CAMHS Operational Guideline 2025

3rd Edition

National Policy ☐ National Procedure ☐ National Protocol ☐ National Guideline ☒
National Clinical Guideline ☐

HSE CAMHS Operational Guideline (3rd Edition)

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Short summary:
This guideline aims to standardise and streamline operational practice and has been issued to assist employees in having a consistent approach to delivering CAMHS nationally.
Description:
This Operational Guideline aims to: • Align operational practice to the intended outcomes of the 2024-2027 Child and Youth Mental Health Office Action Plan • Build on the existing good practice already in place in CAMHS. • Provide an Operational Guideline that CAMHS teams can adhere to. • Ensure that legislative and regulatory requirements are met. • Ensure that all employees and management are clear on their roles and responsibilities. • Ensure that children, adolescents and their parent(s) are clear on the service provided by CAMHS. • Ensure that referral agents and other agencies involved in the provision of care to children and adolescents are clear on the service provided by CAMHS. • Provide a framework for audit and evaluation.

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Contents

CAMHS in 2024 – a year in numbers

Figure 1

Community CAMHS caseload

213,682
appointments attended.

At the end of 2024, Community CAMHS had **17,769** open active cases

14,806 referrals to Community CAMHS were accepted.

Child/ Adolescent Population

There are
1.2 million
under 18s in Ireland.

Community CAMHS waiting times

93.6%
of urgent referrals to Community CAMHS were responded to within 3 working days.

62.4%
of new/re-referred referrals seen within 12 weeks, not all of routine.

Community CAMHS services

In 2024, there were
81 Community CAMHS teams
providing services across the country, including 5 Specialist Eating Disorder Teams.

CAMHS inpatient Services

Inpatient services
were provided by
4 units, with 72 funded beds.

CAMHS Inpatient Activity

230 children or adolescents
were admitted to HSE/HSE funded inpatient units.

CAMHS workforce

CAMHS has
1,093 dedicated professionals
providing services to children and adolescents across Ireland.

Figure 2 - Child and Youth Mental Health Service Delivery Diagram

The HSE both directly provides and, in partnership with our community and voluntary partners, funds a comprehensive range of mental health services for children and young people including mental health promotion, early intervention, targeted community-based support, as well as more specialised community based and inpatient services.

CAMHS is funded to provide specialist and intensive specialist mental health services, represented by the bottom two sections of this mental health service delivery diagram.

Foreword

National Director, Access & Integration

As part of its commitment to the ongoing development of quality mental health services for children and adolescents, a dedicated National Child and Youth Mental Health Office (CYMHO) was established in September 2023. Under the leadership of the Assistant National Director, Donan Kelly, and National Clinical Lead, Dr Amanda Burke, the office has oversight of service delivery and improvement programmes related to child and youth mental health. The CYMHO published its 3-year Action Plan in February 2025.

The HSE both directly provides and, in partnership with our community and voluntary partners, funds a comprehensive range of mental health services for children and young people including mental health promotion, early intervention, targeted community-based support, as well as more specialised community based and inpatient services. Child and Adolescent Mental Health Services (CAMHS) are provided by the HSE for the small proportion of children and young people with moderate to severe mental health disorders, who require more specialist supports.

It is with great pleasure that the CYMHO present the third edition of the CAMHS Operational Guideline. This guideline reflects the dedicated and consistent efforts of our mental health services staff and aims to provide consistency and transparency in the delivery of CAMHS across the country.

The original CAMHS Standard Operating Procedure (SOP) was published in 2015, and the second edition (CAMHS Operational Guideline) was updated in 2019. This new, updated Operational Guideline follows an extensive review and consultation process, incorporating feedback from service users, family members, frontline staff, and management within HSE mental health services, as well as other organisations working with children and adolescents.

Since 2019, several key documents have been published to inform service improvements across CAMHS, including; Look-Back Review into CAMHS in South Kerry ('Maskey Report'), (2021), National Audit of Prescribing in CAMHS, (2023), National Audit of Adherence to the CAMHS Operational Guidelines Report (2024), the Independent Review of the provision of CAMHS in the State (2023), Mental Health Commission and the CYMHO Action Plan 2024-2027.

These documents have been comprehensively reviewed to ensure that all relevant recommendations have been incorporated into this revised Operational Guideline.

CAMHS are specialist clinical services serving a small proportion of the population. We strive to optimise the use of available resources to address the priority mental health needs of children and adolescents. The service levels described in this guideline are ambitious, and it is anticipated that full implementation may take some time in each area, depending on available resources.

I would like to take this opportunity to thank staff across CAMHS for their ongoing commitment and dedication to improving the mental health of our children and young people. The publication of this updated guideline will undoubtedly provide further support in this endeavour.

Grace Rothwell
National Director, Access and Integration
Health Service Executive (HSE)

Foreword

National Clinical Lead, Child and Youth Mental Health

As National Clinical Lead for Child and Youth Mental Health Services (including CAMHS), I am pleased to present the third edition of the CAMHS Operational Guideline. This document reflects the dedication, expertise, and lived experience of a wide range of contributors, children and adolescents, their families, front-line professionals, and our partners across the wider health and social care system.

Mental health is a critical foundation for the healthy development and wellbeing of all young people. Our responsibility as a national mental health service is to deliver care that is compassionate, evidence-based, safe, and consistent across all communities. This updated guideline marks an important step toward that goal.

CAMHS teams support a small proportion of our youth whose moderate to severe mental health disorders require multidisciplinary intervention. The impact of timely, appropriate care for these young people is profound. This guideline ensures clarity on how services are accessed, delivered, and transitioned, and provides a consistent operational framework aligned with best practice, national policy, and relevant legislation.

A key feature of this edition is its renewed emphasis on recovery, participation, and partnership. We recognise that young people and their families must be active participants in their care. This approach respects their voices, supports shared decision-making, and promotes hope and autonomy, essential elements of recovery in child and adolescent mental health.

The development of this guideline involved a comprehensive review and consultation process, and I want to express my gratitude to everyone who contributed. Their insights have shaped a document that not only supports service delivery, but also reaffirms our collective commitment to continuous improvement, transparency, and accountability.

We are proud of the progress reflected here, but our work does not end with publication. Successful implementation requires strong clinical leadership, robust governance, and a shared commitment at every level of our health system. I look forward to working with all stakeholders to embed this guideline in daily practice, and ultimately to strengthen the quality and equity of mental health care for young people across Ireland.

Dr Amanda Burke
National Clinical Lead,
Child and Youth Mental Health
Health Service Executive (HSE)

1. Guideline Background and Context

1.0 Health Service Executive Child and Adolescent Mental Health Services

Health Service Executive (HSE) Child and Adolescent Mental Health Services (CAMHS) provide specialist mental health services to those up to the age of 18 years, who have moderate to severe mental disorders[1] that require the input of a multi-disciplinary team. These services are often referred to as *CAMHS*.

1.1 Guideline Statement

1.1.1 A guideline is a statement which guides or directs a certain course of action. It aims to streamline particular processes according to best practice (*HSE PPPG Framework,* 2016). In 2015, CAMHS developed an overarching Standard Operating Procedure (SOP) to assist employees in having a consistent approach to delivering CAMHS nationally (*HSE PPPG Framework,* 2016). This was reviewed and updated and renamed as the CAMHS Operational Guideline (COG) in 2019.

1.1.2 This revised 2025 version includes all relevant legislative and policy updates, as well as reflecting the recommendations from various audits, reports and consultations.

1.1.3 It is expected that all CAMHS teams will adhere to the guideline in its entirety. Where this is not occurring, clear reasons must be documented in clinical files and/or reported through relevant regional governance structures.

1.2 Purpose

1.2.1 The purpose of the HSE CAMHS Operational Guideline is to guide consistency in the service delivery of CAMHS throughout the country. This Operational Guideline aims to:

- Align operational practice to the intended outcomes of the 2024-2027 Child and Youth Mental Health Office Action Plan.
- Build on the existing good practice already in place in CAMHS.
- Provide an Operational Guideline that CAMHS teams can adhere to.
- Ensure that legislative and regulatory requirements are met.
- Ensure that all employees and management are clear on their roles and responsibilities.
- Ensure that children, adolescents and their parent(s) (ref Glossary) are clear on the service provided by CAMHS.
- Ensure that referral agents and other agencies involved in the provision of care to children and adolescents are clear on the service provided by CAMHS.
- Provide a framework for audit and evaluation.

1. For the purpose of this document, the World Health Organisation definition of mental disorder is used to cover both community and inpatient CAMHS. Ref glossary definitions in Appendices.

1.3 Scope

1.3.1 This Operational Guideline applies to all staff engaged in the delivery of CAMHS by, or on behalf of, the HSE in Community and Inpatient settings.

1.3.2 This Operational Guideline is available to all stakeholders, including partner agencies, referral agents, children and adolescents and their parent(s).

1.3.3 The scope of this Operational Guideline is limited to guidance on the day-to-day operations in CAMHS. This is not a clinical guideline and therefore it does not provide direction in relation to clinical decision making. This is more appropriately covered by CAMHS staff members' clinical knowledge base and by professional, representative and regulatory bodies.

1.3.4 This Operational Guideline does not override the individual responsibility of CAMHS staff to make decisions appropriate to the circumstances of individual children and adolescents in consultation with their parent(s).

1.3.5 This Operational Guideline provides a summary overview of the process of referral, assessment, care planning, treatment and discharge in CAMHS. This is not to be viewed as a replacement for existing policies or legislation outlined in Section 1.4 below.

1.4 Alignment with HSE National Priorities, Legislation/Other Related Policies

1.4.1 The CAMHS Operational Guideline has been reviewed in line with the requirements laid out in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs) (2016).

1.4.2 The HSE has prioritised targeted improvements and investment in Child and Adolescent Mental Health over recent years, recognising the challenges in current service provision including levels of access, capacity and consistency in quality of services provided. These challenges have been comprehensively discussed in a number of key reports, produced both internally within the HSE and from external parties. These reports include:

- Look-Back Review into CAMHS in South Kerry ('Maskey Report'), 2022.
- National Audit of Prescribing in CAMHS, (2023), HSE.
- National Audit of Adherence to the CAMHS Operational Guidelines Report (2024), HSE.
- Independent Review of the provision of CAMHS in the State (2023), Mental Health Commission.
- 'Transforming Youth Mental Health Services in Ireland: A New Model', Sharing the Vision Youth Mental Health Transitions Specialist Group, 2024.
- Enhanced Transition Plan, Sharing the Vision Youth Mental Health Transitions Specialist Group, 2024.

1.4.3 In 2023, the Child and Youth Mental Health Office (CYMHO) was established, with the appointment of a National Clinical Lead and an Assistant National Director for Child and Youth Mental Health. This office has responsibility for the Child and Youth Mental Health Service Improvement Programme nationally.

1.4.4 A number of key related documents have been developed to inform improvements to services since the last version of this guideline was published. These include:

- CYMHO Action Plan 2024-2027.
- Model of Care for CAMHS Hubs (2023).
- the National Clinical Programmes, including the:
  - National Clinical Programme for Self-Harm and Suicide related ideation.
  - Eating Disorders Service (spanning Child and Adolescent and Adult Mental Health Services).
  - Early Intervention in Psychosis.
  - ADHD in Adults.
  - Model of Care for Dual Diagnosis services which sets out pathways to access Adolescent Dual Diagnosis services.
  - Connecting for Life which sets out Ireland's strategy to reduce suicide.
  - CAMHS in Intellectual Disability National Model of Service (Service Improvement Programme).

1.4.5 In addition to this, a number of HSE policies have been developed since 2019 which will further support improved delivery of CAMHS services, including:

- Sharing the Vision: A Mental Health Policy for Everyone (2020).
- Patient Safety Strategy 2019-2024.
- Stronger Together – HSE Mental Health Promotion Plan.
- Young Ireland: The National Policy Framework for Children and Young People 2023-2028.

1.4.6 Information from these policies, reports and documents has been considered in the development of this revised Operational Guideline.

1.5 Relevant legislation, policies and guidelines under development

1.5.1 Adult Mental Health Services (AMHS) are currently developing an Operational Guideline. CAMHS and AMHS are working together to ensure alignment of guidelines in relation to transition of adolescents to adult services.

1.6 Supporting evidence

1.6.1 This Operational Guideline should be read in conjunction with the legislation and policy in Appendix 3. This is not an exhaustive list.

1.7 Roles and Responsibilities

1.7.1 The HSE is currently undergoing significant organisational restructure, moving from a centralised structure to the creation of six health regions.

1.7.2 Responsibility and accountability for the services provided within the six HSE Regions lies with the respective Regional Executive Officers (REOs). Further information about this can be found in the HSE Performance and Accountability Framework, which describes the role of the REO within the HSE structure in more detail.

1.7.3 Integrated Health Area (IHA) managers are responsible for the overall health and well-being of the population within its dedicated geography, providing a leadership role across the entire health and social care continuum, collaborating with all public, voluntary and independent providers to champion a population health approach in service planning and delivery. They lead a senior team with operational management of service delivery across Community Health Networks (CHNs), including community and inpatient CAMH services.

1.7.4 The IHA Management team will provide clinical governance, quality assurance and functional support for all mental health services in the IHA and has responsibility for:

- Familiarising themselves with this Operational Guideline and how it applies in practice.
- Applying the best use of available resources for the implementation of this Operational Guideline.
- Ensuring that appropriate systems are in place to communicate this Operational Guideline to all employees, service users, parent(s) and other services and stakeholders directly affected by it.
- Ensuring this Operational Guideline is integrated into local policies and procedures, protocols and guidelines.

1.7.5 All CAMHS employees have responsibility for:

- Familiarising themselves with and adhering to the content of this Operational Guideline.
- Documenting any non adherence to the Operational Guideline in relevant case files and escalating any instances of non adherence through their local governance structures.
- Seeking to ensure that the best interests of children, adolescents and their parent(s) are at the centre of all decisions made by CAMHS.
- Ensuring that they are aware of their roles under the Children First Act (2015) and for following the HSE Child Protection and Welfare Policy.

1.7.6 The CYMHO has responsibility for:

- Providing assurance and support to ensure a shared understanding of performance, national consistency, and areas requiring enhanced focus and support in child and youth mental health services.
- Developing overarching national models and frameworks to improve access to integrated child and youth mental health services.

1.8 Implementation and Audit

1.8.1 The REO or IHA manager and their delegated mental health leads in each area must oversee the implementation and subsequent self-assessment of this Operational Guideline.

1.8.2 An overarching implementation plan has been developed to support this Operational Guideline (see Appendix 8). This can be adapted at local level to reflect regional variation and support services to implement this Operational Guideline in each area.

1.8.3 Staff should have access to all relevant mandatory training required for their roles. Additional training supports are available to all CAMHS employees through HSE Land and locally, which may be beneficial in providing support for the implementation of this Operational Guideline.

1.9 Self-assessment and Quality Improvement

1.9.1 Self-assessment is a structured process where a team or individual evaluates their own performance against an agreed set of standards or best-practice criteria. This process supports identification of problems, risks and opportunities through honest review and is effectively the 'diagnosis' stage in a Quality Improvement cycle.

1.9.2 Self-assessment contributes to continuous improvement by providing a structured opportunity to assess performance and identify improvements required for the CAMHS team.

1.9.3 A self-assessment tool has been developed to accompany this guideline. A 'how to' guide can be seen in Appendix 6. This survey should be completed in full every two years (or in sections throughout that period).

1.9.4 Responses can be submitted online via MS Forms or via a paper-based template (see links in the 'how to' guide in Appendix 6). Each CAMHS clinical team lead (or delegated person) will be responsible for the implementation of the tool and any subsequent identified quality improvement plans.

