journal homepage: http://kont.zsf.jcu.cz
DOI: 10.32725/kont.2025.044

KONTAKT / Journal of nursing and social sciences related to health and illness

Original research article

# Child clients' perspectives on the continuity of professional care for children and adolescents with mental illness

Klaudie Němečková *, Alena Hricová

*University of South Bohemia in České Budějovice, Faculty of Health and Social Sciences, Institute of Social and Special-paedagogical Sciences, České Budějovice, Czech Republic*

**Abstract**
The study focuses on the experiences of children and adolescents with mental health problems in the context of continuity of professional care in the Czech Republic. Using a qualitative methodology, 33 in-depth interviews with young people aged 11–18 who had personal experience with various forms of psychiatric, psychological, or social intervention were analysed. The aim was to capture their perceptions of transitions between institutions, barriers in the system, and needs that were not met during care. Data analysis through reflective thematic analysis revealed six key areas influencing the experience of continuity of care: layered trauma, experience with institutions, communication and participation, continuity of services, absence of case management, and stigma. The results show that care is often fragmented, lacks continuity and relational continuity, and the burden of orientation in the system remains mainly on families. Individuals who can offer safety and understanding play a significant role. The study highlights the need for systemic implementation of coordinated support, strengthening interdisciplinary collaboration, and greater involvement of children in decision-making processes. The findings provide suggestions for improving practice and highlight the importance of listening to the voices of young people in the development of mental health care.

**Keywords:** Children's mental health; Continuity of care; Interdisciplinary collaboration; Service availability; Social work

## Introduction

The mental health of children and adolescents currently represents a significant challenge; not only for healthcare but also for educational and social systems in several European countries, including the Czech Republic. Epidemiological studies confirm that up to a fifth of children will experience psychological difficulties during adolescence that are so severe that it affects their daily functioning and school attendance. The growing number of cases of eating disorders, anxiety and depression, and suicidal behaviour increases the pressure for effective and coordinated support – and not only from institutions.

A key concept in caring for this vulnerable population is continuity of care. It is understood as an uninterrupted, coordinated sequence of involved actors that correspond to the child's and their family's current needs. However, in practice, continuity often fails. International and Czech studies show that children and their families are in contact with multiple institutions where cooperation is fragmented, transitions between services are poorly planned, information is not shared, and the role of a system guide is often missing. The consequence of these systemic weaknesses is not only an increased risk of a child falling between the systems, but also deepening uncertainty, traumatisation, and stigmatisation – both from the environment and within the care system itself. Although mental health care reform in the Czech Republic has developed new community and inter-professional services, their interconnection and effective functioning remain a challenge. This study aims to describe young people's experience with continuity of care and to identify the main barriers and needs through a qualitative analysis of interviews with children and adolescents. This approach allows us to capture the voice of those who experience the system and enrich existing quantitative data with contextual and relational aspects essential for adequate mental health support.

### *Theoretical definition*

In the professional literature, continuous care is considered an essential pillar of effective support in child and adolescent mental health. It represents systematically coordinated, ongoing and long-term care that reflects the client's changing needs over time and across different service systems. According to Adair et al. (2005), continuity of care has the potential to improve the quality of life of clients, help their social inclusion, and reduce symptoms in people with severe mental illness. Biringer et al. (2017) add that through continuity, space is cre-

* **Corresponding author:** Klaudie Němečková, University of South Bohemia in České Budějovice, Faculty of Health and Social Sciences, Institute of Social and Special-paedagogical Sciences, Jírovcova 1347/24, 370 04 České Budějovice, Czech Republic; e-mail: nemeck06@zsf.jcu.cz; http://doi.org/10.32725/kont.2025.044

Submitted: 2025-06-06 • Accepted: 2025-09-25 • Prepublished online: 2025-09-26
KONTAKT 27/4: 384–390 • EISSN 1804-7122 • ISSN 1212-4117

ated to create a therapeutic alliance that provides clients with a sense of security and motivation for active cooperation. Clients usually express greater satisfaction if the care is provided by a permanent professional with whom they can establish a deeper relationship, which leads to more open communication (Adair et al., 2005; Biringer et al., 2017). Hoertel et al. (2014) point out that longitudinal continuity of care may even have an impact on reducing mortality in patients with severe mental disorders, such as schizophrenia, major depression, or bipolar disorder. The transition from child to adult psychiatric care is a specific period when continuity of care is crucial. Toulany et al. (2019) demonstrate that adolescents with severe mental illness who remained in contact with primary care providers during this transition had a lower need for acute medical interventions, including hospitalisations and emergency rooms. Fontanella et al. (2015) focus on a vulnerable group of children in foster care. These children face significant risks of discontinuity due to frequent placement changes and the absence of stable health care. The study shows that regular outpatient visits are more frequent among those children who already had established care, were taking psychotropic medications, or suffered from chronic illness. From the perspective of families and providers, continuity of care represents a meaningful connection of services over time.

