Transforming Youth Mental Health Services in Ireland: A New Model

Recommendations to enhance, improve and transform youth mental health services in the short, medium and long-term

Prepared by the Youth Mental Health Transitions Specialist Group to support the implementation of Sharing the Vision Recommendation #36

HSE

Sharing the Vision
A Mental Health Policy for Everyone

Rialtas na hÉireann
Government of Ireland

Contents

List of Abbreviations

StV	Sharing the Vision, A Mental Health Policy for Everyone
CAMHS	Child and Adolescent Mental Health Services
AMHS	Adult Mental Health Service (inclusive of Clinical Care Programmes for adults)
MHS	Mental Health Services
CHO	Community Healthcare Organisation
FCS	Family, Carers and Supporters
RHA	Regional Health Area
YMH	Youth Mental Health
VCS	Voluntary and Community Sector

Executive Summary

Sharing the Vision, A Mental Health Policy for Everyone (StV) is Ireland's national mental health policy. It aims to enhance the provision of mental health services and supports across a broad continuum from mental health promotion to specialist mental health delivery during the period from 2020 to 2030. The vision embodied in StV is to create a mental health system that addresses the needs of the population through enhancing the inclusion and recovery of people who have complex mental health difficulties. It promotes a vision where service providers should work in partnership with service users and their families to facilitate recovery and reintegration through the provision of accessible, comprehensive, and community-based mental health services.

Governance and oversight of the progress of implementation of the policy is provided through the National Implementation Monitoring Committee (NIMC) supported by a Reference Group of Service Users.

A number of specialist groups were formed to address the implementation of the complex recommendations contained in the policy. One of these is the *Youth Mental Health Transitions Specialist Group* which was established in September 2021 with a focus on implementation of StV Recommendation 36:

> *Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS. The age of transition should be moved from 18 to 25, and future supports should reflect this.*

The specialist group focused its work into two separate, but interrelated workstreams:

Workstream 1: Development of an enhanced transitions plan (including implementation plan) to support individuals transitioning from CAMHS to AMHS at 18 years.

Workstream 2: Development of a reconfiguration plan, including prioritised and phased recommended actions, in order to plan for the provision of age-appropriate specialist mental health services up to age 25.

The recognition of the need for change and improvement in child and adolescent and youth mental health has been the subject of much focus in recent years and especially since the publication of the Look-Back Review into CAMHS in South Kerry ('Maskey Report'). Since the initiation of this work the need for ongoing and meaningful engagement with all relevant stakeholders has been a core focus for the specialist group.

There has been extensive consultation with stakeholders working in and engaged with mental health services to understand the realities, concerns and future visions and hopes of stakeholders, and this has been a key influencer of the recommendations contained in this report.

In recognition that young people should be central to the process of transformative change in the child and youth mental health service sector the principle of *'nothing about us, without us'* is increasingly recognised. Listening to, exploring, and understanding young people's experiences of accessing mental health services has been a priority throughout the work of the specialist group.

The specialist group has developed recommendations to enhance, improve and transform child and youth mental health services. It sets out a vision for long-term reconfiguration of how child and youth mental health services are delivered, proposing a single point of access be introduced with a dedicated multi-sector triage function and development of new youth mental health services to serve the 'missing middle' whose needs are not met by current mental health services. It also sets out five recommendations that can be implemented to support the long-term vision with themes of 'Transition', 'Shared Care', 'Access', 'Training' and 'Research and Evaluation'. A Youth Mental Health (YMH) model of care is required with governance structures at a national, regional and local level explicitly defined and agreed particularly in light of emerging changing organisational structures in the HSE through the establishment of Regional Health Areas (RHAs). The successful implementation of this transformational YMH service will require the explicit support and commitment of resources and leadership from the *Department of Health* and the *Department of Children, Equality, Disability, Integration and Youth.*

Section 1
Background and Context

Authors[1]: Caroline Heary, Gary Donohoe, Barbara Dooley, Eilis Hennessy, Holly Hanlon, Colm McDonald, Padraig MacNeela and Kristine Vu.

The social landscape for young people has changed dramatically in recent decades. For many, an extended period of education, later age of marriage and childbirth, coupled with significant social, technological, and economic global changes has contributed to a more protracted and complex transition into adulthood (Arnett et al, 2014). The lives of young people at this stage of life are fluid, and often characterised by instability and change.

There is a very clear consensus in the literature on the requirement for youth mental health services to be responsive to the needs of youth and the dynamic and changing context in which young people live. Killackey et al. (2020) highlight the complex and evolving issues at this stage of life, and the fluid symptom patterns and comorbidity commonly seen in this age. Numerous authors highlight the importance of adopting a developmental lens when providing care to young people and the importance of attending not only to presenting symptoms but recognising the impact of mental ill health on education, employment, relationships and developing autonomy (Killackey et al., 2020; Malla et al., 2021). Those consulted by the authors on behalf of the specialist group firmly believed in the importance of developing a service that was tailored to the developmental needs of young people at this stage of life.

There is increasing emphasis on the period of life from adolescence into young adulthood as a core window of opportunity for enhancing mental health outcomes in young people (Fusar-Poli, 2019). The onset of mental ill health peaks in adolescence and early adulthood, with 50% of all mental disorders developing before the age of 15 years and 75% by the age of 25 (Kessler, et al., 2007).

The paediatric model of care which involves a transition to adult services at approximately 18 years of age is at odds with this epidemiological evidence. This model fails to recognise that this is the age when young people are most vulnerable to mental health difficulties (McGorry et al., 2013). McGorry et al. (2007) argue that the system is weakest where it should be at its strongest, with young people facing a cliff edge at a time when they need most support. This service configuration contributes to discontinuity of care and provides an inadequate structure for addressing the needs of young people living with mental health difficulties. Those who need care for the first time as they approach the age boundary can find it difficult to access support in a timely manner (McNicholas et al., 2015). Furthermore, a reluctance to engage with adult services that are medicalised and not aligned with the developmental needs of young people is a frequent barrier to accessing care (Plaistow et al., 2014).

1. Heary, C., Donohoe, G., Dooley, B., Hennessy, E., Hanlon, H., McDonald, C., MacNeela, P., Vu, K. (2023) Review of Youth Mental Health Services for Young People up to age 25. HSE Working Document (unpublished)

Models of care

Over the past 20 years, in response to the discontinuities of care observed, we have witnessed a shift internationally towards multiple new models of youth mental health care that are designed to support youth mental health in a developmentally appropriate, recovery oriented and responsive manner. Many of these models seek to address the silos between specialist child and adolescent mental health services and adult services or the gaps between primary care provision and secondary care services.