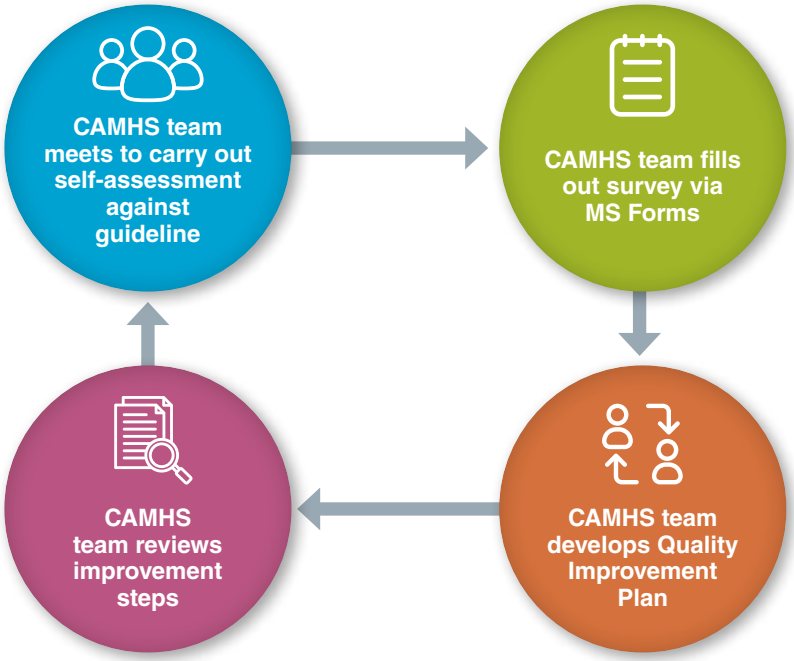


Figure 3 - Self-Assessment Process Flowchart

1.10 Revision process and stakeholder involvement

1.10.1 The review of this guideline took place in line with in line with the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines, 2016. The revision process has included the review of several key policies and reports (as listed in section 1.5) and has involved stakeholder feedback.

1.10.2 A list of sources and stakeholders involved in this review can be seen in Appendix 4.

1.10.3 This guideline will now only be available online, ensuring that regular updates can be made in line with best practice and/or any change in legislation and policy. This is a controlled document: While this document may be printed the electronic version posted on the website is the controlled copy and can only be guaranteed for 24 hours after downloading.

2. Principles and Values Guiding this Operational Guideline

2.1 Principles and Values

2.1.1 The clinical services provided by CAMHS are aimed at children and adolescents with moderate to severe mental health needs. All CAMHS services should be delivered under the following guiding principles:

Figure 4

2.1.2 CAMHS should be evidenced based, aligned with best clinical practice and regularly reassessed in line with emerging research. The impact and outcomes of services should be measured and assessed over time to embed a culture of patient safety and improvement. CAMHS should cultivate a service environment where children and young people will feel included and valued. Children and young people should be able to access mental health supports without experience of stigma.

2.1.3 In order to ensure that barriers to care are removed, special consideration should be given to children and young people with mental health needs from the following populations due to the increased incidence of mental disorders:

- members of the LGBTQ+ community.
- the Traveller community.
- children in care.
- those who are homeless.
- those who have issues with substance misuse.
- those who come in contact with the criminal justice system.
- asylum seekers, refugees and migrants.

2.1.4 In line with A National Framework for Recovery in Mental Health Services, 2024-28 CAMHS should be recovery oriented. Recovery means different things to different people. For most people it means being able to live their best life even when facing mental health difficulties. Adopting a recovery-oriented approach in CAMHS is about supporting children and adolescents and their parent(s) to find hope, to be empowered to make choices about their own care, and to have control over their own goals and how to achieve them.

2.2 HSE Values

2.2.1 The HSE's values are:

- Care.
- Compassion.
- Trust.
- Learning.

CAMHS encourages a culture where all staff live by these values every day, as they interact and deal with colleagues and members of the public.

2.3 Involving Children and Adolescents

2.3.1 Involving children and adolescents in their care is at the core of a recovery-oriented service and has many therapeutic advantages.

2.3.2 CAMHS teams should seek to ensure that children and adolescents are supported and encouraged to be actively involved in all decisions which affect them, and that their views will be given due weight in accordance with their age and maturity *(Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) 1990).*

2.3.3 Children and adolescents should be given opportunities to work with their CAMHS teams to achieve goals and outcomes that are important to them.

2.3.4 Children and adolescents should be provided the opportunities for empowerment and encouraged to be part of all aspects of service design, delivery and evaluation of the CAMHS services.

2.3.5 Active engagement can be facilitated through the development of advocacy groups as well as in their day-to-day care. Examples of good practice already in place throughout the country include actively seeking feedback, ensuring communications are in plain English, placing QR codes to on-line surveys or suggestion boxes in the community CAMHS waiting areas and Inpatient Units, producing satisfaction surveys and conducting focus groups on specific topics.

2.3.6 The development of recovery education colleges and the use of Patient Reported Experience Measures (PREMS), and Patient Reported Outcome Measures (PROMS) will also provide information to support CAMHS teams to continuously improve their service. Teams should communicate how feedback has been listened to, heard and acted upon.

2.3.7 Children and adolescents are the recipients of the service and therefore have a unique perspective and knowledge of where mental health services are working well or where they need to be improved.

2.3.8 There is a range of user-friendly, free to access digital resources which can complement mental health service delivery such as information-based websites and mobile apps, including 'Navigator'. Consideration should be given to directing children, adolescents and family members towards the resources highlighted on the HSE's www.yourmentalhealth.ie website, e.g. by referencing the site on referral or appointment letters.

2.4 Involving Parent(s)

2.4.1 CAMHS teams should aim to build and maintain collaborative relationships with parent(s) and seek to involve them fully in their child or adolescent's care planning and mental health treatments. Parent(s) have expert knowledge of their child or adolescent which is vital information to inform decision making in relation to treatment and care planning.

2.4.2 CAMHS teams should inform parent(s) about their child or adolescent's mental disorder, diagnoses, coping strategies and advise on how to support them at home. They may recommend other community and family support services which can be accessed outside of appointments.

2.4.3 CAMHS teams should encourage parent(s) to recognise their own needs, strengths and resources in supporting their child or adolescent.

2.4.4 CAMHS teams should be aware of local family support services (including recovery learning opportunities) and should signpost these as appropriate.

2.4.5 CAMHS teams should recognise and address any barriers to engagement and ensure that services are aware of cultural diversity and designed to respond to the family's needs and preferences.

2.4.6 Parent(s) should be encouraged to take part in Engagement Forum meetings, organised through local mental health services or the office of HSE Mental Health Engagement and Recovery (MHER). More details can be found on www.hse.ie/mentalhealthengagement.

2.4.7 In an inpatient setting, parent(s) and families should be encouraged to visit regularly and there should be a dedicated visiting space for families.

3. Clinical Governance and Children First

3.1 Clinical Governance Structures in HSE Mental Health Services

3.1.1 Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of health users when delivering care.

3.1.2 Clinical governance involves having the necessary structures, processes, standards, and oversight in place to ensure that safe, person-centred and effective services are delivered.

3.2 Clinical Governance

3.2.1 Clinical governance within the HSE is overseen by the office of the Chief Clinical Officer and their team. Clinical governance is covered in detail in the HSE publication, *An Initiative of the Quality and Patient Safety Division: Sharing our Learning, 2014* and in the *HSE Clinical Governance Framework.*

3.2.2 Within each Integrated Health Area, the IHA Manager works in partnership with identified clinical leadership roles to ensure that mental health clinical governance structures are in place. This includes medical, nursing and health and social care professional leadership.

3.2.3 The IHA Management team ensures that clear lines of accountability, responsibility and authority to oversee quality and safety are identified across mental health services (including CAMHS) within each IHA.

3.2.4 It is recommended that a CAMHS specific clinical governance structure should be in place (for each IHA or an agreed geographical area), and should comprise:

- CAMHS Clinical Director.
- CAMHS Director of Nursing.
- Heads of Discipline for CAMHS Health and Social Care Professional Leads.
- General Manager.
- Business Manager (or similar/equivalent).

3.3 Clinical Governance in CAMHS Teams

3.3.1 The CYMHO Action Plan includes an intention to develop a shared clinical governance model across CAMHS in order to reflect the many different professions involved in the overall care pathway. In practice, shared clinical governance means improved distribution of responsibilities, cooperation and interdisciplinarity within CAMHS teams, ensuring children and young people receive quality and safe care leading to better health outcomes and experiences.

3.3.2 Each CAMHS team must have clear accountability structures in place to achieve the delivery of high-quality, safe and reliable services (*Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement, 2017*).

3.3.3 There is a clearly documented management structure which includes corporate and clinical governance responsibilities and reporting relationships.

3.3.4 The Consultant Psychiatrist is the Clinical Lead on the team. Each member of the CAMHS team also has a professional and management reporting relationship through their discipline specific line management structure.

3.3.5 Each member of a CAMHS team has the professional responsibility to carry out clinical work with children and adolescents within their scope of practice, as defined by their professional and regulatory bodies such as the Medical Council, the Health and Social Care Professionals Council (CORU), the Nursing and Midwifery Board of Ireland (NMBI) and the Psychological Society of Ireland (PSI).

3.3.6 Each member of a CAMHS team has the responsibility to actively participate in Clinical Audit and Quality Improvement Activity, and a lead should be nominated from the clinical team to link in with IHA/regional audit committees.

3.3.7 Each individual CAMHS team member knows their responsibility, level of authority and to whom they are accountable.

3.3.8 Each individual CAMHS team member seeks to demonstrate how the principles of quality and safety can be applied in their diverse practice to pursue improved outcomes for children and adolescents and their families. This is best achieved in a culture of trust, openness, respect and caring.

3.4 Children First

3.4.1 The Children First Guidance (Children First: National Guidance for the Protection and Welfare of Children, 2017) promotes the protection of children from abuse and neglect. It sets out the definitions of abuse, how to recognise it, and explains how reports should be made to Tusla – The Child and Family Agency.

3.4.2 Under the Children First Act (2015), all CAMHS services have a number of statutory obligations including, (within three months of commencement of services).

- Undertaking a Risk Assessment of any potential for harm (as defined in the Act) to a child or adolescent.
- Preparing a Child Safeguarding Statement specifying the service being provided and the policies and procedures that are in place to manage the risks identified.
- Appointing a Relevant Person for the purposes of the risk assessment and child safeguarding statement.
- Guidance and a template for the Child Safeguarding Statement can be found here.

3.4.3 All CAMHS staff are obliged to complete the Children First e-learning module *Introduction to Children First* through HSELanD and any other child safeguarding trainings as required by their role.

3.4.4 The Children First Act 2015 places specific legal child safeguarding obligations on certain people known as Mandated Persons.

Mandated Persons have two main legal obligations under the Act:

- To report the harm of children above a defined threshold to Tusla - Child and Family Agency.
- To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.

For further information on Mandated Persons, please see here.

3.4.5 CAMHS staff, who are Mandated Persons, can be asked by Tusla to provide “such information and assistance as it may reasonably require and is, in the opinion of the Agency, necessary and proportionate in all of the circumstances of the case” (Children First Act 2015). This assistance will aid Tusla in assessing if a child, who is the subject of a mandated report, or any other child, has been, is being, or is at risk of being harmed.

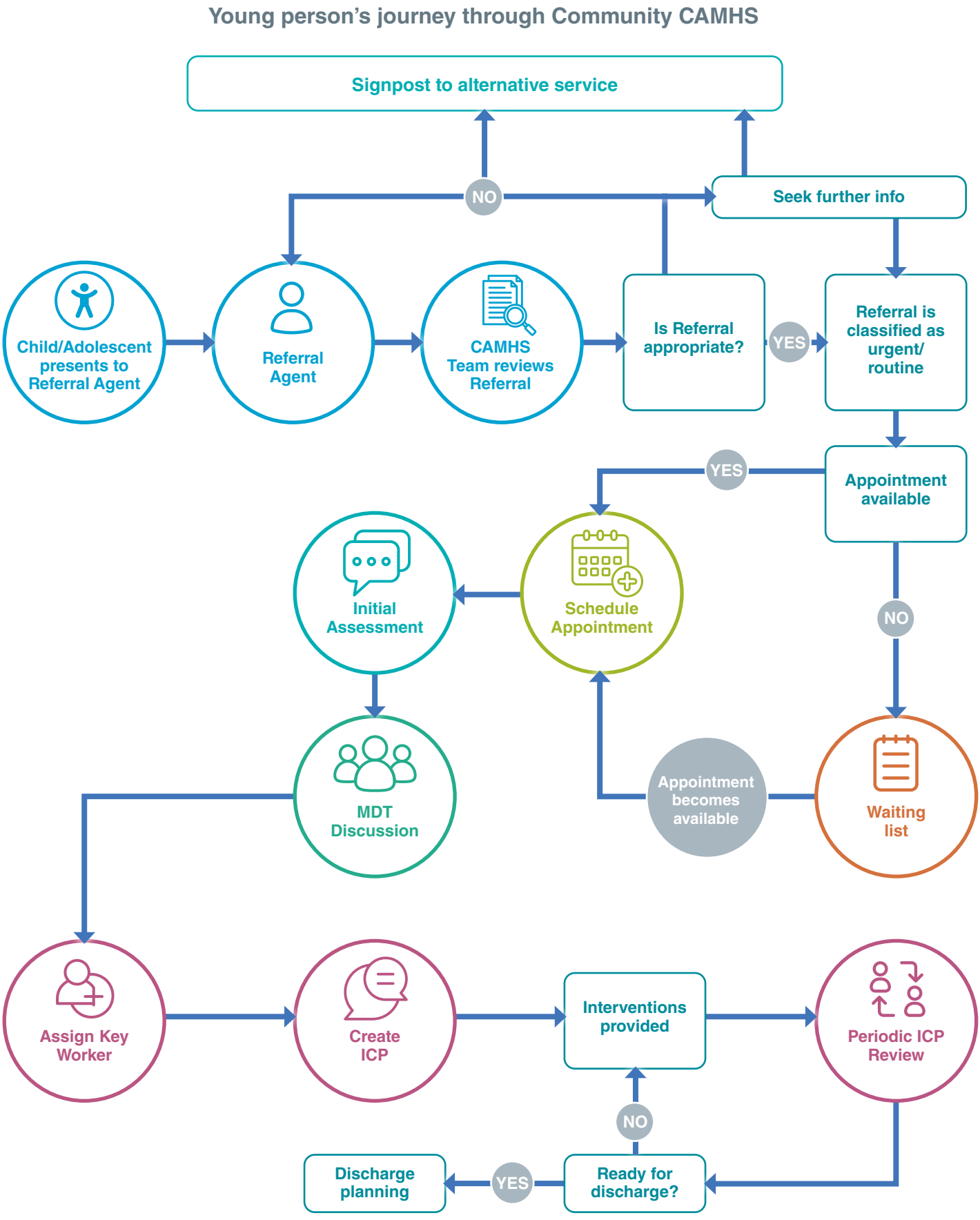
3.4.6 Assistance may include the provision of verbal or written information or reports and attendance at meetings arranged by Tusla. Extensive information and training on Children First can be found on the Tusla website (www.tusla.ie).

3.5 HSE Child Protection and Welfare

3.5.1 In accordance with the HSE Child Protection and Welfare Policy (2016) CAMHS teams should have clear processes to:

- ensure appropriate record management of child protection and welfare records.
- ensure appropriate safeguarding risk mitigation (e.g. lone working policy).
- complete a Children First compliance self-audit checklist annually.

4. Community Child and Adolescent Mental Health Services



Note: Continue to assess at every stage whether CAMHS is the right service for the child or adolescent.

Figure 5 - Journey through Community CAMHS

1. Child or adolescent presents to Referral Agent.
2. If appropriate for CAMHS, Referral Agent completes Referral Form (see Appendix 7) and sends to relevant CAMHS Team. If not appropriate for CAMHS, Referral Agent will signpost to alternative services.
3. CAMHS Referral is reviewed by CAMHS team.
4. Decision is made regarding whether CAMHS is the right service for the child or adolescent.
5. If referral is deemed inappropriate, it is returned to the Referral Agent, with signposts to alternative services.
6. If CAMHS is deemed the right service for the child or adolescent, the referral is classified as either urgent or routine.
7. If appointment is available, it is scheduled based on level of urgency.
8. If appointment is not available, the child or adolescent is added to the waiting list until an appointment becomes available at which point an appointment is scheduled.
9. An Initial Assessment is carried out by CAMHS team.
10. Multi-disciplinary Team (MDT) discussion takes place following the Initial Assessment.
11. A Key Worker is assigned following MDT discussion.
12. An Individual Care Plan (ICP) is developed in collaboration with the child or adolescent, the parent(s) and the CAMHS team.
13. Interventions are provided according to the ICP.
14. Regular periodic reviews of the ICP are carried out.
15. On review, if the child or adolescent is deemed ready for discharge, discharge planning is initiated.
16. On review, if the child or adolescent is not deemed ready for discharge, further interventions are provided.

4.1 Community CAMHS

4.1.1 CAMHS provide evidence based mental health services to those aged up to 18 years who have moderate-severe mental disorders that require the input of a multi-disciplinary mental health team.

4.1.2 Community CAMHS refers to all child and adolescent mental health services that are not inpatient services. The vast majority of CAMHS interventions are delivered in the community, close to people's homes.

4.1.3 The assessments and interventions provided by CAMHS teams depend on the severity and complexity of a child or adolescent's presentation. These assessments and interventions are carried out in partnership with the child or adolescent and their parent(s).

