Standards for Child and Adolescent Mental Health Services (CAMHS)

NPC

SUPPORTING PARENTS
SUPPORTING CHILDREN

NPC Vision

The National Parents Council want to see an Ireland where every child has the opportunity to reach their full potential.

NPC Mission

The National Parents Council exists to ensure that all parents are supported and empowered to become effective partners in their children's education. NPC will work to increase the capacity and capability of the education sector, to achieve true partnership and deliver better outcomes for all children and young people.

Values

NPC knows that when parents and schools work together, children do better. Therefore, NPC believes that in order to achieve this parents must feel:

Engaged: Parents must be actively engaged in the education of their children.

Supported: Parents' involvement in children's education must be supported by the attitudes, beliefs and practices of all members of the school and broader education community.

Partners: Parents must be viewed as partners in facilitating children's learning and be supported in this role by the school and broader education community.

Valued: Parents should be viewed as full partners in the decisions that affect their children and their family.

Welcomed: Parents should be welcome in the school, and their support and assistance sought as a valuable resource to support children's education in the school.

Connected: All communication and dialogue with parents must be regular, open, two-way and meaningful.

National Parents Council Key Activities

SERVICE DELIVERY

NPC's services are developed to empower parents so that they can support their children in all aspects of education.

HELPLINE

The NPC helpline is a national confidential service for parents. The helpline staff listen and give information and support to parents to help them make the best possible decisions for and with their children.

TRAINING AND DEVELOPMENT

The NPC Training and Development programme is a national programme of training, development and support for parents. The purpose is to empower parents to play an active part in their child's education at every level.

WEBSITE

The NPC's website www.npc.ie aims to provide parents with information regarding education at early years, primary and post primary levels.

ADVOCACY

NPC engages in awareness-raising activities and campaigning and lobbying at a national level on the objectives of its Strategic Plan.

REPRESENTING PARENTS

NPC represents the voice of parents through representation on external bodies and other mediums. NPC consults with parents and brings parents' views to bear on education policy.

BUILDING PARTICIPATION

NPC builds participation strategies and activities to ensure parents and children are an integral part of the work of NPC.

Table of Contents

Introduction 05

Survey 06

Survey Findings 07

Additional Areas Included in the Draft Standards 17

Gaps and Missing Areas 24

Clarity and Accessibility 26

Putting the Standards into Practice 27

Additional Comments 28

Appendix 29

Introduction

In February 2026, the National Parents Council (NPC) conducted a consultation with parents as part of a public consultation being undertaken by the Mental Health Commission (MHC) to inform the development of National Standards for Child and Adolescent Mental Health Services (CAMHS). Parents were invited to share their experiences of CAMHS and their views on the standards, supports and service improvements they considered most important for children, young people and families.

The findings from that consultation highlighted several key priorities, including timely access to services, improved communication, greater parental involvement in care and decision-making, better coordination between services, stronger supports for neurodivergent children and young people, meaningful crisis support, family-centred care, and greater accountability across the mental health system.

Following this initial consultation, the Mental Health Commission published the Draft Standards for Child and Adolescent Mental Health Services (CAMHS) for public consultation.

To ensure that parents had a further opportunity to contribute to the development of the standards, the National Parents Council conducted a second consultation.
The purpose of this survey was to explore whether parents felt their views from the initial consultation had been reflected in the draft standards and to gather feedback on the content, clarity and implementation of the proposed standards. Parents were also invited to identify any gaps, highlight areas requiring further development, and share their views on additional topics included in the draft standards that were not strongly reflected in the findings from the first consultation.

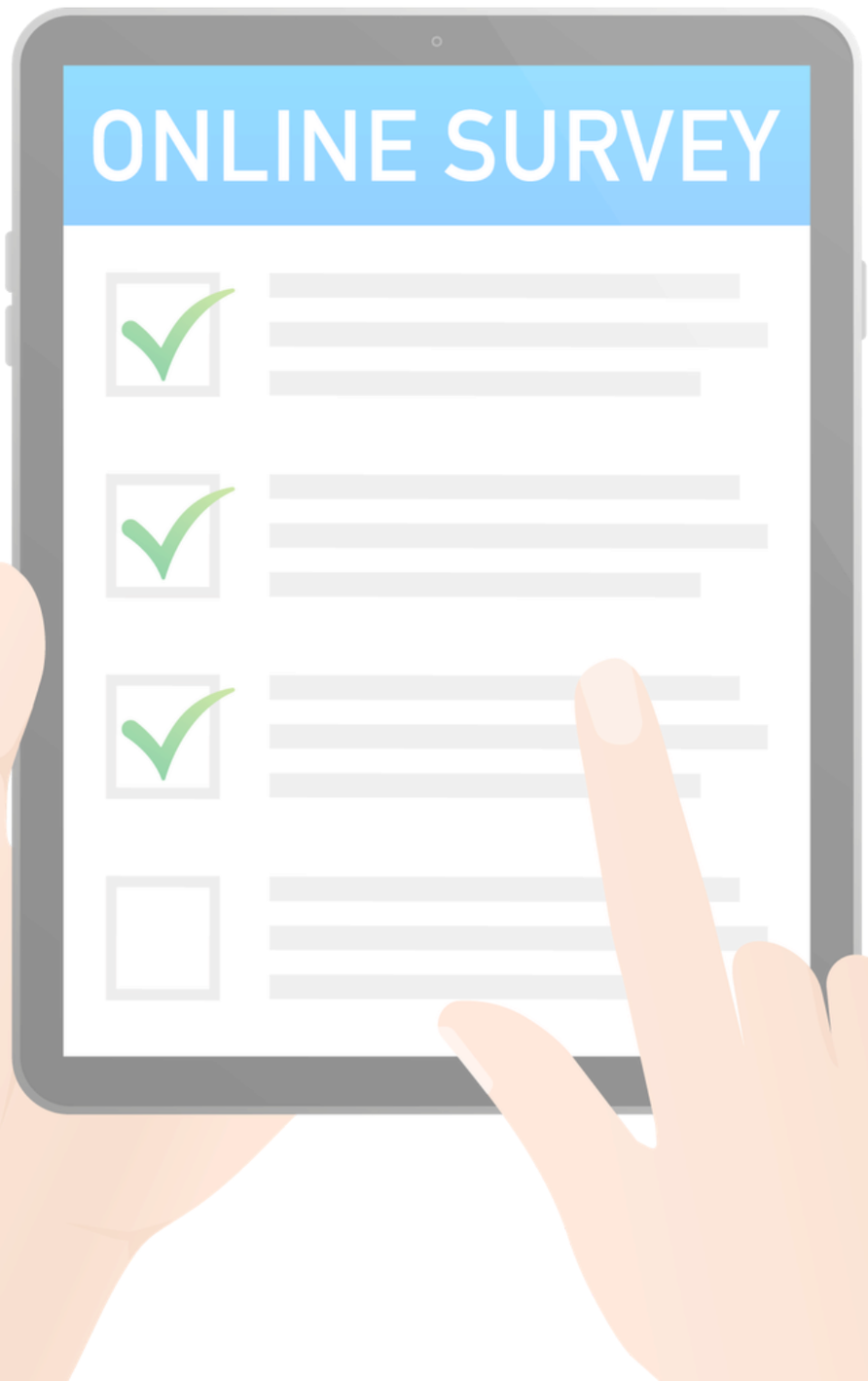
The findings presented here are based on the results of a survey conducted by the NPC in August 2026. The NPC sent the survey to all parents on its mailing list who had given their consent to receive such invitations. The survey was open from 6 August 2026 to 14 August 2026. During this time, a total of 67 parents completed the survey. The opinions of all parents who took part in the survey are shared in this report.

Survey

A survey titled “Standards for Child and Adolescent Mental Health Services (CAMHS)” was distributed to parents following the publication of the draft standards for public consultation. The survey was designed to gather parents’ views on whether the draft standards reflect the experiences, concerns and recommendations they shared during the initial consultation held in February 2026.

It explored parents’ views on the content of the draft standards, any gaps or missing areas, their clarity and accessibility, and how the standards could be implemented in practice. It also sought feedback on a number of additional topics included in the draft standards.

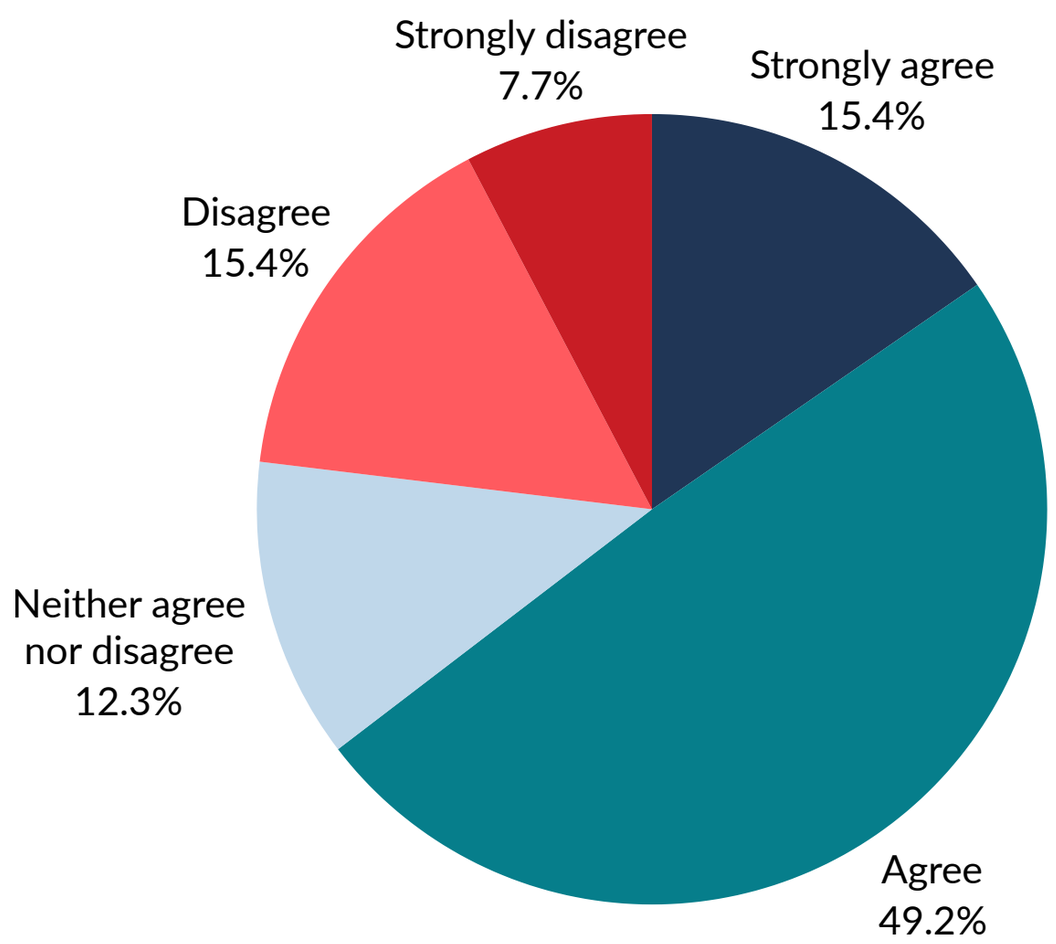
The survey included a combination of multiple-choice and open-ended questions, allowing parents to select responses that reflected their views and provide additional comments where they wished. The main findings of the survey, including key themes and parents’ perspectives, are presented in this report.



Survey Findings

Values and principles

Parents were generally positive about the values and principles contained within the draft standards, particularly in relation to dignity, respect and family involvement. Most respondents felt that the draft standards place sufficient emphasis on treating children and families with dignity and respect. Nearly two-thirds of respondents (64.6%) agreed or strongly agreed with this statement, while approximately one-quarter (23.1%) disagreed or strongly disagreed. A smaller proportion (12.3%) neither agreed nor disagreed (see Figure 1).



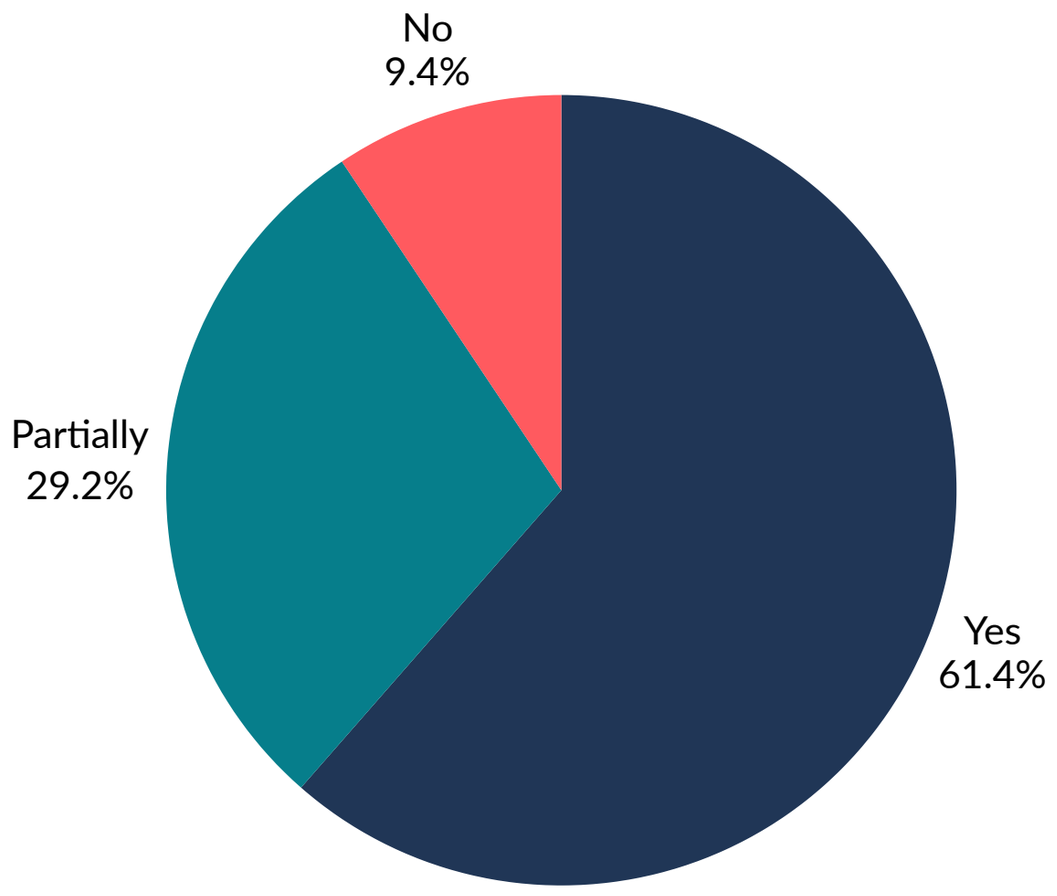
(Figure 1)
Do you agree the draft standards place enough emphasis on treating children and families with dignity and respect?

Although many parents welcomed the language used throughout the draft standards, open-text responses suggested that there was currently a difference between what was written in the document and what many families experience in practice. A number of parents described feeling dismissed, blamed or unheard during their interactions with services. Others highlighted that lengthy waiting times and poor access to support can itself be experienced as a lack of respect for children and families.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Parents were asked whether they felt the draft standards recognise them as important partners in their child's care.

More than 61% of respondents felt that the draft standards adequately reflected the role of parents, while 29% felt this was only partially reflected. A smaller group felt that parents were not sufficiently recognised within the standards (see Figure 2).

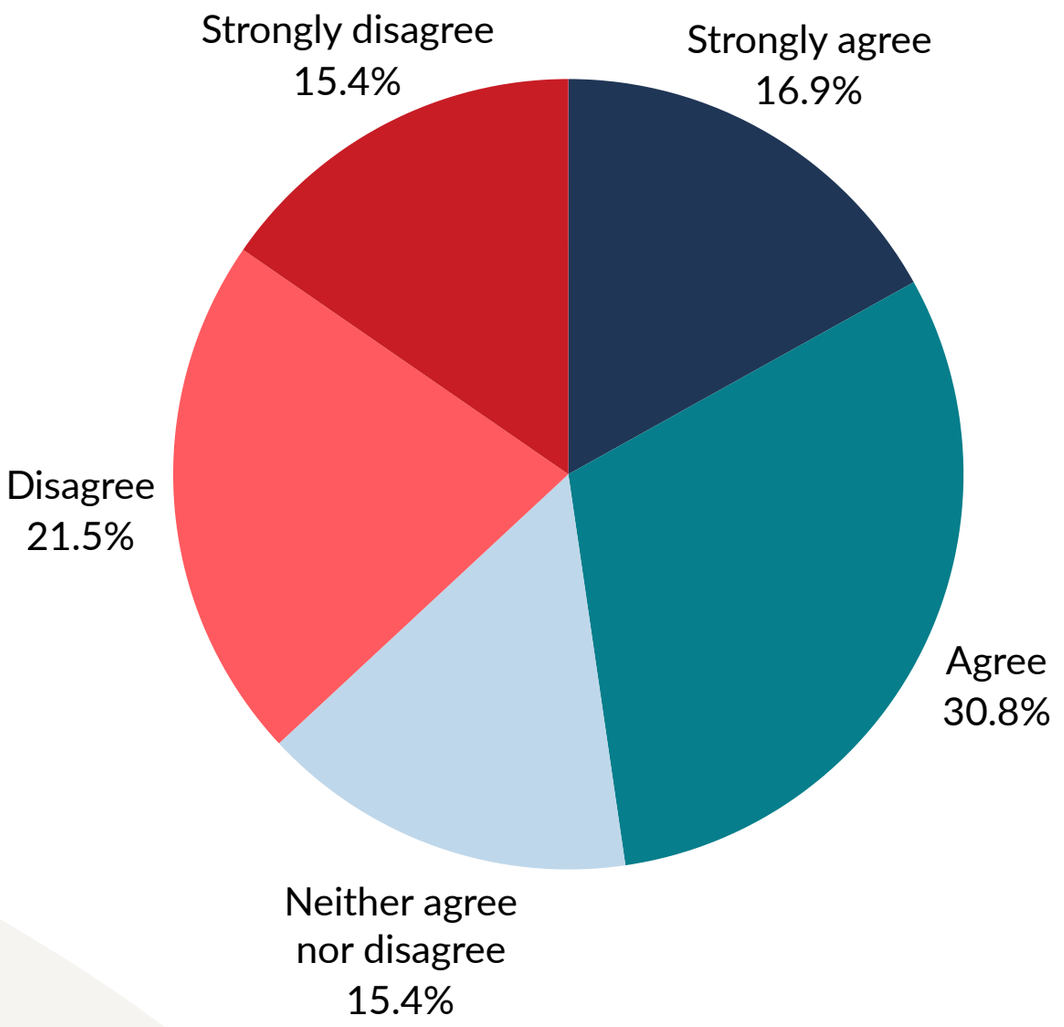


(Figure 2)
Do you think this reflects parents and carers as recognised important partners in their child's care?

