



JIGSAW Young people's
health in mind

Learning from Twenty Years of Jigsaw

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Evidence from two decades
of youth mental health research,
service delivery and implementation

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Learning from Twenty Years of Jigsaw

Evidence from two decades of youth mental health research, service delivery and implementation

Executive Summary

Jigsaw was established in 2006 in response to a gap in early, accessible and developmentally appropriate mental health support for young people in Ireland. From the outset, the model combined youth-focused care with youth participation, family and community involvement, stronger coordination between services, and a commitment to research, evaluation and routine data. These principles continue to underpin Jigsaw's work today, as a nationally coordinated service for young people aged 12 to 25, alongside national mental health promotion programmes.

Over the same period, psychological distress, anxiety and depressive symptoms have increased among young people, alongside growing demand for support. Jigsaw's twentieth year provides a timely opportunity to bring together two decades of research, evaluation and implementation evidence to examine what is now supported, what has changed in our understanding, what remains uncertain, and what this means for the next phase of youth mental health policy and services.

What twenty years of evidence supports

- **Accessible, youth-focused care can be delivered at national scale.** Jigsaw has grown from a small number of demonstration sites into a national network, with sustained engagement from young people and families and broad consistency in short-term outcomes.
- **Many young people improve during brief care.** Meaningful improvement in psychological distress and personal goals is observed for many young people over relatively few sessions, while reliable deterioration is uncommon.
- **A youth model spanning ages 12 to 25 is feasible.** Jigsaw's experience supports organising care around adolescence and emerging adulthood rather than relying on traditional child and adult service boundaries.
- **Relationships and environments shape youth mental health.** The landmark My World Survey (Dooley et al., 2012) highlighted the importance of family and peer relationships, trusted adults, school experience and social support for young people's mental health and help-seeking.
- **Routine measurement can support learning and improvement at scale.** Measures of distress, goals, service experience, access and outcomes have enabled Jigsaw to monitor performance, identify variation and use data to inform care.

What twenty years have changed in our understanding

Experience at scale has changed how several of the original ideas should be understood.

- **Early intervention is about when support is provided, not how mild the problem is.** Many young people who seek help early are already experiencing substantial distress. Early intervention means responding promptly when motivation is high rather than assuming that early support is for only mild difficulties.
- **Brief care should be flexible, not a fixed dose.** Relatively brief support can help many young people, but there is no single number of sessions that is right for everyone. Care needs to be personalised - to respond to the young person, their needs and their progress.
- **Access is about the whole pathway, not just getting through the front door.** Young people need to recognise that support is relevant, know where to go, receive a timely response, engage with care and move easily to other supports when their needs change. Parents, schools and other trusted adults play an important role in helping young people reach care.
- **Prevention extends beyond the individual and beyond mental health services.** The evidence consistently points to the importance of families, schools, trusted adults, communities and wider social environments. As the conditions of growing up have changed, this broadens the focus of prevention from strengthening individual knowledge, coping and resilience towards also addressing the educational, social, economic and digital environments that can protect or undermine youth mental health.

What remains uncertain

Most evidence on clinical outcomes is observational, providing strong information about reach, experience and change during care but less certainty about effectiveness and whether improvements are sustained over time. Equity is a substantial gap. Considerably more is known about young people who reach Jigsaw than about those who do not, and there is limited evidence on whether access, engagement and outcomes are distributed equitably across different groups. At system level, there is much stronger evidence about what happens within Jigsaw than about unmet need, transitions between services, continuity of responsibility and outcomes across the wider youth mental health pathway. Evidence is also less developed on which community or population level interventions can produce sustained improvements in youth mental health.

What this means for the next phase

The central implication is that the next phase of youth mental health reform should move beyond expanding individual services towards building a more coherent system around young people's needs and pathways. This means developing timely and differentiated care that can respond as needs change; strengthening continuity between services; making equity, transitions and outcomes visible through routine data; and using that information to support learning and improvement across the system.

It also means recognising the limits of a service-only response. The expansion of youth mental health services has occurred during a period in which important indicators of youth mental health have worsened. This does not diminish the importance of accessible and effective care. Rather, it demonstrates why services alone cannot be expected to reverse population-level trends. Education, housing, social protection, community development and the wider environments in which young people grow up are also part of the response.

The evidence from twenty years of Jigsaw's work therefore supports the original case for earlier, accessible and youth-focused care, while pointing to a broader conclusion. The focus must now extend beyond providing more youth mental health care to building a connected, equitable and continuously learning youth mental health system, alongside wider action on the conditions that shape young people's mental health.

About Jigsaw and this report

Jigsaw is a national youth mental health charity supporting young people aged 12 to 25. Its work includes brief therapeutic support, mental health promotion and youth participation. Since 2006, Jigsaw has developed from a small number of locally governed demonstration sites into a nationally coordinated service network (Illback et al., 2010; O'Reilly et al., 2022). Its community-based therapeutic services are funded primarily through the Health Service Executive. Neart, Jigsaw's national programme of mental health and wellbeing support for post-primary schools, is funded by the National Educational Psychological Service and the Department of Education and Youth. Public fundraising and project-specific grants also support programme infrastructure and innovation (Jigsaw, 2026).

Jigsaw's Research Department leads a programme of health service research, routine service monitoring and programme evaluation focused on improving youth mental health care. The department works with academic and service partners in Ireland and internationally. This report was prepared by the department and draws together published research, evaluation and routine service data from 2006 to 2026.



1.0 Introduction

Jigsaw was established in 2006 around a set of ideas about how mental health support for young people could be organised differently. These included earlier intervention, accessible youth-focused care, meaningful youth participation and a stronger role for families and communities. The model proposed that many young people could benefit from brief, evidence-informed support, delivered within more connected local pathways (Bates et al., 2009). Over the following two decades, these principles were implemented through a growing service network and adapted in response to evidence, experience and changes in the wider system.

From the outset, Jigsaw invested in research as part of its national infrastructure. This has generated two decades of research, evaluation and documented implementation experience. Jigsaw's twentieth year provides an opportunity to examine the original model against this evidence. This report considers the extent to which Jigsaw's propositions and assumptions are supported, how the model has developed and where evidence gaps and questions remain. This is timely as Ireland seeks to strengthen early intervention and integrated youth mental health care through *Sharing the Vision* and the Health Service Executive (HSE) Child and Youth Mental Health Office Action Plan 2024–2027 (Department of Health, 2020; Health Service Executive, 2025). The report considers what Jigsaw's experience may contribute to these wider developments.

1.1 The problem Jigsaw was designed to address

Many mental health difficulties first emerge during adolescence or early adulthood. A meta-analysis of 192 epidemiological studies estimated that 34.6% began before age 14 and 62.5% before age 25 (Solmi et al., 2022). This places adolescence and early adulthood at a critical point in the development of mental health difficulties.

When Jigsaw was established in 2006, mental health provision in Ireland did not align well with this developmental pattern. Services were largely divided between child and adult systems, while access to specialist care was shaped by age, clinical thresholds and local capacity. Accounts described unclear pathways and limited coordination between community, primary care and specialist services (Illback & Bates, 2011; McGorry et al., 2013). Young people experiencing emerging difficulties, but who did not require specialist treatment, had few clear options for support. Provision organised specifically around young people's developmental needs and preferences was also limited, including youth-friendly routes into care and opportunities for young people to influence the services. Families, schools and communities were not consistently incorporated into how mental health support was organised. *A Vision for Change*, published in the same year, placed greater emphasis on service-user involvement and person-centred, community-based care (Department of Health and Children, 2006). Jigsaw was developed within this reform context, with a particular emphasis on involving young people in shaping services and on organising support around the developmental needs of those aged 12 to 25.

Related approaches were emerging internationally, including headspace in Australia. These models sought to organise accessible care around the developmental needs of young people rather than conventional service boundaries (McGorry et al., 2013). Their shared principles were later reflected in the International Declaration on Youth Mental Health, which called for youth-focused services spanning adolescence and early adulthood (Coughlan et al., 2013). The International Association for Youth Mental Health has since provided a forum for exchanging evidence and implementation experience across these models.