There are many variations emerging with services reviewed by the authors differing in their target age range; whether they operate within a discrete tier of care or cross the boundaries of different tiers of care; and they differ in the range of interventions and supports available. Despite these differences there are many common features including the need for **developmentally appropriate services that are flexible and responsive to the complex and dynamic needs of adolescents and young adults,** supporting **youth participation in service design and delivery;** and the provision of **services that reflect the needs and preferences of diverse young people.**

Killackey et al (2020) recognise that in high resource settings it is now possible to aspire towards *'comprehensive models of care that extend from the community through primary care to secondary care and tertiary levels of sophisticated quality care'.* It is proposed that secondary care would consist of multidisciplinary care, linked to primary care and community organisations, and with face to face and online supports available (McGorry et al., 2022).

As we look to the future, the key driving force in moving forward in Ireland, **is finding a model of service integration that's fit for our national context** (organisational, financial, cultural) and provides seamless and fluid transitions across service tiers. A successful mental health system is one that integrates education-based support, community-based supports and specialist mental health supports for those with more complex needs (Commission Young Lives, 2022, p33). A recent report in the UK outlines what appears to have worked well in the UK models of youth mental health adopted so far (National Collaborating Centre for Mental Health (NCCMH, 2019). These include incremental development, co-production of services with young people and professionals, rooting services within the community and establishing working partnerships across different types of providers.

McGorry and colleagues (2022) suggest that 'filling the gaps' between the entry points for youth mental health care and specialist services remains the key challenge in Ireland. **The development of specialist youth mental health teams, in the absence of building a bridge with the multiple organisations that currently provide early support and intervention, is likely to continue to lead to fragmented and disjointed services. Vertical, seamless integration across the current tiers of service (from primary care to tertiary care) is essential.**

Following a review of the evidence alongside consultations with representatives from youth mental health service providers the following recommendations are made for moving forward:

- Maximise easy access to care for all young people across the country
- Front load appropriate evidence-based early interventions and holistic models of care within primary care context
- Build cross-service partnerships and models of governance to support flexible transitioning of young people across the different tiers of services
- Develop integrated pathways of care that are responsive to the dynamic and changing needs of young people during this developmental stage, with an expanded range of supports available
- Embed the voice of young people and family members in the service transformation process
- Develop specialist teams for complex and persistent conditions to address the needs of transitional age youth (12 to 25 years)
- Embed a research culture to support and drive the process of system transformation.

To conclude

'No one size fits all' and as one of our contributors argued: 'no one has cracked this'. A recent presentation by Pat McGorry at the Sussex Youth Summit (2022) highlighted the need to focus on **what is feasible, what is desirable and what is viable.**

Section 2
Report Development

The Youth Mental Health Transitions Specialist Group was established by the HSE and the Department of Health at the request of the NIMC Steering Committee in September 2021 to progress Recommendation 36 of Sharing the Vision which states:

Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS. The age of transition should be moved from 18 to 25, and future supports should reflect this.

The group included mental health specialists with expertise and remit in the area of youth mental health (see Appendix 1: Membership). The Terms of Reference for the Specialist Group were as outlined in Appendix 2.

Process

The specialist group focused its work into two separate, but interrelated workstreams. The workstreams progressed on parallel timelines.

Workstream 1: Development of an enhanced transitions plan (including implementation plan) to support individuals transitioning from CAMHS to AMHS at 18 years.

Workstream 2: Development of a reconfiguration plan, including prioritised and phased recommended actions, in order to plan for the provision of age-appropriate specialist mental health services up to age 25.

The specialist group employed project management and change management methodologies throughout its work. It adopted a majority approach to decision making.

Meetings

The specialist group met on average once a month with additional meetings with subject matter experts and the Chair, Vice-Chair and Project Manager met weekly.

Research

A Request for Tender for research was issued in early 2022 with two objectives: 1. To carry out a review of national and international evidence and best practice in provision of youth mental health services up to 25 years and 2. To carry out a mapping exercise and report key learnings in relation to current patterns and projected future requirements for young people presenting to HSE MHS, Emergency departments and to VCS mental health services. The tender was awarded to University of Galway. An extensive review of the literature was conducted alongside consultations with 12 youth mental health organisations nationally and internationally. A presentation of the findings was made to the Specialist Group in early 2023 with the final report *'Review of Youth Mental Health Services for Young People up to age 25',* HSE Working Document (unpublished) issued to the specialist group in October 2023 (See Section 1. Background and Context for summary of findings).

Consultations – *'Nothing about us, without us'*

Eight separate consultations with a wide range of stakeholders (as set out in Appendix 3) were held over the lifetime of the specialist group. The objectives of these were to listen to, explore and understand people's experiences of navigating and working in and with specialist mental health systems for young people, to ensure those voices were heard and incorporated into service planning and design. There was a variety of formats employed including online, in-person, survey and focus groups ranging from six to 1,391 participants. These were supported by the HSE, the Department of Health, spunout and the Centre for Effective Services (CES). Thematic analysis of consultation responses was carried out which informed the planning of the specialist group.

The specialist group also consulted with youth mental health subject matter experts nationally and internationally which included the Canadian Youth Wellness Hubs Ontario and Orygen Youth Mental Health Services in Australia.

Section 3
Guiding Principles

The principles which have guided the work of the specialist group and those which should underpin the implementation of the new configuration for youth mental health services have been informed by:

- The core values of **'respect, compassion, equity** and **hope'** contained in StV, coupled with the four service delivery principles of **'recovery, trauma-informed care, a human rights approach,** and **learning'** are central to the recommendations of this report.
- The Sláintecare principle of ensuring every child and young person in Ireland has access to the right mental health care, in the right place, at the right time.
- The World Health Organisation (2012) definition of adolescent-friendly health services (**accessible, acceptable, equitable, appropriate** and **effective**)
- The Global Youth Mental Health Framework (World Economic Forum, 2019) (**youth-centred, accessible, integrated-care, embedded in the community**).
- The National Framework for Recovery in Mental Health (HSE, 2017) principles (**centrality of service user lived experience, co-production, recovery-oriented services and supporting recovery-oriented mental health services**)
- Our commissioned review of best practice in youth-centred mental health service provision in Ireland and internationally carried out by the University of Galway.
- Our extensive consultation process with young people and families, stakeholders and subject matter experts.