Falling Between Services

Parents' views on whether the draft standards adequately address the issue related to children falling between services were mixed.

Almost half of respondents (47.7%) agreed or strongly agreed that the standards do enough to prevent children from falling between services. However, over one-third (36.9%) disagreed or strongly disagreed, while 15.4% neither agreed nor disagreed (see Figure 3).



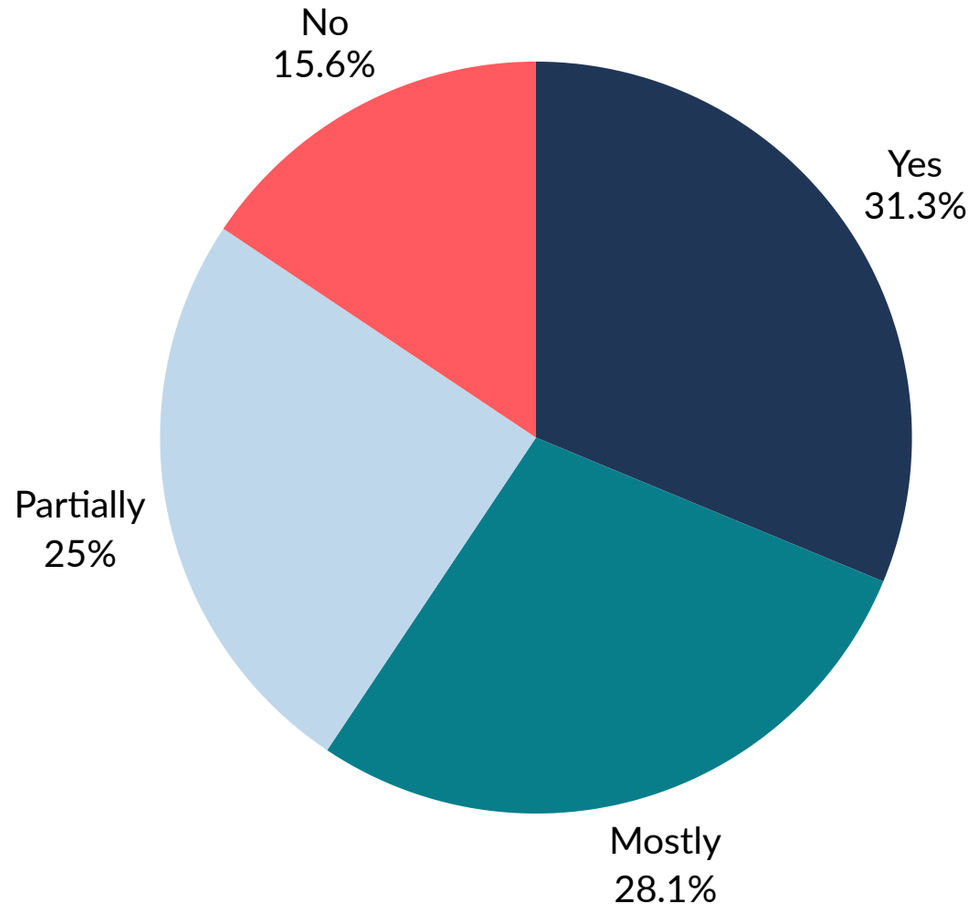
(Figure 3)
Do you agree the draft standards do enough to prevent children falling between services?

The accompanying comments indicate that many parents remain concerned about the practical application of this commitment. Numerous respondents referred to children being passed between CAMHS, Children's Disability Network Teams (CDNTs), Primary Care and school-based supports, with no service taking overall responsibility. Several parents felt the standards describe what should happen but do not sufficiently explain how collaboration between services will be achieved in practice. Concerns were also raised about the continued use of referral thresholds and eligibility criteria, which some parents felt would continue to create barriers to care.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Neurodiversity and Additional Needs

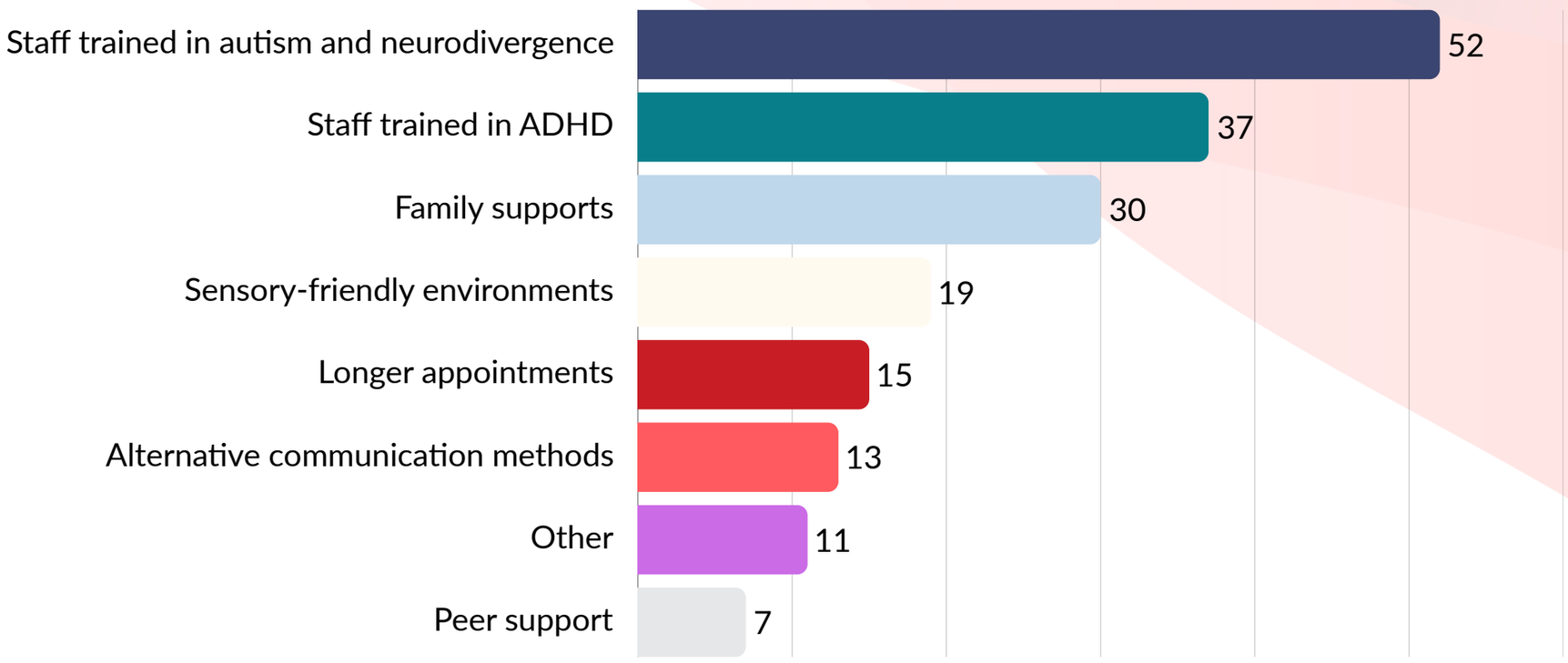
The draft standards received relatively positive feedback in relation to neurodiversity and inclusion. More than half of respondents (59.4%) felt the standards either adequately addressed the needs of autistic and neurodivergent children or mostly addressed them. A further 25% felt the standards only partially addressed these needs, while 15.6% felt they did not adequately address them (see Figure 4).



(Figure 4)
Do you think the draft standards adequately address the needs of autistic and neurodivergent children and young people?

Responses highlighted the importance of staff having specialist knowledge of autism, ADHD and other forms of neurodiversity. Many parents selected staff training in autism and neurodiversity as one of the most important additional supports that should be available. Parents also frequently selected staff training in ADHD, family supports, sensory-friendly environments, longer appointments and alternative communication methods (see Figure 5).

*This is a summary of the parents' voices; please refer to the appendix for full answers.



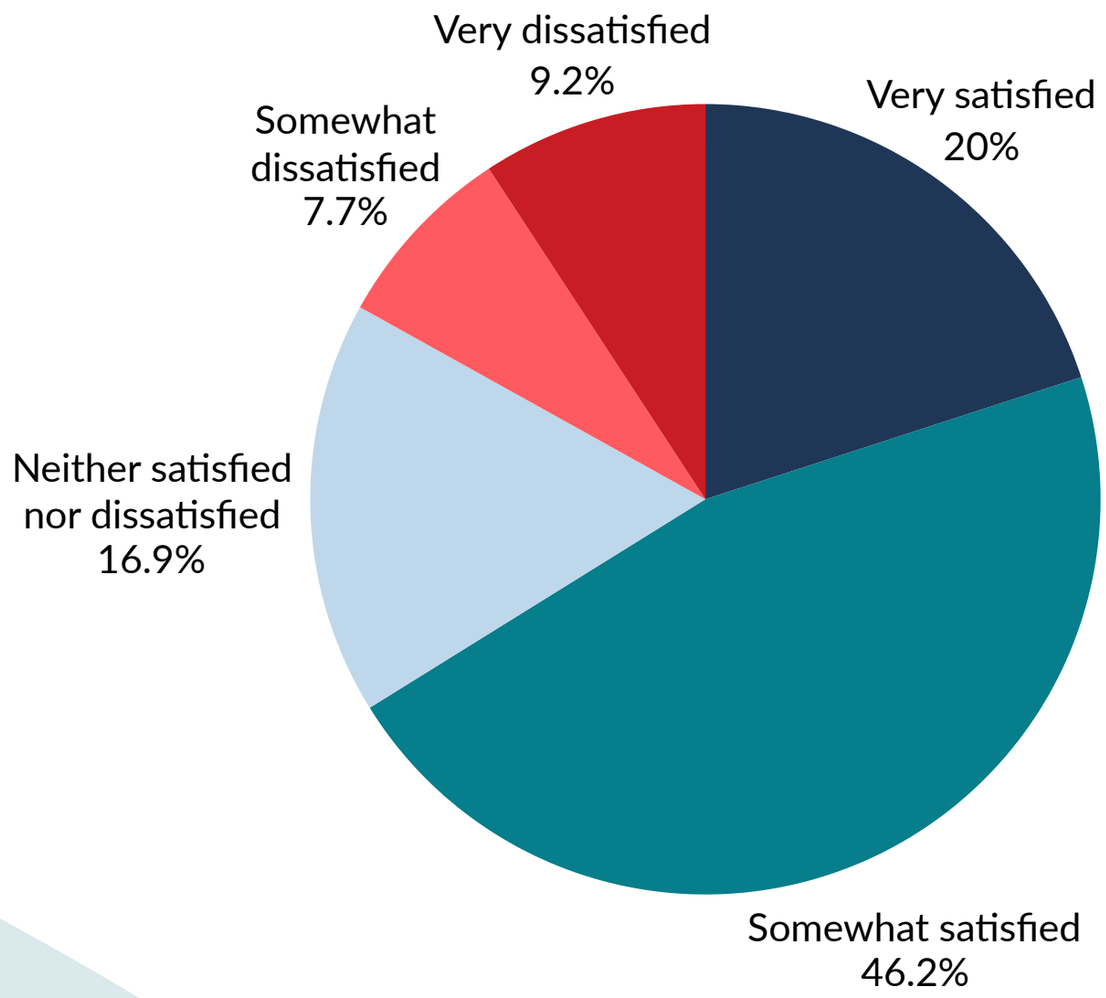
(Figure 5)
What additional supports do you think autistic and neurodivergent children should receive?

Despite welcoming the inclusion of neuro-affirmative language within the standards, many parents remained concerned that neurodivergent children may continue to face barriers to accessing services. Several respondents described experiences where children were refused support, referred elsewhere or were unable to access CAMHS because of their diagnosis. Concerns were also raised about diagnoses such as Fetal Alcohol Spectrum Disorder (FASD) and Pathological Demand Avoidance (PDA), which parents felt are not consistently recognised within services.

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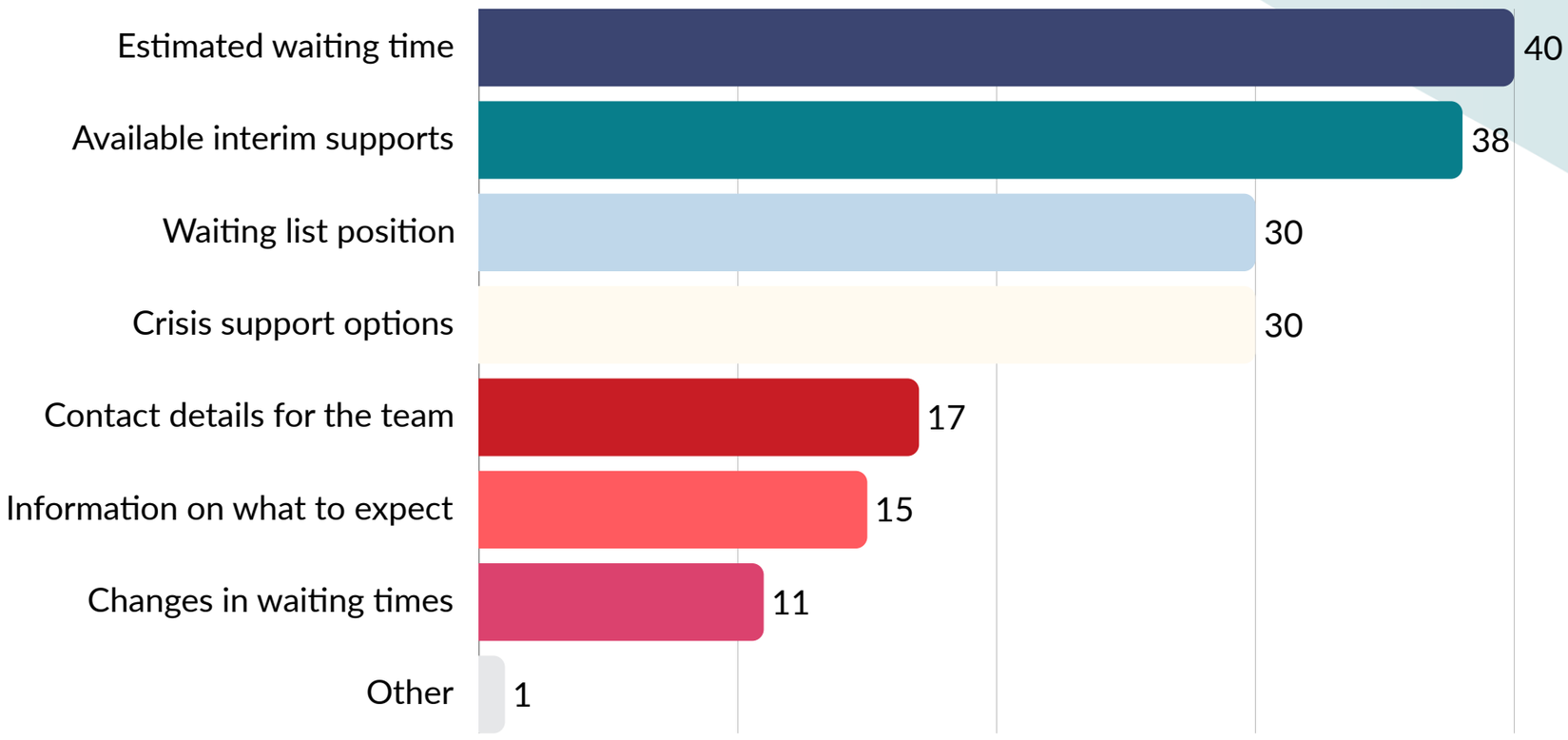
Communication and Information Sharing

Communication emerged as one of the strongest themes throughout the survey. Almost two-thirds of respondents (66.2%) reported being satisfied or very satisfied with the communication commitments included in the draft standards. However, almost one in six respondents remained dissatisfied (see Figure 6).



(Figure 6)
How satisfied are you with the communication commitments in the draft standards?

When asked what information families should receive while waiting for CAMHS, the most commonly selected responses related to estimated waiting times, waiting list positions and information about interim or crisis supports (see Figure 7).