The original Jigsaw model can therefore be understood as a response to a mismatch between when mental health difficulties commonly emerge and how services were organised around young people's needs.

1.2 From demonstration model to national service

Jigsaw began as a demonstration initiative across five communities. The early approach placed considerable emphasis on local development, with young people and community organisations involved in shaping how each site responded to youth mental health need. These sites provided an opportunity to develop the model through practice and to examine whether a different approach could be established within varied local settings (Illback et al., 2010; McGorry et al., 2013).

Early descriptions of Jigsaw combined support for individual young people with a wider concern for how that support was accessed, delivered and connected. Table 1 summarises the main principles underpinning that model. They provide a framework for interpreting the evidence reviewed in this report, rather than criteria that were systematically assessed.

Table 1

Principles underpinning the original Jigsaw model

Original principle	What the principle implied
Early intervention and “no problem too small”	Young people should be able to access support before difficulties become severe or reach the threshold for specialist care.
Accessible, youth-friendly support	Services should be visible, acceptable to young people and easy to enter.
Brief, evidence-informed care	Focused support could meet the needs of many young people experiencing mild-to-moderate difficulties.
Developmental fit	Support spanning ages 12 to 25 could better reflect the development of mental health need than separate child and adult services.
Youth participation	Young people should contribute to the design and delivery of services intended for them.
Families and communities as resources	Families, schools and community organisations should form part of the response to youth mental health need.
Service and system change	Local services should work together to provide clearer and more connected pathways to support.
Evaluation and learning	Research and service data should inform the continuing development of the model.

Note. The table summarises recurring ideas in early descriptions of Jigsaw, including Bates et al. (2009), Illback et al. (2010), Illback and Bates (2011), and McGorry et al. (2013).

Over the following two decades, Jigsaw developed into a nationally coordinated network of services. The model became more clearly defined, with brief therapeutic support assuming a central place alongside mental health promotion and youth participation. New forms of delivery, including online support and national work with schools, extended the original approach. Development was also shaped by changes in demand, workforce capacity and the wider mental health system (O'Reilly et al., 2022).

1.3 Purpose and scope

This report examines what two decades of Jigsaw research, evaluation and implementation evidence indicate about the original Jigsaw model and how it has developed in practice. It considers how the available evidence relates to the model's core principles, what has been supported or refined through implementation, and where important evidence gaps remain. The report also considers the implications of this learning for youth mental health policy, service planning and system development in Ireland.

The report is not a systematic review of each principle, nor is it an evaluation of the Jigsaw model. Rather, it is a synthesis of evidence and implementation learning intended to inform future service development and policy. The primary audience is health service leaders, policymakers, commissioners and practitioners involved in planning youth mental health supports in Ireland.

2.0 Methods

This report used an implementation learning synthesis approach to examine what could be learned from the development of integrated youth mental health services in real-world settings. It brought together published research, routine clinical and service data, internal evaluations and documented implementation experience produced since 2006. The approach was designed to accommodate evidence generated for different purposes and using different study designs, and to examine patterns of learning across research, service delivery and implementation. In line with evidence-synthesis approaches used in health policy and systems research, the purpose was not to conduct a formal systematic review or estimate an overall effect, but to integrate diverse sources of evidence to draw out implications for service development and policy (Langlois et al., 2018; Mays et al., 2005; Dixon-Woods et al., 2005).

A structured PubMed search was conducted to identify research conducted by Jigsaw affiliated researchers. This was supplemented by internal repository searches and consultation with affiliated researchers. The original review included 55 outputs — 45 peer-reviewed studies and 10 additional reports. Studies were coded by design, population, topic and findings and mapped against national mental health research priorities. The evidence base was updated for this report to include six additional peer-reviewed publications published in 2026, bringing the evidence considered to 61 outputs, including 51 peer-reviewed studies. The research team reviewed the mapped material collectively, aligning it with the relevant mental health policy domains. To support interpretation and implementation relevance, emerging findings were reviewed with senior service implementers with direct experience of designing and delivering Jigsaw services at scale. To support quality and interpretive rigour, the report was peer reviewed by two independent senior researchers.

3.0 Results

This section presents the main findings from the synthesis. Most studies used observational designs, drawing primarily on routine service data, large-scale surveys, and secondary datasets. No experimental studies were identified. The evidence base was dominated by studies of young people aged 12-25 years, including Jigsaw service users, students, and participants in population-based surveys. Fewer studies focused on parents, clinicians, school staff, or other stakeholders. Across the independent cohorts included in the review, the evidence base represented more than 70,000 young people, including approximately 33,400 participants from population-based surveys and at least 38,000 from clinical and youth mental health service cohorts. The Results section summarises this evidence across the main areas of Jigsaw's work, while the discussion considers its implications for the future development of youth mental health systems.

3.1. Trends and patterns in youth mental health need

The evidence indicates that youth mental health services are responding to substantial and changing patterns of need. At population level, the My World Survey identified a significant increase in severe depressive and anxiety symptoms among young people between 2012 and 2019 (Dooley et al., 2019). Routine service data show a similar pattern. Figure 1 indicates that average psychological distress among young people accessing Jigsaw increased between 2019 and 2025, with a marked peak during the COVID-19 period. Although distress declined in the immediate post-pandemic period, this reduction was not sustained, with levels increasing again in more recent years.

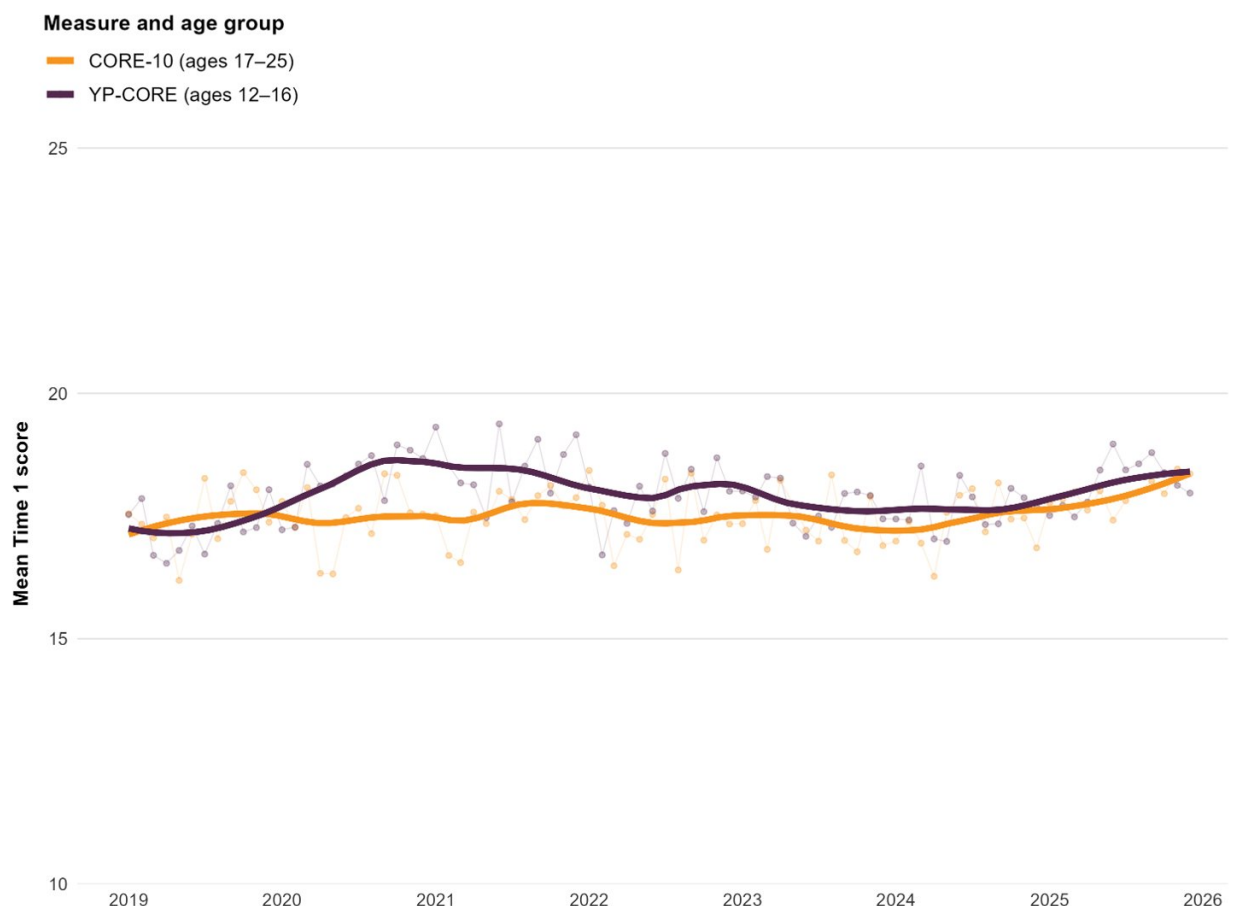
Patterns of distress differ across groups. Young women have consistently reported higher levels of psychological distress than young men (O'Keeffe et al., 2015). Across clinical studies, anxiety has been the most commonly reported presenting difficulty among young people accessing Jigsaw, alongside low mood and sleep difficulties (O'Keeffe et al., 2015; Peiper et al., 2015; O'Reilly et al., 2021; Rossouw et al., 2021; Mac Dhonnagáin et al., 2024).

