European Child & Adolescent Psychiatry
https://doi.org/10.1007/s00787-026-03033-3

ESCAP COMMUNICATIONS

Bridging gaps in youth mental health care: YOUTHreach—a comprehensive European strategy

Thérèse van Amelsvoort[1] · Anouk Boonstra[1] · Karim Lekadir[2,3] · Esmeralda Ruiz Pujadas[2] · Matthew R. Broome[4,5] · Sian Lowri Griffiths[4] · Gary Donohoe[6,7] · Arne Popma[8] · Giovanni de Girolamo[9] · Covadonga M. Díaz-Caneja[10] · Anna-Kaisa Oidermaa[11] · Andreas Bechdolf[12,13,14] · Silvia Evers[15,16] · Ghislaine van Mastrigt[15] · Dorothee Horstkötter[17] · Ricky Janssen[17] · Maria Bulgheroni[18] · David McDaid[19] · Jan R. Boehnke[20,21] · Patrick McGorry[22,23] · Mario Alvarez Jimenez[22,23] · AEGEE[24] · Anita Schick[21] · Ulrich Reininghaus[21,25,26,27] · Sophie Leijdesdorff[1] on behalf of the YOUTHreach consortium

Received: 19 January 2026 / Accepted: 30 March 2026

Abstract
Europe is facing a mental health crisis that will last for decades, impacting the long-term health outcomes, wellbeing and economic productivity of our current generation of young people. Yet, large-scale, comparative research of youth-friendly mental health interventions is lacking. The YOUTHreach consortium aims to bridge this gap and provide a comprehensive European strategy. For this purpose, YOUTHreach will evaluate the clinical effectiveness and cost-effectiveness of three existing and accessible innovative interventions for prevention and early intervention of mental ill-health in youth, developed and tested in co-creation with youth: 1) YEAH, walk-in youth mental health support centres; 2) SELFIE, a transdiagnostic blended ecological momentary intervention; and 3) MOST, a clinical and peer-moderated digital youth mental health platform. In addition, feasibility and acceptability at new sites across Europe will be tested. Furthermore, in partnership with young people, best practice recommendations will be developed based on existing and new data and built into an integrated European youth mental health framework. Finally, awareness and accessibility of these interventions among policymakers, healthcare professionals, the general public, and youth—the target group—will be raised. YOUTHreach aims to contribute towards transformation of the present traditional mental healthcare system and providing the next generation with a better perspective in terms of health, wellbeing and productivity.

Keywords Youth mental health · Co-creation · Early intervention · Health services research · Prevention · Adolescence

Introduction

Mental health problems account for 35% of the global economic burden of non-communicable diseases, exceeding the impact of cancer, diabetes or heart disease. In Europe, total costs of mental illness have been conservatively estimated to exceed 4% of GDP (>EUR600 billion) [1]. In youth, particularly in females, the prevalence of mental ill-health has escalated over recent years [2, 3]. The consequences are profound and adversely affect young people's social development, quality of life, education, income, and future mental and physical health outcomes including premature mortality [4]. Factors contributing to the current mental health crisis among youth include childhood adversity, the pervasive influence of social media, poverty and economic uncertainties, climate change, increased substance abuse, the aftermath of the COVID-19 pandemic, ongoing conflicts in Europe and beyond, and the growing number of displaced persons [5]. This confluence of factors signals a mental health crisis that may last for decades and will affect long-term health and economic productivity. Alarmingly, nearly half of all young people in Europe report unmet mental health care needs, with merely 20–30% of those experiencing mental health problems receiving care [1, 6]. Barriers towards adequate help include (self-)stigma, insufficient mental health literacy,

Extended author information available on the last page of the article

Published online: 25 April 2026

scarcity of youth-friendly mental health services, long waiting lists, high rates of co-morbidity, and poor transition from adolescent to adult services around the age of 18 [7]. Important risk groups include young people with pre-existing mental health conditions, intellectual disabilities or substance use, children of parents with mental disorders, individuals from lower income backgrounds, migrants and/or ethnic minorities, and individuals identifying as LGBTQ + or gender/neuro diverse [4]. Although the societal and economic impact of mental ill-health is overwhelming, investment in prevention and treatment of poor mental health has been relatively neglected compared to other diseases [8]. An urgent response is thus needed aimed at preventing and treating early stages of youth mental ill-health [9] to reduce its individual, economic and societal burden. In addition, a growing lack of specialized workforces in Europe – an estimated 4.1 million by 2030—calls for alternative approaches [10].

Over the last decades, promising developments have emerged aimed at transforming the traditional mental health care system, providing youth-friendly support for people aged 12–25 years and overcoming the harmful service split around the age of 18 [4]. The first and best-known examples are the Australian headspace [11] walk-in centres that have resulted in piloted adaptations across Europe [12–14]. Additionally, with many young people using mobile phones, youth mental interventions should also innovate digitally, and promising results have been found for a guided self-help daily life intervention (SELFIE) [15], and a clinical and peer-moderated digital treatment platform (MOST) [16–18]. These promising interventions are currently at different stages of maturity in terms of implementation and validation and face substantial gaps in their evidence base. Despite the promise these three types of interventions hold, existing studies have been relatively small and fragmented, and a significant gap in large-scale, real-world research of these promising interventions persists. The YOUTHreach consortium, consisting of 8 European countries (Belgium, Estonia, Germany, Ireland, Italy, Netherlands, Spain, United Kingdom) and Australia (see Table 1), aims to address these gaps.