4.2 CAMHS Community Mental Health Team

4.2.1 CAMHS teams are multi-disciplinary in nature. This means that they are made up of a range of disciplines with different skills and training, so that children and adolescents can be offered a care and treatment package which addresses their individual clinical needs.

4.2.2 *Sharing the Vision* – A Mental Health Policy for Everyone, 2020 (StV) highlights that clinical and professional developments over the last decade, along with greater emphasis on achieving recovery-oriented outcomes mean that there are a wide range of professions that can support the mental health needs of local populations.

4.2.3 CAMHS teams may consist of a range of professionals including administrators, dietitians, family therapists, nurses, occupational therapists, psychiatrists, psychologists, social care workers, social workers, speech and language therapists, team coordinator, and other therapists as required. Not all CAMHS teams will have all of these disciplines.

4.2.4 StV does not specify team composition but emphasises the importance of determining the specific skills that are required by a team. The composition and skill mix of each CAMHS team should take into consideration the needs and social circumstances of its local population, with flexibility as to how these needs can be met. This could include for example, bringing in sessional workers with specific therapeutic skills and other professionals as required.

4.3 Community CAMHS Aims

4.3.1 The aim of Community CAMHS is:

4.3.2 To provide evidence-based, trauma informed assessment and treatment for children and adolescents with moderate to severe mental disorders, based on their identified needs.

4.3.3 To provide advice, information and support to parent(s). This will assist them to positively support children and adolescents with moderate to severe mental disorders at home.

4.3.4 To provide advice and consultation to referral agents. This aims to enhance their understanding of the role of CAMHS and its referral thresholds to ensure that children and adolescents can access help within the right setting.

4.3.5 To implement the Recovery Approach as outlined in the HSE *A National Framework for Recovery in Mental Health Services 2024 - 2028.*

4.4 Referral and Access

4.4.1 When reviewing a referral to decide if a child or adolescent needs to access CAMHS, a number of factors are considered by the CAMHS team. These include consideration of the child or adolescent's clinical presentation, the level of impairment and impact on their overall functioning.

4.4.2 It is the responsibility of the CAMHS team to decide whether the child or adolescent meets the criteria for a moderate to severe mental disorder.

4.4.3 **Moderate to Severe Mental Disorders**

- Mental disorders are described on a continuum of severity, ranging from mild to moderate to severe. A number of factors are taken into account when defining whether someone has a moderate to severe mental disorder and these include the diagnosis, formulation, the duration of the symptoms and level of functioning in daily living.
- Clinically, the term moderate to severe indicates that the mental disorder is persistent and complex, causing clinically significant distress and/or impairment in daily functioning. This may be in one or more domains such as development, education, relationships, physical health, or self-care.
- In practice, when we say, "moderate to severe," it means the mental disorder lasts a long time and is complicated. It causes noticeable distress or problems in daily life. This can affect areas like growth, learning, relationships, physical health, or taking care of oneself.

4.5 Referral Criteria

Referrals to CAMHS must meet all of the following criteria:

4.5.1 The child or adolescent is under 18 years old.

4.5.2 The child or adolescent presents with:

- a suspected moderate to severe mental disorder or
- a clinical presentation indicative of moderate to severe ADHD

4.5.3 Evidence that comprehensive treatment at primary care level has been unsuccessful, due to the complexity or severity of the presenting mental disorder, or that it was not appropriate in the first instance.

4.6 Types of Referrals Suitable for CAMHS

4.6.1 This is an operational guideline rather than a clinical guideline and this is therefore not an exhaustive list. It is also important to note that not all children and adolescents will fit neatly into a diagnostic category:

4.6.2 The list below gives some guidance on what constitutes a moderate to severe mental disorder.

- Moderate to severe Mood Disorder (e.g. depression, bipolar).
- Psychosis.
- Moderate to severe eating disorder (e.g. anorexia nervosa, bulimia).
- Suicidal ideation/significant self-harm behaviours in the context of a mental disorder.
- Moderate to severe anxiety disorders (e.g. OCD, panic disorder).
- Moderate to severe Attention Deficit Hyperactive Disorder (ADHD) or a clinical presentation of moderate to severe ADHD without diagnosis.

4.7 Specific Considerations

4.7.1 ADHD

4.7.1.1 In recent years, there has been an increase in referrals to Community CAMHS for children and adolescents presenting with a clinical presentation of neuro-developmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD).

4.7.1.2 Children and adolescents who present with a clinical presentation indicative of ADHD should initially be screened to determine whether they meet the threshold of a moderate to severe presentation prior to being referred to CAMHS.

4.7.1.3 A Model of Care for Paediatric ADHD is under development by the National Clinical Programme for ADHD and is due to be published by the end of 2025. Any relevant changes required to this Operational Guideline will be made, as required following publication.

4.7.2 Mental Health Emergency Presentations

4.7.2.1 Community CAMHS teams operate from 9am to 5pm, Monday to Friday. During these hours, and in consultation with the Consultant Psychiatrist, they are available to offer support and assessments for children and adolescents presenting with moderate to severe mental health emergencies (excluding cases involving physical health concerns).

4.7.2.2 A mental health emergency presentation is where there is a significant level of risk to the safety of a child or adolescent who is demonstrating highly acute symptoms of mental disorder, in the absence of physical health concerns.

4.7.2.3 CAMHS teams need to have a mechanism to respond to mental health emergency presentations on a daily basis within working hours. A response means that contact is made with the referral agent by a clinician on the team, in consultation with the Consultant Psychiatrist, and advice or assessment offered.

4.7.2.4 The CAMHS team should provide advice and consultation to a referral agent when the emergency is due to a diagnosed or suspected mental disorder. This can be done, for example, through telephone consultations with the referrer or the provision of designated, protected appointment slots, or the allocation of a daily duty worker rota on the team to provide cover. To support this, a number of teams may work together to facilitate this response. Local arrangements should be clearly agreed with the appropriate Clinical Director/ Executive Clinical Director.

4.7.2.5 It is only in exceptional circumstances, or where there is a physical health risk to the child or adolescent, that CAMHS should advise referral to an Emergency Department during working hours. Clinical triage should take place to confirm that attendance at an Emergency Department is not immediately required.

4.7.2.6 In an emergency situation outside of these hours, or where physical health considerations exist, it is advised that emergency services are contacted or that the child or adolescent is brought to the Emergency Department of the nearest hospital. Consideration should be given to the most appropriate hospital based on age.

4.7.3 Referrals where a diagnosis has already been provided

4.7.3.1 In some cases, there may be referrals to CAMHS where a diagnosis has already been provided (e.g. a referral from a private psychiatrist or a relocation from another jurisdiction). In these circumstances, it is the responsibility of the CAMHS clinician to assure themselves of the diagnosis, as part of their assessment process before continuing treatment.

4.8 Types of Referrals Not Suitable for CAMHS

4.8.1 CAMHS is funded to provide services to children with moderate-severe mental disorders/ ADHD.

4.8.2 CAMHS assessments and interventions are not suitable for children or adolescents whose difficulties are primarily related to learning/social/behavioural needs or difficulties, child protection or welfare concerns, or mild to moderate mental health problems.

4.8.3 There are alternative HSE and government-funded services available to respond to these needs for children and adolescents, e.g. HSE Primary Care Services, HSE Disability Services, Tusla, Jigsaw, NEPS and local Family Resource Centres.

4.8.4 For clarity, **in the absence of a moderate to severe mental disorder,** CAMHS will not accept referrals for children or adolescents who present with the following,

- Those with a mild intellectual disability who don't have a moderate to severe mental disorder. Their diagnostic and support needs are best met in HSE Primary Care/Children's Disability Network Teams in HSE Disability Services. Those with a moderate, severe, or profound intellectual disability and/or moderate to severe deficits in adaptive skills, and a co-occurring moderate to severe mental disorder. Their needs are best met by CAMHS Mental Health Intellectual Disability (MHID) teams, if present. It is acknowledged that there are ongoing efforts to build capacity of CAMHS MHID services, and so in areas where this service is not yet available, shared care and consultation arrangements will be agreed locally with Children's Disability Network Teams. Refer to Shared Care arrangements in Section 4.9.
- Those where the primary concern is a developmental or learning disorder. Examples of these could include Dyslexia or Developmental Language Disorder or Developmental Coordination Disorder. Their needs are best met in HSE Primary Care services, Children's Disability Network Teams, and/or National Educational Psychology Service (NEPS).
- Those who present with child protection or welfare issues where there is no moderate to severe mental disorder present. Their needs are best met by Tusla – The Child and Family Agency and or other family support agencies.

- Those where eating difficulties are not consistent with criteria for an eating disorder and do not involve significant psychological or physical risk.
- Those who are neurodivergent, who do not have a moderate-severe mental disorder. Their needs are best met in services such as HSE Primary Care and/or Children's Disability Network Teams. Where the child or adolescent presents with a moderate to severe mental disorder and neurodivergence, it is the role of CAMHS to provide appropriate multi-disciplinary mental health assessment, diagnosis and treatment for the mental disorder. This may involve joint working or shared care with other agencies including HSE Primary Care, Disability Network Teams, and other agencies supporting children and adolescents.

4.9 Joint Working and Shared Care

4.9.1 There are some children and adolescents who may present with complex/multiple needs and a moderate to severe mental disorder at the same time.

4.9.2 Where the child or adolescent presents with a moderate to severe mental disorder, it is the role of CAMHS to provide appropriate multi-disciplinary mental health assessment and treatment for the mental disorder. This may involve joint working or shared care with other agencies, including HSE Primary Care, Children's Disability Network Teams, National Educational Psychology Service and other voluntary and community agencies supporting children and adolescents.

4.9.3 When information indicates that there is more than one HSE/HSE-funded service that could best meet the child or adolescent's needs, consultation should take place with the other service to determine which is the most appropriate or whether a joint approach to assessment and intervention is indicated.

4.9.4 Teams should refer to the *Joint Protocol for Interagency Collaboration between the HSE and Tusla (2017)* and/or the National Policy on Access to Services for Children & Young People with Disability & Developmental Delay (HSE, 2023) for specific guidance on how to progress interagency engagement to ensure that the needs of the child/adolescent are met.

4.9.5 Prior to sharing information and communicating with other services, CAMHS Teams should comply with local and national policies, procedures, protocols and guidelines including the HSE National Consent Policy, 2022, HSE Data Protection Policy, 2018 and HSE Privacy Notice,2024, the General Data Protection Regulation 2016/679 and the Data Protection Act, 2018.

4.9.6 Clinical referrals can be made between healthcare practitioners in compliance with GDPR, without the need for consent. This includes referrals between all departments in the HSE and referrals to and from HSE services to Section 38 and 39 services and private healthcare providers. It is however good clinical practice to discuss with and inform patients that a referral is being made and that their medical information will be shared for that purpose. This falls under the Interim Guidance on Data Sharing for Referrals under GDPR and the National Consent Policy September 2024 - Version 2.

4.9.7 Services need to agree on the roles and responsibilities of each service in supporting the child or adolescent including which service has lead responsibility for coordination of care.

4.9.8 In situations where an agreement cannot be reached in relation to the management of a case, clinicians from the different services must make every effort to identify an appropriate lead service so that interventions can proceed. Where this cannot be agreed, the matter should be escalated to the Integrated Children's Services Forum or the General Manager as appropriate.

4.9.9 Regular reviews of caseloads should take place to ensure that CAMHS is the most appropriate service to meet the child or adolescent's needs, noting that it may be harmful for a child to attend a service that cannot meet their needs.

4.9.10 It is important for CAMHS to work in partnership with other agencies and groups who have a role in supporting children and adolescents' well-being, health and emotional development. These may include schools, community groups and other statutory agencies.

4.10 Referral Agents to CAMHS

4.10.1 Approved referral agents to CAMHS are listed below. The referral agent will have reviewed the child or adolescent in person prior to submitting a referral to CAMHS. All these referral agents must work in collaboration* with the child or adolescent's General Practitioner (GP) to ensure continuity of care.

- The GP.**
- Paediatricians (informing the GP).
- Consultant Psychiatrists (informing the GP).
- Emergency Department (ED) doctors in conjunction with the ED Consultant (informing the GP).
- Community-based clinicians (at senior/team leader level or above, in collaboration with the GP*).
- Tusla – The Child and Family Agency (team leader level or above in collaboration with the GP*).
- Assessment Officers, as defined under the Disability Act 2005 (in collaboration with the GP*).
- Voluntary and Community Services senior clinician (e.g. Jigsaw in collaboration with the GP*).
- Community Medical Doctors (informing the GP).
- Educational Psychologists from the National Educational Psychological Service (NEPS) (in collaboration with the GP*).

* In collaboration with the GP means the referral agent must ring the GP and discuss and agree the potential referral so it is a truly collaborative referral. Best practice would suggest that a physical health assessment is completed by the relevant medical practitioner (usually the child or adolescent's GP) and the details of this assessment are included in the referral.

** GPs are usually the first point of contact for families. Therefore, they are ideally placed to recognise risk factors for mental disorder and refer to specialist services such as CAMHS.

4.11 Information required for Referrals

4.11.1 Information required regarding the child or adolescent should include:

- Indication of when the child or adolescent was last seen by the referral agent.
- Full description of presenting problem(s) and how they have developed.
- Description of their presentation and/or mental state.
- Development and current functioning.
- Family composition and history.
- Presence of risk and/or resilience factors and evidence of urgency, including any child protection or welfare concerns.
- Details of any other professionals or agencies involved.
- Medical and psychiatric history of the child or adolescent and their family.
- Outline of educational/occupational experience.
- Child or adolescent's view of their current situation.
- Parental view of current situation.

4.11.2 CAMHS referrals should be made by eReferral via the Healthlink system. In exceptional circumstances, referrals can be submitted on the Community CAMHS Referral Form. Use of approved referral processes will support a timely response and facilitate meaningful engagement with the child or adolescent and their family.

* This is addressed in the Interim Guidance on Data Sharing for Referrals under GDPR and the National Consent Policy September 2024 - Version 2.

4.12 Process following receipt of Referral by CAMHS

4.12.1 When a referral is received from the list of approved referral agents (see Section 4.10), it is screened by a member of the CAMHS team, such as the Team Coordinator, in consultation with the Consultant Psychiatrist.

4.12.2 Referrals are screened daily during working hours (Monday to Friday 9.00 a.m. to 5.00 p.m.). This screening process is to;

- Ensure that any child or adolescent at emergent or urgent clinical risk can be identified and provided timely support and/or signposting.
- Confirm that the child or adolescent meets the age and geographical criteria for the team.

4.12.3 If the referral form does not include adequate information to determine if the child or adolescent is likely to meet the threshold for CAMHS, the team should contact the referral agents and other relevant contacts such as parent(s), schools and HSE Primary Care services to ask for additional information. This information can be used to best inform levels of risk, need and functioning in different settings. Please refer to the Interim Guidance on Data Sharing for Referrals under GDPR and the National Consent Policy September 2024 - Version 2.

4.12.4 Following initial screening, referrals will be categorised as 'Emergency', 'Urgent' or 'Routine'.

- **Emergency:** Referral information indicates that there is a significant level of risk to the safety of a child or adolescent who is demonstrating highly acute symptoms of mental disorder. These referrals should be discussed directly with CAMHS by phone.
- **Urgent:** Referral information indicates that there is a clear and present level of acute symptoms of mental disorder and where there is a strong likelihood of considerable deterioration in mental state if left untreated.
- **Routine:** Referral information indicates that the child or adolescent is likely to meet the criteria for a moderate to severe mental disorder and would benefit from assessment/ treatment, but there is no immediate or urgent risk of deterioration.

4.12.5 Emergency referrals will be managed as outlined in section 4.7 above. All other referrals will be followed up in line with the agreed response times outlined below.

4.12.6 All new referrals screened as 'routine' are discussed at a weekly team meeting to confirm whether they meet the clinical criteria for Community CAMHS.

4.12.7 When a referral has been discussed, the category is confirmed as:

- Urgent.
- Routine.
- Not appropriate for CAMHS.

4.13 Referral Response Times

4.13.1 Community CAMHS teams will provide a timely response to all referrals received, dependent on their categorisation of emergency, urgent, routine or not appropriate for CAMHS.

4.13.2 A response means that contact is made with the referral agent and/or parent(s) by a clinician on the team, in consultation with the Consultant Psychiatrist.

4.13.3 The contact should seek to provide information to the referral agent or parent(s) so that they understand the status of the referral and any steps they need to take prior to the first appointment.