Routine data from 2025 provides a more detailed indication of the level of need at presentation. Young people in Jigsaw now complete measures of anxiety (GAD-7), depression (PHQ-9), and psychological distress (YP-CORE or CORE-10) when they first come to Jigsaw. Across validated measures of psychological distress, depression and anxiety, most young people scored within at least the moderate range and

a substantial proportion scored within moderate-to-severe or severe ranges. These findings challenge a simple characterisation of early intervention services as responding primarily to mild or moderate difficulties.

The pattern of need is not adequately captured by symptom severity alone. Analysis of 9,673 young people accessing Jigsaw found considerable variation in the combination of psychological, behavioural and contextual difficulties experienced by young people (Mac Dhonnagáin et al., 2024). Distress frequently occurred alongside difficulties involving family, peers, school and other aspects of young people's lives. Goals set during care extended beyond symptom reduction, with most focused on coping, personal development and interpersonal difficulties (O'Reilly et al., 2022).

Figure 1
Trends in psychological distress in Jigsaw, 2019 to 2025



Note. The y-axis is truncated to 10–25 to improve visibility of change.

The possible score range for both measures is 0–40, with higher scores indicating greater psychological distress.

3.2 Outcomes following brief and early intervention

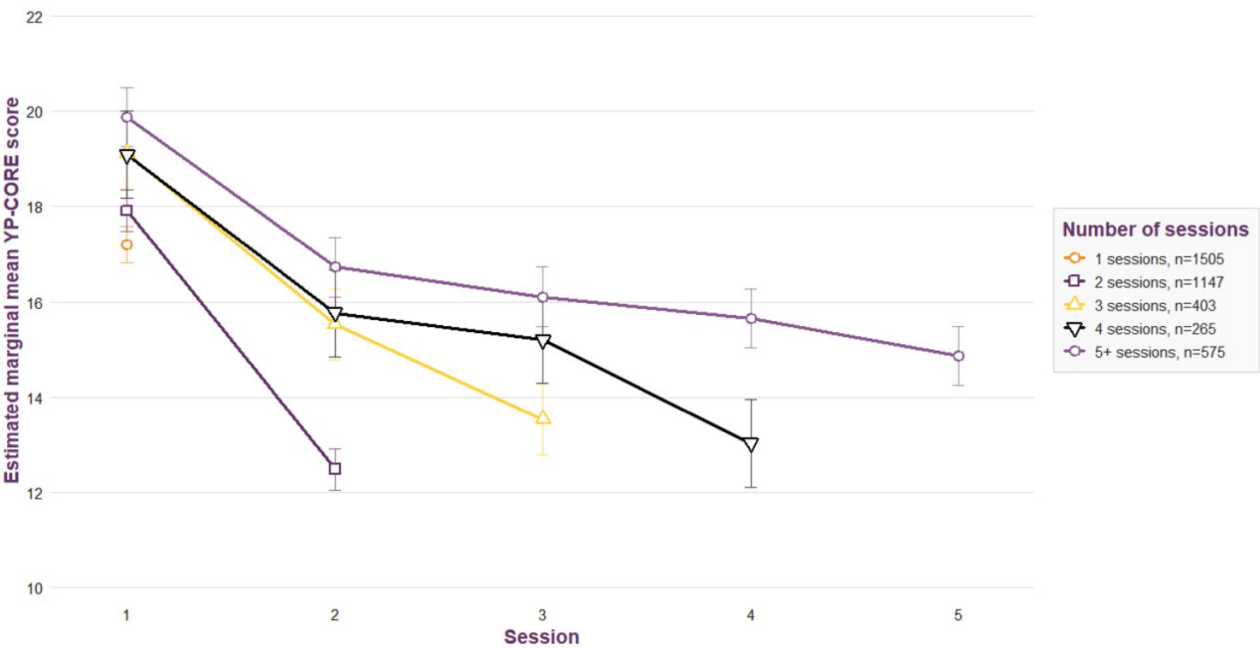
Early intervention youth mental health models were developed to provide support that is timely, accessible, developmentally appropriate and connected to wider care (McGorry et al., 2013). Researchers and implementers have increasingly sought to understand whether brief, community-based youth mental health support can produce meaningful improvement for young people presenting with significant distress, and whether such outcomes can be delivered consistently across a national service network.

Over more than 15 years, Jigsaw’s routine outcome monitoring and service evaluations identified improvement in psychological distress and goal attainment among young people. Analysis of almost 5,000 young people found that approximately two thirds achieved reliable improvement following brief, evidence-informed support (Moore et al., 2025). Figure 2 presents YP-CORE scores by visit and total number of sessions. Reliable improvement was broadly consistent across services with a small degree of variance. The observed outcomes also compared favourably against international benchmarks reported for youth psychological therapies (Moore et al., 2025a; Moore et al., 2025b).

In 2025, Jigsaw introduced a revised pathway designed to provide young people with a therapeutic single session within two weeks of initial contact. Preliminary evaluation found that young people and families continued to report high levels of satisfaction (Moore et al., 2026), while qualitative findings indicated that young people valued receiving support at the point when they were ready to engage (O’Brien et al., Under review). Figure 2 presents YP-CORE scores by visit and total number of sessions. Average distress was lower at the planned follow-up than at intake, with the largest reduction occurring between the first and second measurement points. Scores then tended to stabilise among young people who attended further sessions.

Recent qualitative research helps explain how brief support may produce change. Interviews with 11 young people identified the therapeutic relationship as a non-judgmental and safe foundation, alongside youth-led support, emotional openness and movement towards a more strengths-focused understanding of difficulties. These findings suggest that meaningful brief intervention depends on relational, collaborative, emotion-focused and strengths-based practice (Mac Dhonnagáin et al., 2026).

