quality indicators related to standard 8.1 were found in pre-existing quality frameworks. However, some proposed indicators are listed below:

- percentage of facilities that have a quality improvement strategy
- percentage of facilities that have staff time dedicated to quality improvement
- number of quality improvement initiatives within a service
- proportion of staff who have undergone quality improvement training.

Quality standard 8.2

The service has adequate resources to enable data collection, analysis and reporting.

Rationale

Data for child and youth mental health was reported as lacking by all stakeholders across multiple Member States. This is a key element of improving quality because to understand areas for quality improvement, first the quality of a service must be assessed and data collected, analysed and reported. Furthermore, data such as prevalence and incidence of child and youth mental health conditions are essential to support quality service planning. Lack of resources was a barrier to enabling data collection, analysis and reporting.

Intent

To support quality improvement and data-collection initiatives, the service should provide adequate resources and staff time to conduct and process data, the process should prioritise safe and ethical data management, and results of data collection should be shared with stakeholders and acted upon.

Example activities to meet the standard

- Guidance and protocols exist for effective patient record-keeping, including documenting risk, and ensuring records are signed, validated and dated.
- Sufficient information technology systems exist to allow staff to input electronic records (where appropriate) and to input and analyse outcome measures.
- Information governance arrangements are in place to ensure that data processing and sharing of information complies with legislation, uses information ethically and uses best available evidence to protect personal information.
- Regular audits evaluate the record-keeping and information-management system and practices.
- Data from research (e.g. on prevalence of mental health conditions) is used to plan service delivery.
- Children and families have access to information in compliance with legislation.
- Electronic patient record systems are well coordinated across services and regions within a country to allow for effective data collection and sharing.
- There is dedicated staff time to ensuring smooth processes for effective data collection and synthesis.
- Data on quality is fed back to the service and service users.

Inspiration: measuring standard 8.2

The quality indicators below could potentially be used/adapted to measure standard 8.2.

1. **Measuring capacity for data collection and sharing**
   No measurable quality indicators related to measuring capacity for data collection and sharing were found in pre-existing quality frameworks. However, two proposed indicators are shown below:

- proportion of districts/facilities with a monitoring dashboard allowing for safe and effective data collection and sharing; and
- proportion of facilities with an electronic patient record system which allows for safe and effective data collection and sharing.

2. **Measuring completeness and timeliness of data**
   WHO *(35)* proposes the use of the following indicators to measure data quality for completeness and timeliness:

- percentage of facilities/districts that report each month;
- percentage of facilities that submit complete data for a specific data element/set of data elements; and
- percentage of facilities that submit reports on time.

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