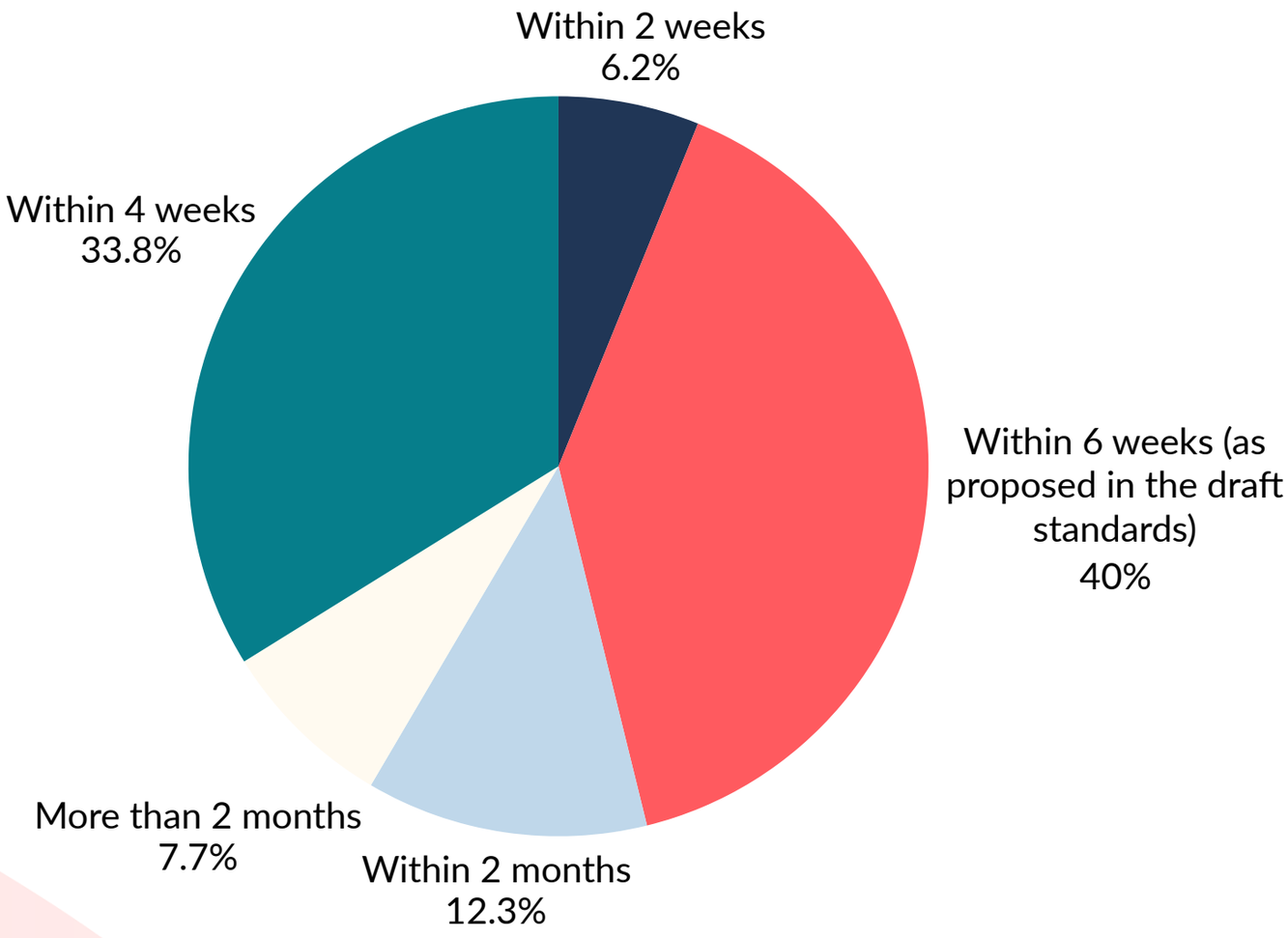
(Figure 7)
What updates do you think families should receive while waiting for CAMHS?

Open responses described current communication as inconsistent, unclear and difficult to access. Many parents spoke about not knowing where their child was on a waiting list, not receiving updates for long periods of time and struggling to obtain information about available supports while waiting. Several parents highlighted that uncertainty and lack of information can contribute significantly to family stress.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

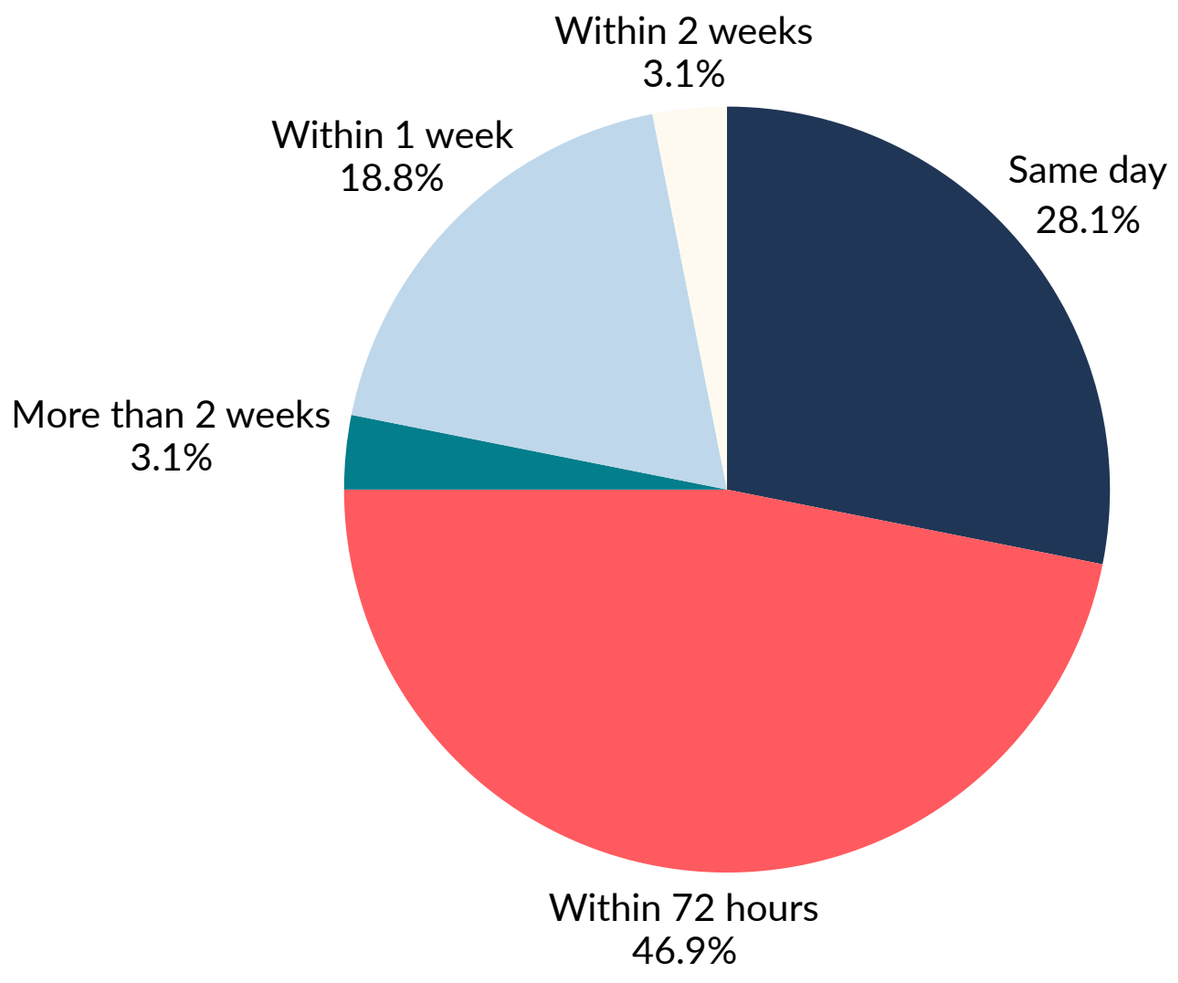
Waiting Times and Access to Care

When asked about the longest acceptable waiting time for a non-urgent referral, the largest group of respondents (40%) selected the six-week timeframe proposed within the draft standards. However, a substantial proportion felt children should be seen more quickly, with 33.8% selecting four weeks and 6.2% selecting two weeks (see Figure 8).



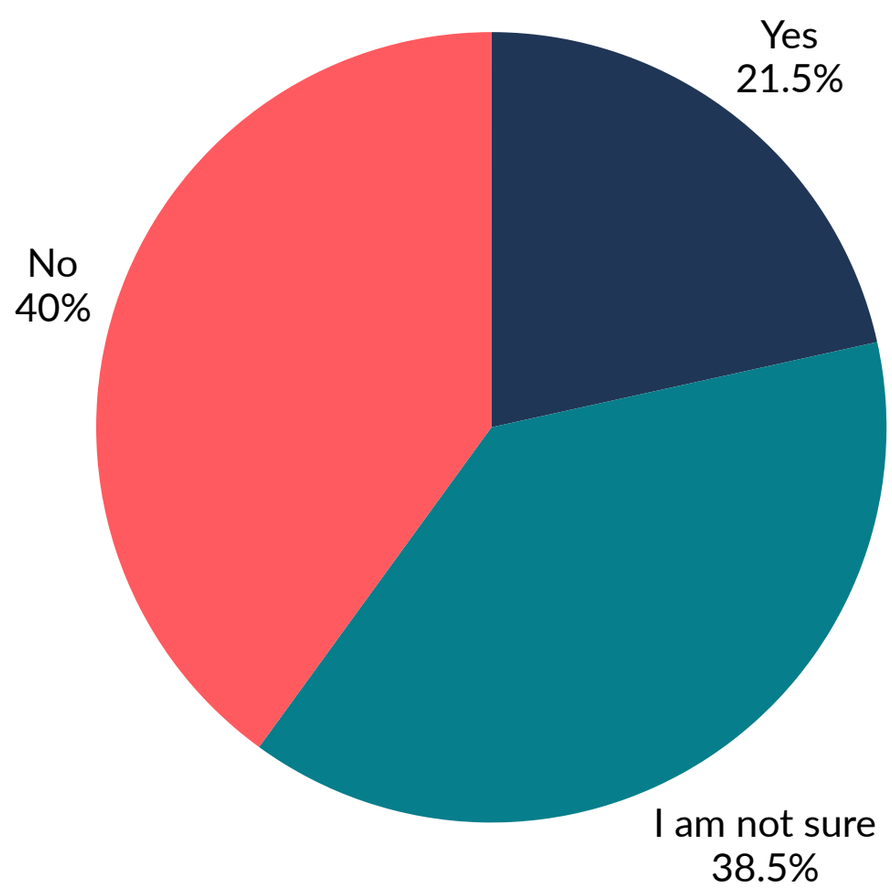
(Figure 8)
What do you think should be the longest acceptable waiting time for a non-urgent referral?

Parents expressed even stronger views regarding urgent referrals. Almost half of respondents (46.9%) felt an urgent referral should be seen within 72 hours, while 28.1% felt a child should be seen on the same day. Only a small number felt waits of more than one week were acceptable (see Figure 9).



(Figure 9)
What do you think should be the longest acceptable waiting time for urgent referral?

Despite support for the proposed six-week timeframe, many parents did not believe the waiting-time commitments included in the draft standards were sufficient. 40% stated that the commitments were not sufficient, while over one-third remained unsure. Only 21.5% felt the commitments were sufficient (see Figure 10).



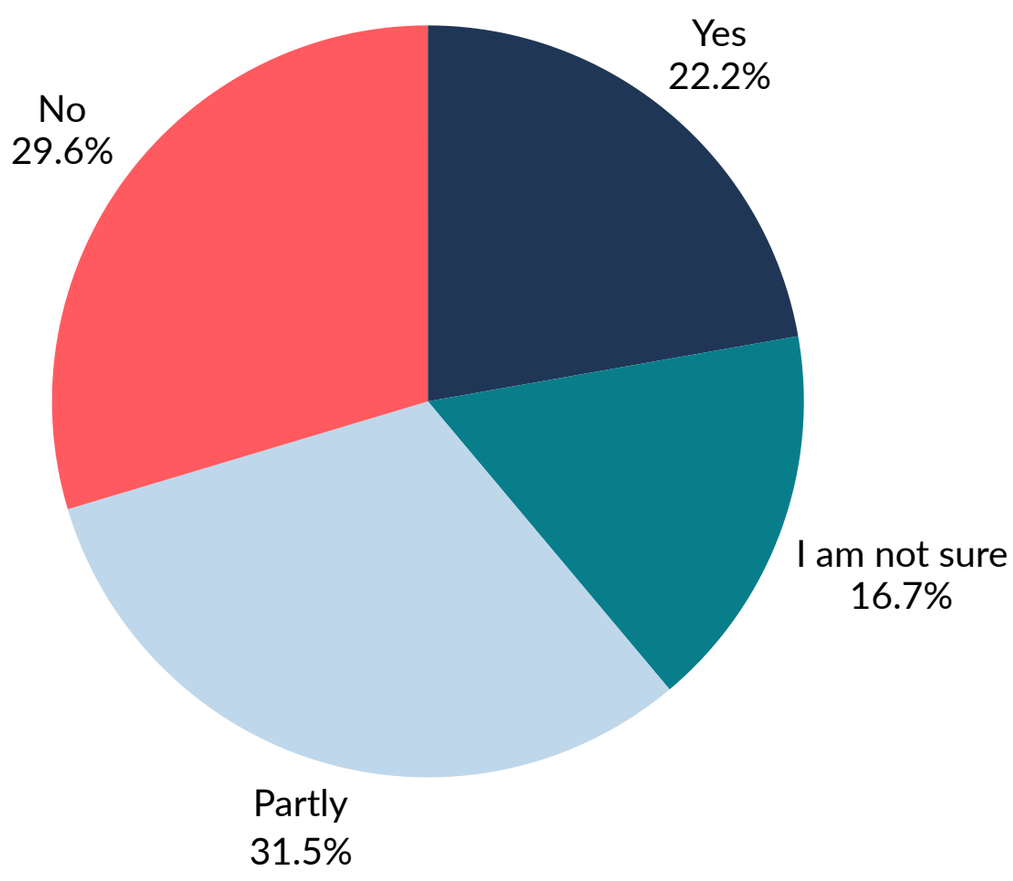
(Figure 10)
Do you think the proposed waiting-time commitments are sufficient?

The qualitative responses demonstrated that concerns about waiting lists continue to dominate many parents' experiences of CAMHS. Parents described lengthy waits, deterioration in children's mental health while waiting, and concerns that referrals classified as non-urgent may become crises if support is not made available quickly enough. Several respondents also questioned how the proposed timeframes would be achieved given current staffing and resource challenges.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

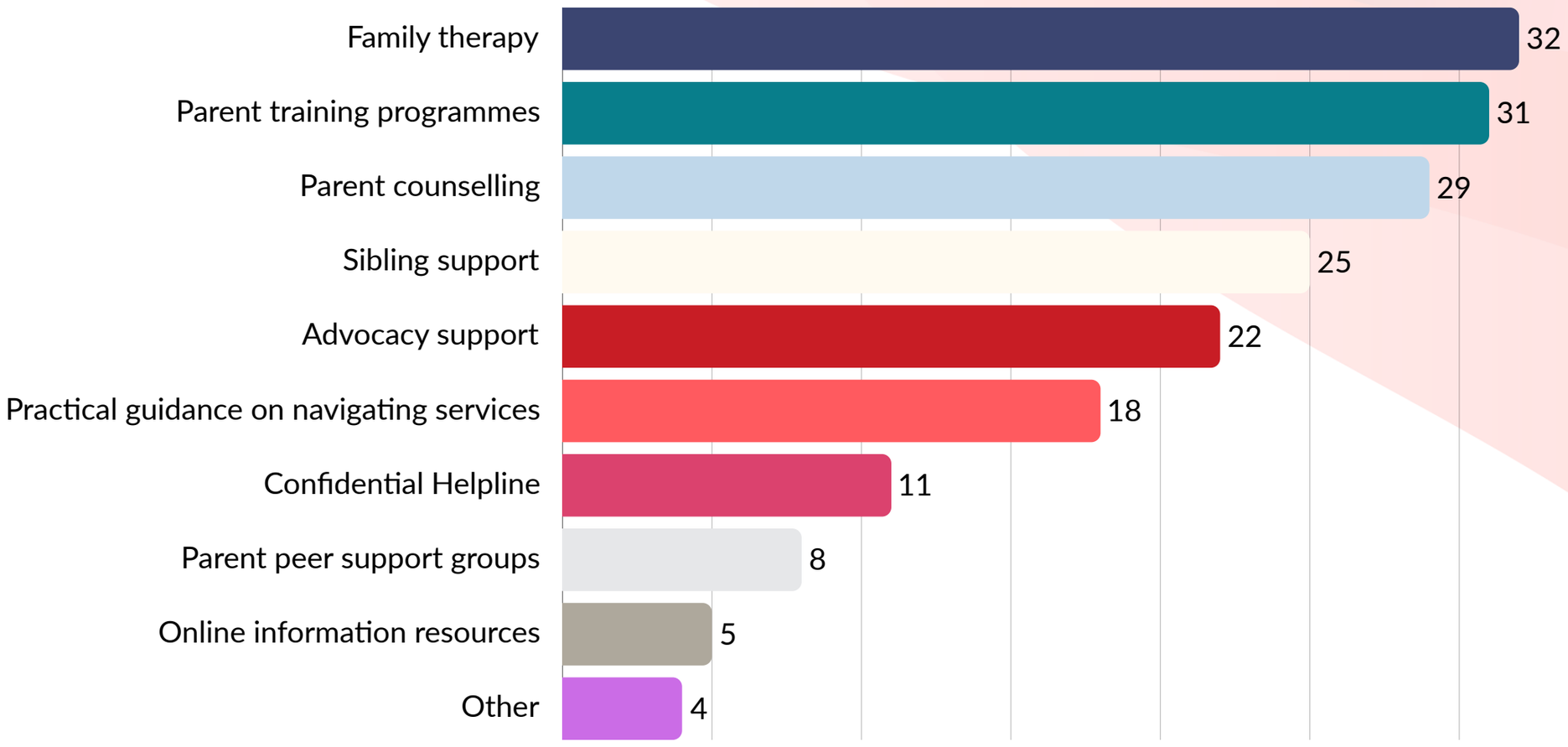
Family Support

Parents were less positive about the extent to which the draft standards provide support for families. Only 22.2% of respondents felt the standards provide enough support for families, while 31.5% believed support was only partially addressed and nearly one-third felt the standards did not go far enough (see Figure 11).



(Figure 11)
Do you think the draft standards provide enough support for families and carers?

