



**August 2026**

**AsI Am Submission to the Mental Health Commission Consultation on the Draft  
National Standards on Child and Adolescent Mental Health Services (CAMHS)**

AsI Am, Ireland's Autism Charity, welcomes the opportunity to contribute to the Mental Health Commission's consultation on their draft National Standards for Child and Adolescent Mental Health Services (CAMHS). We welcome the Commission's extensive engagement throughout the development of these standards and its commitment to ensuring that the voices of children, young people, families and advocacy and representative organisations are reflected throughout the current draft Standards.

Mental health difficulties should not be an inevitable part of being Autistic. However, many Autistic children and young people experience mental health difficulties and co-occurring psychosocial disabilities, which are compounded by the barriers they already experience within society. Social isolation, exclusion, stigma, bullying, navigating long waiting lists for supports, and an education system that is too often neither inclusive nor accessible for Autistic people all contribute to the disproportionately high levels anxiety, depression, trauma and distress experienced by Autistic young people.

Mental health services play a crucial role in both responding to people experiencing mental health crises and ensuring that Autistic children and young people receive timely, compassionate and accessible support that vindicates their rights under the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities.

For many Autistic children and young people, CAMHS often represents a particularly significant interaction they have with the health system and with mental health services. While a positive experience can play a vital role in supporting Autistic people's mental health and wellbeing, negative experiences with mental health services can deepen Autistic people's trauma, discourage them from seeking support with their mental health and wellbeing, worsen any mental health difficulties and increase the risk of suicidality and self-harm. These concerns are consistently reflected in the experiences shared with AsIAm. One respondent told us:

*"The fact that me and my family have had to pay privately to get appropriate care since I was 13 as CAMHS did far more harm than good. It's stiflingly expensive and took a very long time and trauma to find people who could keep me above water."*

Other experiences from our community include:

*"Family member was rejected by CAMHS as needed different service but not told what that was and we were just left hanging."*

*"CAMHS reluctant to see autistic people with mental health issues."*

*"Currently waiting to be accepted by CAMHS but refusing due to autism diagnosis."*

AsIAm welcomes that the draft Standards shows a significant shift towards building a more rights-based, child-centred and trauma-informed model of support. The explicit recognition of trauma-informed practice, the need for accessible mental health supports for Neurodivergent people, and that young people should actively participate in making decisions relating to their mental health marks significant steps forward in ensuring that CAMHS is better equipped to meet the needs of Autistic children and young people.

The draft standards also rightly recognise that, while clinical expertise plays an important part in delivering mental health services, the best outcomes are delivered by listening to children and young people, working in partnership with both young people

and their families and supporters. This approach helps ensure that processes around how decisions are made and communicated are more accessible, that there is better coordination between services. This also ensures that services take a life course approach to meeting the young person's mental health needs and that young people do not feel judged or dismissed.

AsIAM believes that there are several areas where the Standards can be strengthened before they are finalised. Whilst there are key areas where the Standards develop strong principles, they do not currently specify how these Standards should be implemented, monitored and enforced. This is particularly concerning that Autistic children and young people's experiences of mental health services continue to be shaped by where they live, what mental health supports they need and whether clinical professionals possess the requisite training and professional expertise to adequately support our community.

Through our engagement with Autistic people and families, AsIAM continues to hear from community members of having to experience fragmented pathways between CAMHS, Children's Disability Network Teams (CDNTs), Primary Care and other services. Many families must navigate extensive waiting lists with little to no supports, lack of accessible information in relation to their supports and differences in understanding of autism among professionals. The final Standards should set clearer expectations regarding who is responsible for delivering services, what accommodations or supports young people should expect to access, how young people would be supported to make decisions regarding their healthcare and wellbeing, and have clear expectations on how the principles set in the current standards should be translated into practice.

Every Autistic child and young person should be able to access mental health services where they feel safe, understood, listened to and treated with dignity. They should not have to reach crisis point before receiving support, repeatedly explain their circumstances to different services or have their distress misunderstood.