Figure 2
Average youth distress scores by visit and number of sessions



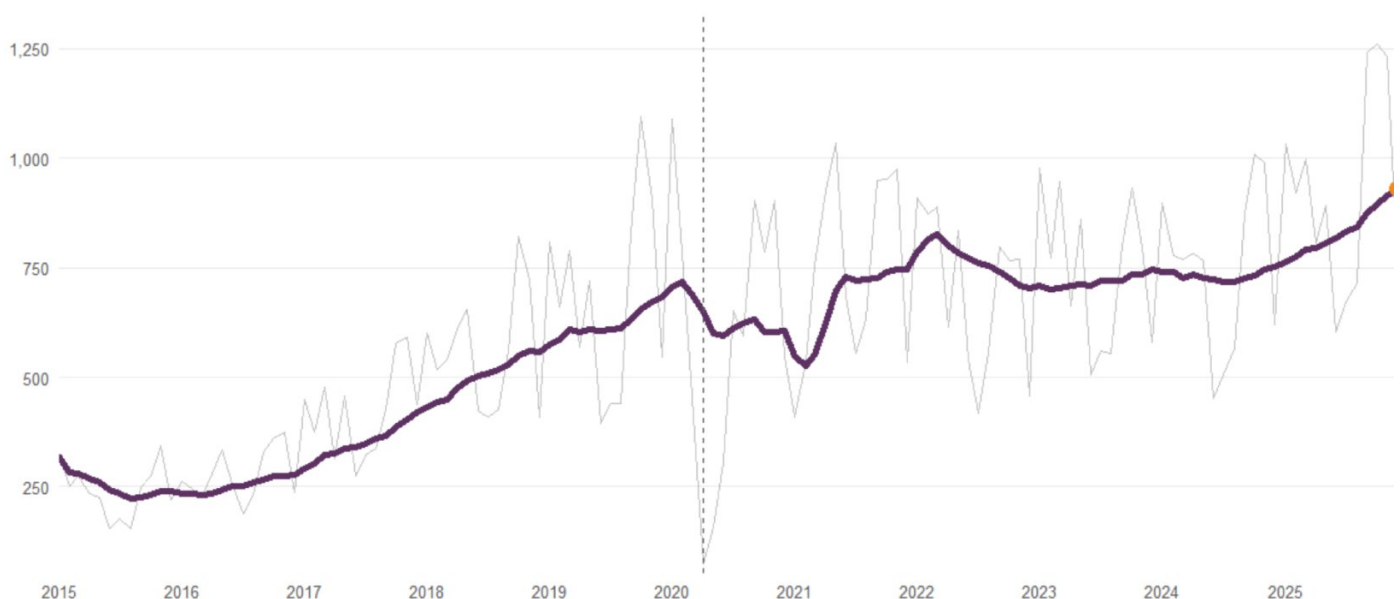
3.3 Access, referral pathways and waiting time

Access to youth mental health support was shaped by more than the availability of a service. Young people and those around them also needed to recognise services as relevant, credible, safe and reachable. Consistently across clinical studies, parents were the most common referral route for younger service users, followed by self-referral and referral from schools and general practice (O'Reilly et al., 2021; Moore et al., 2026). Schools and other trusted adults also played an important role in recognising difficulties and supporting young people to seek help. These findings indicate that access was often supported by the relationships and institutions surrounding the young person rather than occurring through independent help-seeking alone. Referral activity increased substantially over the period examined, from fewer than 1,000 referrals annually during the early years of service development to more than 11,000 in 2025. This pattern indicates sustained and increasing demand for community-based youth mental health support.

Research also indicates that waiting times are associated with clinical outcomes. A 2025 study of over four thousand young people examined factors associated with reliable improvement using routinely collected outcome data (Moore et al., 2025). After adjustment for demographic and clinical characteristics, young people seen within two months were more likely to achieve reliable improvement than those who waited longer. Among young people aged 12–16, waiting more than 60 days was associated with an 11% lower likelihood of reliable improvement. Qualitative findings were consistent with the importance young people placed on receiving a timely response. In a study of fifteen young people who received a therapeutic single session at the point of entry to Jigsaw, all participants described timely access as a central part of their experience (O'Brien et al., Under review). Early studies found that delayed access negatively affected care experiences for youth (Mac Dhonnagáin et al., 2026).

Evidence points to access as a pathway rather than a single event. Relevant stages include recognition of need, disclosure, initial contact, referral, waiting, attendance, engagement, onward transition and outcome. A service can perform well at one stage while young people continue to experience barriers elsewhere in the pathway.

Figure 3
Referrals to Jigsaw, 2006–2025



3.4 Patterns of digital service use and preference

Digital mental health is an increasingly important part of early response in youth mental health, with growing policy and research interest in how digital tools can complement service delivery (see Digital for Care, 2025). Digital approaches can widen access, increase flexibility, provide information at scale and offer additional ways for young people to engage with support. In 2025, in partnership with University College Dublin, researchers compared the demographic profile of traditional Jigsaw services with users of the Jigsaw anonymous national text therapy service (Live chat). Results showed that text therapy users were more likely to be older, gender diverse and experiencing higher levels of distress (Tibbs et al., 2025). This suggests that digital services may reach some young people whose needs, preferences or circumstances differ from those accessing face-to-face provision.

At the same time, Jigsaw's evidence does not support digital therapy as a replacement for in-person services. During COVID-19, when referrals to video therapy were actively encouraged, most young people continued to express a preference for in-person support, and this preference has persisted. This suggests that digital provision can widen access and offer valued choice for some young people, but should be understood as one part of a blended model of care rather than as a substitute for face-to-face services.

3.5 Youth participation in service development, research and governance

Youth participation has been a core principle of Jigsaw since its establishment. Our evidence suggests that participation is relevant at several levels, from young people having agency within their own care to influencing service development, research and organisational decision-making.

At the level of individual care, recent analysis of routine feedback from 1,039 young people found that experiences were dominated by the appropriateness of support and their ability to engage with it. Young people frequently described feeling heard, validated and supported, and placed particular value on non-judgemental therapeutic relationships (O'Brien et al., Under review). These findings do not constitute evidence of formal participation, but they indicate that having a voice and experiencing agency within care are important features of a youth-centred service. Parent feedback also identified a related tension - while young people's autonomy was valued, some parents sought greater information and involvement in care. This highlights the need to balance youth agency and confidentiality with appropriate family involvement.

Participation has developed beyond the therapeutic relationship. Jigsaw has established youth advocate structures across services, a Youth Research Council, and youth representation on the Jigsaw Board and Board subcommittees. Young people have also participated in service development, research and advocacy initiatives. Research on Jigsaw's youth advocacy work reflects a more structured, rights-based approach in which participation is concerned not simply with providing young people with opportunities to express their views, but with ensuring that those views have an audience and can influence decisions (Carey et al., 2025).

The depth of participation has varied across Jigsaw's work. The evidence documents opportunities for young people to be heard and the development of formal participation structures more clearly than it demonstrates the influence of participation on subsequent decisions, services or outcomes. There is currently limited evidence on how youth participation influences organisational decisions, service development or outcomes.