Table 1 Partners of YOUTHreach consortium

No	Organisation name	Acronym	Country
1	Maastricht University (Coordinators)	UM	Netherlands
2	London School of Economics and Political Science	LSE	United Kingdom
3	Fatebenefratelli Brescia	IRCCS	Italy
4	Mittetulundusuhing Peaasi	PEAASI	Estonia
5	University of Birmingham	UoB/BHAM	United Kingdom
6	University of Barcelona	UB	Spain
7	Ab.Acus Srl	ABACUS	Italy
8	University of Galway	NUIG	Ireland
9	Zentralinstitut für Seelische Gesundheit	ZISG	Germany
10	University of Melbourne (associated partner)	UOM	Australia
11	Amsterdam University Medical Centre	AUMC/VUMC	Netherlands
12	Servicio Madrileno de Salud	SERMAS	Spain
13	Charité-Universitätsmedizin Berlin	CHARITE	Germany
14	European Student's Forum	AEGEE	Belgium

Objectives of YOUTHreach

The overarching aim of YOUTHreach, which started on January 1st 2025, is to strengthen youth mental health in Europe by bridging the gap of large-scale, real-world research on accessible youth mental health interventions and to provide a comprehensive European strategy, achieved through five objectives. First, three existing, distinct youth mental health interventions in different modalities will be evaluated after co-creation with young people, across various European regions, healthcare systems, and population groups. Second, a youth-centred, multi-stakeholder framework for multi-faceted in-depth comparison of youth mental health interventions (e.g. clinical effectiveness, cost-effectiveness, acceptability, equity), including new outcome measures and monitoring instruments will be developed. Third, new tools, best practices, and recommendations will be developed to enable country- and person-specific implementation of youth mental health interventions. In addition, open access data, research protocols, and best practices for clinicians, health economists, policymakers, and scientists will be generated. Finally, extensive outreach and networking activities will align and maximise outcomes and impacts across diverse (non-) scientific communities across Europe.

Methods

YOUTHreach is set to evaluate a trio of evidence-based, complementary interventions, forming a holistic, transdiagnostic, multi-modal intervention package for Europe's youth mental healthcare:

YEAH (Intervention 1): YEAH (Youth mEntal heAltH support centres), a European adaptation of the widely implemented Australian 'headspace' centres [8], are walk-in spaces with a youth-friendly and colourful living-room design as opposed to a clinical environment previously

described by youth as cold and uninviting [4]. This intervention, adapted to the local healthcare system, enables help-seeking young people to access services without waiting lists, cost-free, and often without appointment, offering a youth-friendly space to openly discuss concerns (mental, physical, sexual, financial, or social) regardless of mental health status. This intervention was designed to break down barriers that young people typically report regarding their experiences in accessing and receiving mental healthcare, including poor quality and lack of continuity, high financial costs, long waiting lists, and stigma. YOUTHreach will perform the first comparative evaluation of YEAH using a multi-country quasi-experimental design (pre-test post-test non-equivalent control group design with propensity score matching).

SELFIE (Intervention 2): SELFIE is a novel transdiagnostic blended ecological momentary intervention (EMI) for young people exposed to childhood adversity who have low self-esteem [15]. This new generation of digital interventions allows for adaptive real-time transfer of EMI components based on intensive longitudinal data collected using Ecological Momentary Assessment (EMA), capturing digital signals in the real world (*e.g.* social environment, mood, self-esteem, changes in physical or social activity). EMIs function as a 'therapist in the pocket' and can be used to respond with personalised support, allowing young people to manage their own mental health [15] to prevent later mental ill-health. SELFIE has demonstrated feasibility and efficacy in young people (aged 12–26 years) with low self-esteem exposed to childhood adversity in the Netherlands [15], but effectiveness and cost-effectiveness under real-world conditions is yet to be assessed. YOUTHreach will address this gap through a multi-country, parallel-group randomised controlled trial (RCT) in different healthcare systems.

MOST (Intervention 3): Moderated Online Social Therapy (MOST) is an evidence-based, hybrid intervention involving a digital platform combined with professional and peer support, developed in Australia, where it provides integrated digital support via a government-funded platform [16]. MOST merges evidence-based, transdiagnostic, and interactive psychological treatment with professional psychological, vocational, and peer support integrated within a social network of peers. Moreover, MOST provides an enriched therapeutic space – a personal journey—for young people to work safely towards their goals and broaden and rehearse skills. Australian clinical trials have demonstrated that MOST improves vocational recovery, reduces hospital admissions and visits to emergency services by 50% [17], was valued by young people, clinicians and services, and was cost-saving [16]. A recent large-scale real-world evaluation showed 93% satisfaction, and 44% experiencing clinically significant improvements in depression/anxiety [18]. Furthermore, MOST was recently adapted and tested in Europe [19, 20] and YOUTHreach will test clinical effectiveness and cost-effectiveness further in a pragmatic, multi-country parallel-group RCT.