In the UOG review of best practice in the design and delivery of youth-centred mental health services, it is noted that a youth-friendly service is defined as one that is: *"accessible, appealing, flexible, confidential and integrated, where youth feel respected, valued, and welcome to express themselves authentically, without discrimination of any kind; it is a developmentally and culturally appropriate service that mandates youth participation in service design and delivery, to empower youth and help them gain control over their lives"* Hawke et al (2019).

The specialist group highlights the following guiding principles which should underpin the implementation of the report's recommendations:

Child and young person centred: Working in true partnership with children and young people to design and deliver developmentally appropriate services young people want to access. Services should be friendly, attractive and welcoming (both digital and physical) providing non-judgemental and non-stigmatising care and services.

Prevention and early intervention: Children and young people shall enjoy timely access to effective care at all levels of need. Ensuring children and young people can access the right supports at the right time will prevent the escalation of distress and mental health difficulties, improve overall outcomes, and support young people to achieve recovery.

Accessible: Equitable and timely access for all without discrimination or barriers which would prevent children or young people from accessing care. Ensuring those in priority groups* can access care in an equitable and timely way.

Integrated care: Services should prioritise co-location with other youth-friendly services to provide the opportunity for young people to access the support they need in a holistic environment. Services should incorporate appropriate and effective digital solutions to engage young people, facilitate their ownership of the process of engaging with services, and avail of evidence-informed digital interventions to enhance their overall mental health care experience.

* StV and CfL describe priority groups as those displaying evidence of vulnerability to and increased risk of suicidal behaviour and include members of the LGBTQ+ community, the Traveller community, people who are homeless, drug users, people who come in contact with the criminal justice system; people who have experienced domestic, clerical, institutional, sexual or physical abuse; asylum seekers; refugees; migrants and sex workers. This is not an exhaustive list and additional groups such as children in care, care leavers, people with disabilities, people who have severe-to-profound deafness and people with substance (drug and alcohol) misuse problems should be included.

Section 4
The Recommendations

Long-term vision

Young people should be able to rapidly and easily access youth-specific mental health care that provides recovery-focused needs-based and complexity-based care in a flexible and non-stigmatising manner. That care should be delivered in an integrated way with services provided in a single location.

Key Features of *long-term vision*

Future reconfiguration of mental health services for young people should include:

- A 'no wrong door' experience when accessing mental health supports
- Multi-service triage bringing together the major actors in child health service provision in the community
- New youth mental health services for those aged 15-25 years where there are gaps

Single Point of Access: No Wrong Door

All referrals for children and young people with mental health difficulties, aged between 0-25 years, should come via one point of access and self-referral should be supported. This would provide a 'no wrong door' approach to accessing mental health services. The single point of access should be facilitated at a local community level where there is an awareness of adjunctive services in the locale as these vary across the country.

Considerations

Young people and their families/carers should be able to access mental health services via drop-in, self-referral, digital booking and 'soft access' via other co-located, non-mental health services

A single point of access approach will require an electronic case management system to allow inter-organisational communication and seamless movement of information.

There should be a single common online referral form.

Multi-Service Triage at Single Point of Access

A locally assembled team of key community stakeholders in mental health service provision should be in place to triage all referrals received via the single point of access. That team should have the authority to identify the service best placed to meet the child or young person's current mental health needs as presented in the referral.

Considerations

An integrated service team should map to the catchment population of one CAMHS team and one AMHS team i.e. a population of 50,000.

The integrated service team should have representatives from Mental Health Services, Children's Disability Network Teams, Community Healthcare Networks and the Voluntary and Community Sector. As referrals are now dealt with by these services separately within current resource commitments, representatives should be consolidated from these existing resources to streamline the process.

There should be a rotational chairpersonship of equal representation from all service team members and the team should meet regularly but no less than once a week.

The Chairperson of the integrated service team can be from any discipline but should have the authority to make decisions and allocate referrals.

A Standard Operating Procedure should be in place for all integrated service teams ,to include emergency response procedures.

The integrated service team should have visibility of representative service waiting lists.

The date of referral to the integrated services team is the date of access, if a referral moves between services the original access date remains viable and there should be active wait list management approaches employed.

It is important that additional administrative burden should not be experienced by teams facilitating a single point of access so there will be a need to resource administrative and coordination support for integrated service teams.

There needs to be resourcing of an engagement role to support young people and their families/carers as they navigate service(s), this may be a peer worker or a youth worker role.

New Youth Specialist Mental Health Service

A new specialist mental health service for young people between 15 to 25 years should be established, designed to support young people with moderate to severe mental health difficulties at this distinct period of life in which young people are maturing physically, personally, mentally and socially. It would not replace the existing specialist mental health services CAMHS or AMHS. Young people who are accessing supports in CAMHS before 15 years, where it is in their best interest, can remain with CAMHS until 18 years as per current structures. Likewise young people aged between 18 to 25 years can directly access services in AMHS if their presenting needs are better met in AMHS. The Youth Specialist Mental Health Service will deliver needs based, distinct episodes of care.

Considerations

There will need to be targeted investment to create new Youth Specialist Mental Health Services and operationalisation of these services may include phased steps.

Governance will align and evolve with specialist mental health governance structures which may include shared governance arrangements and should be outlined in a Standard Operating Procedure.

Youth Specialist Mental Health Services should operate to a catchment population in line with Regional Health Area integration populations but not more than a population of 150,000.

Youth Specialist Mental Health Services should be co-located with other services which should include Mental Health Clinical Programme teams.

There should be integration with existing specialist mental health services.

A young person should be able attend more than one service at a time with inter-organisational communication facilitated via an electronic case management system.