The final National Standards provide an important opportunity to establish a clear benchmark for compassionate, rights-based and neuro-affirmative mental healthcare

in Ireland. AsIAM hopes that the recommendations in this submission will support the Mental Health Commission in strengthening the Standards to realise this ambition.

### **AsIAM's Observations on the Draft National Standards**

AsIAM believes that the Draft National Standards for Child and Adolescent Mental Health Services mark significant progress towards making mental health services in Ireland more accessible to Autistic children and young people. The Standards set out a vision for CAMHS which is grounded in children's rights and disability rights, and to continually improving services to better meet young people's needs. Importantly, many of the issues highlighted by Autistic people, families and Disabled Persons Organisations, and other representative bodies during the scoping consultation are now included throughout the draft framework.

We particularly welcome that the Standards show a clear shift away from taking a medicalised approach and towards a more rights-based understanding of children's mental health and wellbeing. Rather than simply focusing on diagnosis and treatment, the Draft Standards places a stronger focus on supporting the participation of children and young people in their mental healthcare, making the processes around mental health more accessible, the focus on neuro-affirmative and trauma informed support and promoting crisis prevention and recovery-oriented approaches.

Notwithstanding, AsIAM believes the National Standards would benefit by being more specific in setting out how these standards will be implemented and how services will be regulated in practice. Many standards describe what mental health services should aspire to achieve but do not consistently establish how services will demonstrate how they will measure their performance against these standards or how children and young people's experiences will be measured.

For Autistic children and young people, this distinction is particularly important. A commitment to accessible communication, neuro-affirmative practice or reasonable accommodation will have limited impact unless services are equipped, resourced and required to demonstrate how these principles are being applied in practice.

The following sections consider these issues in greater detail across the relevant themes of the Draft Standards.

## **Safety and Wellbeing**

AsIAM strongly welcomes the strong focus the Mental Health Commission places on safety and wellbeing throughout the Draft National Standards. These standards recognise that rights-based, compassionate mental health services should include relationships where Autistic children and young people are treated with dignity and respect, as well as clinical supports provided by professionals. They also recognise the importance of actively involving children and young people in all decisions relating to their mental health and wellbeing, which will ensure they receive continuity of support from clinical professionals working across services.

However, AsIAM believes that the concept of safety within the final Standards should be broadened further to recognise the specific experiences of Autistic children and young people accessing CAMHS. For many Autistic children, feeling safe also means feeling psychological safety where they feel that they are being listened to by professionals, that services understand and meet their communication preferences. It also means that services are accessible environments that accommodate their sensory needs and know that professionals who understand autism and are that they will listen to them without judgement or prejudice. These are vital to ensuring that children are unlikely to participate meaningfully in assessments or therapeutic support.

A child who is overwhelmed by their environment, cannot communicate in ways that work for them or is concerned or anxious that they would be misunderstood would not be able to fully participate in their mental healthcare, regardless of whether the clinical support will meet their needs.

Psychological safety should therefore be recognised as a fundamental component of building rights-based mental health services alongside physical and clinical safety. Accordingly, AsIAM recommends that the final Standards explicitly recognise psychological safety as a core outcome of CAMHS. We believe that services should be

required to show how they create environments that are predictable, accessible, respectful and responsive to every child's communication, emotional and sensory needs.

### **Embedding neuro-affirmative practice across CAMHS**

AsIAm welcomes the inclusion of neurodivergence and neuro-affirmative practice within the draft Standards. This marks significant progress from the traditional deficit-based or compliance-based approaches that we have witnessed throughout our mental health system. These approaches seek to make an Autistic person fit into neurotypical norms, rather than recognising autism as a different way of thinking and understanding the world and as a natural part of human diversity.

However, while the Standards currently describe neuro-affirmative practice as a principle, this principle needs to be supported by further guidance establishing clear expectations on what neuro-affirmative mental health services look like in clinical practice. While recognising the impact that neurodivergence has on an Autistic person's mental health is an important first step, implementation will ultimately determine whether Autistic children experience meaningful improvements in the mental healthcare they receive and if they feel safe and supported when accessing supports.