Tobon et al. (2015) state that in the event of discontinuity, parents take on the role of coordinators, which places a significant burden on them. This highlights the need for better interdisciplinary and intersectoral cooperation. Nicaise et al. (2020) point to differences in the organisation of health systems across Europe. Systems with stronger local structures and regulations tend to provide better continuity of care. This finding is complemented by the research of Wyngaerden et al. (2019), which shows that people with dense and cohesive social networks are more likely to experience quality continuity of care. Czech research also shows that several limitations burden the process of referring clients to mental health centres. The most common are situations where the client does not fall into the defined target group, the health condition does not allow the use of the service, and a lack of cooperation with the recommended centre or support from the family. Another critical factor is the limited capacity of centres and regional inequalities in their availability (Vondroušová et al., 2025). Adair et al. (2003) and Burns et al. (2009) point out that, despite the benefits, continuity of care remains a difficult concept to grasp. There is no uniform definition and standardised measurement tool, which makes it difficult to compare studies and implement uniform models of care. Multidisciplinary approaches offer an effective way to ensure continuity of care.

The American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Collaborative and Integrated Care and AACAP Committee on Quality Issues (2022) describe integrated care's benefits, bringing a portion of psychiatric services into primary care. This model increases client satisfaction, improves clinical outcomes, and reduces costs.

Camacho-Rubio et al. (2022) highlight the ACT model, which individualises the intensity of support according to the child's needs and provides care in their natural environment. Ramaswamy et al. (2022) emphasise the importance of transdisciplinarity in resource-limited settings. They point out that it is necessary to connect expertise, overall system reforms, and social determinants of health. De Carvalho et al. (2024) confirm that multidisciplinary teams can effectively respond to the first symptoms of depression or anxiety, using CBT as a form of early intervention. Buka et al. (2022) argue for family-centred care, were parents are more involved in the therapeutic process, thereby strengthening family relationships and promoting long-term stability. De Los Reyes et al. (2015) show that involving multiple informants (parents, teachers, caregivers) helps better understand the child's context and leads to more targeted interventions. Cheng et al. (2017) point out the importance of shared decision-making, which leads to increased participation of children and parents and supports adherence to therapeutic plans.

Castrillo et al. (2017) demonstrate that multidisciplinary approaches allow for the combination of psychiatric, psychological, and social interventions in the treatment of childhood depression, leading to improved outcomes. At the organisational level, Kelsay et al. (2017) state that effective implementation of multidisciplinary approaches requires quality educational models that support interdisciplinary collaboration and reflect the development needs of professionals.

Burns and Lloyd (2004) conclude that multidisciplinary models are clinically effective and cost-effective, as they reduce hospitalisations and prevent chronicity.

## Materials and methods

A qualitative descriptive study was conducted. Data were collected through in-depth interviews with children and adolescents aged 11–18 years ($n$ = 33) (see Table 1) in several regions of the Czech Republic between January and December 2024. The inclusion criteria for children/adolescents were: personal experience with mental health problems, contact with health, education or social services in the last three years, and willingness (as well as parental consent for those under 18) to participate in the study. The interviews lasted an average of 65 minutes (35–110 minutes), and the total length of the recorded material exceeded 35 hours – the transcripts of the interviews total 478 standard pages of text, which were used for analysis.

### *Data collection*

In-depth interviews were conducted in person, online, or by phone, according to participant preferences and pandemic-related restrictions, between January and December 2024. The interviewer focused on the onset of mental health problems in children and adolescents, pathways to seeking help, experiences with health, education, and social services, transitions between services, perceptions of support and unmet needs, and suggestions for improvement.

All interviews were recorded, transcribed verbatim, and anonymised. Transcripts and consent forms were stored securely, and access was restricted to the research team only.

### *Data analysis*

A reflective thematic analysis approach was used (Braun and Clarke, 2022).