The three studies include a clinical evaluation, a trial-based and a model—based multi-country health economic evaluation from a societal perspective, and a participatory process evaluation. The primary outcome measure will be psychological distress using the CORE-10 (YEAH, MOST) or SCL-90-R and CORE-10 (SELFIE). The reason for using the SLC-90-R as the main outcome for SELFIE in YOUTHreach was based on recent findings from the Dutch SELFIE RCT [15]. A standardised approach to measure changes in health and other service utilisation, as well as changes in education and work participation which will be standardised across the three interventions to calculate incremental costs. The primary outcome for the economic evaluations (conducted from both public purse and societal perspectives) will be the incremental cost per quality-adjusted life year (QALY) gained measured using the EQ-5D-5L. Other outcome measures include general wellbeing and psychosocial functioning. Assessments will be undertaken at baseline, 3-, 6-, and, 12-month follow-up. A subsample of participants and other stakeholders will be invited to contribute to the process evaluation and an empirical-ethical analysis.

Workpackage framework

YOUTHreach is embedded in the relatively new EU lump-sum funding scheme and therefore has established twelve work packages (WPs) executed over designated months (M) to reach its objectives (see Fig. 1). These WPs are clustered in 3 timeline phases consisting of 4 WPs each: WP 1–4 include the first year (M1-M12) and cover the design phase of the project. WP 5–8 include year 2–4 (M13-M48) and cover the implementation of the project. Finally, WP 9–12 include year 5 (M49-M60) and cover data-analysis and exploitation. More specifically, the WPs are clustered in 4 themes: (1) Youth-centred stakeholder engagement, (2) comparative evaluation studies, (3) data management & infrastructure for data-sharing, and (4) management, dissemination, communication & exploitation. At present, YOUTHreach is in its second year.

Theme 1: Youth-centred, multi-stakeholder engagement (WP 1, 5, 10)

Central to YOUTHreach is the engagement of stakeholder groups from early on (WP1) throughout the project's

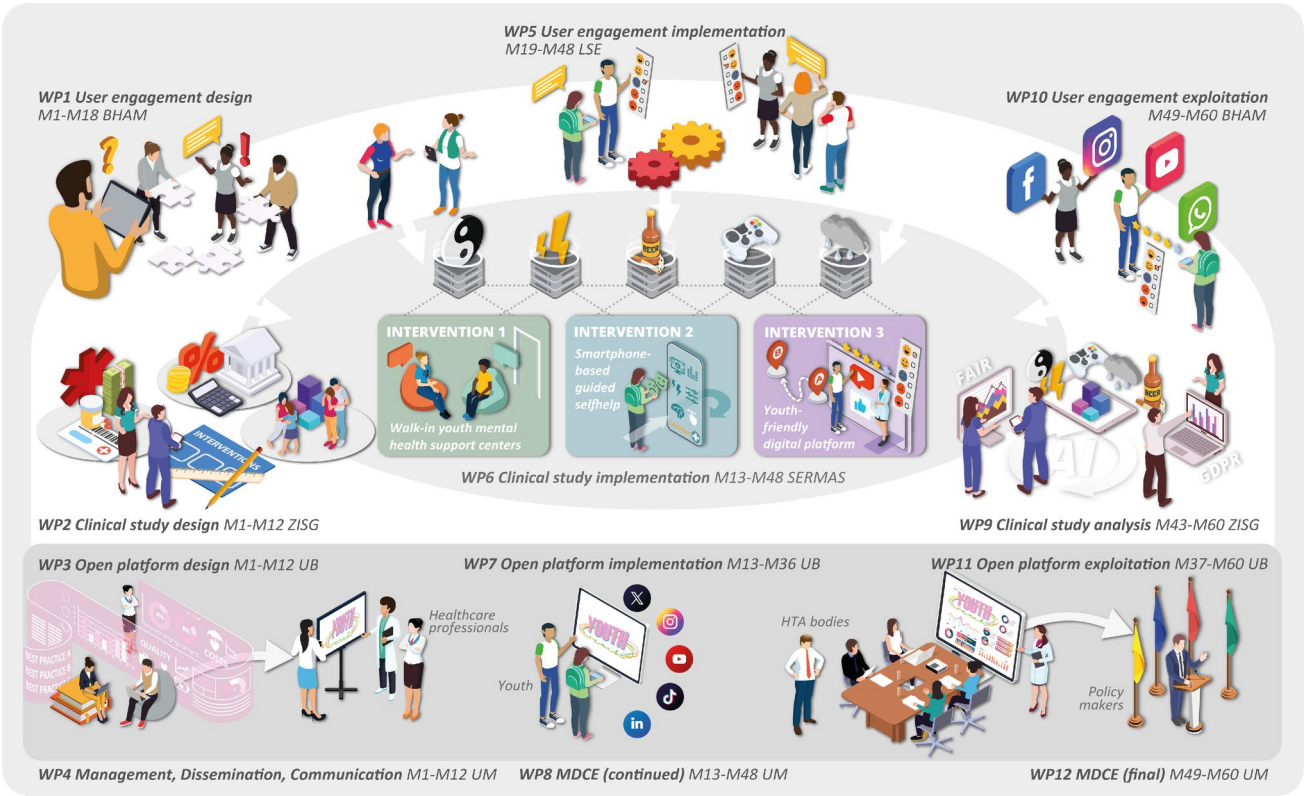

Fig. 1 Overview of YOUTHreach's workpackages including the acronyms of the partners leading the work packages (see Table 1)