4.13.4 Urgent Referrals

- An urgent referral is one where there is a clear and present level of acute symptoms of mental disorder and where there is a strong likelihood of considerable deterioration in mental state if left untreated.
- Once a referral has been identified as urgent, it should be **responded to within three working days** of receipt of referral and seen as soon as possible based on clinical risk.
- Responding to an urgent referral may mean the direct involvement of the CAMHS team or it may mean, for example, telephone consultation with the parent(s) or other agencies to organise an appropriate response to the referral agent.

4.13.5 Routine Referrals

- A routine referral is one where there are clear and present levels of acute symptoms of moderate to severe mental disorder which have been ongoing but can be managed in the short-term by the child or adolescent's support network (i.e. parent(s) or other agencies.)
- Routine referrals should be **seen within 12 weeks or sooner** depending on service demands.
- Responding to a routine referral means that a letter (or other form of written communication) is sent by the CAMHS team to the child or adolescent and their parent(s) to offer them an initial assessment appointment.

4.14 Responding to Referrals that Require CAMHS

4.14.1 For accepted referrals, an initial letter (or other form of communication) should be sent within 2 weeks of referral receipt and should include the following:

- Acknowledgment of the referral.
- Indication of whether the referral has been deemed an urgent or routine referral.
- Estimated waiting time for the first appointment or contact from the CAMHS team. Information on how waiting times may go up or down depending on the demand in the area should be included.
- A list of local community supports and/or useful websites to access while they are awaiting their appointment. Consideration should be given to directing children, adolescents and family members towards the resources highlighted on the HSE's www.yourmentalhealth.ie website and/or the 'Navigator' tool by, for example, referencing the site on referral or appointment letters.
- Advice of what to do in an emergency or if the child or adolescent's presentation worsens.
- A copy of the letter should also be sent to the GP/Referral Agent.
- If an appointment can be offered within 12 weeks, this letter ideally should also include the offer of an appointment with set date/time.

4.15 Responding to Referrals that Do Not Require CAMHS

4.15.1 If a child or adolescent is deemed from the information provided as not presenting with moderate or severe mental disorder and does not require CAMHS, the GP/referral agent and the parent(s) will be advised in writing as soon as possible, and no later than 2 weeks from the date of referral receipt.

- The reason for the child or adolescent not being accepted should be clearly outlined in the letter.
- If further management of this referral is required, this may be coordinated by the GP/referrer through HSE Primary Care or community services. It is proposed that this will be in the future, managed by the Single Point of Access.
- Initial communication to the referral agent can be by telephone in order to provide a timely response as long as it is subsequently supported by a written letter or email.

4.16 Communication, Sharing and Disclosure of Information

4.16.1 CAMHS teams should comply with the *General Data Protection Regulation 2016/679* and the *Data Protection Act, 2018* prior to and when sharing information and communicating with HSE or HSE funded services in line with local and national policies including HSE *National Consent Policy, 2022*, HSE *Data Protection Policy, 2018,* HSE *Privacy Notice, 2024,* the *General Data Protection Regulation 2016/679* and the *Data Protection Act, 2018*.

4.16.2 Teams should be aware that they should not share reports or letters on file from external agencies and should consider asking families to share these directly with requestors.

4.16.3 The CAMHS team must communicate with the referral agent within four weeks of the initial assessment and a summary assessment report should be sent to them.

4.16.4 The CAMHS team should communicate with the parent(s) throughout the assessment process to keep them informed and to advise them of local supports.

4.16.5 Progress in the form of a brief written update to the referral agent should be communicated at a minimum of six-monthly intervals thereafter.

4.16.6 On discharge from CAMHS, a written discharge summary should be provided to the child or adolescent's GP, the referral agent and the parent(s). A link to a template discharge summary can be found in Appendix 7. This should be a brief summary of the assessment and interventions, and progress made in plain English.

4.17 The Initial Assessment

4.17.1 When a referral is accepted by CAMHS, the child or adolescent and their parent(s) are offered their first appointment which is known as an initial assessment.

4.17.2 One of the aims of an initial assessment is to gather background information to try and understand what has been going on in the child or adolescent's life. An initial assessment also seeks to ensure that CAMHS is the right service for the child or adolescent and that they and their parent(s) are happy to attend the service.

4.17.3 The initial assessment will cover a range of areas including personal information, social history, family history, education, physical health, lifestyle factors, risk assessments, strengths and protective factors and the views of the child or adolescent and their parent(s) on the current situation.

4.18 The Key Worker

4.18.1 *Sharing the Vision – a Mental Health Policy for Everyone, 2020* emphasises the need for each child or adolescent attending CAMHS to be allocated a key worker. The allocated key worker will facilitate care coordination, support therapeutic engagement and maintain contact with the child or adolescent, parent(s) and other agencies, ensuring care planning is followed.

4.18.2 When allocated, the key worker coordinates the care provided by all other team members and provides regular updates to the team on the service user's progress. While the key worker is not responsible for delivering all aspects of the treatment, they play a crucial role in ensuring that the Individual Care Plan (ICP) is followed.

4.18.3 The key worker ensures that all clinicians involved in the service user's care are adhering to the plan and are working in a coordinated way, in line with the HSE Best Practice Guidance for Mental Health Services (Supporting You to Meet Regulatory Requirements Towards Continuous Quality Improvement, 2017).

4.18.4 Each child or adolescent should be allocated a key worker as soon as possible after their first appointment, both they and their parent(s) should be informed of who their key worker is and it should be documented in the case file.

4.18.5 The role of the key worker is to establish a relationship with the child or adolescent, and to take responsibility for actively remaining in contact with them and their parent(s). This might involve direct clinical input, following up phone calls, arranging additional support meetings with MDT colleagues' inputs, and collaboratively updating the care plan.

4.18.6 All clinical CAMHS team members can be allocated as a key worker and allocations should be equitable and transparent, based on the child or adolescent's needs.

4.18.7 It is acknowledged that the workload associated with key working will vary depending on the complexity/needs of the child or adolescent, therefore allocations should consider capacity of staff, and this should be monitored regularly through MDT team reviews and caseload audits.

4.18.8 A child or adolescent's key worker may change over time, reflecting changes in the child or adolescent needs or complexity.

4.18.9 The key worker should also support transition of the child or adolescent as they move from CAMHS to alternative services.

4.19 Individual Care Plan (ICP)

4.19.1 All children and adolescents attending CAMHS should have a current ICP. Each child or adolescent should be involved in developing an ICP with their key worker and their parent(s) within a reasonable timeframe following the initial assessment. In some cases, an interim care plan may be appropriate while formulation is ongoing.

4.19.2 An ICP is a clear plan, in plain English, that describes the levels of care, supports and treatment needed to meet the assessed needs of the child or adolescent while they are attending CAMHS.

4.19.3 An ICP should be developed in collaboration with the child or adolescent and their parent(s), and a copy should be provided to them. The ICP should be signed off by all parties.

4.19.4 The ICP can be shared with referral agents and other agencies. In accordance with GDPR and the Interim Guidance on Data Sharing for Referrals under GDPR and the National Consent Policy September 2024 - Version 2. A link to a template ICP can be seen in Appendix 7.

4.19.5 An ICP is individualised and outcomes-focused and should consider what goals the child or adolescent wishes to achieve while attending CAMHS. It should also be recovery-oriented (HSE *A National Framework for Recovery in Mental Health, 2024-2028*).

4.19.6 All CAMHS staff should be aware of communication/language needs and take these into account when designing the ICP. This may involve the use of pictures or other multimedia tools, but they must still be in line with HSE policies on privacy and consent, including HSE National Consent Policy, 2022, HSE Data Protection Policy, 2018 and HSE Privacy Notice, 2018-2020, the General Data Protection Regulation, 2016/679 and the Data Protection Act, 2018.

4.19.7 As a general rule, the ICP should be reviewed and updated when there is a change in their care, a new diagnosis or on request from the child or adolescent or their family. At a minimum, the ICP should be reviewed on a six-monthly basis. The child or adolescent's key worker is responsible for the maintenance and regular review of the ICP, in collaboration with the child or adolescent.

4.19.8 An ICP includes the following:

- A clinical formulation.
- A diagnosis if available.
- Agreed goals between the CAMHS team, the child or adolescent and their parent(s).
- A list of other agencies involved with the child or adolescent.
- An individual risk and safety management plan, including any child protection or welfare concerns.
- Confirmation that a conversation has taken place about discharge planning, including an indicative timeline or date.

4.20 The Team Coordinator

4.20.1 *A Vision for Change – Report of the Expert Group on Mental Health Policy, 2006,* recommended that team coordinators should be in place in all CAMHS teams to allow enhanced management of referrals and clinical inputs as well as to build necessary relationships within the community. Any clinical staff member with the requisite experience may be deemed suitable to perform this role.

4.20.2 As per Sharing the Vision – a Mental Health Policy for Everyone, the creation of a team coordinator role in some teams has resulted in reducing referrals of milder mental health difficulties to secondary services.

4.20.3 To operate effectively the team coordinator will

- Work in consultation with the Consultant Psychiatrist and the MDT to oversee referral processes, prioritise cases, and manage waiting lists effectively.
- Facilitate team operations, ensuring smooth communication across disciplines.
- Act as the primary point of contact for general practitioners, primary care professionals, CDNT and other community resources (including schools), ensuring a seamless care pathway for service users.
- Support the implementation of national guidelines, audits, and quality improvement initiatives to enhance consistent service delivery.
- Support the effective allocation of clinical resources to meet service demands and ensure that caseloads are reviewed regularly.

4.20.4 These responsibilities align with the HSE Best Practice Guidance for Mental Health Services in Ireland, including: HSE Best Practice Guidance for Mental Health Services (2017), the National Framework for Recovery in Mental Health (2018–2020), and Sharing the Vision: A Mental Health Policy for Everyone (2020). Further work is underway to develop a national standardised job description for this role within CAMHS and adult mental health services.

4.21 Multi-Disciplinary Team (MDT) Reviews

4.21.1 Formal reviews are an important part of the management of all open cases.

4.21.2 Each CAMHS team has a weekly team meeting to discuss:

- New Referrals.
- Open Cases requiring review.
- Cases being considered for discharge from the team.

4.21.3 All decisions made at the weekly meeting are recorded in real time in the relevant child or adolescent's file and in an MDT meeting log.

4.21.4 Each open case is formally reviewed by the CAMHS multi-disciplinary team at a minimum of every six months.

4.21.5 The key worker and the administrative staff on the CAMHS team are often best placed to coordinate and make sure that this review takes place when required.

4.21.6 A proforma can be used to record the formal CAMHS MDT weekly meeting and the CAMHS MDT 6 monthly review. See Template in Appendix 7.

4.22 Promoting Attendance at Appointments

4.22.1 CAMHS try to manage non-attendance so that the service can see as many children or adolescents as possible.

4.22.2 If an appointment is cancelled in time, it can be offered to someone else and help reduce waiting lists.

4.22.3 As far as possible, the booking of initial appointments should be flexible and made in consultation with the parent(s) in order to minimise the risk of non-attendance.

4.22.4 All initial appointments should be communicated to the parent(s) in writing with a copy to the GP and the original referral agent.

4.22.5 When offering appointments, CAMHS teams should be conscious of literacy difficulties and communication barriers and how they may affect attendance and access to services. Teams may need to adapt their approach to better support individuals and families with diverse needs.

4.23 Management of Non-Attendance at Initial Appointments

4.23.1 For routine appointments, the CAMHS administrator or other team member contacts the parent(s) at least two weeks before the date of their initial appointment to confirm attendance. This timeline does not apply to urgent appointments.

4.23.2 The use of a *text reminder* sent (48-72 hrs) before the scheduled appointment is recommended as a means of encouraging confirmation and reducing non-attendance.

4.23.3 In the event that a child or adolescent does not attend, the action taken will depend on the level of risk to the individual and will be based on an assessment of risk and professional judgement.

4.23.4 At a minimum, contact should be made with the parent(s) as soon as possible. This may be initiated by the clinician due to be seen or another member of staff.

4.23.5 Once contacted, and based on the reason for the non-attendance, a decision will be made on whether a further appointment is required. An assessment of the risk in non-attendance will inform further management and follow up.

4.23.6 If contact with a parent cannot be made, the GP and other referral agent should be informed. A new appointment date may be offered, or it may be appropriate to re-refer depending on the individual circumstances and if still clinically indicated. A pro-forma letter may be used for this purpose to ensure referring agent(s) are made aware of non-attendance as soon as possible.

4.23.7 If the clinical information in the referral form suggests the child or adolescent may be very unwell or at risk, the GP/referral should be contacted so that they can initiate any further intervention that may be required. A follow-up letter should also be sent.

4.23.8 Children and adolescents should not be discharged for non-attendance at an initial appointment, without consultation with the referrer and/or GP.

4.24 Management of Non-Attendance at Subsequent Appointments

4.24.1 If a child or adolescent is already attending CAMHS but does not attend for their appointments, contact should be made with the parent(s) in the first instance to understand the reasons for the non-attendance.

4.24.2 If contact with parent(s) cannot be achieved, the CAMHS team must inform the GP or referral agent of the non-attendance. A decision will need to be made whether an assertive outreach visit is warranted.

4.24.3 If a decision is made to close a case due to non-attendance, it should be discussed and recorded at the multi-disciplinary team meeting and the GP/referral agent and parent(s) notified in writing that the child or adolescent has been formally discharged from CAMHS.

4.24.4 Any other agencies involved in the referral of the child or adolescent should also be informed of discharge in writing.

4.24.5 If the child or adolescent has been identified as requiring special consideration due to having additional risk factors, (See Section 2.1), the CAMHS team should not complete discharge until a discussion has occurred with the GP and/or referral agent and all attempts to contact the parent(s) have failed.

4.25 Out-of-Hours Arrangements

4.25.1 Out-of-hours is defined as outside of normal working hours (i.e. outside Monday to Friday 9.00 a.m. to 5.00 p.m. and throughout Saturday and Sunday).

4.25.2 Children and adolescents and parent(s) must be provided with details of local out-of-hours arrangements while they are waiting for their first appointment, and again at their first appointment in person.

4.25.3 Emergency out-of-hours presentations are currently required to first attend out-of-hours GP services or if necessary to attend the Emergency Department of the local general Hospital.

4.25.4 Following assessment by an hour-of-hours GP or a Consultant/NCHD in the Emergency Department, and where there is a need, a referral will be made to a CAMHS community team. In an emergency, a child or adolescent may be referred by a Consultant Psychiatrist for an emergency admission to an inpatient psychiatric unit.

4.25.5 As part of the CYMHO Action Plan (2024), out-of-hours integrated crisis responses services (*including CAMHS Hubs and CAMHS Emergency Liaison*) will be expanded to ensure that appropriate supports are available for young people with additional support needs. These services will be introduced in a phased process, as funding becomes available. Local teams should make themselves aware of all relevant out of hours services available in their area.

4.25.6 The HSE website lists a range of national services who receive funding from the HSE and the link should be shared as appropriate Mental health supports and services - HSE.ie

4.26 Feedback and Complaints

4.26.1 Every child and adolescent attending CAMHS, and their parent(s), should be invited to contribute to feedback about their experience of CAMHS. This can be in the form of positive comments, suggestions or complaints.

4.26.2 A culture of co-production and partnership should be developed to support feedback at team level.

4.26.3 The details of the complaint's procedure and the nominated person for dealing with complaints should be on display in a prominent position within each CAMHS premises. Children and adolescents and their parent(s) should be made aware of advocacy or other supports that can assist them in making a complaint.

4.26.4 Formal mechanisms are in place to provide feedback such as Your Service Your Say: The Management of Service User Feedback for Comments, Compliments and Complaints, HSE Policy, 2017. This feedback is used to inform and improve service delivery.

4.26.5 CAMHS staff should explain the complaints procedures to all children and adolescents and their parent(s), and how to use them. This should include reference to advocacy and other independent supports.

4.26.6 The appeals process should also be outlined to all children and adolescents and their parent(s) if they are unhappy with the outcome of a complaint or investigation (*Your Service Your Say, 2017* and *Best Practice Guidance, 2017*).

4.26.7 There are a number of ways in which feedback and complaints can be made about HSE CAMHS which are outlined below:

- **In Person**: Service-users or their families can talk to any member of HSE staff, service manager or complaints officer.
- **Online Form**: Send your complaint securely through the online feedback form.
- **By Email**: Email yoursay@hse.ie with your feedback.
- **In writing**: Send a letter or completed feedback form to any HSE location. Staff can help service –users or their families put their feedback in writing if they require assist.
- **By Phone**: LoCall 1890 424 555 from 9.00 a.m. to 5.00 p.m. Monday to Friday or call 045 880 400. The call will be answered by a staff member from the National Complaints Governance and Learning Team.
- **Through Advocacy Services**: Advocacy Services can provide support to families who want to provide feedback to CAMHS. A list of Advocacy Services can be found here or on the HSE website.