The analysis took place in several stages:

1. *Getting to know each other* – re-reading all transcripts and noting recurring motifs.
2. *Open coding* – that is, units related to care experiences, transitions, needs, barriers, emotions, and recommendations were coded; for example, codes such as "waiting for a specialist", "missing information", "changing many therapists".
3. *Category development* – codes were grouped into broader themes within the dataset (e.g., discontinuity of care, lack of relational support, barriers to access, multidisciplinary

collaboration, stigma, information flow, and participant suggestions).
4. *Topic mapping and triangulation* – from several categories (e.g., "discontinuity", "absence of transitional care", "unguided"), the topic "Continuity of services and the role of case management" emerged.
5. *Theoretical integration* – the final themes were interpreted in relation to the literature on continuity of care (Haggerty et al., 2003; Reupert et al., 2015) and the context of the Czech system.

**Table 1. Basic characteristics of the informant group**

| Variable | *n* | % | Note |
|---|---|---|---|
| Informants – total | 33 | 100 | |
| Gender | | | |
| girls | 27 | 81.8 | |
| boys | 6 | 18.2 | |
| Age | | | |
| <14 | 8 | 24.2 | |
| 15–16 | 15 | 45.4 | |
| 17–18 | 10 | 30.3 | |
| Types of psychological difficulties | | | |
| eating disorders | 12 | 36.4 | anorexia, bulimia, orthorexia (54.5%) including suicidal tendencies |
| anxiety disorders | 18 | 54.5 | |
| self-harm | 14 | 42.4 | |
| PTSD | 4 | 12.1 | including domestic violence |

*Note:* Some participants reported multiple types of psychological problems at the same time (e.g., anxiety and PPP); therefore, the sum of individual categories exceeds the total number of informants. Self-harm is listed as a symptom across various diagnoses. The FHSS ethics committee approved all procedures, No. 018/2023. Participation was anonymous and voluntary. Written informed consent was obtained from all participants and, if necessary, from legal representatives.

## Results

Analysis of interviews with adolescents who have personal experience with the mental health care system in the Czech Republic revealed the layered and complex nature of their life stories, experiences, and relationships with the system and their surroundings. Unlike superficial statistics or formal evaluations, respondents' voices reveal the true landscape of continuity and discontinuity of care as a dynamic network of events, failures, and rare hopes, intertwined with individual struggles for meaning, safety, and acceptance.

More than 170 open codes were created, which were further grouped into 18 categories and then integrated into five key themes.
1. Trauma and layering of problems.
2. Experience with institutions and the care system.
3. Communication, awareness, and participation.
4. Continuity of services and the role of case management.
5. Stigmatisation and secondary victimisation.

Each of these areas will be presented through a synthesis of knowledge and authentic statements from young people, which bring irreplaceable depth and authenticity to the picture of continuity of care.

### *Trauma and problem layering*

One of the most common themes that resonates across all interviews is the experience of long-term, layered trauma. This often begins in childhood and is associated with bullying at school, strained family relationships, or a subtle but persistent lack of a sense of safety and belonging. Participants repeatedly describe how individual negative experiences accumulated and deepened their loneliness and despair: *"I was bullied in elementary school. In the first grade my teacher pushed me away, later I was bullied mainly by girls and then by boys too… It always came back somehow, I always told myself that I was a cancer, that I was worthless"* (Kateřina, 15 years old).

For many children, the family environment is a source of further tension rather than support. The described dynamics range from direct aggression (verbal attacks, trivialising problems) to emotional indifference and misunderstanding on the part of parents: *"Dad is a terrible idiot, he never really cared about me, the only time he wanted to know how I was was at Christmas or my birthday… My brother told me that I should have died before I was born"* (Jana, 13).

Many reported that, even when they wished to share their problems, they were met with misunderstanding, or their disclosures were misused against them: *"At first I told my teachers, the school psychologist, my friends… but I soon found out that the people I trusted had hurt me – they either spread it around or turned it against me"* (Anna, 11 years old).

Long-term lack of trust and failure of loved ones often contribute to the development of anxiety, depression, and suicidal thoughts: *"I started hurting myself when I couldn't do it anymore. My mother found my hands and took me to the paediatrician… I felt like I had failed, that I was bad"* (Bára, 13 years old).

Trauma layering is often exacerbated by loss (e.g., the death of a loved one) or chronic pressure to perform in the family or at school. Negative experiences are not isolated episodes but become a permanent part of the child's identity and experience.