3.6 Mental health promotion, social context and wider determinants

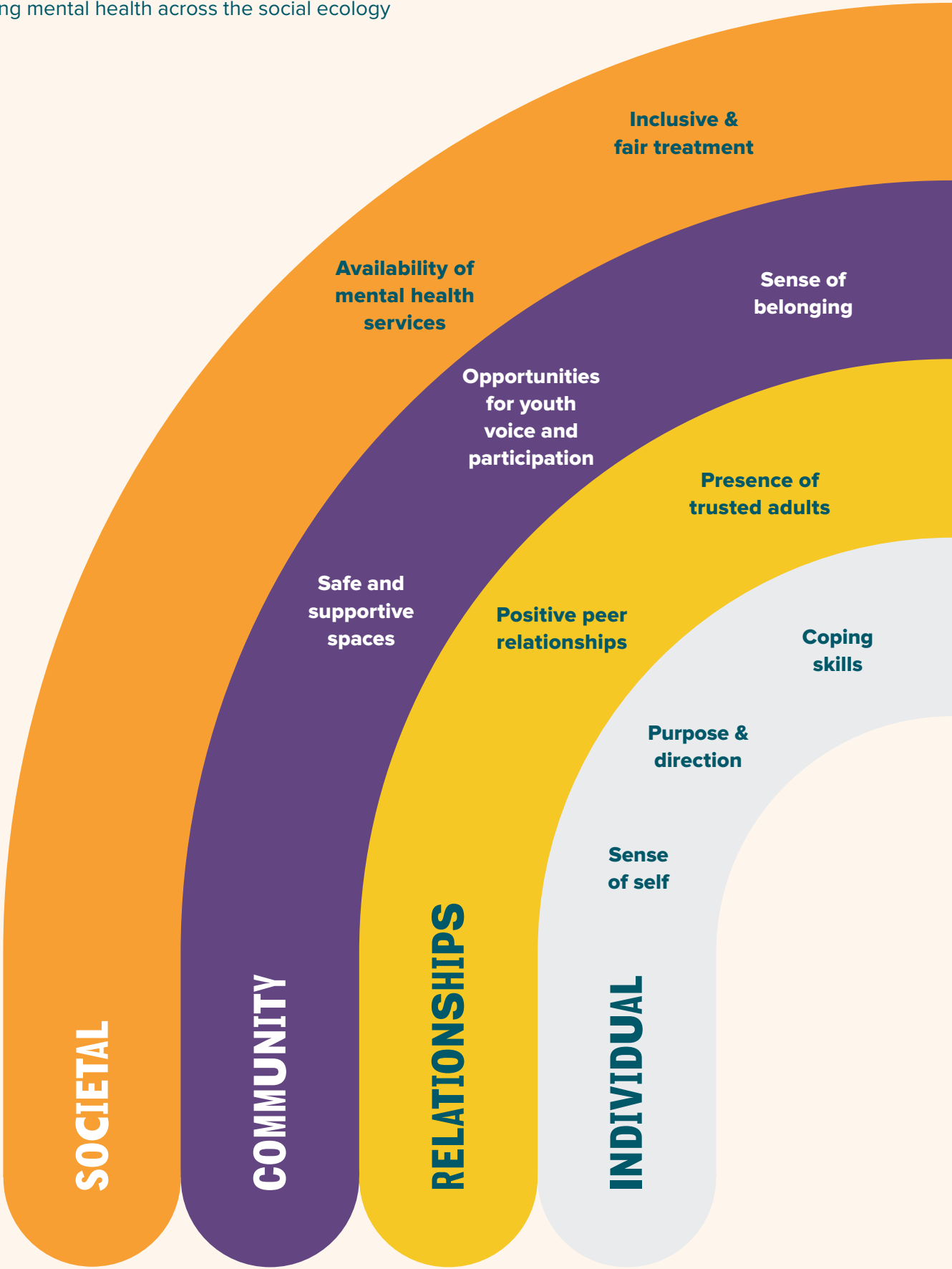
In keeping with its founding principles, Jigsaw research and practice have consistently emphasised the social and relational contexts in which young people's mental health develops. The Jigsaw and UCD My World Survey identified associations between mental health and school experience, peer relationships and social support (Dooley et al., 2012; Dooley et al., 2019). A prominent finding was the protective role of a trusted adult, subsequently communicated through the concept of One Good Adult. Other analyses identified lifestyle profiles associated with differences in mental health, wellbeing and daily functioning (Mahon et al., 2022). Taken together, these studies reinforced the importance of relationships, social support and the environments in which young people grow up.

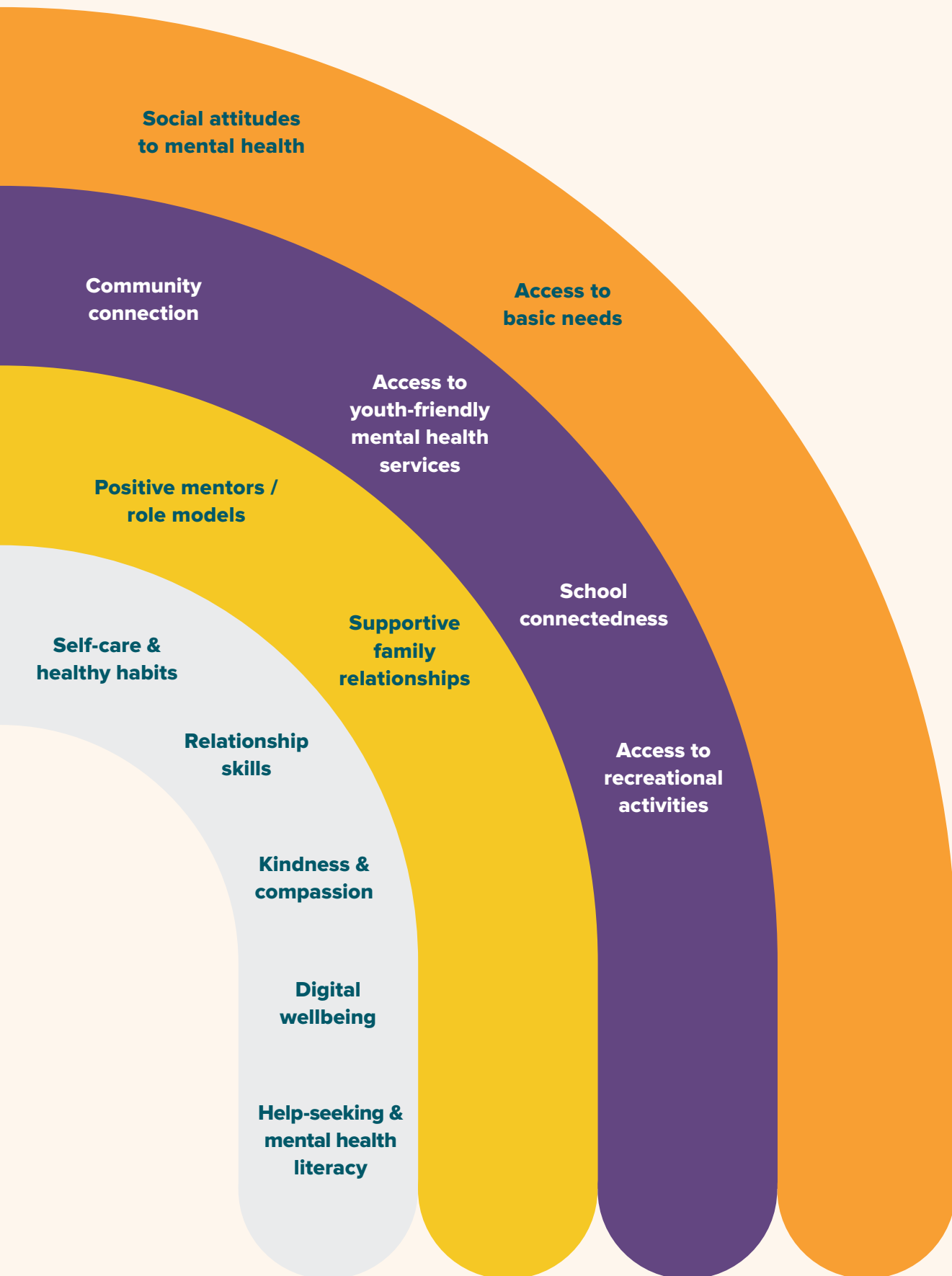
Over the same period, the wider context of youth mental health has become more complex. Young people are developing within changing educational, social, economic and digital environments, with contemporary evidence pointing to multiple and intersecting pressures rather than a single explanation for changing patterns of distress (McGorry et al., 2024). These include academic pressure, housing and economic insecurity, changing social relationships and digital environments (OECD, 2026). These wider developments provide important context for interpreting Jigsaw's emphasis on social and environmental influences on youth mental health.

Jigsaw's approach to mental health promotion developed in response to this broader understanding. Earlier work placed substantial emphasis on mental health literacy, stigma reduction, help-seeking and strengthening the capacity of adults and communities to respond. More recent approaches have placed greater emphasis on protective factors across the environments around young people. This is reflected in the *Building Blocks for Mental Health Framework*, which organises promotion activity across individual, relational, community and organisational levels. In practice, this has informed work with young people, parents, trusted adults, schools and communities, including Neart.