The need for more consistent implementation is clear from the experiences of families engaging with CAMHS, as well as from Autistic people themselves. Community members frequently described services where autism was poorly understood and where professionals did not feel confident in supporting Autistic young people:

*"Complete mis and lack of ND understanding and zero training."*

Another respondent commented simply:

*"Lack of education in CAMHS."*

The [British Psychological Society](#) recently published a series of articles promoting neuro-affirmative practice, in which they highlight that clinical professionals can

support both Autistic people and Neurodivergent people sensitively and which respects their right to live in society as they are.<sup>1</sup> Some of these include:

- Recognise Autistic peoples' experiences as a different way of experiencing and understanding the world, not a 'disorder' needing to be fixed or treated.
- Assessments and supports for Autistic people should move away from pathologising Autistic ways of being towards promoting self-advocacy and a positive Autistic identity, with supports addressing their access needs.
- Respecting Autistic culture and identity and engaging with Autistic people to ensure that they are at the core of designing and accessing supports that meet their needs and vindicate their rights.
- Moving away from using therapies which cause harm to Autistic people or whose goal is to make an Autistic person appear more neurotypical (Applied Behavioural Analysis and similar behaviour-based and compliance-based therapies, social skills training).
- Developing a positive Autistic identity, and advocating for changes to policies, practices, and attitudes to promote the rights of Autistic people.

The [National Autism Implementation Team](#) in Scotland have developed extensive good practice in making mental health services more neuro-affirmative, including [guidance on developing neuro-affirmative assessments and reports](#). For CAMHS to be neuro-affirmative in real terms, clinical professionals need to recognise and support Autistic people's different communication styles, their sensory processing differences, how they emotionally regulate themselves and any wider support needs they have. What may be interpreted by professionals as non-compliance or emotional dysregulation may reflect an Autistic person experiencing sensory overload, anxiety, distress, or Autistic burnout which may have accumulated over time. Equally, clinicians should recognise that many Autistic young people who mask may be more anxious or

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<sup>1</sup> Hartman, D., O'Donnell-Killen, T., Doyle, J. K., Day, A., Kavanagh, M., Azevedo, J. 'What does it mean to be neurodiversity affirmative?', British Psychological Society, January 2024, [What does it mean to be neurodiversity affirmative? | BPS](#) (accessed 16 May 2024)

distressed than they appear during appointments, increasing the risk that their mental health support needs remain unnoticed until they may reach crisis point.

Neuro-affirmative practice also means that services should also focus on supporting an Autistic person's overall wellbeing as their authentic Autistic selves, rather than expecting them to fit into neurotypical expectations or conform to stereotypes. Mental health services should strengthen an Autistic person's right to autonomy, build their confidence and self-esteem and support their participation, but also challenge stigma and negative stereotypes that undermine their wellbeing and perception of themselves.

For neuro-affirmative practice to be embedded across CAMHS, the standards should require all staff to receive mandatory education on autism, neurodiversity and neuro-affirmative practice as part of both their induction and their continuing professional development. This training should extend beyond clinical training to include practical guidance on accessible communication, sensory needs, trauma, autistic burnout, reasonable accommodations and care planning.

### **Autism is not a mental health condition**

One of the more significant barriers that Autistic children experience when accessing CAMHS is diagnostic overshadowing – where their experiences of mental health difficulties may be attributed to autism, or where a professional may attribute a person's experience of their autistic traits to a psychosocial disability or as evidence of mental ill-health.

Autistic children can frequently experience anxiety, depression, trauma or other mental health difficulties arising from some the barriers highlighted earlier. However, if professionals assume that emotional distress is simply "*part of autism*", children may experience significant delays in accessing mental health support. Equally, autistic traits should not automatically be interpreted as evidence of deteriorating mental health.

Clinical professionals need to possess sufficient competencies around autism to distinguish between autism, trauma and mental health difficulties while recognising that these experiences may coexist and interact. Assessments should seek to

understand changes in a child's wellbeing in the context of their Autistic identity, as well as any communication or sensory processing differences they have, and the impact of their sensory environment.