4.27 Transition and Discharge

4.27.1 When a child or adolescent leaves the care of a Community CAMHS team, appropriate processes should be followed to ensure that they are safe and that any clinical risk is mitigated.

4.27.2 'Transfer' or 'transition in a CAMHS setting refers to the process of transferring professional responsibility and accountability for some or all aspects of a patient's care from one healthcare provider to another. This can occur when a patient is transferred between Community CAMHS teams, or when care is handed over to a different Mental Health service.

4.27.3 Effective transfer is crucial for ensuring continuity of care, and maintaining patient safety. It typically involves the exchange of important information about the patient's condition, treatment plans, and any specific needs or concerns.

4.28 Transition to Adult Mental Health Services

4.28.1 If an adolescent of 17 years requires referral to adult mental health services, a *transition* plan within their ICP will be required. This should ideally begin at least 6 months before their 18th birthday. Not all adolescents require a transition plan, but it is essential that all are assessed for transition and the outcome of the assessment of future need is recorded clearly.

4.28.2 Signposting to other supports should be provided to young people, parent(s) and supporters when approaching transition age to include information on Adult Mental Health Services and alternative community supports (e.g. education, employment and social prescribing etc.).

4.28.3 Where required, there should be involvement of additional specialist services to support the transition (e.g. clinical programmes, addiction services etc.).

4.28.4 Joint working between CAMHS and adult mental health services should be considered as an option in the initial weeks of handover to aid a smooth transition from one service to the other. These services operate in a different way to each other (including their development of ICPs) and this can be a significant change for adolescents and their parent(s).

4.28.5 With consent from the adolescent, the Consultant Psychiatrist and key worker will be responsible for initiating a transfer of care to the adult mental health service and ensuring appropriate information is shared. This may include transfer of the clinical file.

4.28.6 A transition meeting between CAMHS and AMHS should take place, and local protocols should be developed to outline the timing, process, administrative requirements and roles and responsibilities for these meetings.

4.28.7 The information required for a transition includes as a minimum a detailed referral letter or a copy of the ICP, risk assessment, record of all medication, details of any physical health needs, and a summary of all MDT interventions.

4.28.8 Any challenges during the transition should be directed to the Executive Clinical Director as required.

4.29 Transition to other CAMHS

4.29.1 Where a child or adolescent is on an active caseload with one CAMHS team and moves to a different geographical area, there must be clear communication and planning between both CAMHS teams to facilitate a smooth transition of care.

4.29.2 Such communication and planning should commence prior to the child or adolescent's move to another area and should be organised by the Consultant Psychiatrist and key worker with a written indication of the current clinical need/risk assessment.

4.29.3 A child or adolescent who is actively under the care of a particular CAMHS team should not be refused or placed on a waiting list with another CAMHS team if they move from one area to another in Ireland. The clinical care should remain with the referring team until the case is formally handed over and accepted by the new CAMHS team.

4.29.4 The child or adolescent's parent(s), the GP and other referral agents should be kept informed of the status of the referral by the referring team throughout the process.

4.30 Discharge from Community CAMHS

4.30.1 Discharge from Community CAMHS occurs when a child or adolescent no longer requires the intervention of CAMHS. This may mean that they have achieved their goals, or it may mean that they are not benefitting from CAMHS, and their needs are better met in another service.

4.30.2 Discharge for most individuals should be seen as a positive outcome and part of the recovery process. Discharge planning should focus on the child or adolescent's recovery and should include a follow up plan with the GP and other community services. It should also include advice and information on the re-referral process to CAMHS in the event of a relapse.

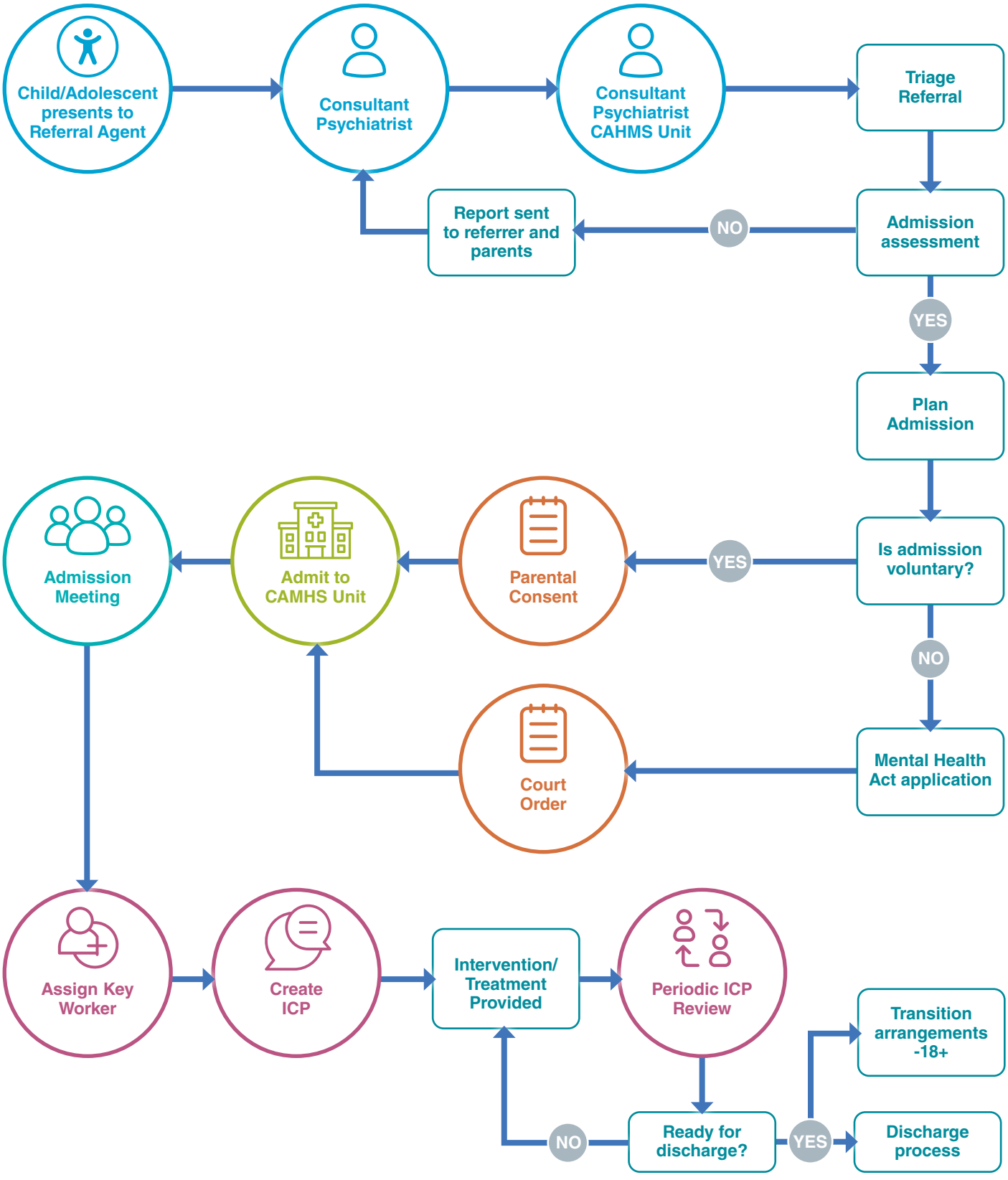
4.30.3 Discussions about discharge planning should begin when the ICP is drawn up, with the child and adolescent and their parent(s). This can help young people, and their parent(s) understand the process, goals and potential outcomes of their involvement with CAMHS. It reinforces for them that their time with CAMHS will be for a specific period of time and in the vast majority of cases the goal is to work towards a point where they can manage independently.

4.30.4 A discharge summary should be shared with the child or adolescent (if over 16 yrs), parent(s), referral agents, and others as required, subject to consent (see link to standardised template in Appendix 7).

4.30.5 A discharge meeting with the child or adolescent, the parent(s) and any community supports who are involved, should occur prior to the formal discharge.

5. Inpatient Child and Adolescent Mental Health Services

Young Persons Journey through Inpatient CAMHS



Note: Continue to assess at every stage whether CAMHS is the right service for the child or adolescent.

Figure 6 - Journey through Inpatient CAMHS

1. The child or adolescent presents to Referral Agent i.e. Consultant Psychiatrist. (See Appendix 7).
2. Consultant Psychiatrist contacts the Consultant Psychiatrist of the CAMHS Inpatient Unit.
3. Referral is triaged to determine whether Inpatient CAMHS is the right service for the child or adolescent.
4. If Referral is deemed not suitable for admission, the CAMHS Inpatient Consultant provides written feedback and recommended alternatives to the referring Consultant Psychiatrist and the child or adolescent's parent(s).
5. If inpatient setting is deemed to be the right service for the child or adolescent, the admission is planned.

   a. If admission is voluntary, parental consent is obtained.

   b. If admission is involuntary Section 25 policy is invoked and a court order is obtained.
6. The child or adolescent is admitted to the CAMHS Inpatient Unit.
7. Admission meeting is held.
8. A Key Worker is assigned.
9. An Individual Care Plan (ICP) is developed in collaboration with the child or adolescent, the parent(s) and the CAMHS Inpatient Team.
10. Interventions and treatments are provided according to the ICP.
11. Regular periodic reviews of the ICP are carried out.
12. On review, if the child or adolescent is deemed ready for discharge, discharge planning is initiated.
13. On review, if the child or adolescent is not deemed ready for discharge, further interventions and treatments are provided.
14. Transition arrangements should be made in advance of a child or adolescent's 18th birthday.

5.1 Inpatient CAMHS

5.1.1 CAMHS Inpatient Units offer assessment and treatment to children and adolescents up to the age of 18 with severe and often complex mental disorders.

5.1.2 CAMHS Inpatient Units are known as *Approved Centres*, and they are inspected by the Mental Health Commission. This means CAMHS Inpatient Units are subject to the *Mental Health Act, 2001*, as amended, corresponding regulations, and the *Mental Health Commission Codes of Practice.*

5.1.3 Currently there is a network of HSE-provided CAMHS Inpatient Units across the country to which this Operational Guideline applies. These units work together to ensure full national coverage of inpatient services.

5.1.4 In addition to existing capacity, the new National Children's Hospital (due to open in 2026) will provide a further 20 inpatient mental health beds.

5.1.5 All units will be resourced and equipped to admit children and adolescents under 18 years presenting with any form of acute or complex mental disorder, including eating disorders. This will require appropriate staff and infrastructure to support care for young people requiring nasogastric (NG) feeding, in line with the increasing national demand for such interventions.

5.2 CAMHS Inpatient Service Aims

The aim of Inpatient CAMHS is:

5.2.1 To provide evidence-based, trauma informed assessment and treatment for children and adolescents with severe and often complex mental disorders.

5.2.2 To provide appropriate assessment, recovery-focused trauma informed treatment and education within a therapeutic environment, with the ultimate aim of achieving clinical improvement.

5.2.3 To provide services close to home, in line with Slaintecare, for children and adolescents with moderate to severe mental disorders who require inpatient care and to accept admissions on a 24/7 basis, including weekends and out of hours.

5.3 Referral and Access to Inpatient CAMHS

5.3.1 The vast majority of CAMHS interventions are delivered in the community close to people's homes in the least restrictive environment possible. Therefore, inpatient services will only be considered when all other interventions in the community have been exhausted or deemed inappropriate to meet the needs of the child or adolescent.

5.3.2 When a decision is being made to admit someone to an Inpatient Unit the child or adolescent, their parent(s) and the CAMHS team will consider the clinical improvements expected against any potential negative impact from an inpatient stay. These may include the impact of being separated from family and friends, any disruption to their education, or the potential of further trauma from being admitted to an Inpatient Unit.

5.3.3 Children and adolescents should be able to maintain contact with their families during their inpatient stay, and their education and future health should not be impaired through a prolonged stay in an Inpatient Unit.

5.3.4 In order to support safety and national oversight, all units will utilise a digital referral tracking system which supports real-time monitoring of referral volumes, status, and outcomes across all CAMHS inpatient Units.

5.4 Referring to Inpatient CAMHS

5.4.1 As CAMHS Inpatient Units are national tertiary services, children must be referred by a Consultant Psychiatrist.

5.4.2 It is recommended that there be a triage/assessment process prior to admission. This will include consultation with the referring Consultant, further information gathering from other services, and assessment by the inpatient team to determine that the threshold for admission is met.

5.4.3 Where the decision is made not to admit a child or adolescent to the CAMHS Inpatient Unit, the referring Consultant and parent(s) are informed of the reasons in writing (*Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2010*). Written recommendations should be made from the inpatient team about appropriate alternatives/treatments.

5.5 Referring to the Appropriate CAMHS Inpatient Unit

5.5.1 The Consultant Psychiatrist will make referrals to their regional unit.

5.5.2 Following an assessment, if the regional CAMHS Inpatient Unit is unable to offer admission, the inpatient Consultant of the regional unit will liaise with the Consultants in the other CAMHS units to request admission to that unit.

5.5.3 Referrals from outside an Inpatient Unit's region will be assessed and prioritised based on clinical need.

5.5.4 This process is supported by weekly communication between the CAMHS Inpatient Units and the HSE Child and Youth Mental Health Office.

5.6 Appropriate Referrals to Inpatient CAMHS

5.6.1 When deciding if a child or adolescent needs inpatient care, a number of factors are considered. These include but are not limited to consideration of their clinical presentation, level of social and family support and the availability of resources and treatment options in the community.

5.6.2 The Inpatient team will also consider the risks and benefits of admission for the child or adolescent.

5.6.3 The final decision regarding admission rests with the Inpatient Consultant Psychiatrist who assumes clinical responsibility for the child or adolescent once they have been admitted, as defined by the *Mental Health Act, 2001,* as amended.

5.6.4 Children and adolescents accepted for admission will on assessment, have a severe and complex mental disorder with clear evidence that:

- Intensive assessment and treatment are required within an inpatient setting.
- There is a level of risk due to their mental disorder that is more appropriately managed in an inpatient setting.

5.7 Referrals Not Appropriate for a CAMHS Inpatient Unit

5.7.1 CAMHS Inpatient Units are specifically designed and staffed to meet the needs of children and adolescents with severe and complex mental disorders, therefore in the absence of a suspected or diagnosed moderate to severe mental disorder, children and adolescents will not be admitted to a CAMHS Inpatient Unit.

5.7.2 It is also important to note that not all children and young people who are referred will meet the threshold for admission, or it may be determined that they may not benefit from inpatient care.

5.7.3 The following presentations will not be admitted:

- Children and adolescents who are deemed to need treatment in an appropriate medical setting in the first instance.
- Children and adolescents who present with extreme behavioural disturbance and emotional instability, in the absence of a moderate to severe mental disorder.
- Children and adolescents who, by being removed from their home environment, may have a further exacerbation of their clinical presentation.
- Children and adolescents with substance misuse issues, in the absence of a moderate to severe mental disorder.
- Children and adolescents with behavioural or conduct disorder issues in the absence of a moderate to severe mental disorder.
- Children and adolescents with a diagnosis of neurodivergence in the absence of a moderate to severe mental disorder.
- Children and adolescents with moderate or severe intellectual disability issues in the absence of a moderate to severe mental disorder.

5.8 Clinical Information required for Referrals to CAMHS Inpatient Unit

5.8.1 Clinical Information that is required for the referral should be included in the Inpatient Referral Form. (See link in Appendix 7). This will facilitate the effective, safe and timely triaging of the referral by the inpatient service. This includes:

- Level of urgency
- Indication of when the child or adolescent was last seen by the Consultant Psychiatrist.
- Full description of presenting problem(s) and how they have developed.
- Description of their presentation and/or mental state.
- Child or adolescent's development and current functioning.
- Family composition and history.
- History of medical/mental illness in the family.
- Outline of educational/occupational experience.
- Goals for admission or expected outcomes after admission.
- Child or adolescent's views and expectations for admission.
- Parent(s) views and expectations for admission.
- Therapeutic interventions received to date and outcome.
- Presence of risk and/or resilience factors, including any child protection or welfare concerns.
- Details of other agencies involved.
- Parent(s) informed consent.

5.9 Process following Referral to a CAMHS Inpatient Unit

5.9.1 When a referral is received from a Consultant Psychiatrist, it is triaged by a senior clinician in the Inpatient Unit. A senior clinician could be, for example, the Consultant Psychiatrist or a Nurse Manager on the Unit.

5.9.2 When a referral has been triaged it will be categorised by the Inpatient team, and will be determined as:

- Emergency.
- Urgent.
- Routine.