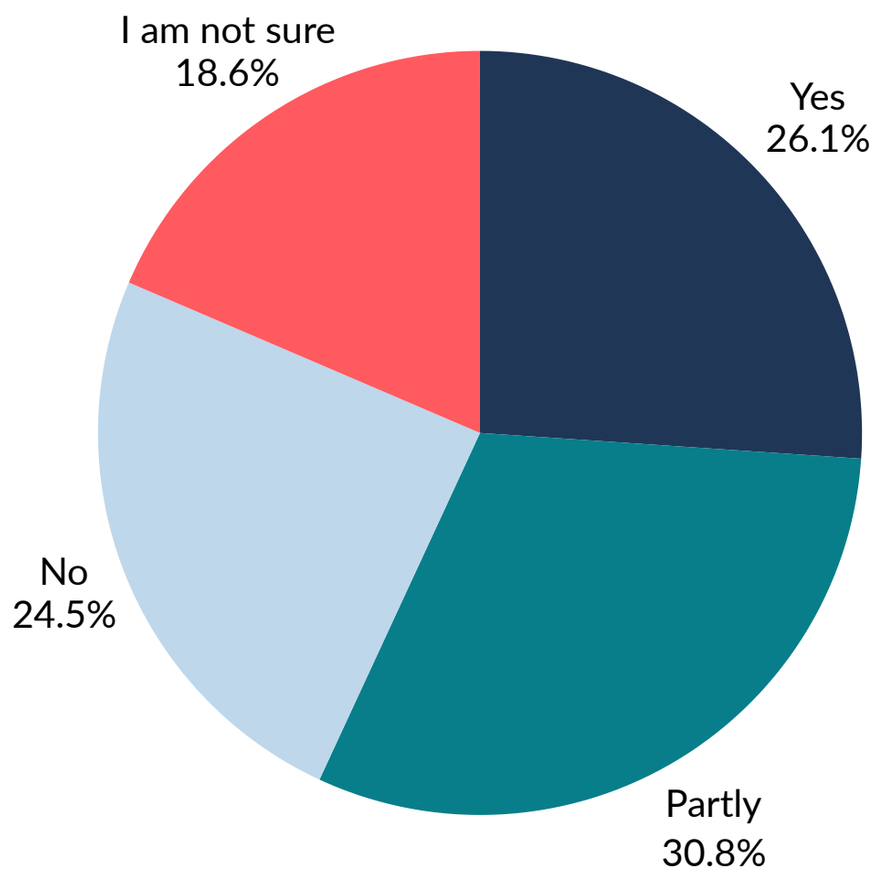
Throughout the survey, parents stressed that mental health difficulties affect the entire family and not only the child receiving services. Respondents frequently requested family therapy, parent training programmes, parent counselling, sibling supports, advocacy services and practical guidance to help families navigate complex systems. Many described feelings of isolation and frustration while trying to support their child and highlighted the need for stronger supports for parents and siblings (see Figure 12).



(Figure 12)
Which supports do you believe would benefit your family?

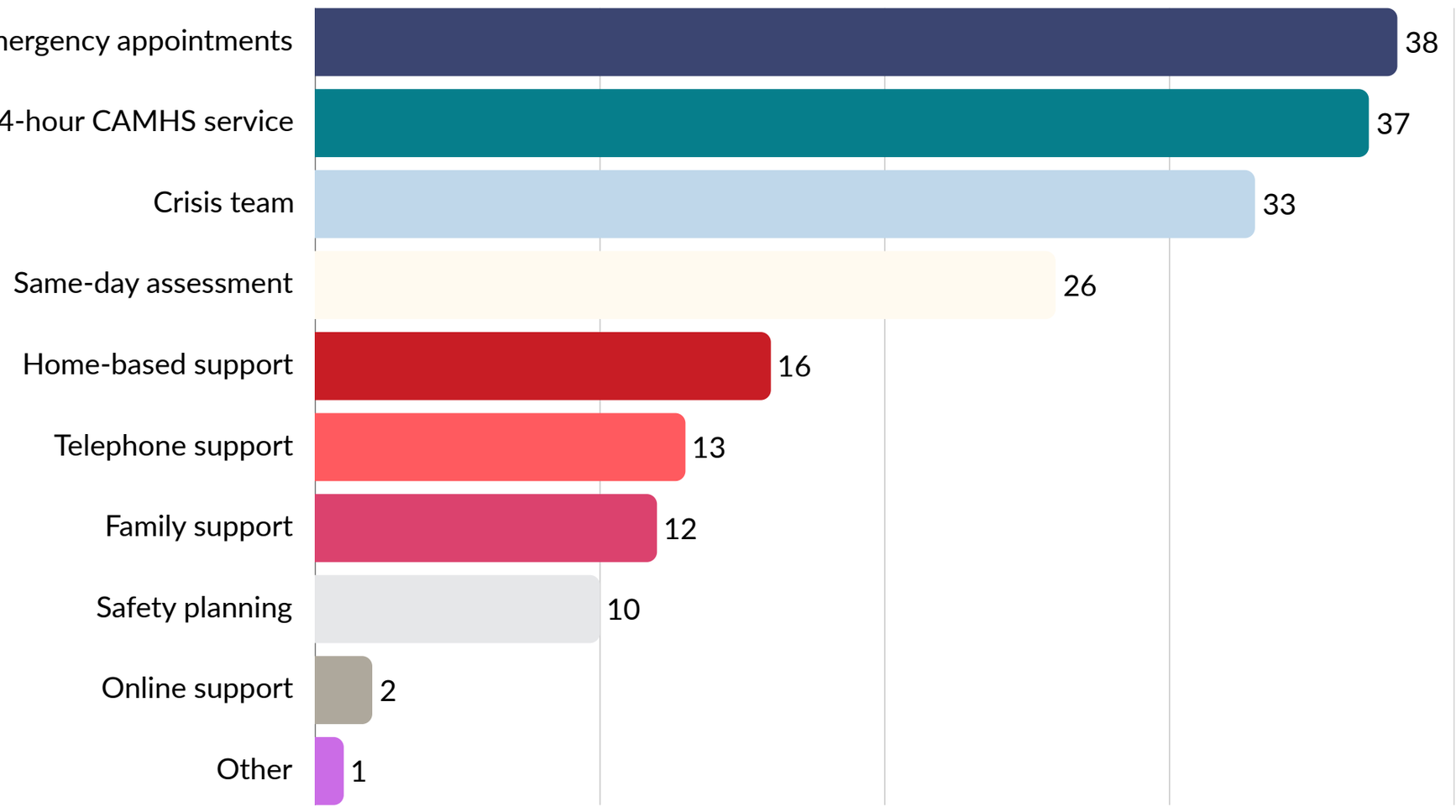
Crisis Support

Views on crisis support were similarly mixed. While approximately one-quarter of respondents felt the standards provide sufficient crisis support, almost an equal proportion felt they do not, and a further 30.8% felt the standards only partially address this area (see Figure 13).



(Figure 13)
Do you think the draft standards provide sufficient crisis support?

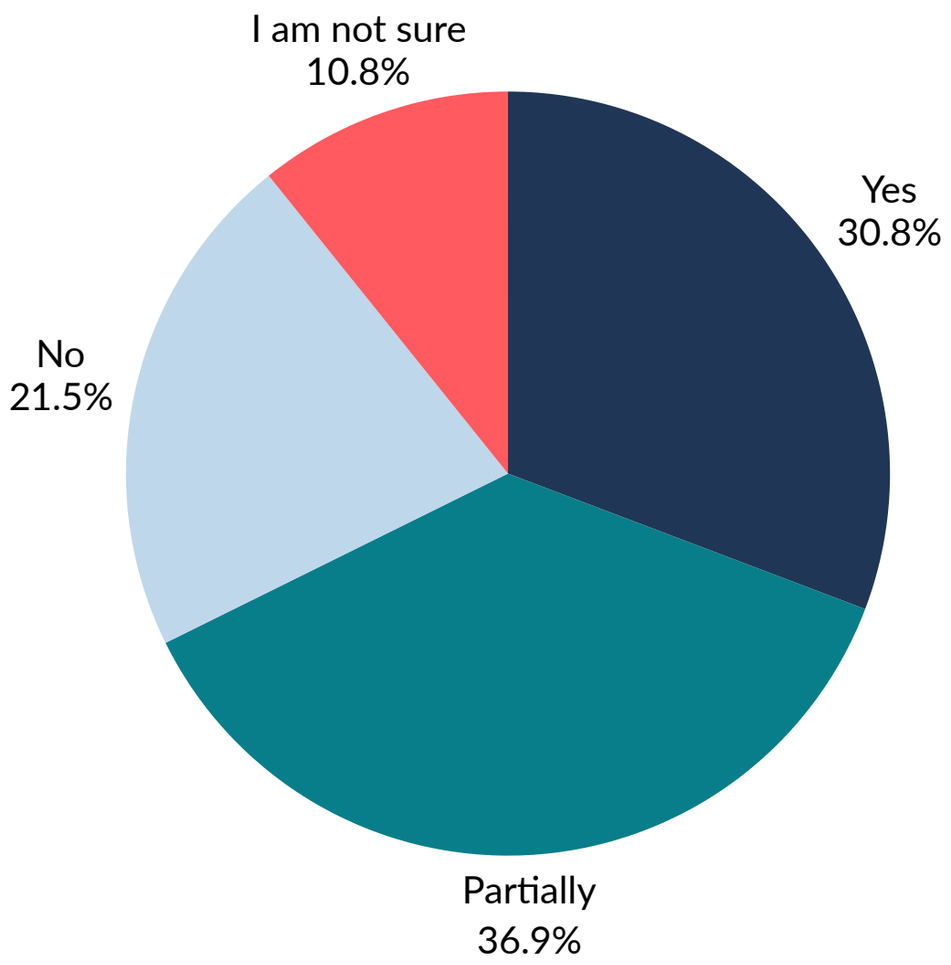
Parents consistently called for stronger crisis services. The most frequently selected supports included emergency appointments, a 24-hour CAMHS service, crisis teams and same-day assessments. Many respondents expressed concern that families currently experiencing a crisis often have no option other than attending accident and emergency departments. Others highlighted a lack of out-of-hours support and limited specialist crisis responses within existing services (see Figure 14).



(Figure 14)
What types of support do you think families should be able to access during a mental health crisis?

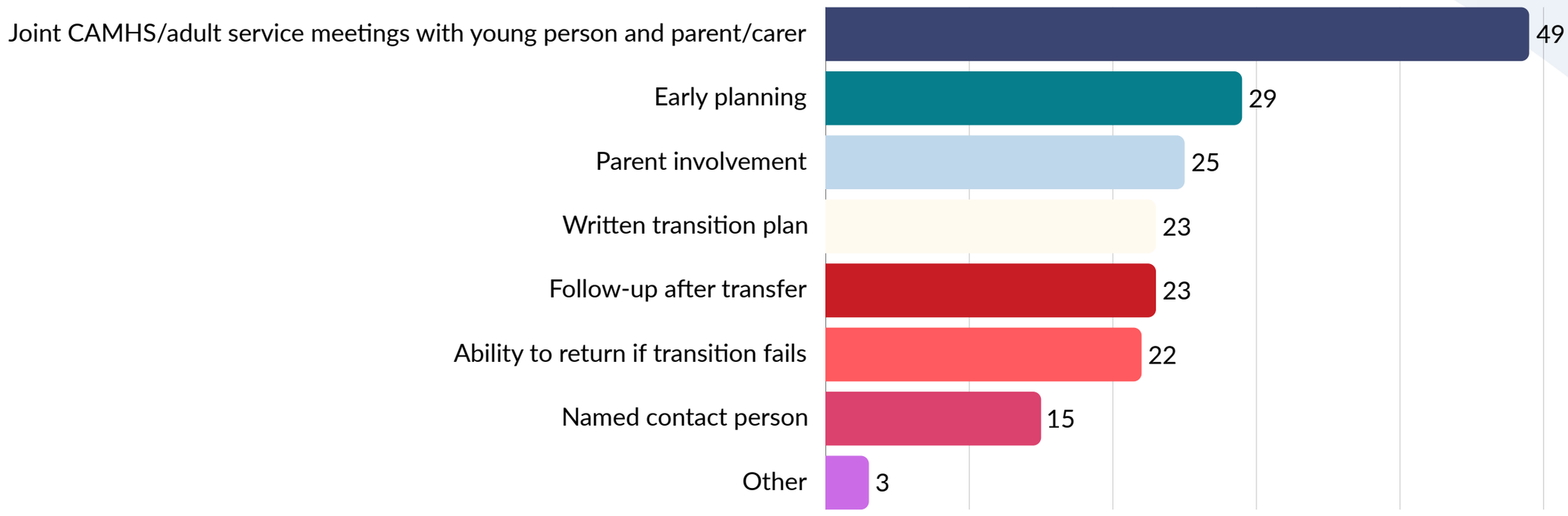
Transition to Adult Services

Transition planning was identified as another area where further detail may be required. Only 30.8% of respondents felt the draft standards provide enough detail on transition to adult services. More than one-third felt that the standards only partially address this area, while just under one-quarter felt there was insufficient detail (see Figure 15).



(Figure 15)
Do you think the draft standards provide enough detail about transition to adult services?

Parents highlighted the importance of joint meetings between CAMHS and Adult Mental Health Services with young people and parents, early planning, written transition plans, follow-up after transfer and the possibility of returning to CAMHS if a transition is unsuccessful. Many parents described transition as a period of significant uncertainty and believed stronger safeguards are required to ensure continuity of care (see Figure 16).



(Figure 16)
What do you think should be included in transition planning?



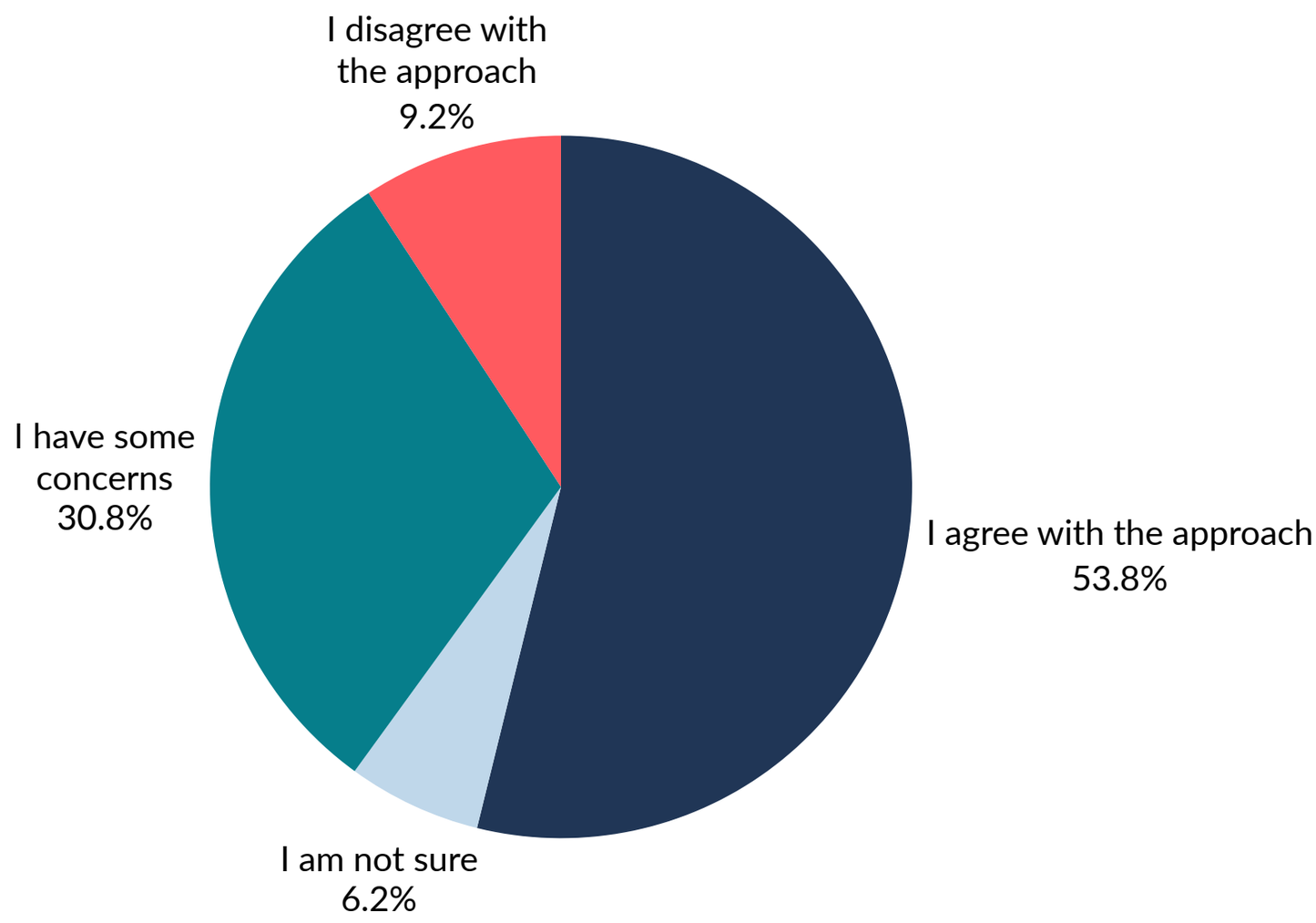
Additional Areas Included in the Draft Standards

The survey also explored parents' views on several topics included in the draft standards that were not reflected in the feedback from parents in the first consultation.

Consent, Decision-Making and Young People's Rights

Parents were asked what they thought about the way consent, decision-making and young people's rights are described in the draft standards.

The majority of respondents expressed support for the approach outlined in the standards. More than half of respondents (53.8%) stated that they agreed with the approach, while a further 30.8% reported that they had some concerns. Smaller numbers indicated that they were unsure or disagreed with the approach (see Figure 17).



(Figure 17)
What do you think about the way consent, decision-making and young people's rights are described in the draft standards?