The standards should require CAMHS professionals to consider these factors during assessment, care planning and follow-on support when working with Autistic young people. Services should also ensure that multidisciplinary expertise where necessary.

### **Trauma-informed care should recognise adverse experiences Autistic people may experience in healthcare and education**

AsIAM strongly welcomes the Commission's decision to place focus on trauma-informed care throughout the Draft National Standards. For many Autistic children and young people, trauma may arise from both negative or adverse experiences, and from the cumulative impact of feeling isolated, being bullied in school, being excluded from activities, facing extended periods without support, repeatedly recounting distressing experiences, while undergoing the assessment process, experiencing sensory overwhelm within healthcare settings, being subjected to restrictive practices, or feeling judged or dismissed.

These cumulative experiences can shape how children engage with mental health services - for example, a young person who has repeatedly felt dismissed or misunderstood may find it more difficult to trust clinicians or not feel safe to share where they may feel vulnerable or need support with. Reflecting these experiences, one young Autistic person who engaged with AsIAM described CAMHS appointments as feeling *"like being on trial in a court case"*.

Trauma-informed care should therefore recognise that services themselves have the potential either to promote healing or inadvertently contribute to re-traumatisation. Every interaction with CAMHS should seek to reduce uncertainty, provide clear and accessible communication, ensure that there is continuity of care and children do not have to repeat their personal histories and maximise children's sense of choice, autonomy and control.

AsIAM particularly welcomes the standards' recognition that continuity of care, integrated working and family-centred support contribute to children's wellbeing. These commitments should be further strengthened by stating that trauma-informed practice should shape all stages of how they engage with CAMHS.

### **Preventing crisis through coordinated, multidisciplinary care**

AsIAM welcomes the standards' emphasis on multidisciplinary working, coordinated care and timely crisis support. The recognition that children should receive integrated support addressing their physical, mental and social wellbeing reflects contemporary evidence that positive mental health outcomes depend upon coordinated responses rather than isolated clinical interventions.

However, CAMHS should not primarily be measured by how effectively it responds once children reach crisis. Instead, services should be judged by how successfully they prevent crises from occurring through early intervention, continuity of care and coordinated support across health, disability, education and community services.

For many Autistic children, crises develop gradually following prolonged periods of not having their needs met, being misdiagnosed or having their diagnosis missed. Families frequently describe being referred between CAMHS, Children's Disability Network Teams and Primary Care services without any single service assuming responsibility for meeting the child's mental health needs. During this period, distress may escalate significantly despite multiple opportunities for earlier intervention.

The standards' commitment to integrated care and interagency collaboration represents an important opportunity to address this longstanding challenge. AsIAM recommends strengthening these provisions by making explicit that organisational boundaries should never delay or prevent access to mental healthcare. Where uncertainty exists regarding what service would be best placed to meet the young person's support needs, children should continue to receive support while services coordinate their response and be in constant communication with the child.

Similarly, multidisciplinary practice should move beyond consultation between professionals towards genuinely sharing responsibility for children's wellbeing. Psychologists, occupational therapists, speech and language therapists, social workers, nurses, psychiatrists and other professionals each contribute distinct expertise that should inform holistic care planning. This collaborative model is particularly important for Autistic children, whose mental health may be influenced by communication needs, sensory processing, family circumstances, educational experiences and broader environmental factors.

### **Theme Three – Accessibility, Equity and Timely Access to Mental Health Services**

#### **Access delayed is access denied**

High-quality, accessible mental healthcare is only meaningful if children and young people can access it when they need it, in environments that respond to their individual needs and uphold their dignity and wellbeing.

AsIAm welcomes the draft standards' recognition that services should be designed around the needs of children and young people rather than expecting children to adapt to services. This represents an important shift towards a rights-based understanding of accessibility and reflects Ireland's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), particularly Articles 9, 19, 21, 25 and 26. Nevertheless, the final standards should go further in ensuring that accessibility is embedded as a measurable expectation across every aspect of CAMHS.