The evidence on impact is less developed than the evidence on reach and acceptability. Mental health promotion initiatives have generally been evaluated through smaller studies, internal monitoring and pre-post designs. Available findings demonstrate short-term changes in outcomes such as mental health literacy and stigma rather than sustained effects on mental health or population-level outcomes (for example, Farrell et al., 2018; Allen et al., 2026). Evidence is therefore strongest for the feasibility and short-term effects of multi-level promotion approaches, while their longer-term impact, safety, unintended effects and contribution to population mental health remain important areas for further evaluation.

Figure 4
The Jigsaw Building Blocks Programme
— promoting mental health across the social ecology





3.7 Routine outcome monitoring, service data and evaluation

Routine outcome measurement has been a sustained component of Jigsaw's research and service evaluation. Early studies examined the suitability of the CORE-10 and YP-CORE for young people attending Jigsaw, establishing a basis for their use in routine practice (O'Reilly et al., 2016). They remain among the largest youth samples using these measures. Measurement was subsequently extended to include goal attainment and service experience, including the Goal-Based Outcome measure and youth and caregiver satisfaction measures (O'Reilly et al., 2021; Doyle et al., 2024).

Routine data have supported repeated analyses of service use and outcomes across the national network. These studies have examined change in psychological distress and goal attainment, variation in outcomes between services and groups, and factors associated with improvement, including baseline distress and waiting time (O'Keeffe et al., 2015; O'Reilly et al., 2021; Moore et al., 2025). The evidence base has incorporated service experience and idiographic measures, alongside clinical outcomes.

This represents one of the most developed areas of Jigsaw's research programme. However, most analyses have been observational and based on routinely collected data. This has provided substantial evidence on outcomes within routine care, but less evidence on causal effectiveness, longer-term outcomes and change across the wider youth mental health system. Routine data have supported analyses of clinical improvement and deterioration, both critical quality and safety data points. More recently, internal research and service-development work has begun to make individual level outcome data analytics available to clinicians in real time to inform care.

3.8 Implementation strategies, adaptation and workforce capacity

Formal implementation research within the Jigsaw evidence base was limited. One study examining implementation of Jigsaw identified 30 implementation strategies over one year. Strategies included evaluation and iteration, stakeholder engagement, training, interactive assistance and clinician support. Interactive assistance accounted for more than half of recorded implementation time, indicating that implementation required substantial ongoing practical support rather than training or guidance alone (Moore et al., 2026).

Across 15 services, differences in engagement were statistically significant but small, while adjusted variation in reliable improvement between services was also modest. Waiting times varied more - median waits ranged from two to seven weeks. These findings indicate consistency in engagement and clinical outcomes across the network, but suggest that timely access is more affected by local implementation conditions. A nationally coordinated network can support consistency through a shared model, common measurement and comparable standards, while still making local variation visible enough to guide implementation support.

The wider evidence base also documents adaptation of the service model, including changes to access pathways, digital provision and school-based programmes (see Tibbs et al., 2026). However, these studies generally evaluated services or interventions rather than the implementation process itself. Evidence remains limited on fidelity, local adaptation, implementation costs, sustainability and the contextual factors associated with successful implementation at scale.

Workforce capacity was identified through consultation with experienced implementers as a persistent constraint. Recruitment and retention difficulties, within a limited national pool of suitably qualified professionals, affected the capacity to introduce and sustain service developments and the volume of care that could be provided. Partnership with universities, schools, education agencies, community organisations and health services was a consistent feature of Jigsaw's development.

4.0 Discussion: Twenty years of evidence, learning and change

4.1 What the evidence supports

Across two decades, the evidence supports the broad direction of the original Jigsaw model. Earlier, youth-focused care has proved feasible, acceptable to young people and families, and capable of being delivered at national scale. Jigsaw has developed from a small number of demonstration sites into a national network with sustained demand and relatively consistent patterns of engagement and short-term outcomes. This experience is consistent with international integrated youth mental health models, particularly headspace, which have demonstrated substantial reach and engagement in routine practice (Rickwood et al., 2023). Comparative evidence remains more limited, but generally points in the same direction, with integrated youth services showing advantages in access and engagement and some evidence of improved depressive symptoms relative to usual care (McHugh et al., 2024).

The evidence supports the potential for meaningful clinical change within relatively brief care. Across Jigsaw studies, most young people show reliable improvement in psychological distress and goal attainment over a limited number of sessions, while reliable deterioration remains uncommon (Moore et al., 2025). These findings are broadly consistent with wider evidence that brief and, for some presentations, single-session interventions can produce meaningful benefits. At the same time, the international literature demonstrates considerable variation in response according to presenting difficulty, age and intervention type (Schleider & Weisz, 2017; Rickwood et al., 2023). Brief intervention can therefore be regarded as a credible component of youth mental health care, without implying that brief or uniform provision will be sufficient for all young people.

A distinct developmental model spanning adolescence and emerging adulthood has similarly proved feasible. Jigsaw's experience reflects a wider international movement towards organising care around the developmental period of youth rather than maintaining a strict division between child and adult systems (Hetrick et al., 2017; Iyer et al., 2019; Henderson et al., 2023). Within such models, youth participation can be embedded across clinical care, research, advocacy and governance. This is consistent with wider evidence supporting collaboration, shared decision-making and meaningful involvement as important features of youth-centred care, although evidence linking participation directly to organisational or clinical outcomes remains less developed (Viksveen et al., 2024).

The evidence further supports the importance of the social and relational context in which youth mental health develops. Jigsaw population research has consistently identified associations with family and peer relationships, trusted adults, school experience and social support (Dooley et al., 2012; Dooley et al., 2019). These findings are consistent with a broader literature showing that youth mental health cannot be understood solely at the level of the individual and that schools, families, relationships and wider environments are relevant to prevention and promotion. Evidence that such approaches produce sustained population-level changes in mental health is, however, less established (Werner-Seidler et al., 2021; Cipriano et al., 2023; Lekamge et al., 2025).

Jigsaw demonstrates that routine measurement can be embedded within a national youth mental health service. Measures of psychological distress, goals, service experience, access and engagement have supported evaluation and service improvement across the network. This provides an important foundation for a more active model of measurement-based care, in which routine information is used not simply to report aggregate outcomes but to inform clinical decisions and support continuous improvement.

4.2 How implementation has refined the model

Twenty years of implementation have altered the meaning of several of the original propositions. One of the clearest changes concerns early intervention. The early model was partly premised on reaching young people before difficulties became severe, with Jigsaw frequently described in relation to mild-to-moderate need. The profile of young people subsequently accessing the service does not fit comfortably within that description. Many present with substantial psychological distress, anxiety or depression, often alongside developmental, relational and social difficulties. Early intervention is therefore more appropriately defined by the timing of the response than by low severity at presentation. In practice, this requires services that can respond to considerable variation in need while maintaining clear and timely pathways to more intensive provision where necessary.

Experience has refined the concept of brief care. Routine outcome data indicate that meaningful improvement can occur over relatively few sessions, but they do not support the idea of a standard therapeutic dose. Young people vary in their presenting difficulties, goals, trajectories and response to intervention. Qualitative evidence places particular emphasis on the therapeutic relationship, collaboration and responsiveness to the young person's priorities. Brief care is therefore better conceptualised as proportionate and needs-led, with duration determined by progress and clinical need rather than by a predetermined number of sessions.

Young people must first recognise a need for support and find an appropriate route into care. They then need a timely response and support to remain engaged. If their needs change, they should be able to move to another form of care without losing continuity. Parents, schools, general practitioners and other trusted adults frequently help them through this process.

The experience of delivering a service across ages 12 to 25 has demonstrated the limitations of treating youth as a homogeneous population. A common developmental model can bridge conventional child and adult boundaries, but developmental stage, severity and pattern of distress, social context and available supports vary within this age range. The implication is not that the youth model should fragment into separate age-defined services, but that it requires sufficient flexibility to provide differentiated care.