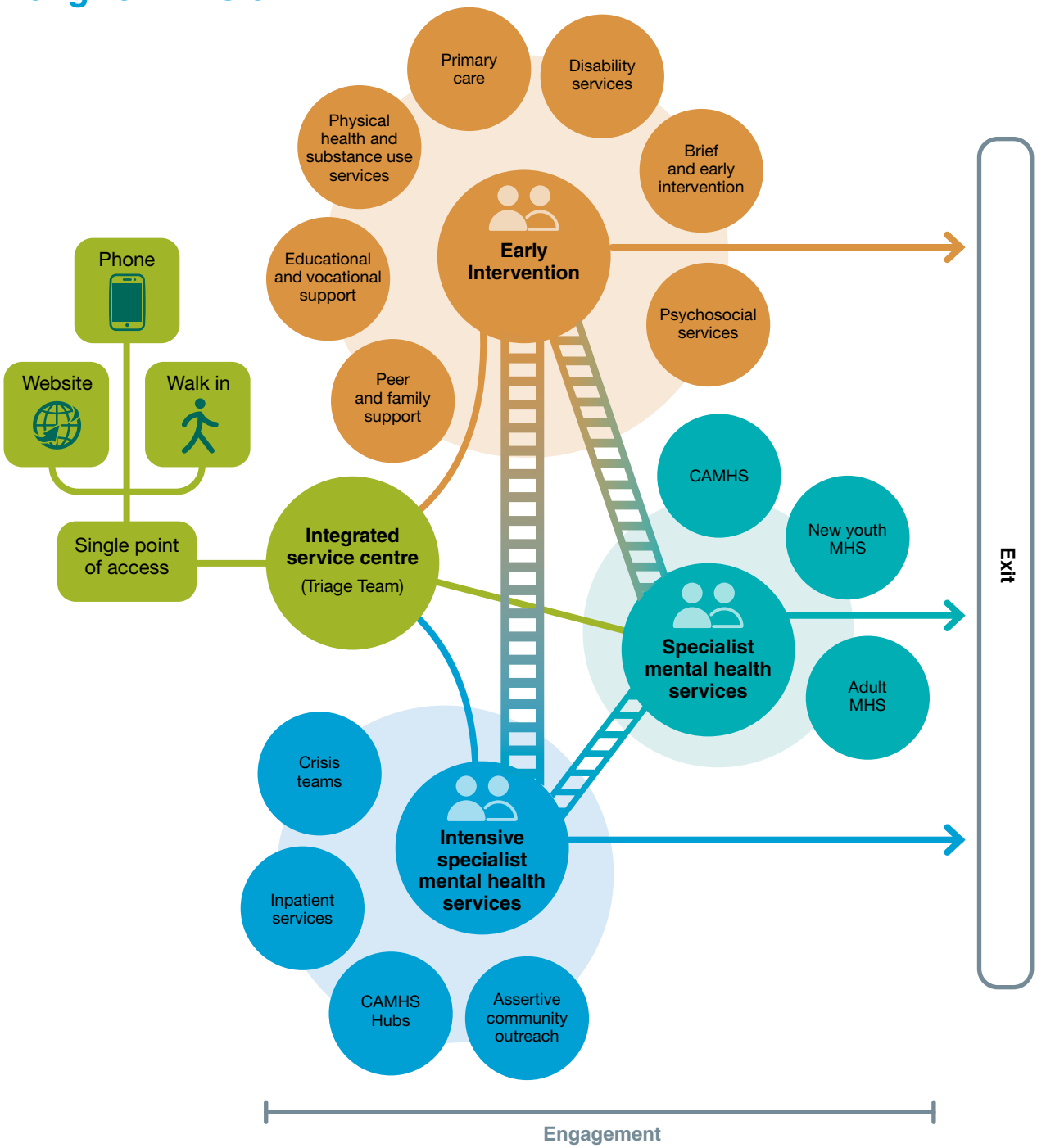
There should be youth-specific evidence and needs based episodes of care with capacity to provide outreach care.

All young people should have a mutually agreed key worker to facilitate coordination and personalisation of services.

There would be no impact on current inpatient service delivery which is regulated under the Mental Health Act.

There should be oversight of mental health interventions on offer within the catchment population, and review and adjustment of service level agreements to ensure consistency in support being offered.

Long Term Vision



Services may include:
- Primary care psychology
- VCS eg. Jigsaw, Pieta, Family Resource Centres
- CIPC
- Drop-in Vocational support
- Community Cafes
- Student Support Services
- GP
- Children's Disability Network Teams 0-18
- Discovery Colleges & Recovery Education Services

Services may include:
- ADHD Services
- Self Harm
- Perinatal
- Dual Diagnosis
- Eating Disorder
- Early Intervention Psychosis

This is a graphical representation of the view of the YMH Transitions Specialist Group as to how future services may be structured. This structure may be amended or altered during implementation.

Recommendations to support the Long-Term Vision

Transformation change can take time to take effect. The specialist group has made **five recommendations designed to complement and support the long-term vision** that mental health services can begin to implement in the **immediate to medium term**. These recommendations aim to **create capacity, support staff,** and **establish the appropriate structures** within the health system to support the move towards the long-term vision for youth mental health services.

The recommendations should be implemented in the short to medium term i.e. 0 to 5 years.

1

Transition

The 'Enhanced Transition Plan' recommendations of the Youth Mental Health Transitions Specialist Group should be implemented across the mental health services

2

Shared Care

There should be phased design and delivery of youth focused mental health interventions that cross CAMHS/AMHS boundaries and integrated pathways with community partners should be enhanced

3

Access

Young people should be able to easily access high-quality mental health services that take into account individual needs and preferences including digital therapeutic supports

4

Training

There should be committed investment and strategic planning for training and continued professional development to enable the workforce to deliver services in an integrated system of youth mental health care

5

Research and Evaluation

All YMH services should be based on a learning health system approach with measurement-based care. There should be planned data collection, research and evaluation that includes the lived experience, staff and service-provider perspective and would allow measurement of outcomes achieved

Recommendation 1: Transition

1

The 'Enhanced Transition Plan' recommendations of the Youth Mental Health Transitions Specialist Group should be implemented across the mental health services.

In recognition of the challenges currently faced and reported by young people who make the transition from CAMHS to AMHS at the age of 18, the specialist group has developed an 'Enhanced Transition Plan'. With its implementation, the experience of young people moving from CAMHS to AMHS will improve.

There are three recommendations with associated goals and implementation actions in the 'Enhanced Transition Plan'. These set out to achieve:

1. Moving from CAMHS to AMHS should be treated as a **continuation of care**, place the young person at the centre, and transitional care plans should be co-produced with young people and where appropriate their support network
2. It is the responsibility of all staff to **effectively collaborate** to ensure a smooth transition for all young people and put in place relevant supports and enabling structures
3. Area management teams should have responsibility for ensuring **all young people experience a smooth transition** between CAMHS and AMHS and this should be evidenced by standardised reporting of performance and person-centred outcomes

Recommendation 2: Shared Care

2

There should be phased design and delivery of youth focused mental health interventions that cross CAMHS/AMHS boundaries and integrated pathways with community partners should be enhanced.