duration (WP 5, 10) to understand young people's needs, optimise youth-friendly intervention delivery, and maximise impact. In addition, health economic, policy, ethical, and technical requirements will be identified to ensure holistic evaluation, promotion, and implementation across Europe. In the first year of YOUTHreach, four advisory and expert groups have been established as part of WP1, which will ensure engagement continuation throughout WP 5 & 10. These are the Youth Advisory Group (YAG), Mental Healthcare Advisory Group (MAG), Health Technology Assessment Focus Group (HAG), and Social Science and Humanities Advisory Group (SAG). The YAG meets regularly to provide input into the study designs and implementation including co-creation of the model structures, such as youth-centred outcome measures and pathways to intervention engagement. The MAG includes psychiatrists, psychologists, educators, social carers, healthcare managers, parents, and representatives from the YAG. This group defines context-specific systems maps, describing pathways to clinical care for young people accessing the interventions at each individual clinical site. The HAG was formed by identification and invitation of stakeholders including health economics, health service researchers, and health technology assessment (HTA) experts from different European countries. The HAG selects suitable study designs and analyses in line with the EUnetHTA framework, considering the views and preferences of the YAG. Young people are integral members of the HAG. Finally, the SAG includes ethicists, social scientists, healthcare professionals, and representative young people from the participating sites. They discuss the perceived ethical issues related to the interventions, including equality, confidentiality, transparency (right to information), autonomy, privacy, and they also investigate ethical issues in research involving minors. The advisory groups were developed through the network of the consortium partners and through (online) advertising. The frequency of the meetings varies, ranging from monthly to yearly. The meetings are international and mostly online. The annual consortium meetings are in person and provide an opportunity for consortium partners and members of the advisory groups to meet in person. The youth advisory group has a central place within the consortium (see www.youth-reach.eu). At present, we are developing local advisory groups in the participating countries to encourage people to join who are not comfortable speaking English.

Theme 2: comparative evaluation studies (WP 2, 6, 9)

Theme 2 constitutes the evaluation of the clinical studies (Fig. 2), spread over its design phase (WP 2), implementation phase (WP 6) and analysis phase (WP 9). The design