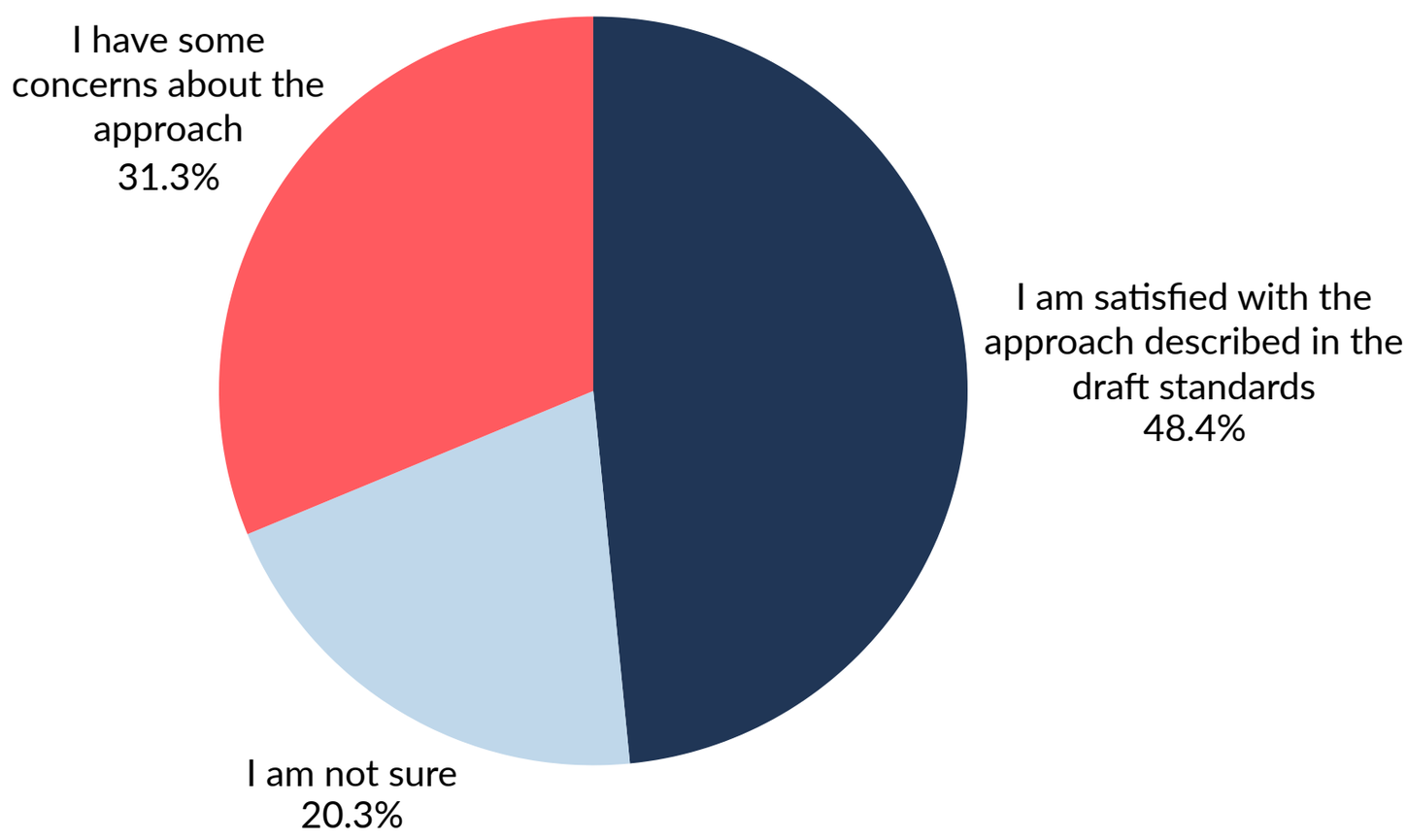
While parents generally supported involving children and young people in decisions about their care, several respondents expressed concerns regarding young people aged 16 and 17 making decisions independently of their parents. Parents commented that age alone does not necessarily reflect maturity, particularly for young people with autism, ADHD, intellectual disabilities or emotional difficulties. Many felt that decision-making should take account of a young person's developmental capacity and level of understanding rather than relying solely on chronological age.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Restrictive Practices and Restraint

Parents were asked about the draft standards' approach to restraint and restrictive practices.

Although views varied, the overall response was generally positive. More than 48% of respondents stated that they were satisfied with the approach described in the draft standards, while a further proportion indicated that they had some concerns. Only a small number felt that important issues were missing or expressed strong dissatisfaction with the proposed approach (see Figure 18).



(Figure 18)
What are your views on the way restraint and restrictive practices are addressed in the draft standards?

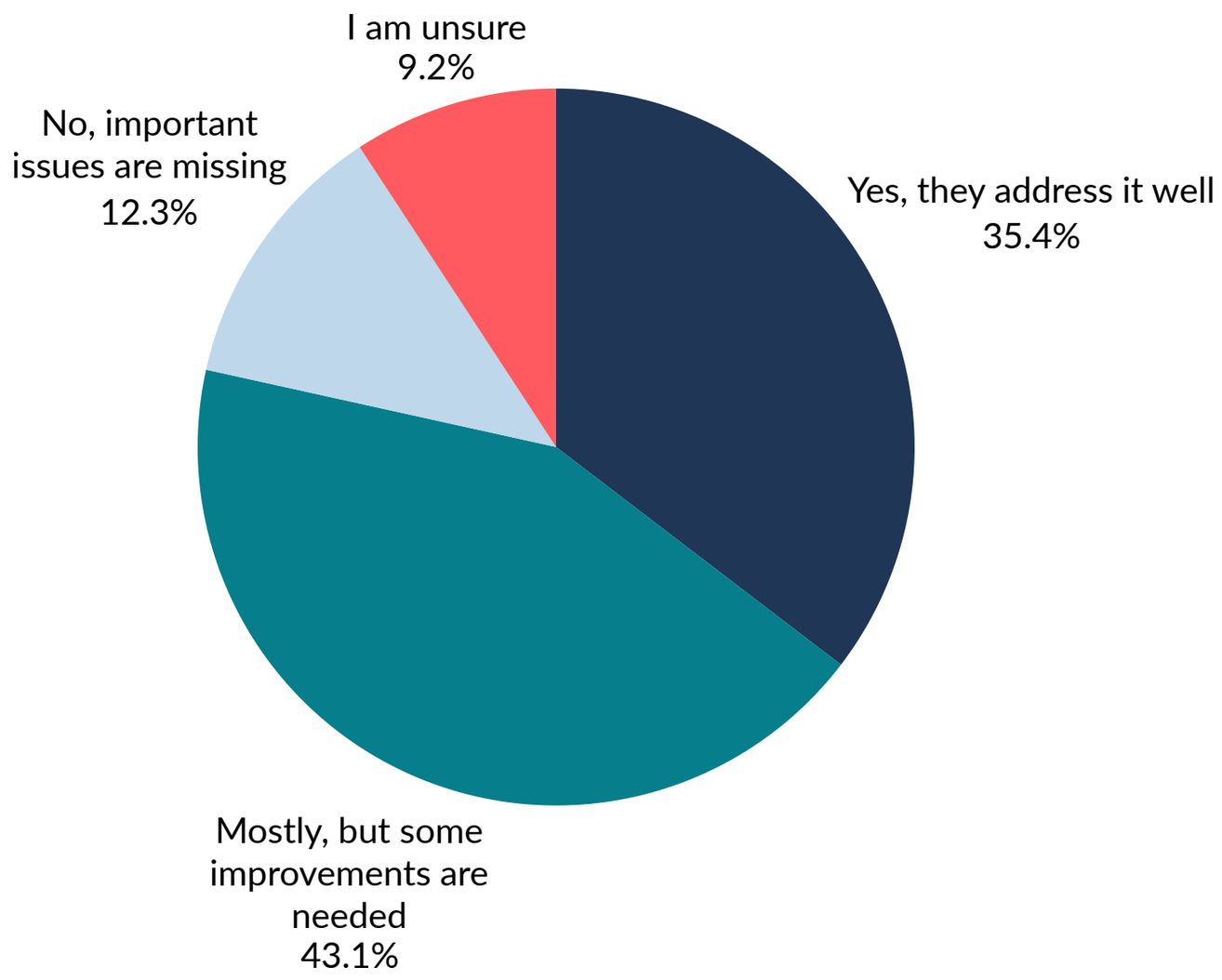
A number of parents welcomed the emphasis on restrictive practices being used only in rare and exceptional circumstances. Others felt additional safeguards should be included, particularly around monitoring, review and parental involvement following any use of restrictive interventions. Some respondents also stressed the importance of staff being highly trained in de-escalation and trauma-informed approaches to minimise the need for restrictive practices altogether.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Medication Prescribing and Monitoring

Parents were also asked whether the draft standards adequately address medication prescribing and monitoring.

Overall, responses were largely positive. More than 35% felt the standards addressed this area well, while 43% felt they mostly addressed it but that improvements were still needed. Approximately 12% felt important issues were missing (see Figure 19).



(Figure 19)
Do you think the draft standards adequately address medication prescribing and monitoring?

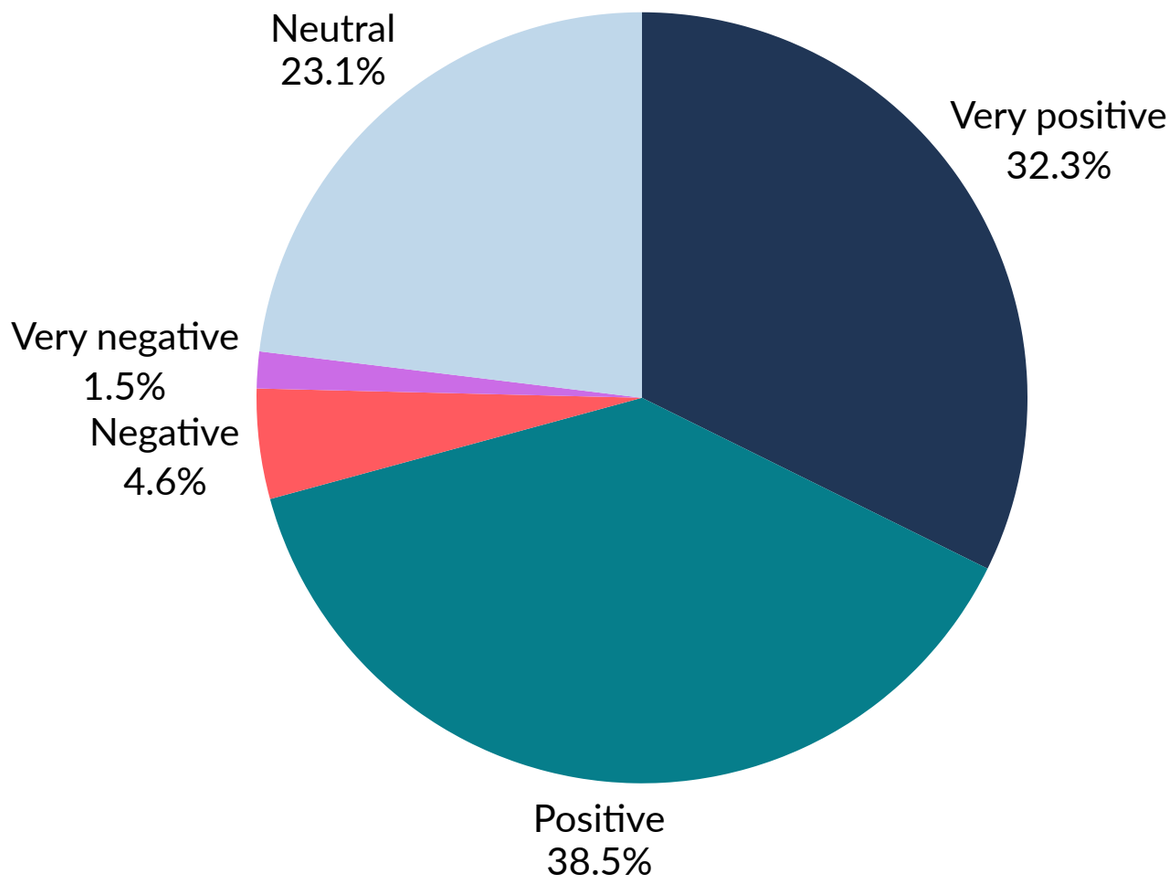
Comments indicated that parents support regular medication reviews, monitoring of side effects and meaningful involvement of families in medication decisions. However, many respondents felt the standards could go further in explaining how medication will be monitored in practice and how families will be supported when making treatment decisions. Several parents highlighted the need for clear information regarding potential side effects, ongoing reviews and alternative treatment options alongside medication.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Electronic Health Records and Digital Systems

The draft standards emphasise the use of electronic health records and digital systems to support communication and continuity of care.

Parents were generally positive about this aspect of the standards. The majority of respondents (approximately 71%) described their views as positive or very positive. Almost one-quarter expressed neutral views, while relatively few respondents expressed negative views (see Figure 20).



(Figure 20)
What do you think about the use of electronic health records and digital systems in CAMHS?

Many parents believed that better information sharing could improve continuity of care and reduce the need for families to repeatedly provide the same information to different professionals. Respondents also noted that effective digital systems could improve communication between services and reduce delays.

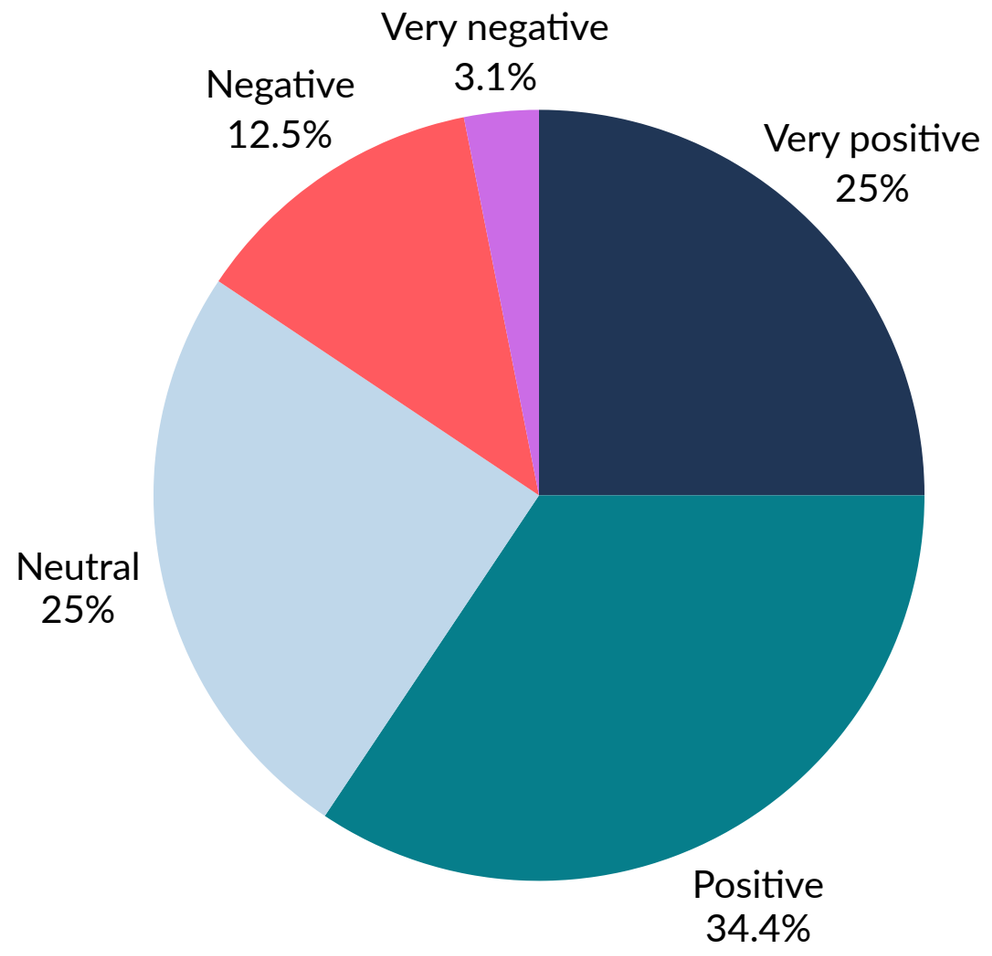
However, some concerns were raised regarding data security, confidentiality and the potential for information to be inaccessible if systems fail. A small number of parents also highlighted the need to ensure that digital systems support care delivery rather than increasing administrative burdens.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Telehealth and Online Appointments

Parents were asked about the proposal to offer telehealth and online appointments as an option within CAMHS.

Many respondents (59.4%) viewed telehealth positively, particularly where it improves access for families or reduces the need to travel. Some parents noted that online appointments may be useful for follow-up consultations or for children who experience significant anxiety about attending appointments in person (see Figure 21).



(Figure 21)
What do you think about offering telehealth and online appointments as an option in CAMHS?

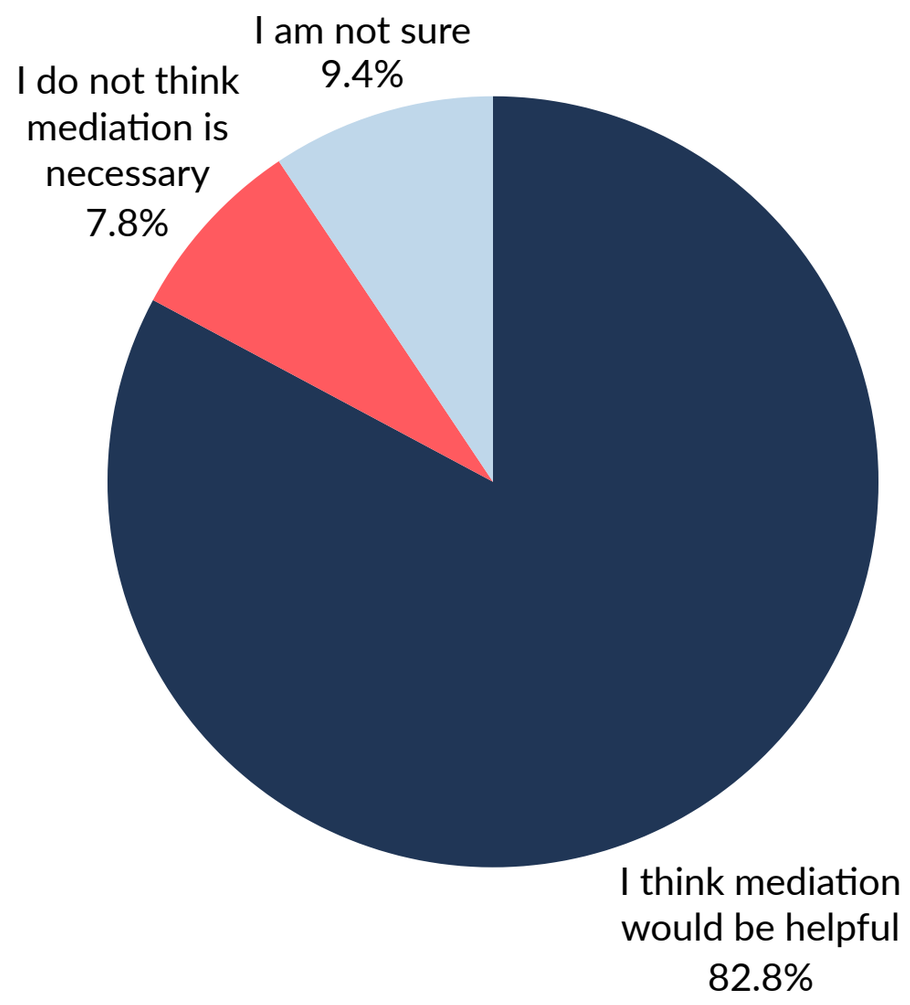
However, concerns were also raised regarding over-reliance on virtual appointments. Several parents felt that telehealth should supplement rather than replace face-to-face contact. Parents frequently commented that in-person appointments are essential for assessments, building therapeutic relationships and recognising non-verbal communication. Some respondents felt virtual appointments may not be suitable for children experiencing significant distress or communication difficulties.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Mediation

Parents were asked what they thought about mediation being available when disagreements arise about care or treatment.