### *Experience with institutions and the care system*

A key theme that runs through all interviews is the experience of institutions – from schools and school psychologists to paediatricians, psychiatric wards, and outpatient specialists. Chil-

dren and young people often describe the care system as chaotic, fragmented, and unable to provide continuity of support during and after the crisis.

Informants state that their journey through the system often began after a severe crisis, e.g., after self-harm or a suicide attempt. A parent or school usually mediated the initial contact with a professional, but information and follow-up care were minimal: *"When the principal saw that I was self-harming, she told me to fill my head with the curriculum. She solved everything through school performance without explaining what was happening to me. When it got worse, they sent me to a psychiatric hospital"* (Kateřina, 15 years old).

Other informants describe similar systematic failures. For example, during hospitalisation in the children's ward, there was a lack of information and basic psychological support: *"I was in the children's ward, everything was foreign, no one explained anything to me. Someone just kept asking me how I was feeling, and then they transferred me to psychiatry. I felt like an item in the system; no one explained what was happening"* (Bára, 13 years old).

Most adolescents mention that their stay in a psychiatric or children's ward was characterised by a strict regime, minimal individualisation, and often a cold, sometimes even humiliating approach from the staff. Children are perceived primarily through their diagnosis, not as unique personalities: *"In a regime – get up, eat, take medication, be silent. I felt... disconnected there. I knew I probably needed it, but it wasn't humane. More like isolation than treatment"* (Bára, 13 years old).

They also point out the lack of clear communication and clarity about their stay: *"I didn't know how long I would be there. No one told me what would happen. I was sitting there with three-year-old children, everything was impersonal"* (Nina, 13 years old).

When hospitalisation ends, continuity of care is often entirely in the hands of the family, who must independently find an outpatient psychiatrist or psychologist. A clear plan and a real transition between institutions are lacking. After discharge, children often describe feelings of loss and uncertainty: *"After discharge – what next? Nothing. Just a prescription. No continuity. Then mom herself looked for a psychiatrist, whom we called. We waited a month. Psychologist – two months. No social services, no coordination. Everything was left to us"* (Lucie, 14 years old).

*"Nobody told me anything, nobody recommended anything. If there was a simple overview of where to turn, it would definitely help"* (Karolína, 17 years old).

Despite the prevailing negative experiences, some statements also contain positive moments; these are most often associated with a specific person who was able to show empathy, listen, and create a "safe haven": *"The choir was a safe place for me. It saved me a lot at that time, as did my viola teacher. It was such a safe place"* (Dominika, 16 years old).

These relationships are often the key to a positive turn of events or weathering the most challenging period.

### *Communication, awareness, and participation*

One of the most fundamental motifs that repeatedly resonates in adolescents' narratives is the complete lack of open, transparent, and partner-based communication on the part of professionals, institutions, and the system itself. This absence of information and participation fundamentally affects not only the treatment process itself, but also the willingness of children to cooperate, develop trust, and engage in their own care. Informants often describe that no one has explained what would happen, why they were transferred from one institution to another, or what the various procedures meant. As a result, they felt more like objects of professional interventions than real subjects of care.

*"I was in a regime – get up, eat, take medicine, be quiet. I knew I probably needed it, but it wasn't humane. More like isolation than treatment. No one told me what was actually happening to me"* (Lucie, 17 years old).

*"I always felt like I was just a piece in the system being moved around. No information, no explanation, just someone always asking me how I was feeling, but no one telling me why or what was going to happen next"* (Katka, 15 years old).

Many informants complain about the passive and even impersonal behaviour of experts; instead of a partnership, they often encounter routine "check-ins" and a minimum of genuine interest:

*"Psychiatrists and psychologists usually didn't explain to me why they were suggesting hospitalisation. No one asked me what I wanted; they just decided for me. I was scared, I needed to ask, to understand"* (Veronika, 18 years old).

*"I had a psychiatrist who always just asked me how I was doing, whether we should change my medication or leave it as it is. He recommended therapy, but when group therapy didn't work for me, no one followed up"* (Bára, 16 years old).

The lack of communication between partners leads to deep loneliness and isolation, with young people describing how, ultimately, the entire burden of making decisions, finding services, and coping with difficulties lies with them and their family: *"After being released, there was no follow-up. My mother then looked for a psychiatrist herself, whom we called. Everything was left up to us; we also had to find a psychologist. It was not coordinated at all"* (Lucie, 17 years old).

The contrast is even more striking with the rare positive experiences with individuals who were able to approach children humanely, with patience and genuine interest:

*"There was a lady at the CDZ who was really interested. She asked what I needed, she was there for me every week. She was the main person I trusted"* (Katka, 15 years old).