Considerations

Youth-focused Group Interventions

- Area Specialist Mental Health management teams should support community mental health teams to develop and deliver **trans-diagnostic youth-focused group interventions** for young people aged 15 to 25 years.
- These should be **jointly delivered**, facilitated by services across the CAMHS and AMHS boundaries with the duty of care remaining with the referring service for the duration of intervention.
- **Collaboration with Voluntary and Community Services and Primary Care** and community-based organisations such as Discovery Colleges Recovery Education Services, should be explored and enhanced for group interventions with consideration given to equity of inclusion of priority groups* deemed to be 'at risk'.
- A **youth mental health consultation/ liaison model** should be adopted to ensure formal links between mental health services and primary care (aligned with Recommendation #17 of StV).
- There should be a focus on recovery.
- Consideration should be given to delivering group interventions in a **variety of suitable community settings** which may include non-health settings e.g. libraries, community centres etc. (aligned with Recommendation #30 of StV).

Co-Location

- Planning should begin for a **model of co-location** to include specialist mental health services, mental health clinical programmes and primary care and community-based services.
- All stakeholders, inclusive of people with lived experience and their family/ supporters, should be involved in structured service design processes for all redesigns or new builds (aligned with Recommendation #98 of StV).

Easy access

- There should be identified centres of innovation supported to test and evaluate a 'no wrong door' approach to accessing mental health services.
- These could include approaches such as café-style drop-in self-referral, online bookings, peer-worker assisted access etc.
- Stepped age inclusion criteria could be adopted in the short to medium term.

Development of youth-focused, collaborative group interventions, co-location of services or innovative approaches to enhancing access to services will be deemed as demonstration of feasibility to be a pilot site for future youth mental health service investment.

*StV and CfL describe priority groups as those displaying evidence of vulnerability to and increased risk of suicidal behaviour and include members of the LGBTQ+ community, the Traveller community, people who are homeless, drug users, people who come in contact with the criminal justice system; people who have experienced domestic, clerical, institutional, sexual or physical abuse; asylum seekers; refugees; migrants and sex workers. This is not an exhaustive list and additional groups such as children in care, care leavers, people with disabilities, people who have severe-to-profound deafness and people with substance (drug and alcohol) misuse problems should be included.

Recommendation 3: Access

3

Young people should be able to easily access high quality mental health services that take into account individual needs and preferences including digital therapeutic supports.

There should be identified centres of innovation supported to test and evaluate a **'no wrong door'** approach to accessing mental health services that could include approaches such as café-style drop-in self-referral, online bookings, peer-worker assisted access etc. In the short- to medium-term stepped age inclusion criteria could be adopted. Technology should be leveraged to promote access, choice and quality of service provision.

Considerations

- In the short-term, referral pathways as outlined in the CAMHS Operational Guideline (2019) should be adhered to consistently across the country but a review of pathways to support increased access, which may **include self- and parent- referrals and drop-in facilities**, is needed.
- Young people should not experience an interruption to their mental health care plan if they experience a change in circumstance e.g. moving to attend college or work, experiencing homelessness, leaving the statutory care system, or moving whilst in the reception and integration system.
- In circumstances where a young person moves location (e.g. attending college), if preferable to them, they should be given the option to remain with their existing mental health service provider facilitated through **telehealth** approaches.
- Young people should be given the **choice** to access mental health support via telehealth or in-person, where clinically appropriate taking into consideration the young person's needs and preferences.
- **Peer youth workers** trained to effectively support young people to access mental health services should be available in every community.
- Youth friendly resources supporting young people to understand how they can access mental health supports, as well as understand what level of support they may need, should be readily available through the HSE website.
- All young people should have access to **clear understandable information** on the treatment approaches being offered in their individualised care plan, and the recovery pathways open to them.
- All young people should have access to **advocacy** services (aligned with StV Recommendation #65).
- Link workers in the community (e.g. teachers, youth workers, social care, allied health professionals, Gardaí, Probation officers, social workers etc) should be able to avail of **training** in how to best identify a young person's level of need, and how to support them to access the right service.
- All hospitals should have **specialist mental health liaison services** operating 24/7 who can fast-track young people to the support service best placed to meet their needs.
- Young people should be able to manage their appointments through an online system.
- Young people should be able to access phone or text-based mental health supports 24hours a day, 365 days a year.

Recommendation 4: Training

4

There should be committed investment and strategic planning for training and continued professional development to enable the workforce to deliver services in an integrated system of youth mental health care.

To achieve transformational change in how mental health services for children and young people are delivered in Ireland, **significant investment**, and **targeted training** of the workforce across all levels of service delivery needs to take place. To bring about change it is important that the vision for an integrated youth mental health service is developed with the participation of staff and that they feel **empowered to action change. Implementation science** will be key to leading the transformational change needed and to keep the culture and ethos of the services focused on integration and outcomes.

Types of Training and Continuing Professional Development

In recognition of the need to enable the workforce to deliver transformational change, the specialist group has identified three core staff development areas: *1. Culture and Ethos, 2. Change Management* and *3. Clinical Skills.*

1. Culture and Ethos related training:

Measurement based care: Staff should be empowered to value the importance of measuring inputs and outcomes in a standardised way to improve outcomes for young people. Enhancing the skill set of staff to value and confidently gather health system performance data in conjunction with young people and their supporters should be planned and ongoing.

Equity: There should be equity in investment in training across disciplines and across regions to support sustainable mental health services and to motivate and enable staff to deliver an integrated service.

Inclusivity and Engagement: Training and continued professional development should include the perspectives of people with lived experience and minority and seldom-heard voices.

Integrated Service Delivery: Planned professional development should include a focus on integrated working across services which has been shown to improve staff retention, improve workforce mental health and satisfaction levels and reduce service provider burden. There should be effort made to deliver training and professional development interventions jointly to CAMHS and AMHS teams as this will promote confidence in skill sets of teams and will help shift the current barriers between services.

Culture: Training and staff development approaches should be delivered between and across services and service levels to promote the transformational change in how services will be delivered.

Recovery Focused: All staff should be supported to work with a recovery focused approach.

2. Change Management related training:

There should be a training infrastructure that will support transformation of systems and care pathways.

There should be planned training with a view to reconfiguration implementation.

There should be investment in training the workforce leaders in areas such as implementation science, project management, change management and culture competency.