This proposal received one of the strongest levels of support among the additional topics. The vast majority of respondents indicated that they believed mediation could be helpful, while only a small number stated that mediation was unnecessary or that they were unsure (see Figure 22).



(Figure 22)
What do you think about mediation being available when disagreements arise about care or treatment?

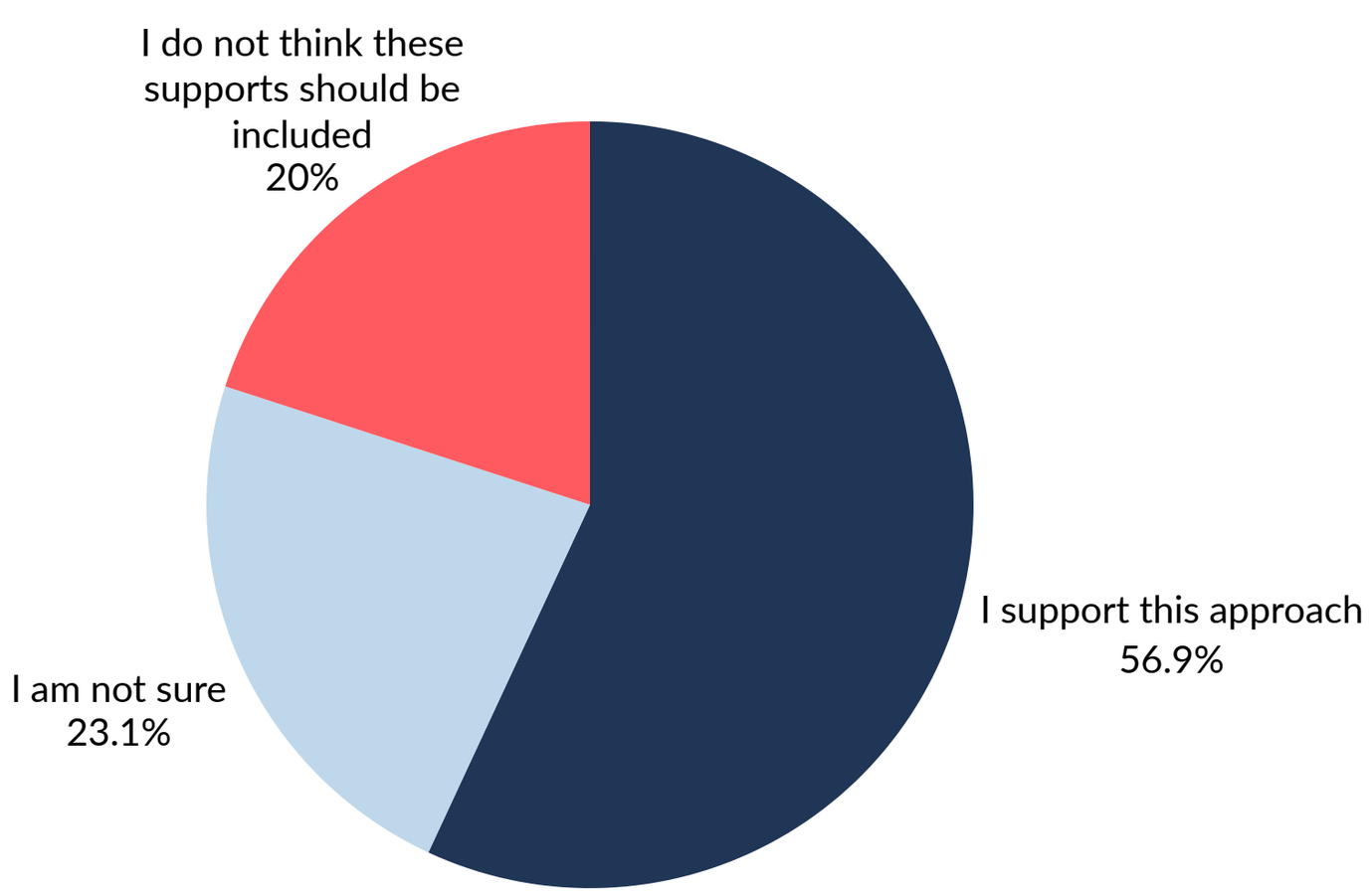
Parents viewed mediation as a potentially useful way of resolving disagreements between families and services without escalating concerns into formal complaints processes. However, some respondents emphasised that mediation should remain voluntary and should not replace access to complaints procedures or independent review mechanisms where necessary. A small number also questioned whether mediation would be appropriate in high-conflict situations or cases involving safeguarding concerns.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Community, Cultural and Faith-Based Supports

Parents were asked for their views on the inclusion of community, cultural and faith-based supports within the standards.

The majority of respondents (57%) supported the inclusion of community, cultural, and faith-based supports, while others stated that they did not think these supports should be included or indicated uncertainty (see Figure 23).



(Figure 23)
What do you think about including community, cultural and faith-based supports within the standards?

Comments suggested that parents generally value community supports, peer supports and voluntary organisations that help children and families remain connected to their communities. However, several respondents questioned whether faith-based supports should be included within national standards, particularly where family beliefs may differ or where children may not wish to engage with religious organisations. Others felt such supports should remain available where they reflect the wishes and values of individual children and families.

*This is a summary of the parents' voices; please refer to the appendix for full answers.

Gaps and Missing Areas

Parents were asked whether any important topics or issues were missing from the draft standards and, throughout the survey, a number of recurring gaps were identified. While many respondents welcomed the overall direction of the standards, they felt that several important issues required further detail, stronger commitments or more explicit requirements.

One of the most common concerns related to referral pathways and access criteria. Parents questioned how decisions are made about whether a child is accepted into CAMHS and highlighted situations where children with severe anxiety, autism, ADHD, self-harm or complex needs had been refused services or redirected elsewhere. Several respondents felt the standards should include stronger safeguards around referral decisions, clearer acceptance criteria and mechanisms for reviewing decisions when families disagree with an outcome.

Many parents also felt that the standards should more clearly address collaboration between CAMHS, CDNTs, Primary Care and schools. While respondents recognised that the draft standards refer to joined-up working, there remained concerns that children could continue to be moved between services without receiving meaningful support. Parents wanted clearer accountability regarding which service is responsible for supporting a child and how services will work together when a young person presents with overlapping needs.

Neurodiversity was another area where parents felt additional detail was required. Although respondents welcomed references to neuro-affirmative practice, many believed the standards should contain stronger commitments regarding autism, ADHD and other neurodevelopmental conditions. Some parents also highlighted the need for recognition of conditions such as FASD and PDA and called for greater clarity around how children with multiple diagnoses will be supported.

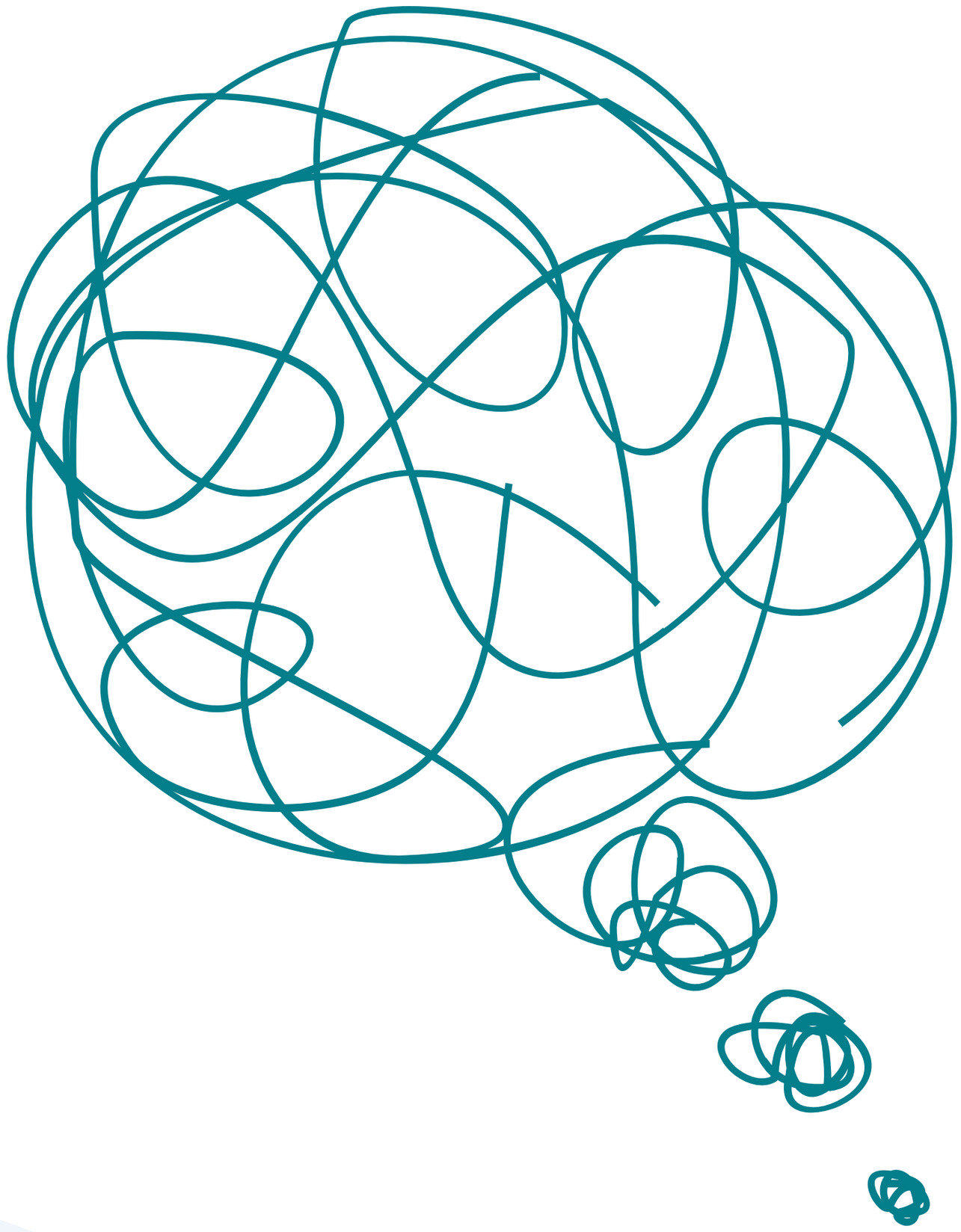
Several respondents felt that family supports require significantly more detail. Parents wanted clearer commitments around parent counselling, sibling support, family therapy, advocacy and practical support for families navigating services. Many stated that references to supporting families were too broad and did not explain what support should actually be available.

Concerns were also raised about crisis intervention. Parents felt the standards should contain stronger commitments regarding crisis response, particularly around same-day access, crisis teams, home-based support and out-of-hours services. A number of respondents questioned whether providing information about crisis pathways alone would be sufficient without access to actual crisis services.

Transition planning was another area where parents felt greater detail was needed. Respondents requested more information about how transitions would be managed in practice, particularly for young people with autism, ADHD or ongoing high levels of support needs. Many felt the standards should include clearer commitments regarding follow-up support, named contacts and opportunities to return to CAMHS if a transition is unsuccessful.

A smaller number of respondents raised specific issues which they felt were missing entirely from the standards. These included support for families experiencing domestic abuse, post-separation conflict, parental alienation concerns, school refusal, FASD, continuity of staffing, school referral pathways and support for children whose mental health deteriorates while awaiting assessment.

*This is a summary of the parents' voices; please refer to the appendix for full answers.



Clarity and Accessibility

Parents generally found the themes and overall intentions of the standards understandable. However, many respondents felt that parts of the document lacked clarity and that important commitments were expressed in language that was too broad or open to interpretation.

Several respondents commented that words such as "should", "consider", "support" and "where appropriate" appear frequently throughout the draft standards. While parents understood the intent behind this language, some questioned whether it creates sufficient accountability. Many felt stronger wording would provide greater confidence that services will be required to deliver the standards rather than simply being encouraged to do so.

A recurring theme was the desire for more practical examples. Parents stated that the standards describe what good care should look like but often provide limited detail about how this will be achieved. For example, some respondents questioned what "family support", "clear communication", "interagency collaboration" or "continuity of care" would look like in practice. Others asked for more specific explanations regarding waiting time commitments, referral processes and crisis support arrangements.

A number of respondents felt that the draft standards were written from a service or policy perspective rather than a parent perspective. These parents suggested that shorter summaries, plain-language guides and practical examples would help families better understand their rights and what they should be able to expect from services. Some respondents specifically suggested the development of clear information leaflets explaining referral pathways, waiting lists, care planning and transition arrangements.

Several parents also highlighted the need for terminology that is accessible to children and young people. Respondents emphasised that information should be available in age-appropriate formats and communication should be adapted to the individual needs of children, particularly those with communication difficulties or neurodevelopmental conditions.

Overall, while the principles behind the standards were widely understood and supported, many parents felt that greater specificity and simpler explanations would improve understanding and confidence in the final standards.

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Putting the Standards into Practice

Throughout the survey, implementation emerged as one of the strongest themes. While many parents welcomed the ambitions set out within the draft standards, there was widespread concern about whether the standards could be delivered without significant changes to current service capacity and resources.

The issue most frequently linked to implementation was staffing. Parents repeatedly stated that successful implementation will require additional psychologists, psychiatrists, therapists, nurses, social workers and support staff. Many respondents believed that workforce shortages are currently the biggest barrier to reducing waiting times, improving communication and ensuring continuity of care. Several parents referred to unfilled vacancies, maternity leave cover and high staff turnover as ongoing challenges that would need to be addressed.

Funding was another commonly raised issue. Many parents felt that the standards would only be effective if accompanied by sustained investment. Respondents frequently described previous experiences where positive policies existed but services lacked the resources required to deliver them. As a result, a recurring message throughout the survey was that implementation should be supported by measurable commitments, adequate staffing and ongoing monitoring.

Parents also highlighted the importance of training. Many respondents felt that staff will require additional support to implement the standards consistently, particularly in areas such as neurodiversity, family-centred practice, communication, trauma-informed care and interagency working. Several parents suggested that meaningful implementation will depend on ensuring all staff have a shared understanding of the standards and how they should be applied.

Another theme concerned accountability. Parents frequently suggested that independent monitoring, inspection and reporting would be required to ensure implementation occurs consistently across the country. Many felt that public reporting of outcomes, waiting times and compliance with the standards could help build confidence and ensure services remain accountable for delivering improvements.

Many respondents also emphasised the need for culture change. Parents described experiences where families felt unheard, where communication was poor, or where services worked in isolation from one another. Several responses suggested that implementation will require not only procedural change but also a commitment to more collaborative, family-centred ways of working.

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Additional Comments

In their final comments, many parents reflected on the difference between the aspirations contained within the draft standards and the reality of current experiences of CAMHS. Respondents frequently described the standards as positive, comprehensive and well-intentioned, but many questioned whether they would result in meaningful change without strong implementation and accountability arrangements.

A common message throughout the survey was that parents want to see action rather than further commitments on paper. Respondents repeatedly highlighted waiting lists, inadequate staffing, poor communication and difficulties accessing services as ongoing challenges that should be prioritised. For some parents, improving these issues was considered more important than the introduction of additional standards or policies.

Many respondents also expressed a desire for a more joined-up system of care. Parents frequently described the experience of navigating multiple services, repeating information to different professionals and trying to coordinate support themselves. Several suggested that children would benefit from more integrated models of care where services work together around the needs of the child rather than expecting families to coordinate support independently.

A number of respondents highlighted the emotional impact that delays and gaps in support can have on families. Parents described feeling exhausted, isolated and overwhelmed while trying to access help for their children. Many emphasised that when a child experiences mental health difficulties, the entire family can be affected and that family support should therefore be viewed as an essential component of care.

Finally, many parents expressed hope that the standards could deliver positive change if they are properly implemented. While concerns about resources, waiting times and accountability were common, respondents generally welcomed the focus on dignity, rights, participation, communication, neurodiversity and family involvement. Many viewed the standards as a positive foundation and emphasised the importance of ensuring that the commitments they contain are translated into meaningful improvements in children's and families' experiences of CAMHS.