The meaning of youth participation has developed from an emphasis on involvement towards a stronger concern with influence. Jigsaw has established mechanisms through which young people can contribute to care, research, advocacy and governance. The existence of these structures demonstrates that participation can be embedded within an organisation. The more substantive question is whether young people's views have an audience and shape subsequent decisions. Meaningful participation requires opportunities for young people to express their views, together with the resources and decision-making processes that allow those views to influence decisions.

Understanding of prevention and mental health promotion has broadened in parallel. Jigsaw research has repeatedly demonstrated the importance of families, relationships, trusted adults, schools and social support, while the wider context in which young people are growing up has changed substantially across educational, digital, social and economic domains (OECD, 2026). This is closely aligned with the Lancet Psychiatry Commission's call for youth mental health responses to address the modifiable risk and protective factors associated with wider social, economic, technological and environmental change (McGorry et al., 2024). This shifts the emphasis away from prevention understood as improving individual knowledge, coping or resilience. The environments surrounding young people can themselves protect or undermine mental health. Prevention consequently requires attention to families, schools, communities, digital environments and wider systems, alongside interventions directed at individual young people.

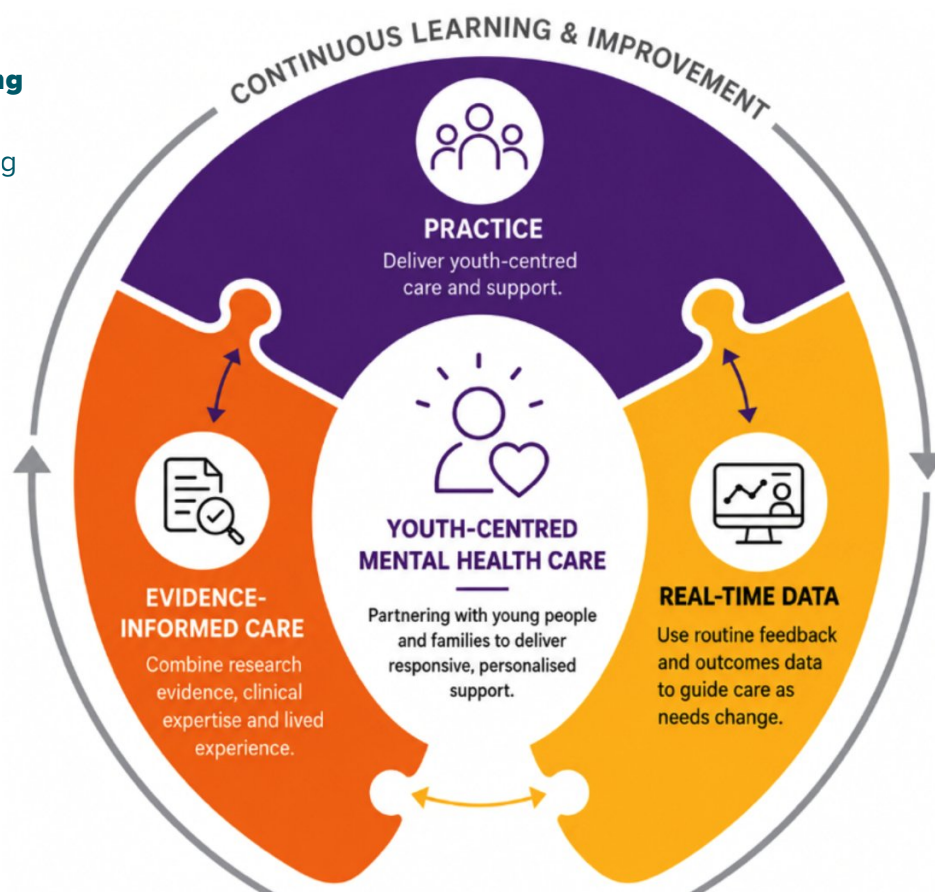
Implementation at national scale has generated a further distinction between scaling a service and transforming a system. Common governance, shared service approaches and routine measurement have contributed to relatively consistent delivery across Jigsaw, while local adaptation, workforce capacity, partnerships and sustained implementation support remain important. These findings suggest that implementation infrastructure is integral to scale rather than something required only during initial service development.

The wider system ambition is more difficult to assess. Jigsaw was originally conceived as part of a more integrated network of youth mental health supports. Twenty years later, there is substantially stronger evidence about the functioning of Jigsaw than about the functioning of the system around it. The existence of partnerships and referral arrangements cannot, by themselves, establish integration. From the perspective of the young person, integration depends on whether routes are clear, transitions are timely, responsibility is continuous and support can change

as needs change. A strong individual service therefore does not necessarily equate to a well-functioning youth mental health system.

Routine measurement has undergone a comparable development. Its initial role was primarily evaluative: describing service activity and examining outcomes across groups and services. Measurement now encompasses symptoms, goals, service experience, access, engagement, improvement and deterioration, with increasing emphasis on using this information closer to the point of care. This changes the function of data from documenting what happened to informing what should happen next, both for individual young people and for services. Taken together, these developments reflect a shift towards a Jigsaw learning health system, where data generated through routine care are increasingly used to inform practice, service improvement, implementation and research. Figure 5 illustrates this continuous cycle of evidence and learning, and how information from individual care can contribute to improvement across the wider service.

Figure 5
**The Jigsaw learning
health system**
Continuous Learning
Wheel Infographic



4.3 What remains uncertain?

The key evidence gap concerns causal effectiveness. Much of the Jigsaw research, like the wider IYMHS literature, is observational and based on routine service data. These studies are examples of practice-based evidence as they provide valuable evidence about reach, engagement, change during care and implementation in real-world settings. However, to establish with confidence what would have occurred in the absence of intervention, pragmatic, controlled and quasi-experimental studies are needed. This would help to determine effectiveness, mechanisms of change, sustained outcomes and variation in benefit across different groups of young people.

Equity remains a substantial gap. The evidence base contains more information about young people who reach Jigsaw than about those who do not. Average measures of waiting time, engagement or clinical improvement do not show whether access and benefit are distributed equitably. Future research needs to examine who reaches care, who waits, who disengages and who benefits, including differences associated with socioeconomic position, ethnicity, disability, gender, geography and intersecting characteristics.

Important questions remain about the wider conditions shaping youth mental health. The evidence supports the relevance of relationships, schools, trusted adults and social support, but the relative contribution of contemporary educational, digital, social and economic pressures is less well established. There is a corresponding evidence gap concerning which policy and population-level responses can modify these conditions and produce sustained improvements in mental health, particularly for groups experiencing greater disadvantage.

Evidence for mental health promotion is similarly uneven. Existing evaluations establish reach, acceptability and shorter-term changes in outcomes such as

mental health literacy and stigma more clearly than sustained effects on mental health or wellbeing. Future evaluation should therefore examine implementation, safety and unintended consequences alongside effectiveness, and determine whether multi-level approaches achieve changes beyond the individuals directly participating in programmes.

Implementation research remains limited. Questions persist about which elements of the model require consistency, where adaptation is beneficial, the resources required to implement change, workforce sustainability and the conditions associated with effective implementation at scale.

Perhaps the most significant system-level uncertainty concerns what happens between organisations. Jigsaw has much stronger evidence about what occurs within its own services than about transitions, continuity, repeated assessment, unmet need or outcomes across the wider youth mental health pathway. Understanding these interfaces is essential if integration is to be assessed from the perspective of young people rather than inferred from the existence of services and referral relationships.

4.4 Implications for the youth mental health system in Ireland

The findings have implications beyond the future development of Jigsaw. They suggest that the next phase of youth mental health reform in Ireland should move beyond establishing accessible individual services towards developing a more coherent system organised around young people's needs and pathways. This direction is consistent with Sharing the Vision and the HSE Child and Youth Mental Health Office Action Plan, particularly their emphasis on prevention and early intervention, coordination and continuity, social inclusion and continuous improvement.