The absence of dialogue and understanding leads many adolescents to shut down, lose motivation, and even a feel resistance towards the entire care system: *"When they were constantly checking me, weighing me, and deciding what I couldn't eat, I felt like closing myself off even more. Instead of cooperating, I felt like avoiding everything"* (Bára, 16 years old).

### *Continuity of services and the role of case management*

When relaying their stories, respondents repeatedly mention that one of the most pressing problems is the complete breakdown of the continuity of services. No one in the Czech system would guide them and their family through the complex path between the individual segments of health, social, and school care. The burden of orientation and decision-making rests on the shoulders of the family and the young person from beginning to end. A recurring experience is the situation when, after being discharged from hospital or finishing acute care, young people and their families are left without any follow-up plan. No one explains their options, who to turn to, or where to look for support. In practice, securing follow-up care is a matter of luck, personal acquaintances, and parents' perseverance, or it remains completely unavailable.

Informants very often describe the need for "someone who would be there" – someone who understood the system and was able to connect services and provide continuous support. This role, common for example in some foreign models (the so-called 'case manager'), practically does not exist in the Czech environment:

*"I think there should be someone who can help orient themselves, both young people and parents. Someone who can be there, who is not afraid to talk about difficult things, and has a humane approach. More like a guide in the chaos, not an official"* (Veronika, 18 years old).

The lack of guidance and the absence of systemic support mean that most of the burden of organisation, information, and decision-making falls on the parents. This leads to overload, despair, and a feeling that they are entirely responsible for the care of the child, which further deepens the insecurity and loneliness of the young person involved: *"I dealt with everything alone or with my mother, no one really advised us what to do. It was challenging, we didn't know where to turn"* (Dominika, 16 years old).

This situation has a long-term impact – not only on the child's recovery, but on the mental health of the entire family. It also encourages youths to withdraw into themselves and lose trust in the system that should be their support.

### *Stigmatisation, secondary victimisation, and what young people really need*

The stigma associated with mental illness and the use of psychiatric or psychological services is still deeply rooted in the broader society and its institutions. In interviews, young people repeatedly describe how their difficulties have been trivialised, pathologised, ridiculed, or used against them. Secondary victimisation, i.e., further harm by those who should be supportive, is one of the most painful aspects of their experience. Stigma often begins at school, where a child's difference is quickly visible and can lead to exclusion or bullying:

*"I was never popular; they laughed at me for not wearing designer clothes. When a classmate told me I was fat and that I should stop eating, I developed anorexia. When I started getting sick, I collapsed at home, I exercised to get rid of everything"* (Veronika, 18 years old).

Even professionals and schools often unknowingly participate in further harm: *"When I mentioned psychological problems, I heard that I was making things up, that I wanted to be interesting. When I discussed it with the class teacher, I was the bad one. I shouldn't take everything so seriously"* (Bára, 16 years old).

*"The psychiatrist said there was nothing wrong with me, that I just wanted attention. When I saw the psychologist at school, he discussed what I told him with the teachers an hour later"* (Veronika, 18 years old).

This approach leads to young people losing trust, not only in their surroundings but also in themselves. They stop confiding, close in on themselves, and lose faith that anyone will take their problems seriously. The motif of a person preferring to remain silent and suffer internally rather than risk further injury is repeated:

*"At first, I talked about it with my friends and teachers, but then I realised it only hurt me. Everyone was discussing it; they didn't help me at all, quite the opposite. Today I'm careful about what I say to whom"* (Bára, 16 years old).

*"When I was having a bad time, I would sometimes get completely crazy and then my classmates and teacher would laugh at me. It wasn't any better at home. Ultimately, I felt weird that I couldn't be normal"* (Veronika, 18 years old).

In their recommendations and wishes, the informants address the professional system, schools, parents, and society as a whole. Their main demands can be summarised as follows:

- **The need for acceptance and openness:**
  *"That there may be a safe place – at home, at school, in any service. Where you will not be judged, but accepted"* (Lucie, 17 years old).
- **Greater awareness and understanding:**
  *"This should be talked about more. So that not only parents, but also educators are trained in what eating disorders, depression, etc. are. When someone suffers from PPP, they don't want to be constantly respected or strictly watched. It would help if the school weren't just a passive bystander, but a real partner"* (Bára, 16 years old).
- **Timely and understandable contact with a specialist:**
  *"If there were a simple overview of where to turn, it would definitely help. One wouldn't have to fumble around for weeks"* (Katka, 15 years old).
- **Guide/case manager availability:**
  *"That there would be someone who could help young people and parents orient themselves. To be able to be close, and not to be afraid to talk about difficult things, to have a human approach"* (Veronika, 18 years old).
- **Emphasis on relationship, empathy, and support instead of control and directiveness:**
  *"I needed someone to listen to me without immediately judging or giving advice. To be there for me and endure it"* (Bára, 16 years old).