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Appendix

Would you like to tell us more? (dignity and respect)

1. Should protect children more
2. na
3. The Staff at CAHMS should try and connect with the child by what ever means possible. Not labelling behaviours as the first port of call
4. Children typically have a natural inclination to love and maintain relationships with both parents, particularly where both parents have previously been loving, supportive, and meaningfully involved in their lives. Accordingly, where a child appears to unreasonably reject, fear, or vilify a parent with whom they previously shared a loving relationship, and where there is no clear and proportionate justification for such a dramatic change, this may raise concerns about the possibility of external influence. Such influence can include persistent negative messaging, psychological pressure, manipulation, coercive control, or other behaviours that may undermine the child's independent thoughts, feelings, and relationship with the other parent. This does not mean that every rejection of a parent is evidence of alienation, nor should a child's genuine experiences or allegations ever be dismissed. However, a sudden and unexplained breakdown in a previously loving parent child relationship warrants careful, objective, and child centred examination of all relevant circumstances, including whether the child's views have been freely formed or may have been influenced by pressure, fear, loyalty conflicts, or repeated exposure to negative portrayals of the other parent.
5. Holistic within a family.
6. Childrens voices should definitely be listened to and even if they dont speak they should be given the time to be listened to and respected and not looked down upon . Definitely agree care and compassion needs to be shown as its so hard to be given that even in Adult Mental Health Services you dont feel heard so it is even more important for children to feel cared for thats what they deserve
7. The real problem is not replacing people when they go on maternity leave. No response or a long wait is what's disrespectful.
8. seems to be ok on paper but there are lots of different approaches from staff at CAMHS and retraining and oversight must be in place to ensure the staff are all working in same manner
9. Respect and dignity are great goals, giving an actual service to children and not fobbing them off to cut list numbers would be even better
10. Unless the actual mechanisms for this to happen are outlined, I dont think it goes far enough. E.g. will staff be using (and trained in) the Lundy model? Plain language, etc.? These are common standards in adult healthcare and are routinely missing in care so unless they are defined for CAMHS I would not have much faith, no.

11. no
12. Fanilies who are perceived not to meet access criteria are being kept at the gate so cannot be heard
13. Need more in depth support mechanisms by camhs team to help children and adolescents
14. The document is 56 pages, I have no idea if it places enough emphasis on dignity and respect. That is a strange question to ask parents.
15. Is person centred care their right?
16. The staff themselves are very respectful, however the service is grossly underfunded and the waiting times are nothing short of negligent. One of my children was with CAMHs and has since been discharged. She needs to be seen again as she wishes to recommence medication for ADHD and has to be re-referred back into the system and I've been told "they would hope to see her before she is 18". She is 16 now and was with CAMHS, had her DX and had previously trialled medication with them. We were told when being discharged that if she required their services again, it would be simply a case of making a phone call but this is not the case.
17. The report states that but the experience of the parent in gaining the dignity and respect so well alluded to in the draft standards is in direct opposition to the stated goals of care.
18. I am waiting 4 years to be contacted by camps and nothing my childnisbthe one suffering it took 3 year for her to be seen by the cdnt and only 3 appointments when is the help because I dont see it I see myself and other families struggling it's unfair for any child to be left behind
19. Have their views listened to and responded too
20. The draft is good but it is just words. There is a big difference between what it is the law and what the reality is. It took me years to get my child diagnosed and the help that I got was: you are doing an amazing job, you can find more help in internet.
21. It be great if they actually did
22. Privacy is a huge issue - patients overlapping and bumping into each other in waiting rooms
23. Alot needs to improve with CAMHS
24. If a child has a diagnosis of autism they camhs team tend to push parents aside saying behaviour is down to the diagnosis of autism and moderate id I disagree with that response I have had from camhs id
25. The waiting lists are too long with no transparency as to when appointments will be available and if children do not meet the CAMHS threshold there is no other support pathway available for them.
26. Standards should include also listening to what family members concerns are
27. I would like the parent's accounts and views to be valued over schools as they only see one side of the child for a few hours. Parent's are there 24hours .
28. The draft will have to be put into practice for any change

29. I felt my first appointment I was treated respectfully but it wasnt trauma informed. The psychologist didnt use age appropriate language and asking me questions in front of my daughter that I couldn't answer truthfully as it was about my families mental health and suicide
30. Legitimate concerns disregarded

Would you like to tell us more? (parents and carers as partners in their child's care)

1. Parents are with kids all the time the know what is best
2. no
3. Consider parents. The parent is the one with the child 24 /7. So a strong word .
4. Yes parents and carers should definitely be informed because they need to know about treatment for their child and to help them and their child to understand what's going on its very difficult to be not given an input into treatment options or decisions its very important for children to understand what's going on too
5. The child chooses whether they are involved
6. The document reads well, but how is it enacted?
7. As before, needs to be practically defined and steps to achieving this in the day to day outlined for it to actually happen.
8. CAMHs treat the parents as the sole support for the child. There is no engagement with the schools, GP or any other support services in our experience. The parents are the ones driving the whole process and begging for services. Instead, they send you on a course that you could probably teach at this point and you feel obliged to complete it for fear of being turned away for potential services that never come.
9. It's too vague especially when dealing with mental health.It reads like a HR policy for a corporate company rather than a specialist area such as mental health for children and teenagers.
10. I think staff should be more prepared. I have read many books about my child' sproblem. I knew much more than the staff and completely ignored.
11. Very important to support family. The long wait times affects the whole family and let's down the child
12. Alot of parents have there own parenting questioned as part of this process this is dis-empowering to parents when so much responsibility is put on them while supporting a vulnerable child/teenager
13. Recognise executive functioning delays in neurodivergent children.
14. Parents views should be taken on board just as much as young person. A parent usually wants when is best for their child and sometimes the child needs to be guided.

15. It takes highly qualified and experienced Clinical Psychologists to determine if a child has been alienated from the other parent through manipulation and fear.Once a coercive narrative becomes embedded, the child may begin filtering both past and present through it. Warmth, reassurance or attempts to reconnect may be interpreted as manipulative; a parent saying no, setting a limit or enforcing a routine may be recast as controlling or punitive; a delayed response becomes abandonment, and one mistake becomes proof of a lifelong pattern. Each new interaction is interpreted through the negative account already in place. Positive memories can become increasingly difficult to retain in their original form. A holiday once remembered with enjoyment may later be described as frightening or fake. A parent, grandparent, sibling or other significant family member previously experienced as loving may be recalled as having ulterior motives. Earlier closeness, humour, routines and shared experiences are discounted because they Over time, this process can interfere with autobiographical memory, emotional flexibilit and trust in one's own perceptions. The child learns to organise memory, expectation and interpretation around an imposed account tha preserves alignment while progressively displacing their lived experience. What appears to be an independent judgemer may instead reflect selective recall, distorted prediction, repeated reinterpretation and cognitive dissonance reduction. The rejection a parent or family member becomes easier to maintain when every memory and new interaction is made to support it.conflict with what the child now feels required to believe. Memory distortion often develops through selective emphasis rather than complete also be absorbed as further evidence. Rejecting someone the child once loved creates psychological conflict, especially when that person remains caring or contact goes well. Strengthening the belief that the relationship was always harmful can reduce the discomfort created by the child's hostility, exclusion or participation in accusations. The negative account becomes psychologically useful because it makes their conduct feel justified. Mixed feelings and contradictory evidence then become difficult to tolerate. Acknowledging one good memory, one caring act or one positive interaction could destabilise the account the child relies upon for relational security. Rigid conviction may therefore reflect restricted ambivalence rather than a clear and independently formed understanding of the past. Over time, this process can interfere with autobiographical memory, emotional flexibility and trust in one's own perceptions. The child learns to organise memory, expectation and Memory distortion often develops through selective emphasis rather than complete fabrication. Negative details are magnified, positive information is removed, and the emotional meaning of an event is repeatedly revised until the negative account feels like the only credible version. Cognitive distortions can then preserve the imposed narrative.

The child may predict that contact will go badly before it occurs, assume they know the other person's motives, treat anxiety as proof of danger, focus almost exclusively on negative details, or turn one disappointment into a conclusion about the entire relationship. Care, apologies and positive interactions may be dismissed as manipulation rather than allowed to challenge the narrative.A self-reinforcing cycle can follow. The child expects harm, enters contact guarded or hostile, interprets ordinary interactions negatively, and uses the resulting tension as confirmation that the original belief was correct. If the targeted parent or family member becomes distressed, defensive or overly cautious, that response may

Would you like to tell us more? (children falling between services)

1. Need change now
2. Who is actually going to be at the forefront to implement this strategy for each family. I hope that families know who to go to rather than the book being passed around
3. no
4. Services that are available may not be able to meet demands.
5. Consent but if a member of the team feels communication with other members is valid to communicate with out consent. As a parent may not agreed with the diagnosis and not engage with services. Leaving the child at risk or lacking support. Included gp in mdt
6. Yes I think the draft is well set out but I think it will come with a lot of challenges and will take a really long time to come into affect and children need the help now but it also is taking far too long for children to be given the help they need
7. We will see how it works in practice
8. seems to be ok on paper but there are lots of different approaches at present and NO OVERLAP between services . One service is dependent on what parents report from the other - I wonder will CAMHS communicate in reality
9. Absolutely not. I have had a 7 year old with suicidal ideation refused from the CDNT to Primary Care because she wasn't considered complex. Despite a diagnosis of ASD requiring referrals to dietician, North Cork Psychology, OT, physio. She clearly also has ADHD but CAMHs will not see her as she is under the care of North Cork Psych. I am left chasing all of these services for years. Another one of my children was referred to CAMHs as an urgent case after developing an anxiety related tic disorder and eventually diagnosed also with ADHD. She initially trialled medication but felt that she didn't want it at the time. We were discharged, being told that if she required an appointment in the future it would simply be a case of calling. When she decided that she wanted to try meds again, I called and was told no, she would need to be re-referred back onto the waiting list and would hopefully be seen before her 18th birthday - she is 16.

10. In Ireland, the issue is less that concerns about parental alienation are ignored, and more that the term itself is controversial and not formally recognised as a medical or psychiatric diagnosis in Irish law. Here are the key reasons: 1. It is not a recognised diagnosis “Parental Alienation Syndrome” was proposed by Richard Gardner in the 1980s, but it is not included in diagnostic manuals such as the DSM-5. Because of this, Irish courts are cautious about treating it as a standalone condition. Courts prefer evidence-based psychological assessments rather than labels. 2. Irish family law focuses on the child’s welfare Under the Guardianship of Infants Act 1964 (as amended), the best interests of the child are the first and paramount consideration. Courts look at: The child’s views (where appropriate) Evidence of harm or emotional damage Each parent’s ability to support the child’s relationship with the other parent If a parent is actively undermining the child’s relationship with the other parent, courts may address it — but usually under concepts like: Failure to facilitate access Emotional harm Coercive or controlling behaviour The court may appoint: A Section 32 expert (psychologist) A Guardian ad Litem Mediation services 3. Judicial caution There is concern internationally (including in Ireland) that the term “parental alienation” can sometimes be misused in high-conflict cases, particularly where allegations of abuse are also present. Irish judges therefore tend to focus on: Proven behaviour Documented breaches of court orders Professional reports rather than adopting the alienation label. 4. It is indirectly addressed Although the phrase may not appear in judgments, Irish courts do intervene where: A child is being turned against a parent without justification Court-ordered access is repeatedly obstructed A parent makes unfounded allegations In serious cases, the court can: Vary custody or access Enforce compliance orders Impose costs In practical terms Irish courts will respond to: Breaches of court orders Emotional harm to the child Obstruction of contact But they generally avoid framing matters as “parental alienation syndrome.” If you’d like, I can also outline how this is currently being discussed in Ireland (including Law Reform Commission commentary and recent case trends), or how it can be framed effectively in an Irish Circuit Court context without using the term itself.
11. The standard hinges on the child being accepted by CAMHS.Discharge into nothing is still a gap
12. More actual services needed, government funding not charitable organisations having to fill the gaps. Transparency and the right staff and systems must be put in place. This cannot be a reason a digital id is required for children, file sharing does not need it
13. The standards themselves won't 'do' anything. Funding, training, time, resource allocation, etc. will enable this welcome way of working to be done. Standards without practical resourcing are relatively meaningless
14. Should is not a compelling verb that reassures that services will collaborate
15. More robust interagency cooperation

16. Simple good leaflets needed to explain the whole process to people. As service users we should not care or even know that CAMHS is entirely separate to HSE primary care etc.
17. This is a good start but honestly these services should just be combined under one roof, with kids seeing whoever on the team Is relevant to their care. It makes no sense that my kids see one service for autism, then camhs for. Adhd. It leads to each service saying the other service is responsible for that childs issues, with little support being provided.
18. There isn't guidelines on HOW to avoid children falling through the gaps.
19. The use of the word 'should' implies that it is optional. In addition, the wording is far too vague. The whole issue around CAMHS, CDNTS and Primary Care is that as parents, there is zero transparency.is that
20. That organisations cant push a chikd to another service as they 'dont deal with' that issue. An acknowledgement if dual diagnosis and taking responsibility for holistic care.
21. Particularly sharing reports and repeat filling out of same questionnaires
22. Again. The draft is good. I can see children falling between the cracks and nobody bothers about them.
23. Again it be great if it happened
24. Is it still the case that one can’t attend primary care or CDNT if attending CAMHS?
25. But this will only work when staff take holidays or we'll deserved breaks that staff are in place to step in and support the child and families
26. It's so unfair that a child has to wait years for a service they need my child is going into 5th class over 3 years waiting for speech therapy so unfair he's only recognised now as a need
27. Many children are let down with no clear pathway of support
28. There should be a process of reviewing decisions made with the CAMHS in person and not just a letter.
29. Less waiting and more appointments for professionals daily. Also child/family should have access to the same team of caregivers
30. From my engagement there was no multiagency working. Only thing that happened was getting forms filled by the teacher and previous school reports.
31. Kids with severe anxiety should be automatically accepted into Camhs as this is one of the things they need to be accepted yet my child has been refused twice now.This is why they fall between stools.Camhs pass it off onto CDNT to deal with. Also, once a child is accepted, there should be a care plan put in place and we should not be told to either medicate or that our child will be taken off their books. That is unfair when some areas provide a lot more care and considering we have to bend over backwards to get in in the first place. Different therapy approaches should be offered first before medication.
32. No time frames
33. It seems okay on paper bit whether it will work reality remains to be seen. Systems and processes can be cumbersome and slow.

Would you like to tell us more? (needs of autistic and neurodivergent children and young people)

1. One boxes doesn’t fit all. I feel that services such as OT should be better tailored towards the patient and age appropriate. Outdated questions really are off putting to a child trying to understand why they are there and how this person in front of them can help.
2. no
3. Children with conditions can't be put into a box. Services need to review child as a whole person and make a treatment about that child
4. Yes this is great as I know lots of children and young people aren't able to avail of the current services because of dual diagnosis or other reasons. I think at the moment its really poor that a lot of children who are neurodivergent are excluded from the services. I definitely agree with the new standards laid out and believe that these will provide greater help for this.
5. As autism is prioritised, ADHD falls by the wayside
6. Pur child has FASD - CAMHS know nothing about it an don't want to know and yet our child has a hidden disability and refused to treat her because they wanted her assessed for ASD. Is there recognition and training for neurodiversity outside of ASD
7. I think there is still potential for a service to interpret 'support that is appropriate for theirs needs' as not within their service; and bounce them back.
8. Should is not strong enough. Autistic children will have access to CaMHs services
9. If this happens "Access regardless of co-occurring conditions" that will be a amazing and greatly appreciated.
10. One joined up service is needed.. if the services were combined that would remove the current practice of passing kids from cdnt to camhs and vice versa
11. The standards that are drafted are not put into practice. The system needs to be adequately funded and staffed in order to better serve children and their families.
12. As it stands CAMHS won't assess for ADHD if they suspect ASD, so you get to the top of the list only to be sent elsewhere and if an ADHD assessment is needed you start at the bottom of the list again. There is NO reason why assessments cannot co-occur. They use different criteria.
13. Talking about adjusting lighting is so far removed from the core support needed, it's like throwin a pebble in the ocean. Getting actually occupational therapy session for an autistic child, psychology sessions for an ADHD teenager with depression or access to a dietician for a child with sensory issues on food - where is the detail on that?
14. Children can’t be turned away because their autistic
15. My son really struggled in school and lack of services he should have had didn't help him

16. Thats interventions are not based on a single model of approach *cognitive behavioral) but that other more neuriaffurmibg approaches, such as person centred and relationship based, are used as well and professionals are willing to both work with other therapists and upskill themselves.
17. It doesn’t clarify if a child can attend CAMHS as well as CDNT or primary care. Does child have to give up possible current services if taken on by CAMHS?
18. There are many children parents referred onto parent support programs because the waiting list for both disability and mental health services are under resourced
19. Camhs need to acknowledge that there are serious mental health issues that overlap with neurodivergence.
20. There needs to be greater accountability with professionals
21. Things take longer to process so more time is definitely needed. Waiting times to be kept short.
22. I was told that my child was self harming because she was autistic and it was part of an autistic profile while I completely disagree with and fought for further supports.
23. Autonomy for kids also as many can be demand avoidant or have PDA
24. All people have different needs at different stages so a one stop approach will not work.Time needs to be spent with each individual to understand their own personal requirements.
25. More funding and qualified Psychologists are urgently needed to deal with mental abuse that leads to the denial of access to either parent. A loss too big for words: coercive control in the lives of children of divorce and separation with some Neuro divergent children in divorce and separation are overshadowed by parental experience to the extent where they align with one parent and completely reject the other. That is a simple fact, which cannot be denied by anyone, though the reason for it is argued about constantly. This behavioural presentation in a child of divorce and separation, is not about the contact a child has with their parent or the conflict between parents or the complexity of divorce, it is not about the myth that fathers use false claims of alienation of children to continue to abuse mothers and it is not about the other side of that myth, which is that only mothers alienate fathers. This is about coercive control in the lives of children of divorce and separation, it is about the behavioural patterns seen in some parents which impact children severely and render them helpless to do anything other than align with one parent and reject the other. Coercive control, which is described as pattern of behaviours which are designed to remove agency from someone so that they conform to the wishes of the controlling person, causes children to lose contact with their integrated sense of self as well as their right to an unconscious experience of childhood. Coercive control in post separation family life is centred on children because they are the most vulnerable people within the family system. When the family separates, the only people who have to find a way to relate to all adults in the system, are the children.