For too many Autistic children, barriers to accessing mental health services begin long before they meet a clinician. Families frequently describe navigating complex referral pathways, repeated assessments, uncertainty regarding service eligibility and prolonged waiting periods while organisations determine which service is responsible for providing support. These barriers can allow mental health difficulties to escalate, often resulting in children only receiving support when they have reached crisis point or when their wellbeing deteriorates. The case study of a community member's experiences in trying to get support for their son Rían highlights the tribulations that

many families within our community face when their loved one faces when their Neurodivergence impacts their ability to access mental health support:

### **Case Study: Rían**

An Autistic child, Rían, was referred to CAMHS for an additional assessment of ADHD. The service's initial process involved 2 screening questionnaires, the first of which was completed by his parents and school. Although the information indicated that child had traits that were consistent with ADHD, Rían's case was initially closed on the basis that these were better explained by his earlier diagnosis of autism, and that further assessments were not needed at the time.

"While features of ADHD are certainly true of *Rían* from the information provided these are better accounted for by his existing confirmed neurodivergences."

Notes from his files revealed that the decision to curtail the original screening and triage process was made upon receiving the school report, before the parents' report was available. Following a complaint from Rían's family about the curtailed process, the case was reopened and further screening information was provided. However, the family subsequently received a decision that the clinic would not give further consideration to a potential ADHD diagnosis. The letter closing the case was sent within 24 hours of the screening questionnaire being completed. Notes from his files highlighted that the decision was made in minutes and was not discussed by a multidisciplinary team. They were concerned that the information had not received sufficient clinical consideration and that Rían's autism had overshadowed consideration of a possible co-occurring condition.

Rían's family raised concerns about how the clinic screened and assessed him, including whether sufficient account had been taken of how he presented across different settings and the possibility of masking. They were also concerned that the complex screening information appeared to have been processed very quickly and without any evidence of multidisciplinary assessment. In addition, they reported being directed towards another service because of Rían's autism, despite a previous multidisciplinary Assessment of Need having already considered this service unnecessary and despite having been discharged from all other community supports as they were not required.

"The Team have stated that, if the clinical picture should remain following intervention from CDNT, they would be very happy to accept a re-referral and screen Rían for ADHD"

Rían's family decided to pursue an alternative assessment, where a multidisciplinary team considered their referral and placed the child on a waiting list for ADHD assessment.

Case like this and like what many Autistic people and families experience show why why final Standards should set clear expectations for monitoring waiting times for monitoring waiting times across all stages of accessing CAMHS. Where children face significant delays, services should provide regular communication to young people and their families, interim supports and clear information about when and how support will be provided, in line with commitments made under the [\*Sharing the Vision Implementation Plan\*](#).

### **Accessibility must be understood as more than physical access**

AsIAm strongly welcomes the draft standards' commitment to accessibility. However, accessibility should be understood as a comprehensive principle that extends across every interaction a child has with CAMHS.

For Autistic children, barriers frequently arise through inaccessible communication, unfamiliar clinical environments, sensory overload, inflexible appointment processes or assumptions regarding communication styles rather than through physical access alone. Children may require more information in plain language, visual supports, additional processing time, alternative methods of communication or modifications to appointment environments to participate meaningfully in assessments and treatment.

Reasonable accommodations should therefore be viewed as fundamental components of safe and effective healthcare rather than discretionary adjustments made only when requested. Many Autistic children and families may not know which accommodations are available or may feel reluctant to request adjustments because of previous experiences of stigma or misunderstanding.

The standards should therefore require CAMHS services to proactively identify, discuss and implement reasonable accommodations from the point of referral onwards. This should include consideration of communication preferences, sensory needs, appointment scheduling, waiting environments, information formats and family involvement.

Accessibility should become a measurable outcome of service quality rather than an aspirational principle. Services should be expected to demonstrate that children receive information in formats they understand, that accommodations are consistently implemented and reviewed, and that children report feeling able to participate fully in their care.