## Discussion

This study provides one of the few perspectives on the continuity of care for children and adolescents with mental health problems in the Czech Republic – from the perspective of those who are actually involved in the support system. The findings point to several structural and procedural barriers that prevent the implementation of accurate continuity of care, and reveal deep gaps in continuity, relationships, and participation that fundamentally impact both subjective and objective care outcomes.

One of the most fundamental themes that emerged in the analysis is the experience of discontinuity of care. Children and adolescents repeatedly described that their journey through the system was fragmented, unpredictable, and full of unclear transitions between individual institutions (e.g., paediatrician–hospital–psychiatry, school–ambulance–community). These transitions were often initiated only during an acute crisis, without sufficient preparation, information, or involvement of the child and family. This phenomenon, frequently referred to as "tossing the package", is also described in detail in foreign studies (see Haggerty et al., 2003), where it is associated with an increased risk of relapse, drop-out from treatment, and secondary traumatisation. The absence of relational continuity, i.e., a long-term guide in whom the child could develop trust and who would know their story across institutions, was strongly felt. Constant staff turnover and short consultations (often no more than 10–20 minutes) make establishing a truly therapeutic relationship impossible. The result is lower adherence to recommended care, increased loneliness, and loss of meaning and passivity from the child and family. This aspect is essential for the effectiveness of systemic interventions. Waiting times, regional differences in the availability of services, lack of information and stigma were other significant barriers. Informants described how they often obtained information about available services late (or not at all), and the decisive role here was played by a "random guide" (an enlightened psychologist, a school worker) rather than systemic support. This phenomenon aligns with foreign knowledge, where a close connection between low information, stigma and late entry into the system is repeatedly documented (Gulliver et al., 2010; Henderson et al., 2013).

Stigma is manifested in families ("it's not a disease, it's puberty") and schools ("this is not addressed at school"), which leads to a further extension of the period without adequate help. An important finding is the lack of cooperation between institutions. Regular case conferences, information sharing, and multidisciplinary team involvement are the exception. It is clear from the statements of adolescents that they also perceive incompetence or overload of professionals, which may indicate existing systemic limits, as is also stated in the professional literature (e.g., Reupert et al., 2015). The strength of this study is the in-depth analysis of an extensive dataset from two perspectives (users × professionals), the emphasis on authenticity, and the presentation of problems and examples of good practice. The gender composition of the sample – with a predominance of girls – reflects broader trends noted in the professional literature. Girls are generally more open about naming their mental health problems, more likely to seek informal and professional help, and more likely to be identified by their peers. In contrast, boys experience stronger stigma, pressure to be independent, and fear of weakening their masculine identity, leading to lower participation and late entry into the care system (see Bosco et al., 2020; Haavik et al., 2019; Li and Gal, 2022; Wendt and Shafer, 2016). Nevertheless, the results provide important insights for practice and systemic change.

## Conclusion

The analysis showed that the Czech system of care for children and adolescents with mental health problems suffers from fundamental fragmentation, the absence of long-term support, and weak continuity of services. The greatest vulnerability arises in moments of transition, especially between institutions and when returning from health care to everyday life. Children and adolescents often feel like a "tossed package", without sufficient information, peer communication, and a real opportunity to participate in decisions about their treatment.

Positive changes occur when the system is enriched with individual guidance, interdisciplinary cooperation, and the child's and their family's needs are respected. Stigma, secondary victimisation, and lack of emotional support fundamentally worsen the chances of successful recovery and return to everyday life.

The study highlights the need to create a more effective case management system, expand multidisciplinary teams, and systematically educate professionals, educators, and parents. It is also essential to strengthen the participation of children and families so that they have the opportunity to co-create their care plan. Without these changes, the system risks continuing to generate new layers of trauma and resignation, rather than supporting the healthy development, safety, and dignity of the most vulnerable children.