Staff and managers should be trained to promote and guide professional development in youth mental health and to encourage staff engagement in training and research.

3. Clinical Skills based training:

There should be definition of the competencies for recruitment i.e. core skill set, required to work in the area of youth mental health such as communication, flexibility, integration; team working, youth engagement

Where staff identify a gap in clinical skill set to work in the area of youth mental health, they should be supported to access training. These gaps may include clinical areas such as self-harm, emotional dysregulation, eating disorders, substance misuse, ADHD, Early Intervention Psychosis etc.

Clinical training could be sourced from existing resources in the mental health services and knowledge sharing between staff and across services and regions should be supported e.g. via local consortiums, co-delivery of training between CAMHS and AMHS teams, training delivery by Mental Health Clinical Care Programmes, joint CAMHS/AMHS continuing professional development events.

Peer support worker training could play a key role in the new YMH service transformation.

Consideration should be given to developing new training modules and courses in collaboration with HSELand and international organisations such as Orygen.

The specialist group recommend the establishment of a **dedicated lead team** which can monitor and guide the training needs as the service develops. To that end, there should be consideration given to the establishment of a national YMH Training multidisciplinary committee within HSE structures, which should include young people with lived experience and family members and supporters, and could have a number of functions:

- Undertake to carry out a training gap analysis which would include input from clinicians working in CAMHS, AMHS, Clinical Programmes.
- Carry out planning to deliver training/ professional development across *Culture and Ethos, Change Management* and *Clinical Skills* areas.
- The committee should include dedicated resource to manage administration of the function e.g. mapping of services to meet identified training priorities, processing of applications, supporting local training delivery etc.
- Design and carry out approaches to evaluate all training delivered.
- Identify opportunities to promote youth mental health via local, regional and national platforms.
- Identify opportunities for collaborative bottom-up and top-down learning e.g. through conferences, shared platforms etc.
- Team enhancement.

Recommendation 5: Research and Evaluation

5

All YMH services should be based on a learning health system approach with measurement-based care. There should be planned data collection, research and evaluation that includes the lived experience, staff and service-provider perspective and would allow measurement of successful outcomes achieved.

Young people should be able to access safe, effective mental health services that are **consistent in quality**. Development of research, data and evaluation capability to demonstrate achievement of **best mental health outcomes**. Capturing the views and experience of young people and their supporters is an important data source.

Considerations

Governance: A model of care for Youth Mental Health Services (YMHS) should be developed with **clear governance structures**. There should be a national YMHS data collection strategy and all services should have common measures and a common data platform. These measures should be used to inform service planning and development and be co-produced with young people and staff.

Quality assurance: YMHS should be delivered as learning health systems with emphasis on design, implementation, evaluation, and adjustment of the YMHS. All co-produced as far as possible with young people.

Measurement-based care: A culture and ethos of **measurement-based care** is essential to the success of YMHS. It is important to measure inputs and outcomes in a standardised way to improve outcomes for young people. Service-provider experience should also be measured and data should be examined for emerging trends. **Outcome monitoring should be central** to the data collection strategy. Outcomes should include clinical measures of function and satisfaction with service.

Identify research priorities: YMHS should get **ring fenced funding for research** year on year, and this can be complemented by additional once-off funding. Along with evaluation of services delivered there should be a focus on emerging trends and how best to respond to them e.g. Artificial Intelligence.

Integration and Partnership: Data collection should be designed to align with the Irish Health System Performance Assessment (HSPA) framework, and with other national and international relevant data sources. This should be done in partnership with national stakeholders e.g. Health Research Board and international stakeholders such as Orygen and Ontario Youth Wellness Hubs. **Young people should be included as research partners.** Ultimately consideration should be given to establishing a multi-stakeholder, all-Ireland, cross-university academic youth mental health research centre with national and cross-border funding and funding from international sources such as Wellcome Trust or EU. This would establish Ireland as an international centre of excellence for youth mental health research and services.

Section 5
Enablers

The specialist group has identified critical success factors required to bring about transformational change.

Organisational and Government Commitment

The successful implementation of this transformational YMH service will require the explicit support and commitment of resources and leadership from the *Department of Health* and the *Department of Children, Equality, Disability, Integration and Youth.*

Resourcing

Investment in sufficient numbers of staff with the appropriate skill and training mix with minimum staffing thresholds to be agreed.

Investment in training and supervision supports for all teams and staff.

Investment in a modern youth friendly built environment with the aim of co-location and integration other youth-friendly services.

Investment in the digital infrastructure to support access to service, record keeping, case management, and a dynamic health learning system.

Governance

Development of a YMH model of care is required.

Governance structures at a national, regional and local level need to be explicitly defined and agreed.

Culture

The successful implementation of this YMH model will require a large-scale cultural shift that cannot be underestimated.

Any prospective implementation site will need to demonstrate high levels of cultural readiness at a local and regional level, in order to be considered for this new innovative YMH service.

This organisational culture will need to support all aspects of the YMH guiding principles into the design, development and delivery of these new YMH services.

Planning and Design

A team with diverse expertise in the areas of change management, service design, development and delivery need to be appointed to lead implementation.

Planning and design needs to include expertise in the areas of implementation science, culture change and learning health systems[1].

Data and Research Evaluation

Expertise and academic partners in research, implementation science, learning health systems[1] and measurement-based care should be embedded in all stages of implementation and roll-out.

Staff need to be supported to understand their role in gathering and providing data.

There needs to be IT structures in place that will support data gathering and sharing.

Training

Induction must be provided to all staff (clinical and non-clinical) joining the YMH service.

All staff will require training to ensure core YMH competencies are developed and maintained on an ongoing basis.

An approach to sharing expertise through Communities of Practice[2] for Youth Mental Health and Youth Mental Health learning networks should be supported.