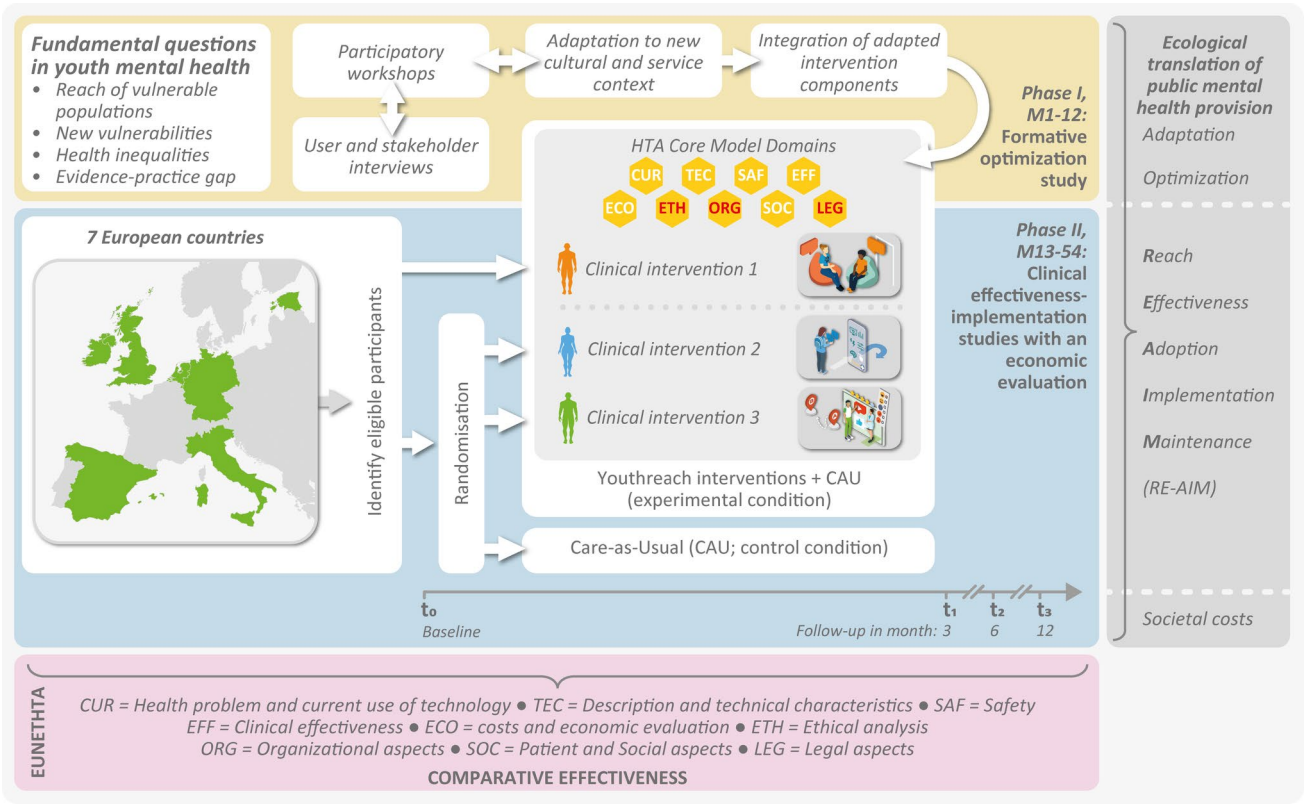

Fig. 2 Design of clinical studies using RE-AIM and EUnetHTA framework

phase (WP2, year 1) consisted of compiling the three intervention study protocols, obtaining ethical approval, and registration in public registries. The health-economic analysis plans (adhering to CHEERS 2022 and EUnetHTA) will be published in the Open Science Framework (OSF). Tools and training materials for the three clinical interventions have been adapted and translated into the languages of participating countries. In co-creation with the YAG, the range of outcome measures used for the (cost-)effectiveness analyses have been determined based on their importance to young people. In parallel, a tailor-made, country-specific Resource Use Measurement (RUM) has been piloted, to identify the use of health and other services that young people consider important. In year 2–4 (WP 6), recruitment of help-seeking young people (12–25 years) and data collection will take place, executing the co-designed controlled studies across sites. Recruitment will take place through the already existing support centres (YEAH), online adverstising, and primary care and mental health care services (SELFIE, MOST). Recruitment strategies will be adapted to the local situation of the participating countries. Subsequently, comparative clinical and economical evaluation of the collected data will be done in the project's final year, involving the analyses, promotion, and exploitation of results including clinical and economic impact assessment (WP 9).

Theme 3: data management & infrastructure for sharing (WP 3, 7, 11)

To ensure long-term impact of project outcomes, both data handling and management have an important place within the consortium. A comprehensive and live document containing the project's Data Management Plan (DMP) has been developed (WP 3), which will be updated regularly (WP 7) and finalized (WP 11) towards the project's end. Ethical and legal requirements for data re-use, including authorisations and data processing agreements, have been identified (WP 3). Furthermore, data flow has been mapped to build a data governance architecture, defining all necessary agreements under applicable data protection legislations. The necessary data preparations, leveraging existing data from already-operating sites will be carried out in year 1 and 2 (WP 3 & 7). In the same period, a data catalogue and federated analytics platform for the YOUTHreach multi-centre data will be set up. To achieve that, the (EU-funded) Youth-GEMs (gene-environment interactions and youth mental health trajectories) federated data platform (www.youth-gems.eu) will be adapted for use in YOUTHreach and metadata on the three interventions that are related to the new data which will be collected from the clinical studies (WP 6) will be uploaded. These will be cross-linked through the federated

network set-up (WP 3, WP 7). The technical infrastructures and requirements at each site will be analysed and support will be provided for each site to set up their node within the federated network. Subsequently, predictive models will be built using artificial intelligence (AI) aiming to predict health-related quality of life, social and occupational functioning and psychological distress (WP 7). These models will be tested using a series of external tests across the different clinical sites. Finally, the building blocks of the developed AI models will be provided in the open repositories (WP 11) to promote future research on youth interventions.

Theme 4: management, dissemination, communication & exploitation (WP 4, 8, 12)

In the first year, the consortium's governance structure was set up, including executive steering committee meetings with the WP leaders and annual meetings with the advisory board. In addition, a trial steering committee and IPR exploitation group were formed. A central repository was set up to centralise all project documents. Furthermore, a communication and dissemination plan was developed and a website created (www.youth-reach.eu). A first YOUTHreach press release to announce the project was made and further highlights of the project are posted on social media regularly. The project's Key Exploitable Results (KERs) were discussed and further conferred regularly by the intellectual property rights (IPR) exploitation group. Finally, other initiatives and EU projects of relevance for collaborations were and will continue to be identified, including projects funded under the same call. Where applicable, interactions have been started. The final results will be communicated through social media, scientific publications, and meetings with stakeholders including policymakers.