### *Limitations*

This study has several limitations that must be considered when interpreting the results. The sample of respondents was not gender-balanced – girls predominated, which may affect the generalizability of the conclusions. The informants' statements are subjective and reflect their experiences and psychological state. The research was conducted in several regions and does not fully consider regional differences in care availability. The perspective of other actors, such as parents or professionals, is missing here, which limits the complexity of the view of the system. Furthermore, the time frame for 2024 does not capture any possible systemic changes. Given the professional background of the researchers, a particular interpretative bias cannot be ruled out. Nevertheless, the studies provide valuable insights from the perspective of care users and suggestions for further research and practice.

### *Funding*

The research was financially supported by the University of South Bohemia in České Budějovice (project reg. No. GA JU No. 133/2024/S).

### *Ethical aspects and conflict of interest*

The authors have no conflict of interest to declare.

## References

1. Adair CE, Mcdougall GM, Beckie A, Joyce A, Mitton C, Wild CT, et al. (2003). History and measurement of continuity of care in mental health services and evidence of its role in outcomes. Psychiatr Serv 54(10): 1351–1356. DOI: 10.1176/APPI.PS.54.10.1351.
2. Adair CE, McDougall GM, Mitton CR, Joyce AS, Wild TC, Gordon A, et al. (2005). Continuity of care and health outcomes among persons with severe mental illness. Psychiatr Serv 56(9): 1061–1069. DOI: 10.1176/APPI.PS.56.9.1061.
3. American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Collaborative and Integrated Care and AACAP Committee on Quality Issues (2022). Clinical Update: Collaborative Mental Health Care for Children and Adolescents in Pediatric Primary Care. J Am Acad Child Adolesc Psychiatry 62(2): 91–119. DOI: 10.1016/j.jaac.2022.06.007.
4. Biringer E, Hartveit M, Sundfør B, Ruud T, Borg M (2017). Continuity of care as experienced by mental health service users – a qualitative study. BMC Health Serv Res 17(1): 763. DOI: 10.1186/s12913-017-2719-9.
5. Bosco N, Giaccherini S, Meringolo P (2020). A gender perspective about young people's seeking help. J Prev Inter Community 48(2): 132–146. DOI: 10.1080/10852352.2019.1624353.
6. Braun V, Clarke V (2022). Conceptual and design thinking for thematic analysis. Qual Psychol 9(1): 3–26. DOI: 10.1037/qup0000196.
7. Buka SL, Beers LS, Biel MG, Counts NZ, Hudziak J, Parade SH, et al. (2022). The Family is the Patient: Promoting Early Childhood Mental Health in Pediatric Care. Pediatrics 149 (Suppl 5): e2021053509L. DOI: 10.1542/peds.2021-053509L.
8. Burns T, Lloyd H (2004). Is a team approach based on staff meetings cost-effective in the delivery of mental health care? Curr Opin Psychiatry 17(4): 311–314. DOI: 10.1097/01.yco.0000133835.26920.ff.
9. Burns T, Catty J, White S, Clement S, Ellis G, Jones IR, et al. (2009). Continuity of care in mental health: understanding and measuring a complex phenomenon. Psychol Med 39(2): 313–323. DOI: 10.1017/S0033291708003747.
10. Camacho-Rubio J, Rivas Cambronero E, Andrés Camazón P, Camacho-Rubio M, Reyes Marrero R, et al. (2022). A call for the implementation of Assertive Community Treatment for children and adolescents. Acta Psychiatr Scand 146(1): 101–102. DOI: 10.1111/acps.13438.
11. Castrillo P, Guijarro R, Cerviño M (2017). Multidisciplinary Approach to Several Mental Disorders: Clinical Case. Eur Psychiatry 41(Suppl.): S712. DOI: 10.1016/j.eurpsy.2017.01.1271.
12. Cheng H, Hayes D, Edbrooke-Childs J, Martin K, Chapman Wolpert M (2017). What approaches for promoting shared decision-making are used in child mental health? A scoping review. Clin Psychol Psychother 24(6): O1495–O1511. DOI: 10.1002/cpp.2106.