5.9.3 When triaging a referral, the inpatient CAMHS staff may contact the referring Consultant to seek further information. They may also contact other services or supports in the child or adolescent's life such as Tusla, schools and HSE Primary Care services to further inform the assessment process. This is subject to the GDPR and is in line with the CAMHS team responsibilities as set out in Section 4.9 and obtaining the appropriate consent.

5.10 Referral Response Times

5.10.1 When a referral is received, a senior clinician from the CAMHS Inpatient Unit will respond to the referring Consultant.

5.10.2 The referring Consultant must ensure that they are contactable by mobile phone to discuss referrals. If they are not contactable, the processing of the referral may be delayed.

5.10.3 A response means that contact will be made by telephone within the following timeframes:

- 4 hours (emergency)
- 24 hours (urgent)
- 7 days (routine)

5.10.4 In an emergency situation, telephone contact must be made to the CAMHS Inpatient Unit by the referring Consultant to ensure receipt of referral and to ensure compliance with the GDPR.

5.10.5 Until the child or adolescent has been admitted by the inpatient team, the referring Consultant continues to hold clinical responsibility for the child or adolescent's care.

5.10.6 Explanation of types of referrals

- An **emergency** referral to an Inpatient Unit is appropriate where the is a clear and imminent risk to the child or adolescent or to others due to their mental disorder.
- An **urgent** referral to an Inpatient Unit is appropriate where the child or adolescent has active symptoms of acute mental illness and where there is a strong likelihood of considerable deterioration in mental state if left untreated.
- A **routine** referral to an Inpatient Unit is appropriate where the child or adolescent has active symptoms of acute mental illness which have been ongoing and are likely to benefit from inpatient treatment, but which can be managed in the short-term by the child or adolescent's support network (i.e. family and community CAMHS).

5.10.7 Emergency Admissions

- In the interests of safety and continuity of care, admissions are usually planned during routine working hours. However, emergency admissions (i.e. within 24 hours of referral) are facilitated when appropriate.
- In the event of an emergency admission taking place through the Emergency Department, where the child or adolescent is not previously known to the CAMHS Inpatient Services, a Joint Review meeting with the responsible community CAMHS team should take place within 5 working days following admission.
- Even in the case of an emergency, it is not always possible to secure a CAMHS inpatient bed. Therefore, all other alternatives will need to be explored, such as attendance at a day hospital, increasing community supports, admission to a general hospital or, as a last resort in exceptional circumstances, and where clinically indicated in the best interests of the child or adolescent, admission to an adult psychiatric unit.

5.11 Admissions to Adult Psychiatric Units

5.11.1 Admissions of children and adolescents to adult psychiatric units do occur in exceptional circumstances, for the shortest period of time, where there is no safe community or inpatient alternative.

5.11.2 An admission to an adult unit can only be made if there is no bed available in any CAMHS Inpatient Unit nationally or where a clinical decision is made in the best interest of the child or adolescent.

5.11.3 There are rules and legislation governing how an admission to an adult unit is carried out. These are detailed clearly in the Mental Health Commission Code of Practice Relating to admission of children under the Mental Health Act 2001, 2006 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Health Act 2001 Addendum, 2009. The Mental Health Commission (MHC) have recommended the following guidance for an admission to an adult unit:

- the child or adolescent must have access to a CAMHS team and Consultant.
- there should be 1:1 nursing.
- the child or adolescent should have a single room and segregated bathroom facilities.
- the MHC must be notified within 72 hours of the admission.
- the child or adolescent's individual care plan should include education requirements.

5.11.4 There are a number of reasons why a child or adolescent under 18 years would be admitted to an adult Inpatient Unit and these include:

- the child or adolescent is an immediate risk to themselves or others.
- a clinical decision has been taken which is made in the best interest of the child or adolescent. For example, distance of the Inpatient Unit from the child or adolescent's home may make it difficult for families to maintain contact or to be involved in interventions and treatment. The views of the child or adolescent and parent(s) are also given consideration as appropriate to the clinical presentation.

5.11.5 The referring CAMHS team or Consultant Psychiatrist must be able to demonstrate what alternatives were explored prior to admission.

5.12 Admission to a CAMHS Inpatient Unit

5.12.1 When a decision is made to admit a child or adolescent to a CAMHS Inpatient Unit, and a bed is available, they attend the Inpatient Unit for admission with their parent(s).

5.12.2 The child or adolescent is oriented to the Inpatient Unit, and they are provided with written information about the unit.

5.12.3 The child or adolescent will have an assessment and formulation of their needs, and this assessment is carried out in an area which ensures their privacy and dignity (Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2010).

5.12.4 An initial care plan is completed by the admitting clinicians. It details the immediate treatment and interventions required for the child or adolescent. This may include for example levels of observations required, medication, etc.

5.12.5 An initial care plan is not a replacement for the multi-disciplinary ICP which must be completed within seven days of admission.

5.12.6 Treatment will take place alongside assessments and starts at the point of admission. The care and treatment plan will be modified and updated regularly as the child or adolescent's needs change.

5.13 Admission Process – Voluntary

5.13.1 The vast majority of admissions to CAMHS Inpatient Units are voluntary admissions. Consent for admission of a child to the Inpatient Unit is required from one of the child's parent(s). The consent process is guided by the Mental Health Act, 2001, as amended.

5.13.2 Under the Mental Health Act, 2001, as amended, a child is a person under the age of 18 years other than a person who is or has been married. This means that while the child or adolescent's views on a voluntary admission should be sought, consent for admission and treatment can only be given by their parent(s).

5.13.3 Valid consent for admission and treatment must be informed consent. This means that the parent(s) and child have sufficient information to be able to understand the nature of what is proposed, and the potential risks and benefits involved. See https://healthservice.hse.ie/staff/procedures-guidelines/hse-consent-policy/

5.13.4 Information should be provided in plain language at regular intervals to facilitate understanding in line with the HSE plain language guidelines - https://assets.hse.ie/media/documents/HSE_Plain_Language_Guidelines.pdf.

5.13.5 Multilingual resources should be provided to children and adolescents and their parents who require them and a HSE approved translator may be needed in certain circumstances to facilitate understanding https://www.hse.ie/eng/services/publications/socialinclusion/lostintranslationreport.pdf.

5.14 Involuntary Admissions to CAMHS Inpatient Units

5.14.1 A small minority of children or adolescents will need to be admitted to a CAMHS Inpatient Unit involuntarily. Section 25 of the Mental Health Act, 2001, as amended, allows for the involuntary admission of children.

5.14.2 It sets out that the HSE may make an application to the District Court for an order authorising the detention and treatment of a child, who is suffering from a mental disorder and requires treatment which they are unlikely to receive unless this order is made.

5.15 CAMHS Inpatient Teams

5.15.1 A CAMHS Inpatient Unit is staffed by a range of multi-disciplinary professionals who have experience in treating severe and complex mental disorders in children and adolescents, which require the level of treatment only available in an inpatient setting.

5.15.2 These multi-disciplinary professionals may include dietitians, nurse managers, nurses, occupational therapists, pharmacists, psychiatrists, psychologists, social care staff, social workers, speech and language therapists, and other therapists as required.

5.16 Use of Inpatient Beds and Bed Capacity

5.16.1 CAMHS Inpatient Units have an agreed capacity. If capacity at any unit needs to change on a temporary basis (e.g. due to staffing challenges), this should be agreed with the relevant Registered Proprietor and IHA manager in advance of notification to the MHC and all other Inpatient Units.

5.16.2 Each CAMHS Inpatient Unit should, as far as possible, ensure that it has an emergency bed available so that the Unit can respond to emergency admissions on a 24/7 basis.

5.16.3 When accepting a referral, the capacity of the Inpatient Unit to meet the needs of a particular child or adolescent will be considered.

5.16.4 The capacity of the Inpatient Unit is dependent on how acute the child or adolescent's presentation is, the presentation of the other children or adolescents on the Unit, and the available staffing levels.

5.16.5 The Inpatient Unit must be able to meet the therapeutic needs of the child or adolescent while maintaining a safe and functioning unit within available resources. This includes having the appropriate clinical expertise and physical infrastructure in place to manage admitted children and adolescents presenting with highly complex, dysregulated, or challenging behaviours. Where seclusion is required, it must only be used as a last resort in accordance with national HSE guidance and the Mental Health Commission's Code of Practice on the Use of Seclusion.

5.16.6 It is expected that, once deemed suitable for admission by the Inpatient Consultant, units will admit a child or adolescent living within their region supporting the provision of care close to home. A decision to admit a child or adolescent to a unit outside their catchment area should only occur in exceptional circumstances, where there is a clear, documented clinical justification in the best interests of the child.

5.16.7 If the Unit does not have the capacity to admit, there must be ongoing communication between the referring and inpatient Consultants. This will ensure that the child or adolescent and parent(s) are aware of the timeline for admission. The regional Inpatient Unit is responsible for coordinating with other Inpatient Units to access a bed in the event that a bed is not available locally.

5.16.8 Distance from home must be carefully considered when planning an inpatient admission, as visiting and supporting a child or adolescent who is placed at a distance from their home could place a considerable burden on parent(s).

5.17 Home Leave

5.17.1 Home leave is an integral and therapeutic part of the overall Individual Care Plan and discharge plan. Home leave is an essential part of ongoing risk assessment, and helps to ensure successful reintegration into home, education and social activities. Home leave provides opportunity for a child or adolescent to reengage with their friendship circle as appropriate. It assists with the transition from inpatient to community-based CAMHS.

5.17.2 Prior to home leave taking place, parent(s) should be provided with support, advice and emergency contact numbers should a crisis arise while a child or adolescent is on leave at home. As part of a risk management plan, contact may be maintained with parent(s) via phone check-ins during periods of leave.

5.18 Individual Care Plan (ICP)

5.18.1 In line with the Mental Health Commission regulation, an Individual Care Plan is a set of goals describing the care and treatment needed for the child or adolescent's admission.

5.18.2 The ICP should be developed collaboratively between the child or adolescent, their parent(s) and CAMHS team, including key worker.

5.18.3 All children and adolescents within CAMHS Inpatient settings must have a written ICP which is completed within 7 days of admission in accordance with the *Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements towards Continuous Quality Improvement, 2017.*

5.18.4 The ICP should be reviewed on a weekly basis by the multi-disciplinary team. When changes are made, a revised copy should be provided to the child or adolescent and their parent(s).

5.18.5 An ICP should include a summary of the following:

- A clinical formulation.
- A diagnosis if available.
- Agreed goals between the CAMHS team, the child or adolescent and the parent(s).
- Medical and psychiatric history.
- Physical health needs including history and current medications.
- Risk assessment and management plan including strengths and protective factors.
- Psychosocial history including family and social supports.
- Communication abilities and needs.
- Educational, occupational and vocational requirements.
- A discharge/transition plan which includes a provisional discharge date.

5.19 Risk Assessment and Risk Management

5.19.1 The range and nature of risk behaviours in a CAMHS Inpatient Unit can be complex. These can include risks to children themselves, risk to others, and risk from others. Staff within CAMHS Inpatient Units therefore have a broad understanding of risk assessment and management planning and have a range of risk management strategies available which can be tailored to the needs of an individual child or adolescent.

5.19.2 Staff within the CAMHS Inpatient Unit should ensure that there are controls in place to identify, assess, measure and manage risks, including both clinical and non-clinical risks.

5.19.3 Risk assessment and management planning must involve a consideration of the individual child or adolescent's risk and environmental factors.

5.19.4 Positive risk-taking should be considered to allow children and adolescents to engage in activities that are meaningful to them and will help promote their recovery; where there is a clear clinical benefit to the child or adolescent; and where the identified risks can be managed.

5.20 Multi-Disciplinary Team (MDT) Reviews

5.20.1 Clinical MDT review meetings should be held weekly (at a minimum) throughout the inpatient admission or at a frequency determined by the child or adolescent's clinical needs, especially if their stay is likely to be short.

5.20.2 People attending such reviews may include the child or adolescent and the responsible inpatient CAMHS team representatives (Consultant Psychiatrist, key worker, and CAMHS Unit staff).

5.20.3 It is essential that the child or adolescent's views are integral to this process. This is facilitated by completion of the headspace toolkit and engagement with their keyworker.

5.20.4 The referring Community CAMHS team should be informed of the progress of the child or adolescent throughout the inpatient stay.

5.21 Discharge Planning

5.21.1 Discharge from a CAMHS Inpatient Unit occurs when a child or adolescent no longer requires this level of care. This may mean that assessment has been completed, they have achieved their goals, or their care can be managed in a community setting.

5.21.2 Discussions about discharge planning should begin early in the admission, when the Individual Care Plan is drawn up. This should be done in collaboration with the child or adolescent and their parent(s).

5.21.3 Discharge planning should focus on the child or adolescent's recovery and must include a follow-up plan with the Community CAMHS team, the GP and other community services.

5.21.4 A discharge meeting should occur, attended by the child or adolescent, their parent(s), representative(s) from the local Community CAMHS team, prior to formal discharge from the Inpatient Unit. The Consultant Psychiatrist from the community team must attend in person or virtually.

5.21.5 Discharge may need to be considered when it is deemed that the continued admission is counter-therapeutic or appears to worsen the child or adolescent's mental state or compromises the safety of others on the Unit.

5.21.6 The discharge plan must ensure that there are clear processes in place for follow-up including planned outpatient appointments. The discharge plan should clearly indicate who is responsible for each process within the inpatient and community teams. This must be put in place in advance of discharge.

5.21.7 At the completion of treatment, the GP, referring Consultant and parent(s) should receive a preliminary written discharge summary outlining the outcomes of the inpatient interventions and ongoing recommendations.

5.21.8 Within 14 days a comprehensive discharge summary should be sent to the Consultant Psychiatrist who will be assuming clinical responsibility.

5.21.9 Where indicated, there will be multi-agency involvement in discharge planning. These may include but are not limited to:

- Tusla – the Child and Family Agency, including aftercare programmes for 16/17-year-olds moving out of care.
- Community Disability Network Teams.
- Primary Care Services.
- Mental Health Intellectual Disability Teams.
- Local paediatric hospital/unit.
- Primary/post-primary schools/Youth Reach and third level colleges (including NEPS where appropriate).
- Adult Mental Health Services.
- Residential care services if the child or adolescent is in the care of Tusla – the Child and Family Agency.
- Private providers of inpatient treatment or residential placement.
- Voluntary agencies supporting the child or adolescent's recovery.
- Court appointed representatives – Guardian ad Litem.

5.22 Transition to Adult Services

5.22.1 If an adolescent of 17 years and above requires referral to adult mental health services (AMHS), a transition plan within their ICP will be required. This should ideally begin at least 6 months before their 18th birthday.

5.22.2 On their 18th birthday, the relevant adult mental health service must assume responsibility for their care.

5.22.3 Not all adolescents require a transition plan, but it is essential that all are assessed for it and the outcome of the assessment of future need is recorded clearly.

5.22.4 Signposting to other supports should be provided to adolescents, parent(s) and supporters, when approaching transition age to include information on AMHS and alternative community supports (e.g. education, employment and social prescribing etc.).

5.22.5 Joint working between CAMHS and adult mental health services should be considered as an option in the initial week of handover to aid a smooth transition from one service to the other. These services operate in a different way to each other, and this can be a significant change for adolescents and their parent(s).

5.22.6 The adolescent's Consultant Psychiatrist and key worker will be responsible for initiating a handover to the adult mental health service and ensuring appropriate information is shared.

5.22.7 As appropriate, where required, there should be involvement of additional specialist services to support the transition (e.g. clinical programmes, addiction services etc.).

5.22.8 The information required for a transition includes as a minimum, a detailed referral letter or a copy of the ICP, risk assessment, record of all medication, and a formal handover of all MDT interventions including physical health needs.

5.22.9 CAMHS should be available to the to the receiving team to provide consultation for at least 3 months following transition to ensure continuity of care.

5.22.10 Any challenges during the transition should be escalated to the Executive Clinical Director in the relevant area. If this involves two regional health areas, the respective ECDs will work collaboratively to find a resolution.

5.22.11 Joint care review/handover meetings must be organised by the CAMHS Inpatient team with the key agencies/services who will be taking on the care of the adolescent once they move on from the Inpatient Unit.

Appendices

1. Glossary

Approved Centre: An "approved centre" is defined in the Mental Health Act 2001 as "a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder". It is registered with the Mental Health Commission.

Child: a child is defined under the Child Care Act 1991 as a person under the age of 18 years other than a person who is or has been married.