### **Ending fragmented pathways between CAMHS, CDNTs and Primary Care**

AsIAm strongly welcomes the inclusion of a *"No Wrong Door"* approach within the Draft Standards. This reflects one of the most consistent concerns raised by Autistic children, families and professionals, and is particularly important for Autistic children, who may require support from CAMHS, Children's Disability Network Teams (CDNTs), Primary Care and other services at the same time.

Despite improvements across the health service, many Autistic children continue to experience fragmented referral pathways between CAMHS, CDNTs, Primary Care and other community-based services. Families frequently report being redirected between services because responsibility for meeting a child's needs is disputed. This can pose particularly particular concerns where a child's autism and mental health needs coexist. Too often, children encounter situations where CAMHS may deem their needs to be primarily disability-related while children who present to disability services may find that services may consider their support needs to be primarily mental health-related.

For children experiencing anxiety, depression, self-harm or emotional distress, which Autistic people are more likely to experience, these delays can have profound consequences. Mental health needs rarely remain static while waiting lists or referral

disputes are resolved. Instead, they frequently become more complex, requiring greater intervention later that may have been avoided through timely support.

AsIAM therefore recommends that the final standards explicitly prohibit services from refusing assessments or follow-on supports solely because a child has an autism diagnosis, an intellectual disability, other forms of Neurodivergence including ADHD or complex support needs. Mental health services should remain responsible for responding to an Autistic child or young person person's mental health support needs regardless of their diagnosis, difference or disability.

Similarly, where uncertainty exists regarding which service is best placed to coordinate care, the Standards should require children to continue receiving support while services collaborate to determine appropriate pathways. The Standards should also make clear that the child being Autistic or their disabilities or support needs should never be grounds for services refusing access to mental health assessments or support, particularly where the child is having difficulties with their mental health and wellbeing.

### **Timely support vital to addressing the mental health crisis among the Autistic community**

AsIAM welcomes the recognition throughout the draft standards that timely access to mental healthcare is essential to achieving positive outcomes. However, the standards should establish stronger expectations regarding waiting times and supporting children to access interim supports whilst waiting for the supports they need.

Long waiting periods are not neutral experiences. For many children, extended delays mean that their mental health and wellbeing deteriorates, taking a toll on their family, their education is more likely to be disrupted, and they are more likely to experience a mental health crisis. For Autistic children, having to fill in the blanks themselves of how trying to access mental health support may go may also increase anxiety, emotional dysregulation and disengagement from education and feeling supported within their community.

Children should not have to become significantly more unwell before services consider them to be eligible for support.

The standards should therefore require services to monitor waiting times from referral through assessment, intervention and ongoing review. Where waiting times exceed nationally agreed thresholds, children and families should receive meaningful interim supports, regular communication regarding expected timelines and opportunities to access community-based interventions where appropriate.

### **Equitable mental health services requires understanding intersectionality**

AsIAm welcomes the draft standards' recognition that children and young people experience mental healthcare differently depending on their identity, culture and circumstances.

Autistic children are not a homogenous group. Many children also experience additional barriers relating to intellectual disability, ADHD, physical disability, ethnicity, socioeconomic disadvantage, gender identity, sexual orientation or membership of the Travelling, Roma or migrant communities. These intersecting identities may increase the likelihood of unmet mental health needs while simultaneously making services more difficult to access.

Equity therefore requires more than providing identical services to everyone. It requires services to identify where barriers exist and proactively adapt their practices to ensure that every child can participate equally and not feel further stigmatised or discriminated against needing support with their mental health.

The standards should require services to routinely collect and publish disaggregated data on access, waiting times, outcomes and experiences for different groups of children. Without meaningful data, inequalities remain hidden and opportunities for improvement are lost.

### **Communication is an accessibility issue**

Communication should be treated as core part of making mental health services more accessible.

Accessible communication should go beyond providing information in Easy-to-Read. It should encompass every interaction between professionals and children, including how questions are asked, how information is explained, how consent is supported and how decisions are communicated.