13. de Carvalho MLSND, Costa MR, Simões NS, Ferro EM, Ueda BR, de Oliveira MC, et al. (2024). Child mental health: Early detection and interventions in anxiety disorders and depression. Lumen et Virtus XV(XXXIX): 3106–3115. DOI: 10.56238/levv15n39-116.
14. De Los Reyes A, Augenstein TM, Wang M, Thomas SA, Drabick DAG, Burgers DE, Rabinowitz J (2015). The validity of the multi-informant approach to assessing child and adolescent mental health. Psychol Bull 141(4): 858–900. DOI: 10.1037/a0038498.
15. Fontanella CA, Gupta L, Hiance-Steelesmith DL, Valentine S (2015). Continuity of care for youth in foster care with serious emotional disturbances. Children and Youth Services Review 50: 38–43. DOI: 10.1016/J.CHILDYOUTH.2015.01.004.
16. Gulliver A, Griffiths KM, Christensen H (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. BMC Psychiatry 10: 113. DOI: 10.1186/1471-244X-10-113.
17. Haavik L, Joa I, Joa I, Hatløy K, Stain HJ, Langeveld J (2019). Help seeking for mental health problems in an adolescent population: the effect of gender. J Ment Health 28(5): 467–474. DOI: 10.1080/09638237.2017.1340630.
18. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R (2003). Continuity of care: a multidisciplinary review. BMJ 327(7425): 1219–1221. DOI: 10.1136/bmj.327.7425.1219.
19. Henderson C, Evans-Lacko S, Thornicroft G (2013). Mental illness stigma, help seeking, and public health programs. Am J Public Health 103(5): 777–780. DOI: 10.2105/AJPH.2012.301056
20. Hoertel N, Limosin F, Leleu H (2014). Poor longitudinal continuity of care is associated with an increased mortality rate among patients with mental disorders: Results from the French National Health Insurance Reimbursement Database. Eur Psychiatry 29(6): 358–364. DOI: 10.1016/j.eurpsy.2013.12.001.
21. Kelsay K, Bunik M, Buchholz M, Burnett B, Talmi A (2017). Incorporating Trainees' Development into a Multidisciplinary Training Model for Integrated Behavioral Health Within a Pediatric Continuity Clinic. Child Adolesc Psychiatr Clin N Am 26(4): 703–715. DOI: 10.1016/j.chc.2017.06.001.
22. Li T, Gal D (2022). The Marlboro men don't cry: Understanding the gendered perceptions of people seeking mental health care. J Exp Psychol Appl 28(2): 423–437. DOI: 10.1037/xap0000360.
23. Nicaise P, Giacco D, Soltmann B, Pfennig A, Miglietta E, Lasalvia A, et al. (2020). Healthcare system performance in continuity of care for patients with severe mental illness: A comparison of five European countries. Health Policy 124(1): 25–36. DOI: 10.1016/j.healthpol.2019.11.004.
24. Ramaswamy S, Seshadri S, Bunders-Aelen J (2022). Shifting landscapes of global child mental health: Imperatives for transdisciplinary approaches. Asian J Psychiatr 69: 103002. DOI: 10.1016/j.ajp.2021.103002.
25. Reupert A, Maybery D, Nicholson J, Gopfert M, Seeman MV (Eds). (2015). Parental Psychiatric Disorder: Distressed Parents and their Families (3rd ed.). Cambridge: Cambridge University Press, 390 p.
26. Tobon JI, Reid GJ, Brown JB (2015). Continuity of Care in Children's Mental Health: Parent, Youth and Provider Perspectives. Community Ment Health J 51(8): 921–930. DOI: 10.1007/s10597-015-9873-5.
27. Tobon JI, Reid GJ, Goffin RD (2014). Continuity of Care in Children's Mental Health: Development of a Measure. Adm Policy Ment Health 41(5): 668–686. DOI: 10.1007/s10488-013-0518-0.
28. Toulany A, Stukel TA, Kurdyak P, Fu L, Guttmann A (2019). Association of Primary Care Continuity With Outcomes Following Transition to Adult Care for Adolescents With Severe Mental Illness. JAMA Netw Open 2(8): e198415. DOI: 10.1001/jamanetworkopen.2019.8415.
29. Vondroušová K, Kociánová P, Lazarová R (2025). Referring clients to mental health centres after discharge from a psychiatric hospital. Kontakt 27(2): 185–193. DOI: 10.32725/kont.2025.029.
30. Wendt D, Shafer K (2016). Gender and Attitudes about Mental Health Help Seeking: Results from National Data. Health Soc Work 41(1): e20–e28. DOI: 10.1093/HSW/HLV089.
31. Wyngaerden F, Nicaise P, Dubois, V, Lorant V (2019). Social support network and continuity of care: an ego-network study of psychiatric service users. Soc Psychiatry Psychiatr Epidemiol 54(6): 725–735. DOI: 10.1007/s00127-019-01660-7.