Child Safeguarding: Action that is taken to promote the welfare of children and protect them from harm. While protecting children from abuse is one part of safeguarding, children and young people also need safeguarding for them to grow, develop and achieve their full potential. (Tusla Child Safeguarding: A Guide for Policy, Procedure and Practice p6).

Consent: Consent is the giving of permission or agreement for a treatment, investigation, receipt or use of a service or participation in research or teaching. Consent involves a process of communication about the proposed intervention in which the person has received sufficient information to enable them to understand the nature, potential risks and benefits of the proposed intervention. Seeking consent should usually occur as an on-going process rather than a one-off event. For further details refer to HSE National Consent Policy, 2022.

Custody: As a result of parental separation or divorce proceedings, one parent may be granted sole custody. A copy of the order granting custody or the separation agreement could be sought to verify that only one parent is entitled.

Eating Disorder: Eating Disorders are a group of clinical mental health conditions that involve very serious disturbance in eating behaviours and in how people control their weight as a result of core preoccupations and negative thoughts and feelings about eating, weight or shape.

Evidence-Based Practice: This requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources.

Guardianship: This is the collection of rights and duties that a parent (or non-parent) has for a child. Guardians make decisions for a child and are responsible for their welfare. A child's parents are most commonly their guardians; however, guardians can be appointed by a parent or by a court order. Further information is available from the Courts Service of Ireland (Guardianship).

Guardianship rules post 2016 (Children and Family Relationships Act 2015): an unmarried father will automatically be a guardian if he has lived with the child's mother for 12 consecutive months after 18 January 2016, including at least 3 months with the mother and child following the child's birth. If there is disagreement as to whether they have been cohabiting for the required length of time, an application for the necessary declaration can be made to the court.

Healthlink: Healthlink provides an electronic messaging service that allows clinical patient Information to be securely transferred between Hospitals, Health Care Agencies and Medical Practitioners in real time.

Health Regions: The HSE is organised into 6 health regions. Each health region provides health and social care services for the people in that area.

Integrated Health Area: Integrated Healthcare Areas are the substructures within each of the 6 health regions. There are 20 Integrated Healthcare Areas across Ireland. Integrated Healthcare Areas bring together both acute and community services as well as other non-HSE providers.

Key worker: A key worker is a point of contact on the CAMHS teams who coordinates care, not only within the mental health service but also across systems (e.g. education, social welfare, etc.) for the service user. Key workers do not deliver all of the treatment, but they are responsible for making sure that other professionals are keeping to what was agreed in the care plan. (*HSE mental health best practice guidance, Sharing the Vision: A Mental Health Policy for Everyone (2020)*).

Mandated Person: Mandated Persons are people who have contact with children and/or families who, by virtue of their qualifications, training and experience, are in a key position to help protect children from harm. The Children's First Act 2015 places a legal obligation on these people, many of whom are professionals, to report child protection concerns at or above a defined threshold to Tusla – Child and Family Agency. Schedule 2 of the Children First Act 2015 provides a full list of people who are classified as mandated persons.

Mental Health: The World Health Organisation defines Mental Health as not just the absence of mental illness but also the presence of "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". (*World Health Organisation*).

Mental Disorder (World Health Organisation definition): The World Health Organisation defines Mental Disorder as "a broad range of problems with different symptoms. However, they are generally characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others. (World Health Organisation).

Mental Disorder (Mental Health Act 2001 definition): 'Mental Disorder' is defined in section 3 of the Mental Health Act 2001. It means mental illness, severe dementia or significant intellectual disability where – (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (c) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

Mental Illness (Mental Health Act 2001 definition): 'Mental Illness' means a state of mind of a person which affects the person's thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons.

Multi-disciplinary Team: A multi-disciplinary team is a group of health care workers who are members of different disciplines or professions, e.g. Psychiatrists, Social Workers, etc., each providing specific services to the service user. The team members independently treat various issues a service user may have, focusing on the issues in which they specialise. The activities of the team are brought together using a care plan. This helps coordinate individual services and encourages team working towards a specific set of service user goals.

Parent(s): In this document parent(s) is used throughout to refer to a child's father or mother, or both, or their legal guardian or anyone acting in loco parentis. Detailed information on guardianship is available on: https://services.courts.ie/Family-Law/arrangements-for-children/guardianship.

Partner Agencies: The Community / Voluntary / NGO Sectors provide a range of services to people with mental health problems. These include support services, self-help, and community groups.

Relevant Person: A person who is appointed by a provider of a relevant service, as part of the requirements of the Children First Act 2015, to be the first point of contact in respect of the provider's Child Safeguarding Statement. The relevant person can provide information about how the child safeguarding statement, and any associated risk assessment, was developed and will be able to provide a copy, on request. For further information see HSE Guidance for Developing and Reviewing a Child Safeguarding Statement, Part A.

Section 25 Order: A Section 25 Order is an order made by the District Court pursuant to Section 25 of the Mental Health Act 2001 that a child may be admitted and detained for treatment in a specified approved centre for a period not exceeding 21 days.

Tusla – Child and Family Agency: The specific role of Tusla is to promote the welfare of children who are at risk of not receiving adequate care and protection. Tusla has responsibility for child welfare and protection services, family support, educational welfare and a range of other services, including those relating to domestic, sexual and gender-based violence. (*Children First: National Guidance for the Protection and Welfare of Children, 2017*).

2. List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Services
ARI	Advancing Recovery Ireland
CAMHS	Child and Adolescent Mental Health Services
CAMHS-ID	Child and Adolescent Mental Health Service in Intellectual Disability
CMHT	Community Mental Health Team
CORU	Health and Social Care Professionals Council
CYMHO	Child and Youth Mental Health Office
CYMHS	Child and Youth Mental Health Services
CYP	Child or Young Person
ED	Emergency Department
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSCP	Health and Social Care Professionals
HSE	Health Service Executive
HSELanD	HSE Learning and Development Platform
ICP	Individual Care Plan
IHA	Integrated Healthcare Areas
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and others
MDT	Multi-Disciplinary Team
MHC	Mental Health Commission
MHER	Mental Health Engagement and Recovery
MHID	Mental Health Intellectual Disability
MHS	Mental Health Services
MOC	Model of Care
NCHD	Non-Consultant Hospital Doctor
NCP	National Clinical Programmes
NEPS	National Educational Psychology Services
NFHMS	National Forensic Mental Health Service
NGO	Non-governmental Agency/Organisation
NMBI	Nursing and Midwifery Board of Ireland
PPPG	Policies, Procedures, Protocols and Guideline
PSI	Psychological Society of Ireland
REO	Regional Executive Officer
StV	Sharing the Vision

3. List of relevant legislation and policies

The content of this guideline should be read in conjunction with the following legislation and policies. This is not an exhaustive list.

- Department of Children, Disability and Equality (2005), *'Disability Act, 2005, SI14 of 2005'.* Dublin: Stationery Office
- Department of Children, Disability and Equality, (2014), *'Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020'*. Dublin: Government Publications
- Department of Children, Disability and Equality, (2015), *'Children First Act 2015, SI36 of 2015'*. Dublin: Government Publications
- Department of Children, Disability and Equality, (2015). *'National Youth Strategy 2015-2020'.* Dublin: Government Publications
- Department of Children, Disability and Equality, (2017), *'Children First: National Guidance for the Protection and Welfare of Children'*. Dublin: Government Publications
- Department of Children, Disability and Equality, (2018), *'LGBTI+ National Youth Strategy 2018-2020: LGBTI+ young people: visible, valued and included'.* Dublin: Government Publications
- Department of Children, Disability and Equality, (2019), *'National Strategy on Children and Young People's Participation in Decision-Making'.* Dublin: Government Publications
- Department of Children, Disability and Equality (2024) *'Child Care Act 1991(Revised, updated to 30 September 2024)'.* Dublin: Stationery Office
- Department of Children, Disability and Equality, (2024), *'National Traveller and Roma Inclusion Strategy II 2024-2028'*. Dublin: Government Publications
- European Union Parliament (2016), 'General Data Protection Regulation, 2016/679', Brussels: EUR-Lex
- Department of Health, (2012), *'Future Health – A Strategic Framework for Reform of the Health Service, 2012-2015'.* Dublin: Government Publications
- Department of Health, (2017). *'Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025'.* Dublin: Government Publications
- Department of Justice, Home Affairs and Migration, (2012), *'Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, SI24 of 2012'*. Dublin: Stationery Office
- Department of Justice, Home Affairs and Migration, (2012), *'National Vetting Bureau (Children and Vulnerable Persons) Act 2012, SI47 of 2012'.* Dublin Stationery Office
- Department of Justice, Home Affairs and Migration, (2018) *'Data Protection Act 2018, S17 of 2018',* Dublin: Stationery Office
- Health Service Executive, (2013). *'Open Disclosure National Policy'.* Dublin: Health Service Executive
- Health Service Executive, (2015) *'Assisted Decision Making Capacity Act, 2015'.* Dublin: Health Service Executive
- Health Service Executive, (2016), *'Child Protection and Welfare Policy 2016'.* Dublin: Health Service Executive
- Health Service Executive, (2016), *'Report on the Listening Meetings'.* Dublin: Health Service Executive

- Health Service Executive, (2017), *'Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement'*. Dublin: Health Service Executive
- Health Service Executive, (2017), *'Your Service Your Say: The Management of Service User Feedback for Comments, Compliments and Complaints: HSE Policy'* Dublin: Health Service Executive
- Health Service Executive, (2018), *'Data Protection Policy'*. Dublin: Health Service Executive
- Health Service Executive, (2018). *'Family, Carer and Supporter Guide'.* Dublin: Health Service Executive
- Health Service Executive (2018), *'National Clinical Programmes for Eating Disorders, 2018. Eating Disorders Services, HSE Model of Care for Ireland'.* Dublin: Health Service Executive
- Health Service Executive: National Office for Suicide Prevention, (2018). *'Self-Harm and Young People: An information booklet for parents and concerned adults'.* Dublin: Health Service Executive
- Health Service Executive, (2019), *'Patient Safety Strategy 2019-2024'.* Dublin: Health Service Executive
- Health Service Executive, (2022). *'National Consent Policy'.* Dublin: Health Service Executive
- Health Service Executive, (2023), *'Mental Health Engagement and Recovery Strategic Plan: Engaged in Recovery, 2023-2026'.* Dublin: Health Service Executive
- Health Service Executive, (2023), *'Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023'.* Dublin: Stationery Office
- Health Service Executive, (2024), *'Engagement in Recovery Framework 2024-2028, Mental Health Engagement and Recovery Office'.* Dublin: Health Service Executive
- Health Service Executive, (2024), *'HSE Privacy Notice – Patients and Service Users'.* Dublin: Health Service Executive
- Health Service Executive, (2025). *'National Service Plan 2025'.* Dublin: Health Service Executive
- Mental Health Commission, (2001), *'Mental Health Act, 2001 (Approved Centres) Regulations, 2006, SI551 of 2006'.* Dublin: Stationery Office
- Mental Health Commission, (2001), *'Mental Health Act, 2001 SI25 of 2001(Involuntary Admission of Children)'.* Dublin: Stationery Office
- Mental Health Commission, (2006), *'Code of Practice relating to Admission of Children under the Mental Health Act 2001'.* Dublin: Mental Health Commission
- Mental Health Commission, (2009). *'Code of Practice relating to Admission of Children under the Mental Health Act 2001: Addendum'.* Dublin: Mental Health Commission
- Mental Health Commission, (2025). *'Judgment Support Framework (JSF) – Version 6.1'.* Dublin: Mental Health Commission. Dublin: Mental Health Commission
- Mental Health Commission, (2025), *'MHC Guidance for Staff working in Mental Health Service on the Care and Treatment of LGBTQIA People'* Dublin: Mental Health Commission
- Tusla – The Child and Family Agency, Health Service Executive, (2017), *'Joint Protocol for Interagency Collaboration between the Health Service Executive and Tusla – Child and Family Agency, to Promote the Best Interests of Children and Family'.* Dublin: Tusla
- United Nations Human Rights Office of the High Commissioner, (1989). *'Convention on the Rights of the Child'.* Geneva: ONHR

4. Contributing list of sources and stakeholders

Reports

- National Audit of Adherence to the CAMHS Operational Guidelines Report (2024), HSE.
- Enhanced Transition Plan: Recommendations and implementation plan to support transition from HSE Child and Adolescent Mental Health Services to HSE Adult Mental Health Services. Prepared by the Youth Mental Health Transitions Specialist group to support the implementation of Sharing the Vision (2024).

Consultation

Type of Consultation	Participants
Public Consultation A public survey was made available via social media and more than 370 responses were received from:	Young people and their families
	General Practitioners
	Jigsaw
	Tusla
	Youth Advocate Programmes Ireland
	Irish Association of Social Workers
	Health and Social Care Professionals
	Tipperary F.U.S.S
	HSE Staff
	CAMHS Staff
	Children's Disability Network Team Staff
Stakeholder Engagement Consultations were held with the following representatives or they were offered the opportunity to review draft versions and provide feedback.	HSE Mental Health Engagement & Recovery
	HSE Primary Care
	HSE Disability
	HSE/ICGP Clinical Lead in Mental Health
	Mental Health Commission
	National Educational Psychology Service (NEPS)
	HSE National Clinical Group Lead, Mental Health
	HSE National Clinical Programmes: – ADHD – Eating Disorders – Mental Health Intellectual Disability – Self-Harm
	HSE National Quality and Patient Safety
	HSE Children First National Office
	HSE Sharing the Vision Policy Implementation Team

Multi-Disciplinary Review Group

A multi-disciplinary review group was established to review the COG and to make recommended updates based on stakeholder consultation, evidence-based practice, and policy, legislative and regulatory updates.

Membership of MDT Review Group	
Name	**Role and position**
Dr Amanda Burke	National Clinical Lead, Child & Youth Mental Health
Sarah Hennessy	Programme Lead, Child & Youth Mental Health
Paula Callaghan	Senior Speech & Language Therapist, HSE Dublin and North East
Yvonne Doheny	Assistant Director Of Nursing, HSE Dublin and South East
Professor Brendan Doody	Clinical Director, HSE Dublin and Midlands
Mairead Doyle	Dietitian Manager, HSE West and North West
Dr Michael Drumm	Principal Psychology Manager, HSE Dublin and North East
Dr Tom Foley	Consultant Child & Adolescent Psychiatrist, HSE West and North West
Elaine Gahan	Principal Social Worker & Psychotherapist, HSE Dublin and North East
Edel Gavin	Assistant Director Of Nursing, HSE Dublin and North East
Caitriona Hanley	Principal Social Worker, HSE Mid West
Mary Harrington	Dietitian, HSE South West
Dr Lisa Kelly	Clinical Director, HSE Dublin and South East (Lucena)
Celine Langton	Programme Support, Child & Youth Mental Health
Helen Maher	Business Manager, HSE Dublin and South East
Kellie McDermott	Clinical Nurse Manager, HSE Dublin and North East
Dr Suzanne McHugh	Senior Clinical Psychologist, HSE Dublin and Midlands
Patrick Meehan	Clinical Nurse Specialist-Mental Health, HSE West and North West
Dr Sonia Morris	Senior Clinical Psychologist , Lucena CAMHS
Dr Tani Mucko	Consultant Child & Adolescent Psychiatrist, HSE Mid West
Dr Fay Murphy	Principal Clinical Psychologist, Lucena CAMHS
Dr Laura Murphy	Principal Psychology Specialist, HSE Mid West
Jason O'Connor	Business Operations Manager, HSE Dublin and Midlands
Brian O'Malley	Director Of Nursing, HSE West and North West
Barry O'Sullivan	Principal Social Worker, HSE South West
Eilis Peoples	Principal Social Worker, HSE West and North West
Dr Eamon Raji	Consultant Child & Adolescent Psychiatrist, HSE West and North West
Dr Udo Reulbach	Consultant Child & Adolescent Psychiatrist, HSE Dublin & North East
Dr AnnMarie Robertson	Consultant Child & Adolescent Psychiatrist, HSE West and North West
Cecily Roche	Occupational Therapy Manager, HSE Dublin and North East
Maureen Tierney	Assistant Director Of Nursing, HSE Mid West
Dr Imelda Whyte	Consultant Child & Adolescent Psychiatrist, HSE Dublin and Midlands
Linda Wilson	Section Officer, HSE West and North West
Natasha Woods	Section Officer, HSE Dublin and North East

5. National Clinical Programmes and Specialist CAMHS teams

Mental Health National Clinical Programmes (NCPs)

NCPs are clinically led services, designed and implemented to provide and improve better clinical outcomes for service users.

The NCPs are part of the Office of the Chief Clinical Officer (CCO) in the HSE. The Mental Health Clinical Programmes are a joint initiative between this office, HSE Mental Health Services, and the College of Psychiatry of Ireland (CPsychI). The overarching aim of the NCPs is to standardise quality evidence-based practice across the Mental Health Services.