A central implication concerns how need is organised within the system. The distinction between

early intervention and low severity has become increasingly difficult to sustain. Young people may present early while experiencing considerable distress, and their needs may change over relatively short periods. A responsive system therefore requires a continuum of support rather than rigid assumptions linking particular levels of need to particular organisations. Movement between lower- and higher-intensity care should be timely without requiring young people to negotiate thresholds or restart the process of seeking help.

Access should be considered in similar terms. Service availability represents only one part of an accessible system. Recognition of need, routes into care, waiting times, navigation, engagement, transitions and continuity all shape whether young people receive appropriate support. This places greater emphasis on the performance of the pathway as a whole. Integration should be judged by the experience of the young person moving through that pathway, rather than by whether individual organisations can demonstrate effective internal performance.

The findings concerning social context broaden the responsibility for youth mental health beyond health services. Families, schools, communities and social relationships can influence mental health, while young people now develop within changing digital, educational, social and economic environments. Prevention cannot therefore rely primarily on interventions intended to make individual young people more knowledgeable or resilient. Education, housing, social protection, community development and wider public policy all influence conditions relevant to youth mental health. A credible population and whole-system response requires attention to these conditions alongside sufficient and effective clinical provision.

The findings concerning scale and integration point to a related distinction. Jigsaw provides evidence that a nationally coordinated youth mental health service can be established with relatively consistent delivery. This does not establish that the wider youth mental health system is integrated. The original ambition of clearer,

connected pathways requires shared responsibility for what happens between services, particularly when needs change or young people move between levels of care. Stronger evidence and accountability are therefore required for transitions across organisational boundaries.

Equity should form part of this assessment. A system capable of reporting average access and outcome measures but unable to identify which groups experience greater barriers or poorer outcomes has only a partial understanding of its performance. Routine examination of differential access, waiting, disengagement and outcomes is therefore necessary if equity is to move from a policy principle to a measurable feature of service quality.

The final implication concerns learning infrastructure. Jigsaw's experience demonstrates the value of routine data for understanding service activity and outcomes. The next stage is to use these data to support clinical decisions, identify non-response or deterioration and guide service improvement. At system level, the same principle requires information that extends beyond individual organisations and makes transitions, unmet need, inequities and outcomes across the pathway visible.

Taken together, the twenty-year learning is broader than the case for accessible youth mental health services. Young people require timely and responsive care, but the evidence increasingly points to the importance of the conditions in which they grow up and the continuity of the pathways they encounter. The next phase of reform in Ireland requires progress at each of these levels: effective services, stronger integration across the youth mental health system, and wider action on the environments that shape youth mental health.

Table 2

Twenty years of learning from the Jigsaw model

Domain	Supported	Refined	Evidence gaps
Early intervention	Earlier, youth-focused support is feasible and valued	Early is about timing, not severity. Many young people present with substantial distress, beyond a simple “mild-to-moderate” description	What is the appropriate and proportionate response to lower levels of distress?
Brief care	Meaningful improvement is observed during relatively brief care in routine practice	Brief should mean flexible, not fixed. Care needs to be relational, needs-led and responsive to progress	Causal effectiveness, mechanisms of change and sustained outcomes
Access	Young people and families engage with accessible, youth-focused care	Access must be timely and extend across the whole pathway. Trusted adults, rapid response, navigation, continuity and choice of route and modality all matter	Equity of access, engagement and outcomes
Developmental fit	A distinct youth-focused model spanning adolescence and emerging adulthood is feasible	Young people are a heterogeneous group. Different profiles of distress, need and context require differentiated, developmentally responsive care	How profiles of need should inform intervention, intensity, pathways and outcomes
Youth participation	Youth participation can be embedded in services, research and governance and is valued	Participation needs to move from voice to influence. Meaningful participation requires support, resources and routes into decision-making	Whether and how participation changes decisions, services, policy and outcomes, and whether influence is equitable and sustained
Scale and system	A community-based youth mental health model can be delivered nationally with broad consistency	Scaling a service is not the same as transforming a system. Scale requires national coordination, local adaptation and active implementation support, while integration depends on clear, timely and continuous pathways across organisational boundaries	Impact on integration, continuity and functioning of the wider youth mental health system
Social Context & wider determinants	Relationships, trusted adults, schools and social support are consistently associated with youth mental health; promotion approaches can improve literacy, stigma and help-seeking	The context of growing up has changed. Educational, digital, social and economic conditions increasingly form part of the context in which distress develops. Prevention has therefore broadened beyond individual knowledge, coping and resilience towards the families, schools, communities and wider environments around young people	Whether young people experience genuinely integrated and continuous pathways; where gaps and unmet need occur; and the impact on outcomes and functioning of the wider youth mental health system
Measurement and learning	Routine measurement at national scale can support evaluation and service improvement	Measurement is moving from retrospective evaluation towards real-time learning. It now encompasses symptoms, goals, experience, access, engagement and outcomes	How to build a wider learning health system that also captures equity, continuity, promotion and system outcomes

Table 3

Priority evidence gaps for the next phase of youth mental health research

Sharing the Vision domain	Priority evidence questions arising from the review
Promotion, Prevention & Early Intervention	Implementing stronger evaluation of youth mental health promotion in Jigsaw, investigating the influence on the mental health of young people, their families, and their communities, and identifying gaps to improve population-level support for young people's mental health. Research should also examine which components are most useful, for whom, and whether there are unintended or differential effects.
Service Access, Coordination & Continuity	Developing a stronger understanding of care pathways to and from Jigsaw, and identifying barriers to inform more robust care pathways and continuity for young people. Particular attention is needed to where young people experience delays, disengagement or gaps in care, and how pathways can better respond to differing levels of need.
Social Inclusion	Identifying inequities in access, engagement, and outcomes among help-seeking young people/Jigsaw attendees, using an intersectional approach, to inform more equitable and inclusive care pathways for young people.
Accountability & Continuous Improvement	Implementing real-time use of routine data, including predictive analytics to support clinicians and identify non-response, deterioration and disengagement. Priorities include identifying variation in outcomes, non-response, deterioration and disengagement, and evaluating whether feedback and data-informed approaches improve care.
Cross-cutting implementation	Conducting controlled, pragmatic and quasi-experimental evaluation; adaptation, de-implementation, workforce and implementation at scale, to ensure high-quality real-world research can inform care provided by Jigsaw and support young people's outcomes. Longer-term follow-up and linkage across services are particularly important.

Limitations

This report has several limitations. It is based primarily on the Jigsaw evidence base and is therefore not a comprehensive review of all youth mental health research in Ireland or internationally. The report was designed as an overview rather than a formal systematic review or meta-analysis, so the findings should be interpreted as a synthesis of key learning. Much of the evidence reviewed comes from observational studies, routine service data, service evaluations and implementation learning. These sources are valuable for understanding real-world service delivery, access, outcomes and system learning, but they limit the extent to which causal conclusions can be drawn. Not all of the Jigsaw evidence cited in the report has been peer reviewed, and some findings are drawn from internal reports, preliminary analyses or studies that are currently in progress. These sources are included because they provide timely and practice-based learning, but they should be interpreted with appropriate caution. Routine service data also have limitations. They reflect young people who accessed Jigsaw and therefore cannot be assumed to represent all young people experiencing mental health difficulties. They may also be affected by missing data, changes in outcome measurement, variation in recording practices and changes to the service model over time. These factors mean that trends and outcomes should be understood as part of an evolving real-world service context rather than as fixed estimates of population need or intervention effect.

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Declaration of interests

The authors are employees of Jigsaw, the organisation. This professional affiliation represents a potential source of bias in the interpretation of evidence. To strengthen interpretive rigour, two senior external researchers reviewed the report. The authors retain responsibility for the interpretations and conclusions presented.

Use of artificial intelligence

Generative artificial intelligence was used to support proofreading, spelling and language checking during preparation of the report. It was not used as a source of evidence or to generate research findings or analyses. All final content was reviewed and approved by the authors.

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