Results

YOUTHreach's impact will be substantial at a scientific, societal, industrial, and economic level. Best practices and methods will be established, that will benefit clinicians, policymakers and scientists working in youth mental health, but also those working in health economics, data science, and beyond. The definition of evaluation criteria and metrics will promote community standards for future controlled studies. Our approach to co-create these solutions with young people ensures that interventions are meaningful, and socially and culturally relevant. By targeting prevention and early intervention, we aim to reduce the escalation of mental health issues before they become debilitating, hopefully resulting in improved health-related quality of life, youth wellbeing, education and employment outcomes (*e.g.* reduced school drop-out), and ultimately reduced healthcare costs. Increasing awareness and accessibility of mental health support will empower young people and foster a more supportive environment for affected youth. The project's emphasis on transdiagnostic outcome parameters will also allow scientific advancements in the way we perceive and investigate mental health. Furthermore, the planned ethical, legal and social implications (ELSI) analyses will facilitate a social licence ensuring inclusion, autonomy, transparency and equality. This is optimised through co-creation, for the intervention to benefit young people across sex, gender, age, ethnic, socio- economic, and LGBTQ+subgroups. The inclusion of clinical centres from several regions of Europe and Australia promotes representativeness, diversity and inclusion in youth mental health across culturally and economically diverse countries. By providing results on clinical- and cost-effectiveness and applicability, the YOUTHreach project will encourage industries to invest, innovate, and expand the production of medical devices (e.g. mobile applications) for youth mental health. By leveraging HTA analyses, we hope to demonstrate a significant return on investment. This reflects the cost savings from effective prevention strategies that reduce reliance on specialised mental health services. Upon completion, YOUTHreach will also deliver a comprehensive FAIR-compliant (Findable, Accessible, Interoperable and Re-usable) large dataset, combining both existing and new data of youth aged 12–25. This dataset, comprehensive in its coverage of socio-demographic, psychosocial, behavioural, and socio-economic variables, along with outcome, educational, and cost/resource data, will serve as a crucial asset for HTA modellers, policymakers, clinical researchers, and AI developers. Additionally, we aim to provide open access research protocols, and proof-of-concept AI models. These contributions aim to enhance the technological toolkit available to researchers and innovators in youth mental health.

Discussion

Multimodal interventions combining in-person and digital support are needed to counteract the profound long-term negative impact resulting from poor youth mental health. It is important to focus on actions, and early and personalised interventions such as those of YOUTHreach, can potentially reduce the need for, and costs of specialist mental healthcare services as well as improve participation in education and employment. To ensure robust evaluation for maximum societal return on investments in youth mental health, it is important to involve stakeholders in discussions

on cost-effectiveness to inform future public funding decisions. YOUTHreach is set to influence both policy and clinical practice across Europe by comprehensive stakeholder engagement through capacity building, a shared vision and to build further on this in the future. We aim to develop seven country-specific recommendations to improve mental health policy and practices across Europe, covering Estonia, Germany, Ireland, Italy, the Netherlands, Spain, and the UK. These recommendations will cater to the unique mental healthcare frameworks and economic contexts of various European regions, ensuring that our approaches are scalable and beneficial across the continent, and could benefit a wide range of relevant professions integral to the referral process and provide ongoing support, including psychiatrists, clinical psychologists, nurses, and psychotherapists but also paediatricians, family doctors, school psychologists, and social workers. The consortium's outreach strategy has started by engaging researchers and other stakeholders in the 7 participating European countries and Australia. To widen reach and impact, we will broaden the initial engagement to encompass all 27 EU countries and professional organisations (e.g., European Psychiatry Association, European Society of Child & Adolescent Psychiatry). Additionally, our partnership with student forum AEGEE will help promote results and recommendations, across the European Union, leveraging AEGEE's robust network covering all 27 member states, ensuring our project's outcomes resonate throughout the European youth community.

Authors' contributions All authors contributed to the study conception and design. The first draft was written by TvA and AB and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Funding YOUTHreach is funded by the European Union under grant number 101156514. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or European Health and Digital Executive Agency. Neither the European Union nor the granting authority can be held responsible for them. CDC has received funding from Instituto de Salud Carlos III, Spanish Ministry of Science and Innovation (PI23/00625) and the European Commission (grant number 101057182, project Youth-GEMs) and honoraria or travel support from Janssen, Johnson&Johnson, and Viatris for activities unrelated to this work.

Data availability No datasets were generated or analysed during the current study.

Declarations

Ethical approval All studies included in the YOUTHreach framework have been approved or are submitted for review by the respective local human research ethics committees. All procedures performed in studies involving human participants will be conducted in accordance with the ethical standards of the institutional and/or national research ethics committee and the WMA Declaration of Helsinki and its latest amendments or comparable ethical standards.

Informed consent Free and voluntary consent to participate in the respective local study will be initially obtained from all individual participants and/or their parents/legal guardians included in the cohorts that will be part of the YOUTHreach framework.

Competing interests The authors declare no competing interests.