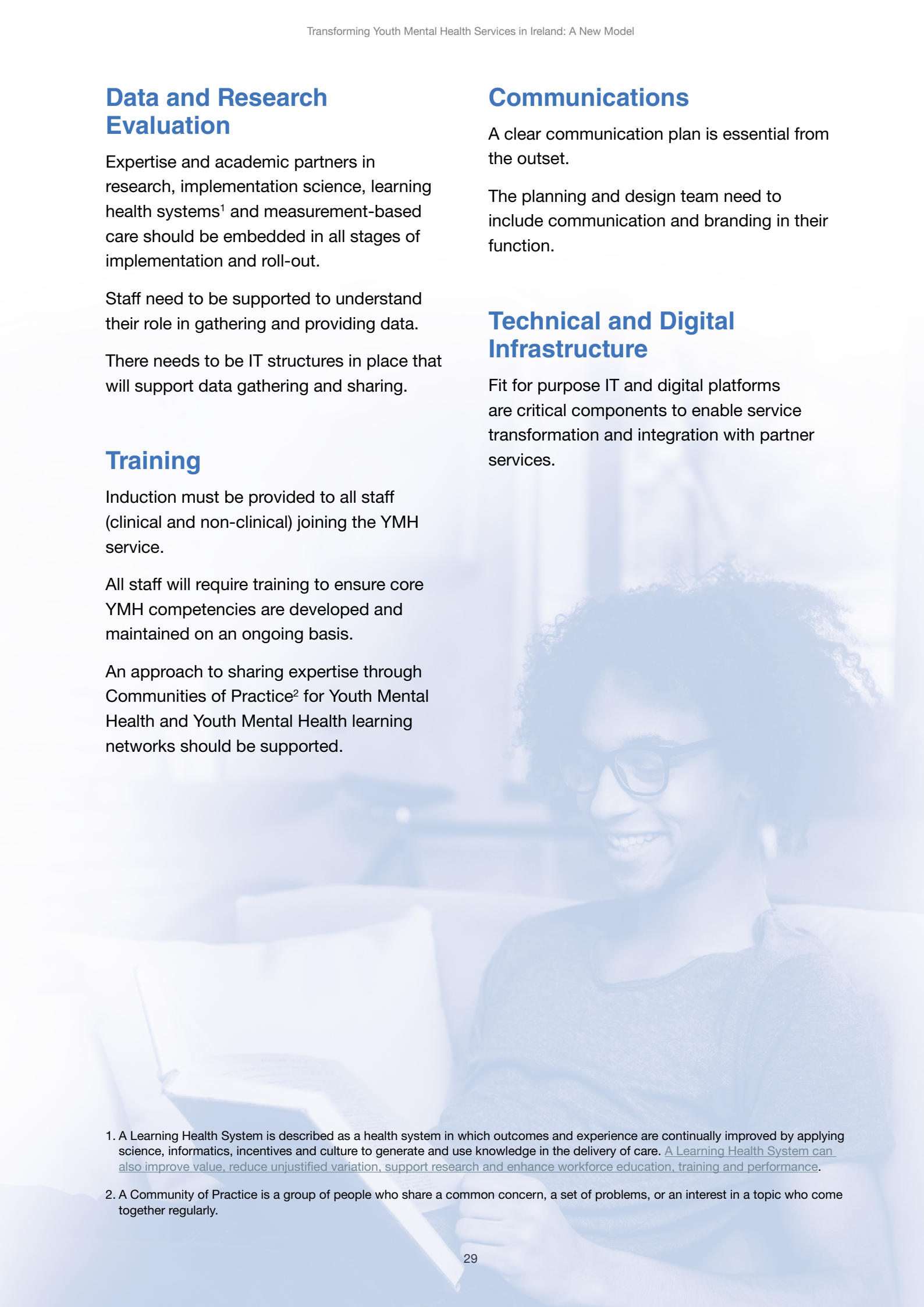
Communications

A clear communication plan is essential from the outset.

The planning and design team need to include communication and branding in their function.

Technical and Digital Infrastructure

Fit for purpose IT and digital platforms are critical components to enable service transformation and integration with partner services.



1. A Learning Health System is described as a health system in which outcomes and experience are continually improved by applying science, informatics, incentives and culture to generate and use knowledge in the delivery of care. A Learning Health System can also improve value, reduce unjustified variation, support research and enhance workforce education, training and performance.

2. A Community of Practice is a group of people who share a common concern, a set of problems, or an interest in a topic who come together regularly.

Appendices

Appendix 1: Membership of the Youth Mental Health Transitions Specialist Group

Specialist Group Membership (Alphabetical Listing)		
Name	**Role**	**Representing**
Paul Braham	Project Sponsor & Vice-Chair	National HSE Mental Health Operations
Dr. Amanda Burke	Specialist Group Member	CAMHS/Psychiatry
Dr. Trisha Byrne	Specialist Group Member	CAMHS Faculty, College of Psychiatrists of Ireland
Prof. Mary Cannon	Specialist Group Member	Youth Mental Health Research
Derek Chambers	Specialist Group Member	Policy Implementation Lead, National Mental Health Operations
Emer Clarke (Sep 2021 – Dec 2022) Sandra Hogan (Jan 2022 – Present)	Specialist Group Member	Communications & Engagement, National HSE Mental Health Operations
Mairead Doyle	Specialist Group Member	Dietetics/CAMHS Inpatient
Dr. Michele Hill	Specialist Group Member	Psychiatry – 3rd Level
Eimear Kealy	Project Manager	Service Improvement Lead, National HSE Mental Health Operations
Kevin Kelly (Sep 2021 – Mar 2023) Dr. Lisa Corrigan (Mar 2023 – Present)	Specialist Group Member	Department of Health
Odhran McCarthy	Specialist Group Member	Psychology/MHS
Fiona McKernan (Sep 2021 – July 2023) Jessica Curtis (July 2023 – Present)	Specialist Group Member	HSE Mental Health Engagement and Recovery
Gillian O'Brien (Sep 2021 – Nov 2022) Conor Boksberger (Nov 2022 – Present)	Specialist Group Member	Youth Mental Health (Jigsaw)
Dr. Karen O'Connor	Specialist Group Member	HSE Clinical Programmes/AMHS/ Psychiatry
Brian O'Malley	Specialist Group Member	Nursing
Ian Power	Specialist Group Member	Youth Advocacy
Jim Ryan (Sep 2021 – Sep 2023) Dervila Eyres (Sep 2023 – Present)	Executive Sponsor	Head of HSE National Mental Health Operations
Michael Ryan	Specialist Group Member	HSE Mental Health Engagement and Recovery
Mark Smyth	Project Sponsor & Chair	CAMHS/Psychology
Margaret Sorohan	Specialist Group Member	National Human Resources Lead, National HSE Mental Health Operations
Siobhan Wells	Specialist Group Member	Occupational Therapy/CAMHS

Appendix 2: Terms of Reference

1. Introduction

The National Implementation Monitoring Committee (NIMC) Specialist Group on Youth Mental Health: Transitions has been established by the HSE Implementation Group, at the request of the NIMC Steering Committee on (date).