There are six NCPs for mental health all at various stages of design and implementation. These are listed below. Please click on hyperlink for further information.

- National Clinical Programme for Self-Harm and Suicide related ideation *(Currently, CHI at Tallaght is the only CHI site actively implementing the National Clinical Programme for Self-Harm and Suicide-Related Ideation (NCPSHI). This programme is delivered by a dedicated nurse specialist working in collaboration with the Paediatric Liaison Psychiatry team. Young people presenting with self-harm or suicidal behaviours receive care in accordance with the NCPSHI Operational Guidance Document. Care is guided by the NCPSHI Four Pillars of Intervention. In line with current paediatric guidelines, CHI at Tallaght provides services to young people up to the age of 16. All young people referred to Liaison Psychiatry for self-harm or suicidal behaviours are assessed by a team member. Those presenting during working hours are assessed within two hours whenever possible. Referrals made outside of working hours are admitted under the care of the General Paediatrician and subsequently reviewed by Liaison Psychiatry the following day. Decisions regarding referral to onward services are made following the initial assessment. The majority of young people are referred to CAMHS; however, some are directed to voluntary services or returned to the care of their GP. A small proportion are referred to inpatient psychiatric units.).*
- In addition to this, the SCAN U service in Donegal provides a timely assessment and support to GP patients (16yrs-18yrs) who are in suicidal/self-harm crisis and who meet the inclusion criteria. The service aims to reduce the reliance on the ED for such presentations. The service aims to support parents and guardians during this period and also to provide more positive outcomes and better onward referrals to suitable services.
- Eating Disorders Service (spanning Child and Adolescent and Adult Mental Health Services).
- Early Intervention in Psychosis.
- ADHD in Adults (& Children, due to be published in 2025).
- Dual Diagnosis.
- Specialist Perinatal Mental Health.

Specialist CAMHS teams

CAMHS ID: Child and Adolescent Mental Health Services: Intellectual Disability

CAMHS ID services are specialist mental health services for children with a moderate to profound intellectual disability, where there is a concern about a moderate to severe mental disorder, for example a depressive illness, psychosis, a moderate to severe anxiety disorder that has not responded to intervention provided by primary care or the Children's Disability Network Team (CDNT) or ADHD.

A moderate to severe mental disorder is one where the child experiences significant distress and impairment from baseline in two or more areas of functioning as a result of the mental disorder, not as a result of their disability.

CAMHS ID services are separate and distinct but closely linked to the CDNT, who adopt a social care approach to support the child's disability. It is best practice for a child to be linked with their CDNT and receiving disability or ASD specific interventions as appropriate, prior to referral to CAMHS ID for assessment of symptoms of a mental disorder.

The primary source of referral to the CAMHS ID service is the General Practitioner. Other sources of referral include Consultant Psychiatrists and Paediatricians. If the CDNT manager wishes to initiate a referral, this needs to be accompanied by a medical referral providing details of medical assessment, past medical and family history and treatment.

The CAMHS ID team provides:

- Multidisciplinary assessment, formulation, diagnosis and treatment of mental disorders which significantly impact on everyday functioning to a degree that requires specialist CAMHS-ID input.
- Development of co-produced individual mental health care plans.
- Provision of multidisciplinary team interventions to treat mental disorder
- Promotion of recovery from mental illness in a way that best supports the child or adolescent's complex needs.
- Provision of appropriate and specific staff and carer mental health education and training.
- Development of discharge and after-care planning.
- Mental health medication management.
- Liaison with CDNT, education services and mental health services.
- Working with acute children's mental health services during crisis presentations, where appropriate.

Children and adolescents with intellectual disability living with a mental disorder, may not only need support from a specialist mental health service, but also at various points or simultaneously, from all community services (primary care, CDNT, paediatrics and inpatient services) during their illness, treatment and recovery.

The HSE national model of service CAMHS ID supports the best practice principle of joint and collaborative working of the CAMHS-ID team with primary care, community mental health services, developmental paediatrics, disability services and if required Inpatient Units, in order to provide integrated person-centred care. This is in line with the recommendations of the Sláintecare ten-year plan published by the Department of Health 2019.

CAMHS ID services adopt a recovery approach to assessment and treatment of mental disorder. Discharge is discussed and planned throughout the child or adolescent's journey with the CAMHSID team. This is achieved through regular and ongoing care planning.

Not all children referred will remain open to CAMHS ID until the age of eighteen years, and some will require transfer to adult services on reaching their eighteenth birthday. The aim is to ensure that service users are discharged from the service at the right time, and that appropriate follow-up care is in place. On recovery from mental illness, the service user will be discharged to the care of the general practitioner, with advice on:

- Ongoing management of their mental disorder. (if required).
- Links to other non-mental health services in place or those recommended for consideration by the general practitioner.
- Guidance on how to refer the child/adolescent back to the CAMHS-ID team if this is required in the future (for those aged under 18 years).

These details should be explained in a detailed closing letter to the child's GP.

CAMHS Eating Disorder Teams

CAMHS Eating Disorder Teams provide specialist outpatient eating disorder care for children and young people under the age of 18 years with moderate to severe eating disorders. They operate across an assigned regional area and are embedded within existing mental health services. Most young people with eating disorders are treated as outpatients. CAMHS Eating Disorder teams are part of a stepped model of care that includes outpatient, hospital and inpatient care so young people can receive the right treatment based on their clinical need. CAMHS Eating Disorder Teams are multidisciplinary mental health teams that include dietitians and paediatricians. Team members are trained in the assessment and treatment of eating disorders. CAMHS eating disorder teams work closely with comm CAMHS, medical teams, liaison psychiatry teams and GPs to provide specialist eating disorder care across their region. Young people must be physically well enough to be outside of hospital care to attend CAMHS eating disorder teams.

The most commonly treated eating disorders are anorexia nervosa, OSFED and bulimia nervosa. Anorexia nervosa or suspected anorexia nervosa is always considered to be a moderate to severe eating disorder. In collaboration with other HSE services, CAMHS Eating Disorder Teams may provide support for ARFID (avoidant restrictive food intake disorder) and binge eating disorder when specialist mental health input is required. When young people have additional mental health needs, CAMHS eating disorders teams can operate a shared model of care with their local community CAMHS team. Where young people are attending their community CAMHS team with an eating disorder, additional support can be provided their CAMHS eating disorder team. This may be indicated in areas where it is more convenient for families to attend their local CAMHS team closer to their home.

The aims of CAMHS Eating Disorder Teams are to provide early intervention through specialist assessment and evidence-based treatments for eating disorders. Referral criteria include up to the age of 18 years and suspected anorexia nervosa or other moderate to severe eating disorders. Referrals can be accepted from GPs, community CAMHS, paediatric/medical teams, liaison psychiatry and CAMHS Inpatient Units. CAMHS Eating Disorder teams aim to offer assessments within 2-4 weeks of referral and to start treatment within the 2-4 weeks of assessment. Family based therapies are the most commonly delivered treatments. Individual therapy can also be provided where appropriate. In addition, the following are provided: psychiatric reviews, dietetic assessment, meal coaching skills, group therapy, psychoeducation, medication and physical health monitoring.

Inpatient treatment can be recommended when a child or adolescent is not responding to outpatient treatment and/or is too unwell physically to be treated safely outside of hospital. CAMHS Eating Disorder teams can refer young people to medical hospitals. CAMHS eating disorder teams can also refer young people to CAMHS approved centres for psychiatric inpatient treatment. When young people are discharged from an inpatient setting, their care returns to the CAMHS eating disorder team. CAMHS eating disorder teams discharge to GPs or community CAMHS teams. When young people require eating disorder care after their 18th birthday, CAMHS Eating Disorder teams can refer to the adult eating disorder team in their region or to their local adult mental health team. CAMHS Eating disorder teams can continue to treat young people after their 18th birthday to complete a course of treatment.

6. Self-assessment of adherence to the CAMHS Operational Guideline – 'a how-to guide'

What is self-assessment

Self-assessment is a vital tool for Child and Adolescent Mental Health Services, enabling teams and individuals to critically evaluate their own practices against established standards and guidelines. By engaging in honest and structured reflection, self-assessment helps identify strengths, uncover areas for improvement, and promote accountability. This process supports continuous quality improvement, ensuring that services remain responsive, effective, and aligned with national priorities and best practice frameworks.

Self-assessment empowers CAMHS teams to enhance the quality and safety of care delivered to service users, fostering better outcomes and experiences for individuals and their families.

Self-assessment vs audit

While self-assessment is an opportunity for teams to subjectively discuss and consider their own practices against the guideline, it is expected that a more formal audit of casefiles should be carried out on a regular 6 monthly basis to objectively confirm that the service is meeting all required standards. A sample file audit tool can be found here.

Self-assessment survey

A survey has been developed to support teams in their self-assessment of adherence to the COG. This survey is being hosted on MS Forms, which should be easily accessible on your HSE computer using a valid HSE email address.

It is expected that this survey should be completed every 2 years and will form part of a broader audit schedule for your team.

There are 28 questions in total. The main questions required a yes/partial/no response, and depending on the response provided, you may be prompted to provide further information via free text.

Where the answer provided is 'partial' or 'no', you will be asked further questions in order to identify opportunities for quality improvement.

How to complete the survey

- The identified team member(s) should follow this link.
- This will open an MS Forms survey.
- *(Please note – only those with HSE email addresses will be able to access this link. If you are unable to access it, please use the MS Word version of the survey, found here.).*
- Please complete the demographic information requested – this is so that the uptake of the survey can be measured.
- Please work through the questions in sequence.
- Once you have completed all questions, there is an option to request that your responses be emailed to you, please select 'yes' so that you can keep a local record of your responses.

Tips for responses

It's important to remember that the tool is intended to help teams identify areas of strength and areas for improvement, so teams should endeavour to be as honest as possible in their responses.

The table below shows a general guideline to support decision-making by the team about the most appropriate response to the questions.

Response	Frequency of adherence (as agreed by team)
Yes	90-100%
No	0-50%
Partial	50-90%

Quality Improvement Plan

The survey has been designed to support the identification of quality improvement opportunities and your responses to Q 20-24 can be used to populate a Quality Improvement Plan for your team. A template can be found here.

7. Standardised Forms

The following forms have been standardised in advance of the upcoming electronic health record to be implemented across CAMHS.

CAMHS teams are strongly encouraged to use these forms. They can be accessed via this link:

Form name
ADHD Review Document
Additional Information Consent Form
AWOL Checklist
Clinical Practice Form for Physical Restraint
Community CAMHS Initial Assessment
Community Discharge Summary
Community Individual Care Plan
Consent to Completion of Digital Measures
Eating Disorder Initial Assessment
Inpatient Discharge Summary
Inpatient Individual Care Plan
Inpatient Nursing Admission Assessment
Inpatient Nursing Screening Form
Inpatient Psychiatric Assessment Form
Inpatient Record of Young Person's Property
Inpatient Referral Form
Inpatient Transfer Form
Initial Assessment ADHD
MDT Discussion
Medication Consent Form
Physical Examination pro-forma
Physical Restraint Care Plan
Restrictive Practice Debriefing Form
Risk Assessment Tool
Search Form
Transition Plan Checklist

A multi-disciplinary review group was established to review the COG standardised forms and to make recommended updates.

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Membership of Forms Group

Name	Role
Annemarie Dineen	Senior Social Worker (Functional Lead) HSE Community Connect
Professor Brendan Doody	Clinical Director, HSE Dublin and Midlands
Brian O'Malley	Director Of Nursing, HSE West and North West
Dr Maria Migone	Clinical Director, Lucena CAMHS
Edel Gavin	Assistant Director Of Nursing, HSE Dublin and North East
Eilis Peoples	Principal Social Worker, HSE West and North West
Dr Faddy Oraha	Psychiatry Registrar, Eist Linn, Child & Adolescent Inpatient Service
Dr Fay Murphy	Principal Clinical Psychologist, Lucena CAMHS
Isobel Cuddigan	Senior Speech and Language Therapy (Functional Lead), HSE Community Connect
Dr Jennifer Laing	Senior Clinical Psychologist (Functional Lead), HSE Community Connect
Martha Adebayo	Assistant Director Of Nursing (Functional Lead), HSE Community Connect
Natasha Woods	Section Officer, Louth Meath Mental Health Services
Dr Petra McLoughlin	Senior Registrar, Linn Dara Services
Sarah Hennessy	General Manager, Child and Youth Mental Health Office
Dr Sonia Morris	Senior Clinical Psychologist, Lucena CAMHS
Dr Tom Foley	Consultant Child & Adolescent Psychiatrist, HSE West and North West
Dr Tom Sharpe	Senior Registrar, Donegal Services
Yvonne Doheny	Assistant Director Of Nursing, HSE Dublin and South East

8. Implementation Supports and Resources

The HSE Child and Youth Mental Health Office has developed a number of resources to support local regions and teams to implement the 3rd Edition of the CAMHS Operational Guideline (COG, 2025).

Introduction

In June 2015 the Mental Health Division of the HSE developed a Standard Operating Procedure (SOP) for both in-patient and community Child and Adolescent Mental Health Services (CAMHS). This document was developed to support CAMHS services to be delivered in a consistent and timely fashion, regardless of where the service is accessed throughout the country. In 2019, following extensive review and consultation around the SOP, the CAMHS Operational Guideline (2nd Edition) was published.

The 3rd edition of the COG is now published following review of the 2019 document, to take into consideration the views of service users, family members, front line staff and management working within HSE mental health services and in other organisations working with children and adolescents.

The main objectives of the guideline are:

1. Align operational practice to the intended outcomes of the 2024-2027 Child and Youth Mental Health Office Action Plan.
2. Build on the existing good practice already in place in CAMHS.
3. Provide an Operational Guideline that CAMHS teams can adhere to.
4. Ensure that legislative and regulatory requirements are met.
5. Ensure that all employees and management are clear on their roles and responsibilities.
6. Ensure that children, adolescents and their parent(s) are clear on the service provided by CAMHS.
7. Ensure that referral agents and other agencies involved in the provision of care to children and adolescents are clear on the service provided by CAMHS.
8. Provide a framework for audit and evaluation.

	Resource	Target Audience	When
1.	**Videos** – outlining changes in this version with Project Sponsor and CAMHS staff	Staff, referrers and users	November 2025
2.	**CAMHS Staff briefing document** – outlining updates/changes in the revised guideline	CAMHS Staff	November 2025
3.	**Email** – outlining review process and main changes for all relevant stakeholders	CAMHS Staff and delivery partners	November 2025
4.	**Local implementation plan template** – to all CAMHS teams	CAMHS Staff and Regional Leadership	November 2025
5.	**Webinar** – outlines changes in detail to support CAMHS teams and management with local implementation	CAMHS Staff and Regional Leadership	December 2025
6.	**Email** – National Director Access and Integration and all REOs requesting support with regional implementation	National Senior Leadership and Regional Executives	December 2025
7.	**Implementation evaluation survey** – to all CAMHS teams	CAMHS Staff and Regional Leadership	March 2026
8.	**Quality Improvement Plan** – for completion following self-assessment, here under Forms	CAMHS Staff and Regional Leadership	November 2025

Local Implementation

Regional leadership teams should develop their own local implementation plans to ensure adoption of this updated version of the CAMHS Operational Guideline.

Local plans should incorporate:

- Implementation actions
- Implementation barriers/enablers
- Tasks required to implement actions
- Person(s) responsible for delivery of actions
- Timelines
- Expected outcomes

A template to document local implementation plans can be found here under Forms

9. Programme Board

This 3rd Edition of the CAMHS Operational Guideline was formally approved by the Child and Youth Mental Health Programme Board on 30th October 2025.

Membership of the CYMH Programme Board	
Name	**Role**
Dr. Amanda Burke	National Clinical Lead - National Youth Mental Health Office (Co-Chair)
Mr Donan Kelly	Assistant National Director - National Youth Mental Health Office (Co-Chair)
Ms. Sarah Hennessy	Senior Responsible Officer, CYMH Service Improvement Programme and CYMH Programme Lead
Michelle Butler	Senior Responsible Officer, CYMH Service Improvement Programme
Paul Braham	Senior Responsible Officer, CYMH Service Improvement Programme
Ms. Ann Donaghey	Head of Service, Mental Health CHO5
Mr. Derek Chambers	General Manager National Mental Health Operations, Programme Lead for Sharing the Vision
Dr Amir Niazi	National Clinical Advisor and Group Lead – Mental Health
Michael Ryan	General Manager, HSE National Office of Mental Health Engagement and Recovery