References

1. European Union (2022) Health at a Glance: Europe 2022 State of Health in the EU Cycle: State of Health in the EU Cycle. OECD publishing. https://www.oecd.org/en/publications/health-at-a-glance-europe-2022_507433b0-en.html
2. Castelpietra G, Knudsen AKS, Agardh EE et al (2022) The burden of mental disorders, substance use disorders and self-harm among young people in Europe, 1990–2019: findings from the Global Burden of Disease Study 2019. Lancet Reg Health Eur. https://doi.org/10.1016/j.lanepe.2022.100341
3. Organisation for Economic Co-operation and Development (2021) Supporting young people's mental health through the COVID-19 crisis. OECD Publishing. https://doi.org/10.1787/84e143e5-en
4. McGorry PD, Mei C, Dalal N et al (2024) The lancet psychiatry commission on youth mental health. Lancet Psychiatry 11(9):731–774. https://doi.org/10.1016/s2215-0366(24)00163-9
5. Mental health Promtion and Prevention: best pratices (2025). OECD. https://www.oecd.org/en/publications/mental-health-promotion-and-prevention_88bbe914-en.html
6. Ghafari M, Nadi T, Bahadivand-Chegini S, Doosti-Irani A (2022) Global prevalence of unmet need for mental health care among adolescents: a systematic review and meta-analysis. Arch Psychiatr Nurs 36:1–6. https://doi.org/10.1016/j.apnu.2021.10.008
7. Leijdesdorff S, Klaassen R, Wairata D, Rosema S, van Amelsvoort T, Popma A (2021) Barriers and facilitators on the pathway to mental health care among 12-25 year olds. Int J Qual Stud Health Well-being 16(1):1963110. https://doi.org/10.1080/17482631.2021.1963110
8. McDaid D, Hewlett E, Park A (2017) Understanding effective approaches to promoting mental health and preventing mental illness. OECD, Paris. https://doi.org/10.1787/bc364fb2-en
9. Ulhaas PJ, Davey CG, Mehta UM et al (2023) Towards a youth mental health paradigm: a perspective and roadmap. Mol Psychiatry 28(8):3171–3181. https://doi.org/10.1038/s41380-023-02202-z
10. Zapata T, Azzopardi-Muscat N, Falkenbach M, Wisma M. (2023) From great attrition to great attraction:Countering the great resignation of health and care workers. Eurohealth 29(1).

11. Rickwood D, McEachran J, Saw A, Telford N, Trethowan J, McGorry P (2023) Sixteen years of innovation in youth mental healthcare: outcomes for young people attending Australia's headspace centre services. PLoS One 18(6):e0282040. https://doi.org/10.1371/journal.pone.0282040
12 Boonstra A, van Amelsvoort TAMJ, Klaassen RMC et al (2024) Evaluating changes in functioning and psychological distress in visitors of the @ease youth mental health walk-in centres. BJPsych Open. 10(3):e101. https://doi.org/10.1111/eip.13443
13. O'Keeffe L, O'Reilly A, O'Brien G, Buckley R, Illback R (2015) Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people. Ir J Psychol Med 32(1):71–77. https://doi.org/10.1017/ipm.2014.86
14. Bechdolf A, Hanser S, Baumgardt J et al (2024) Soulspace: integrated youth mental health care in Berlin, Germany-an introduction to the program and a description of its users. Early Interv Psychiatry 18(7):571–577. https://doi.org/10.1111/eip.13522
15. Reininghaus U, Daemen M, Postma MR et al (2023) Efficacy of SELFIE a transdiagnostic ecological momentary intervention for improving self-esteem in youth exposed to childhood adversity: findings from a multi-centre randomized clinical trial JAMA. Psychiatry 81(3):227–239. https://doi.org/10.1001/jamapsychiatry.2023.4590
16. Engel L, Alvarez-Jimenez M, Cagliarini D et al (2024) The cost-effectiveness of a novel online social therapy to maintain treatment effects from first-episode psychosis services: results from the horyzons randomized controlled trial. Schizophr Bull 50(2):427–436. https://doi.org/10.1093/schbul/sbad071
17. Alvarez-Jimenez M, Koval P, Schmaal L et al (2021) The horyzons project: a randomized controlled trial of a novel online social therapy to maintain treatment effects from specialist first-episode psychosis services. World Psychiatry 20(2):233–243. https://doi.org/10.1002/wps.20858
18. Alvarez-Jimenez M, Nicholas J, Valentine L et al (2025) A national evaluation of a multi-modal, blended, digital intervention integrated within Australian youth mental health services. Acta Psychiatr Scand 151(3):317–331. https://doi.org/10.1111/acps.13751
19. van Doorn M, Monsanto A, Wang CL et al (2023) The effects of a digital, transdiagnostic, clinically and peer-moderated treatment platform for young people with emerging mental health complaints: repeated measures within-subjects study. JMIR Mhealth Uhealth 11(1):e50636. https://doi.org/10.2196/50636
20. Dwan-O'Reilly M, Harrington SM, Gavin C et al (2025) Moderated online social therapy (MOST) in help-seeking young people: pilot randomized controlled study. J Med Internet Res 27:e73269. https://doi.org/10.2196/73269

Authors and Affiliations

Thérèse van Amelsvoort[1] · Anouk Boonstra[1] · Karim Lekadir[2,3] · Esmeralda Ruiz Pujadas[2] · Matthew R. Broome[4,5] · Sian Lowri Griffiths[4] · Gary Donohoe[6,7] · Arne Popma[8] · Giovanni de Girolamo[9] · Covadonga M. Díaz-Caneja[10] · Anna-Kaisa Oidermaa[11] · Andreas Bechdolf[12,13,14] · Silvia Evers[15,16] · Ghislaine van Mastrigt[15] · Dorothee Horstkötter[17] · Ricky Janssen[17] · Maria Bulgheroni[18] · David McDaid[19] · Jan R. Boehnke[20,21] · Patrick McGorry[22,23] · Mario Alvarez Jimenez[22,23] · AEGEE[24] · Anita Schick[21] · Ulrich Reininghaus[21,25,26,27] · Sophie Leijdesdorff[1] on behalf of the YOUTHreach consortium