Mothers and fathers who separate only have to focus on their own new life journey and how the child fits into that, the child has to fit into two new adult lives and make sense of their own life within that requirement. If one parent is controlling prior to family separation, that control pattern will switch to the next available 'object relationship,' which is most often the child. The control is designed to keep parental defences in place and the child becomes the regulatory 'object' which enables that. All it takes to control a child is to cause an abandonment threat because children are completely dependent upon adults for their survival. Triggering the survival strategy, through intermittent threat/reward, along with a variety of other control behaviours such as gas lighting and guilt tripping which are interspersed with intensive love and attention, ensures compliance. If personality disorders are present or psychiatric issues such as encapsulated delusion, the child's autonomy is further overwhelmed and their sense of an independent self is removed.In such circumstances, the attachment to a once loved parent will be suppressed and split off and a false self will arise which defends the child against the conscious awareness that someone they love is hurting them. The appalling reality for children who are harmed in this way, is that understanding of coercive control of children, in places where it should be front and centre of our thinking, is completely absent. In the UK for example, where where recently I read rapturous reports of 'fascinating talks' about coercive control of women in divorce and separation, by an organisation which should be focused on the needs of children in the family courts, the shift back to a place where children's needs are considered invisible from the rights of their mothers is clear. In some quarters, coercive control is only ever talked about in terms of what men do to women and women's control of children, through the boundary violations which are recognised in psychological terms as child abuse, are even advocated as being healthy for children. The narrative of good mothers/bad fathers, which is the foundation stone upon which ideologic

Would you like to tell us more? (communication commitments)

1. no
2. You lack adequate funding to make a substantial difference and to identify the children in urgent need.
3. Lots of parents go private to get child seen. How does that play into getting serviceand valid are private service
4. Yes this is great and I think it should definitely help as parents or guardians are so worried about their children it would help them by receiving acknowledgement etc
5. Again, the issue is replacing people on leave or maternity leave
6. As previously, admirable but will it be enacted?
7. Recommendations like these dont seem to materialise in reality, more funding and proper organisation of all systems in place must be put in place. The laws are there about waiy times but not being adhered to, fix this first
8. As elsewhere stated, is this going to be actually resourced? Nice standards; meaningless unless you have the staff to do this. To send the letters. To have integrated systems where staff can clearly see the queue and communicate this
9. It's difficult to trust that this will happen
10. It needs to be implemented
11. Please, please improve this. I realise now even thinking back on how terrible communications have been for my family I am starting to cry.
12. Give clear reason if referral not accepted, instead of saying referral is inappropriate
13. Again, the draft standards do not match the service provided in reality
14. What information on waiting times? My son has been waiting 3.5 years for psychology services. I ring every few months to see if he is still on 'the list' but it's all a mystery to me. What are the next steps that will be outlined? It's all very vague across waiting times and next steps again. What does 'clear communication' entail? Is it a report of a phonecall?
15. I want to se it will it be stuck too
16. Track status for assessments online
17. If you train your staff, and they show some empathy, then the draft is rrally good.
18. Who can refer? Schools know children better than than GP yet school can’t refer
19. Will believe when see it
20. Very poor communication from CAMHS teamd regarding waiting lists and follow up support
21. Action speaks louder than words
22. How it is written is fine but will it be put into practice as this is not my experience of how it works
23. The draft standard in writing are sound but if not put into practice which rarely are not worth the paper/screen they are written on.

24. Decisions on whether a child is accepted or not is made without any communication with the parent and without even seeing or knowing anything about the child. That system is not right. I understand hundreds of referrals come in consistently but there is a difference between anxiety and severe anxiety and if the referral says moderate orsevere then it should be taken seriously and they should be accepting the child
25. At present waiting times are horrendous and communication is very poor.

Would you like to tell us more? (waiting-time commitments)

1. no
2. More qualified and experienced staff available with specialised knowledge.
3. A childs needs could become more urgent over the waiting period
4. The issue is replacing people on maternity leave for continuity of care
5. My son (15) attempted suicide and his referral was triaged as non urgent. Absolutely no contact until we received the appointment.
6. Most people are forced to bring urgent child case to the a&e to get assistance, cahms should make themselves available much quicker so they doesn't have to happen. Refusing acceptance onto the list to fudge wait times has to stop too, just because a doctor didn't include the exact buzz word cahms want doesn't warrant wasting everyone's time just so they dont have to adhere to above recommendations
7. Once again, the standards are impossible for the staff to adhere to. The service needs to be funded and staffed in order to provide care within these guidelines.
8. What is the definition of URGENT? How is this communicated?
9. The waiting time should be individual. An initial assessment made within 72 hours and then if situation is critical timewise, the person should be seen immediately
10. All CAHMS will do to address waiting times in their area is refer everyone that they cannot see back to Primary Care. They have been doing it for years. How do you proposed to address that with a focus on waiting times???
11. When a child asks for help, help should be given straight away
12. It depends on what is non urgent! In our case it started out as non but because of wait time months turned into emergency
13. Waiting lists are two long
14. Waiting and not knowing how to navigate the issue one is going through is scary for any parent let alone the child who dont understand what is happening. Even some one to help explain how to get through this tough time
15. I was referred to the service 18 months ago and had our first appointment and nothing since.
16. For urgent it may need to be same day.

Would you like to tell us more? (support for families and carers)

1. no
2. More funding for Mental Health is urgently needed
3. Childrens mental health difficulties can be extremely hard on every person in a childs family and I think its important for parent and sibling support as well because some parents really struggle with helping a child at home because they have not been included in the plan or asked how they are or given help as to what are the best options to help at home and counselling service
4. More supports for siblings is very important
5. Again, it is how it is enacted that matters. Consider sibling support where appropriate could mean no support
6. Will this be resourced? Will there be dedicated family liaison staff as part of multi disciplinary teams?
7. They are a great start. I am concerned that they will be perceived as optional versus directive
8. Provide on sure family support professionals
9. The services should not have to be "navigated". It should be holistic and multi-disciplinary teams working with each other. Not the parents being passed from pillar to post with no accountability between services.
10. Who decides when sibling support is 'appropriate'?
11. It will have to play out to see if it’s effective
12. What does 'support' entail? Support as described could be a pamphlet; there are no details at all as to what the support for wellbeing or family participation is supposed to look like and considering siblins? What does 'consider' mean?
13. Help set up carer support groups
14. Again. The theory is a thing , the reality is another.
15. Too vague
16. Very important to have support plan in place. Weekends there is zero help available from Camhs and there should be.
17. There needs to be better community supports for parents
18. This is all based on the CAMHS making the decisions of who gets support. So families still fall through the cracks.
19. The beginning of any issues is where the most help is needed. Help finding the right help, doctors, therapy, etc is something that is lacking.
20. Should include training supports for parents and teachers. Should also help parents with risk assessments.
21. Proper advice on the different types of medications
22. Sibling care should be included regardless to support all children

Would you like to tell us more? (crisis support)

1. no
2. I cannot find enough qualified understanding of the mental health issues we face. Both Health and Legal should compliment and support each other.
3. I think a lot more detailed standards need to be put into place i dont think these are sufficient to help parents
4. I'll see how it works in practice
5. Having to be admitted to hospital through ED, then discharged with no safety planning but a number for Pieta House!
6. It is extremely hard to access crisis services
7. Urgent care needs to be provided to children during a crisis, I have had friends wait hours, turning into days in hospital awaiting interventions for suicidal children. Safety planning and information about supports is insufficient. Actual supports in terms of case workers, psychiatrists, counsellors and psychologists need to be applied and not just for the young person, the parents and other children need to be supported through these times.
8. If the standards manage to implement access to urgent mental health assessments, then it would be sufficient crisis support but if CAHMS refuse so many to reduce waiting times, how will they reasonably provide acccess urgently?
9. Vague - a leaflet outlining a list of emergency services or helplines would Be insufficient
10. Plans need to be in place. Telling families a&e or contacting the garda is wrong! These children and families need support and care 24/7
11. There are no crisis pathways
12. Still leaves parents been pushed between services.
13. Supports when families hit completed burn out. Help around school refusal. How to handle physical violence safely. Social/family work supporra
14. A lot of kids in crisis may have PDA and I think this should be explored as to whether they have it or not

Would you like to tell us more? (transition to adult services)

1. no
2. More details from experienced personnel
3. This is a massive worry for parents as they dont know how their child will react to the change and whether the adult mental health service will adequately help their child
4. Continuity of care can't happen is staffing is patchy
5. Services need to be resourced before3 offering information on a transition. Not everyone agreed 18 is emotionally 18 and may be better served by CAMHS

6. I have been told over and over that there are not adult adhd team or mental health team to assist me with my autism.and adhd diagnosis or follow up care. I have had to pay thousands to get both diagnosis even though I have a medical card. I have been told the same about my child, his adhd isn't severe enough for medication so cahms cant accept him as that's the only support they can offer then there wont be any help for him as an adult either as his needs are more hidden
7. Transition is not about information sharing its reassurnace that support continues in a meaningful way. Terms are too vague
8. It's all just words, nothing actually happening as of yet.
9. More in depth analysis of how this will be implemented
10. Show me the detail! Show me how this will be managed if a child only gets seen at 16?
11. The draft standards are theory of support the practice of care at a practical level is limited in its support for families and children
12. Therapy should be offered, not just medication or your child gets taken off the books

Would you like to tell us more? (consent, decision-making and young people's rights)

1. Children age 16 with adhd and autism should still be parent permission
2. no
3. When a parent controls, dominates, or persistently criticises their child, the child does not stop loving that parent. Instead, they may begin to stop loving themselves.Children are deeply dependent on their parents for love, security, and a sense of identity. When a parent repeatedly uses control, domination, criticism, or emotional manipulation, a child often protects the relationship by turning the blame inward. Rather than rejecting the parent, they may come to believe that they themselves are unworthy, inadequate, or somehow at fault. The greatest casualty of such dynamics is often the child's own self-worth.
4. It's very depend on the child
5. 16 is very young for a troubled person to choose to stop accessing services
6. I amvery concerned that my pda, adhd, autistic child will get too much say in the control of his money etc when he turns 16, I have been told with these conditions he is not as mature as a child his own age so a few years behind therefore think it's wise to treat him as an adult when he turns 18 not 16
7. Will require specific resourcing and training to enable services to provide this. Also needs more holistic training in general for psychiatrists to understand power dynamics which are part and parcel of mental health care but even more so for under 18s
8. If done while meaningfully managing mental health it works

9. I know for support to work the person age 16 and over should have some privacy, parents are fearful however. The not knowing if their child is ok is very difficult
10. Children and young people with mental health issues would need an advocate or assistant to understand and make decisions independently.It sounds good on paper but it is possibly the wrong wording for a delicate situation.
11. 16 is quite young.
12. I have concerns about children over 16, simple because alot of the children are unaware of the support and care needed
13. Parents need to be at the centre of all decisions made and their direct experience of their child's mental health needs to be considered at all times
14. With neurodivergent children their executive functioning can be seriously delayed so their decision making should not be based on their age but their capability of understanding.
15. I think it should also consider families where there is domestic abuse and post separation abuse when a victim cant get a second signature

Would you like to tell us more? (restraint and restrictive practices)

1. no
2. Deescalate is key with early intervention
3. It really depends on the adult. A no blame whistleblowing procedure needs to be in place if individuals are not cut out for de-escalation
4. Putting hands on my child would make him worse, best to remove others for safety
5. This should have more safe guarding involvement including limited periods, 2 staff monitoring 24hr.

Would you like to tell us more? (medication prescribing and monitoring)

1. Including gp
2. More information needs to be given. In practice medication is a long road to get right and parents give up on it
3. There should be specific pharmaceutical review schedules to ensure that more meds are not just being helped on, especially given psychiatrist turnover
4. Education support for families and children is needed to accompany
5. Ongoing monitoring of medication needs more detail.
6. Does treatment end if medication isn’t agreed to?
7. Needs to be monitored very closely
8. It takes so long to be seen so medication information comes too late
9. Might include the side effects so you are fully informed. Maybe support groups with other children or parents who have used medicatio

Would you like to tell us more? (electronic health records and digital systems)

1. there is a risk of people being able to hold records ransom ,or whole archives disappearing due to virus or hack
2. no
3. Allows more funding and time for solutions and remedies
4. Yes it is helpful to receive reminders of appointments etc
5. I am concerned this will be used against the child or parent to be black marked etc
6. Positive but... will this depend on the individual health records being implemented? Because if we are waiting for that then good luck. The other concern i would have is that telehealth options are overused. There is a wealth of body language that is missed when all you can see is a diseembodied head on screen
7. Once it allows right people access right information at the right time and is child focused and not KPI only focused
8. Should not replace inperson appointments
9. Security

Would you like to tell us more? (telehealth and online appointments)

1. Time and expense saver
2. Yes option
3. I really dont think this is appropriate as a professional may not get the total picture of what is going on with the child or at home or in school etc as they cant see the child in person. Professionals dont know whether this type of appointment would suit the child some children may not be comfortable with online or telehealth appointments
4. It can be hard for some people to leave the house
5. may be useful but may be overused by CAMHS if child can't atte3nd due to emotional needs. CAMHS need to offer at home service
6. Would be useful for children who won't leave house
7. This is not a solution for most appointments just the box ticking / checking in ones where it's just a quick discussion to check how things are going. It is very hard for me to get my child to appointments he doesn't want to attend or is frightened of
8. Caution against overuse. Should never be used for assessment and must be supplemental to regular in person contacts
9. First appointment needs to be face to face
10. It is difficult to engage with a person on a screen, appointments should be in person where possible and only online/telehealth for periodic reviews.
11. It might help.
12. Should not replace inperson,but complement
13. It should be optional depending on child’s/parent’s preference. Online isn’t always as effective.

14. It should always be face to face especially as poor mental health can be masked and needs full review to ensure best practice care is provided
15. Might work when child and family have a plan in place
16. I feel one to one is the most effective way of communication.

Would you like to tell us more? (mediation)

1. In cases of Personality Disorders mediation can be manipulated and not in the best interest of the child
2. This is very important. If a professional doesn't have the lived experience they need someone who does to mediate.
3. Will it potentially cause more delays if employees are caught up in mediation?

Would you like to tell us more? (community, cultural and faith-based supports)

1. Qualified and experienced professionals are more important. Unqualified advice can do more damage.
2. The government need to stop relying on others & charities to assist. The issue of child mental health is so important and should be prioritised accordingly
3. Provided this is not kicking the CAMHS issues back to the community. It must also be recognised that there will be considerable geographic variation in capacity and willingness of these type of ancillary organisations to be involved, not to mention a lack of funding for most social enterprises/civil society/community groups. If including then they should be part of multi-disciplinary team communications in case they are giving contradictory support/advice
4. Due to too many voices for the child or young person and then the issues will get o lost
5. It would be better if families did no have to rely on community organisations and charities. I think there is no place for religious or faith based supports for children experiencing difficulties.
6. All faiths - Christians included.
7. Community groups need training abd support to provide these supports
8. Sometime the religious and cultural views of parents are hurtful for the children. Many cultures/religions don't accept gay's rights, women's rights...

Would you like to tell us more? (workforce requirements)

1. More Funding needed
2. Continuity of care and continuous staffing is not mentioned
3. So many different approaches and staff making decisions alone/ one part of CAMHS not speaking with other part and this needs to be addressed hugely
4. Focus is on health/therapeutic qualifications but these alone will not enable what is outlined in the standards, e.g. need plain language, assisted decision making, communication, universal design, mediation and conflict resolution, child participation practices etc.
5. The model of service moving to needs led versus diagnosis lead will take a huge shift in cultire needing high levels of support for even those really experienced
6. Staff need to be adequately trained and not under massive case loads. The HSE needs to recognise that the burn-out rate is too high because the staff are in a very demanding job and are under resourced.
7. It is also important that they care. That they show empathy
8. I wasnt satisfied with the psychologist approach used with my child so it should be improved

Do you think any important topics or issues are missing from the draft standards?

1. no
2. no
3. Specialised cases of abuse need to be addressed
4. N/A
5. Staffing issues. Replace people on leave especially maternity leave
6. FASD as a real issue for 7% of population according to HSE and yet CAMHS do not recognise or offer approprate mental health support desoite mental health being a huge issue in FASD diagnosis. Training and information required
7. I think referral criteria should be standardised in the draft
8. Have these standards been shown and discussed by young people? They need to be at the heart of this.
9. Commitment from governance, services and service users that this is what will happen versus shoukd happen
10. CAHMs have too much power to refuse children in need in order to reduce their lists.
11. No
12. What to do when all this theory is not traslate in the real life. You have to wait years for an answer, the service is really poor, the help offered is none....
13. Just because you’re autistic you shouldn’t be turned away
14. No

15. Ways of referrals. Schools currently can’t refer when they are the ones who know the child extremely well
16. The disconnect between private professionals in the mental health sector and Cambs
17. Yes. How it is determined whether a child is accepted or not needs to change. Severe anxiety should be accepted and anything less should be discussed with the parents before deciding. Therapeutic approaches need to be taken and not just meditation or taken off the books if the parents don't want to medicate their child. Camhs need to collaborate with the CDNT so that the child is getting appropriate supports
18. I am still waiting
19. No

How do you think these standards could be applied in practice?

1. Schools to have the support to do this
2. From experienced personnel
3. Replace people on leave including maternity leave.
4. resources and funding and staffing needed urgently
5. With great difficulty. This is is a great document for a functional CAMHS interfacing with a functional community service
6. They could but they will not be. Time and again this has been proven, consultations seem to be the fix to kick the can down the road and waste money on professional interpretation etc. When in fact if money was put into teams already there things would work better
7. I dont think they will be. Unless you resource these well meaning approaches, it simply won't happen and it will appear to be lip service.
8. Applying a change support plan with quality monitoring on meaningful targets
9. With staff working cooperatively with the interagency model
10. Very difficult to change an institution from within using revised standards alone. Some statistical data is required rather than just all words.
11. N/A
12. Staff should be made responsible for their decissions. If a child need help and a nurse send him home because she doesnt see the ptoblem and the child hurts himself....who is made responsible?
13. Staff training
14. Allow schools to refer
15. The practice and culture of CAMHS is the most important aspect of support delivery to make the standards of best practice for the most vulnerable children in our society
16. An equal standard through out the country.
17. More recruitment if needed, more training for staff to understand the different needs and approaches required
18. At the moment i have no confidence in the service & if ill ever get support for my child & family