The particular focus of this Specialist Group is recommendation 36 of *Sharing the Vision:*

Appropriate supports should be provided for on an interim basis to service users transitioning from CAMHS to GAMHS. The age of transition should be moved from 18 to 25, and future supports should reflect this.

2. Purpose

The purpose of the specialist group is to support the implementation of this recommendation within agreed timeframes, and to provide advice to the NIMC Steering Committee on interim progress and associated recommendations.

3. Timelines

The NIMC Specialist Group on Youth Mental Health: Transitions will be allocated a set timeframe to complete this task, by which time the Group will present a final status report of the implementation of Youth Mental Health: Transitions, as well as any recommendations on further work associated with this service area. This timeframe will be agreed at the inaugural meeting of the Group.

4. Reporting

This Specialist Group will provide regular updates on this work to the National Implementation Monitoring Committee for 'Sharing the Vision' via the HSE Implementation Group as described in the NIMC Terms of Reference for Specialist Groups.

5. Scope

While other recommendations in *Sharing the Vision* are relevant to the mental health of children and young people, this particular recommendation will require a focused approach given some of the associated challenges, for example, relating to the current approach to the education and training of mental health professionals. For this reason, implementation of this recommendation and associated actions will be cognisant of other related recommendations and actions but will have a primary focus on the requirements of Recommendation 36. Related recommendations and actions are include as an appendix to this document.

6. Actions

The specific actions associated with this recommendation are (page 101, Appendix 3, *Sharing the Vision*):

a. Identify required additional supports for individuals transitioning from CAMHS to GAMHS at 18 years.

b. Produce transition plan in line with CAMHS COG.

c. Put in place a nominated key worker to support the transition plan.

d. Additional training provided to up-skill nominated keyworkers.

e. Develop a reconfiguration plan which will facilitate the provision of age-appropriate specialist mental health services up to age 25.

7. Workstreams

There are two main workstreams (and associated outputs) associated with the work of this Specialist Group

Workstream 1: Development of an enhanced transitions plan (including implementation plan) to support individuals transitioning from CAMHS to AMHS at 18 years.

Workstream 2: Development of a reconfiguration plan, including prioritised and phased recommended actions, in order to plan for the provision of age-appropriate specialist mental health services up to age 25.

8. Activities

Workstream 1:

a. In the short-term, and before services can be fully re-configured to a later age of transition, specify needs and additional resources where they are required to provide extra support to young people transitioning from CAMHS to general adult mental health services (GAMHS)

b. Consider the key challenges that individuals experience as part of transitioning from CAMHS to GAMHS.

c. Consider best practice in the support of the transitioning experience, with particular reference to the CAMHS Clinical Operating Guideline (HSE, 2018).

d. Consider the appointment of the role of Key Worker to support the development and implementation of a transitions plan for relevant individuals.

e. Advise, in some detail, on the required additional training of relevant HSE staff to support the competencies and skills in the role of transitions Key Worker.

f. Provide a final report and associated implementation plan.

g. Establish HSE Project Group(s) to support different aspects of this work as required.

Workstream 2:

a. Consider all elements of service provision as they relate to current and likely future demand for CAMHS, the nature of CAMHS service provision, the potential for enhanced upstream mental health support provision to reduce the need for CAMHS and the potential for innovative approaches to service delivery, with a focus on recovery, which would improve the experience of and outcome for young people requiring mental health service support.

b. Prepare a detailed plan which will facilitate the provision of age-appropriate specialist mental health services in alignment with the overall timeframe and approach of both Sharing the Vision and Sláintecare. This may involve the development of a plan to establish a new Youth Mental Health Service, depending on the consideration and consensus of the Specialist Group.

c. Incorporate an analysis of the Mental Health Clinical Care Programmes as they relate to CAMHS, and ensure that service re-configuration complements the ongoing implementation of these Clinical Care Programmes.

d. In the course of their work, take account of workforce planning as integral to CAMHS and mental health service delivery in general.

e. Take account of the current arrangements for the training and education of health professionals as it relates to different population groups across the lifespan and identify solutions that are likely to be required to ensure that the age of transition can be increased to 25 years old.

f. Consider the experience of, and outcomes for, young mental health service users up to the age of 25 to inform the recommendations of this Specialist Group.

g. Establish project groups to support different aspects of this work as required.

Appendix 3: Summary of Consultations

When	Who	How
Q1 2022	Stakeholders and Staff (Group 1)	Online workshop facilitated by the Department of Health
Q1 2022	Stakeholders and Staff (Group 1)	Online workshop facilitated by the Department of Health
Q3 2022	Young People	Online questionnaire facilitated by Spunout
Q3 2022	Young People	Focus Group facilitated by Spunout
Q4 2022	Stakeholders and Staff (Group 1)	Online workshop facilitated by the Centre for Effective Services (CES)
Q3 2023	Young People	In person workshop facilitated by Spunout in Croke Park
Q3 2023	Stakeholders and Staff (Group 2)	In person workshop with support from Spunout & CES
Q4 2023	Parents and Caregivers	Online focus group

Group 1 Stakeholders*

- Psychiatry
- Nursing (CAMHS Cork, Galway, Roscommon, Mayo)
- Psychology (CAMHS & AMHS)
- Speech & Language Therapy (CAMHS & AMHS)
- Social Work
- Dietetics (CAMHS & AMHS)
- Union of Students in Ireland
- Psychological Counsellors in Higher Education in Ireland
- HSE National Clinical Advisor and Group Lead for Children and Youth Health
- HSE ADHD Clinical Programme
- ADHD Ireland
- Youth Advocacy Programmes Ireland
- Department of Further and Higher Education Research Innovation and Science
- National Parents Council Post Primary
- Tusla
- CAMHS Psychiatrist Community Healthcare West
- AMHS Psychiatrist Community Healthcare West
- Jigsaw
- Clinical Director CAMHS Inpatient
- Occupational Therapy CAMHS Inpatient
- Expert by Experience
- National Association of Principals and Deputy Principles
- Head of Service, HSE Mental Helath

* These reflect attendees, not the wider list of invited stakeholders

Group 2 Stakeholders*

* These reflect attendees, not the wider list of invited stakeholders

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Sharing the Vision

A Mental Health Policy for Everyone

Rialtas na hÉireann
Government of Ireland