✉ Thérèse van Amelsvoort
t.vanamelsvoort@maastrichtuniversity.nl

Anouk Boonstra
a.boonstra2@maastrichtuniversity.nl

Karim Lekadir
karim.lekadir@ub.edu

Esmeralda Ruiz Pujadas
esmeralda.ruiz@ub.edu

Matthew R. Broome
m.r.broome@bham.ac.uk

Sian Lowri Griffiths
s.l.griffiths@bham.ac.uk

Gary Donohoe
gary.donohoe@universityofgalway.ie

Arne Popma
a.popma@amsterdamumc.nl

Giovanni de Girolamo
gdegirolamo@fatebenefratelli.eu

Covadonga M. Díaz-Caneja
covadonga.martinez@iisgm.com

Anna-Kaisa Oidermaa
anna-kaisa.oidermaa@peaasi.ee

Andreas Bechdolf
andreas.bechdolf@charite.de

Silvia Evers
s.evers@maastrichtuniversity.nl

Ghislaine van Mastrigt
g.vanmastrigt@maastrichtuniversity.nl

Dorothee Horstkötter
d.horstkoetter@maastrichtuniversity.nl

Ricky Janssen
ricky.janssen@maastrichtuniversity.nl

Maria Bulgheroni
mariabulgheroni@ab-acus.com

David McDaid
d.mcdaid@lse.ac.uk

Jan R. Boehnke
j.r.boehnke@dundee.ac.uk

Patrick McGorry
pat.mcgorry@orygen.org.au

Mario Alvarez Jimenez
mario.alvarez@orygen.org.au

AEGEE
president@aegee.eu

Anita Schick
Anita.Schick@zi-mannheim.de

Ulrich Reininghaus
Ulrich.Reininghaus@zi-mannheim.de

Sophie Leijdesdorff
sophie.leijdesdorff@maastrichtuniversity.nl

[1] Department of Psychiatry and Neuropsychology, Mental Health and Neuroscience (MHeNS) Research Institute, Maastricht University, Maastricht, the Netherlands

[2] Artificial Intelligence in Medicine Lab (BCN-AIM), Department of Mathematics and Computer Science, University of Barcelona, Barcelona, Spain

[3] Catalan Institute for Research and Advanced Studies (ICREA), Barcelona, Spain

[4] Institute for Mental Health, School of Psychology, University of Birmingham, Birmingham, UK

[5] Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK

[6] School of Psychology, University of Galway, Galway, Ireland

[7] Centre for Neuroimaging, Cognition, and Genomics (NICOG), University of Galway, Galway, Ireland

[8] Department of Child and Adolescent Psychiatry, University Medical Center, Amsterdam, the Netherlands

[9] IRCCS Istituto Centro San Giovanni Di Dio Fatebenefratelli, Unit of Epidemiological Psychiatry and Digital Mental Health, Brescia, Italy

[10] Department of Child and Adolescent Psychiatry, Institute of Psychiatry and Mental Health, Hospital General Universitario Gregorio Marañón, Instituto de Investigación Sanitaria Gregorio Marañón, CIBERSAM, ISCIII, School of Medicine, Complutense University, Madrid, Spain

[11] Peaasi, Tallinn, Estonia

[12] Department of Psychiatry and Psychotherapy, CCM, Charité - Universitätsmedizin Berlin, corporate member of Freie Universität Berlin and Humboldt-Universität Zu Berlin, Berlin, Germany

[13] Department of Psychiatry, Psychotherapy, and Psychosomatics Incorporating FRITZ Am Urban and Soulspace, Vivantes Hospital Am Urban and Vivantes Hospital Im Friedrichshain, Berlin, Germany

[14] German Center for Mental Health (DZPG), Berlin-Potsdam Site, Germany

[15] Department of Health Services Research, Care and Public Health Research Institute (CAPHRI), Maastricht University, Maastricht, the Netherlands

[16] Trimbos Institute, The Netherlands Institute of Mental Health and Addiction, Utrecht, The Netherlands

[17] Department of Health, Ethics and Society, Mental Health and Neuroscience (MHeNs) Research Institute, Maastricht University, Maastricht, the Netherlands

[18] Ab.Acus SRL, Milan, Italy

[19] Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science, London, UK

[20] School of Health Sciences, University of Dundee, Dundee, UK

[21] Department of Public Mental Health, Central Institute of Mental Health, Medical Faculty Mannheim, Heidelberg University, Mannheim, Germany

[22] Orygen, The National Centre of Excellence in Youth Mental Health, Parkville, VIC, Australia

[23] Centre for Youth Mental Health, The University of Melbourne, Parkville, VIC, Australia

[24] AEGEE, Brussels, Belgium

[25] Health Service and Population Research Department, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK

[26] ESRC Centre for Society and Mental Health, King's College London, London, UK

[27] German Center for Mental Health (DZPG), Partner Site Mannheim-Heidelberg-Ulm, Ulm, Germany