The standards should therefore require clinicians to ask children about their communication preferences, routinely provide written summaries following appointments, offer visual supports where appropriate and allow sufficient time for information processing and routinely ensure that the child understands how they are being supported. Services should also recognise AAC and visual communication and other communication methods as equally valid ways for children to express their views and preferences.

Children should not leave appointments unsure of what has been discussed, what decisions have been taken or what will happen next.

## **Theme Four – Assessment, Care Planning and Delivery of Supports**

### **High-quality mental healthcare must be personalised, holistic and rights-based**

AsIAm welcomes the emphasis placed throughout Theme Four on comprehensive assessment, multidisciplinary care planning and service delivery which places the Autistic young person at the centre. The standards recognise that children and young people should receive coordinated support that reflects their individual strengths, needs, preferences and goals.

For Autistic children and young people, effective mental healthcare cannot be separated from the broader contexts in which they live, learn and develop. Mental health is influenced not only by clinical factors but also by family relationships, educational experiences, communication needs, sensory environments, social

inclusion, access to supports and experiences of stigma or exclusion. AsIAM therefore strongly welcomes the draft standards' recognition that assessment and care planning should consider the child within the context of their life rather than focusing solely on diagnosis or presenting symptoms.

This life course approach should inform both assessment and intervention models and include that clinicians also consider supports that help Autistic people meet their sensory processing or executive functioning support needs, and how this will interact with their support plan.

### **Assessment should support understanding, not simply diagnosis**

AsIAM welcomes the recognition that assessment is crucial to delivering safe and effective mental healthcare. However, assessments should not be viewed merely as mechanisms for identifying diagnoses or determining whether Autistic children and young people are eligible for services. Instead, they should serve as opportunities to develop a comprehensive understanding of a child's experiences, strengths, challenges and aspirations.

For many Autistic children and families, assessments can be stressful, repetitive and emotionally demanding, where they are often required to recount distressing experiences to multiple professionals, or prove the legitimacy of their child's needs.

The final standards should stipulate that assessments should be collaborative, strengths-based and proportionate. Professionals should seek to understand what matters to the child, what is contributing to their distress, what supports are already working well and what outcomes the child hopes to achieve.

Assessment processes should also recognise that Autistic children may communicate distress differently from their neurotypical peers. Some children may internalise difficulties, making anxiety or depression less visible, while others may communicate

distress through changes in their routine, emotional regulation, school attendance or social participation.

Most importantly, assessments should lead to meaningful support. Children and families should never without support because an assessment process has identified their needs.

### **Care planning must be genuinely co-produced and involve young people from the outset**

AsIAm strongly welcomes the standards' commitment to person-centred care planning and partnership with children, young people and families.

However, care plans should be genuinely co-produced with children and young people and reflect their expressed will, preferences, goals and priorities. Too often, care planning processes focus on what professionals believe is important rather than what matters most to the child themselves.

For Autistic young people, goals may extend beyond symptom reduction or clinical outcomes. A young person may wish to feel more confident attending school, build friendships, participate in community activities, manage sensory overwhelm more effectively or improve their understanding of their own emotions. These aspirations should be recognised as legitimate and meaningful outcomes within care planning processes.

The standards should therefore require that every child has an individualised support plan that:

- is developed collaboratively with the child and family;
- reflects the child's own goals and priorities;
- identifies reasonable accommodations and communication supports;
- outlines responsibilities across the multidisciplinary team;
- is reviewed regularly; and

- can be amended when circumstances or priorities change in collaboration with the child and their family.

Children should also receive accessible copies of their care plans and understand how decisions have been reached.

### **Multidisciplinary care should be the standard, not the exception**

AsIAm welcomes the Draft Standards' recognition of multidisciplinary working as a cornerstone of effective CAMHS provision. For Autistic children and young people, effective support may require expertise from professionals across psychiatry, psychology, occupational therapy, speech and language therapy, social work, nursing and other disciplines.

A multidisciplinary approach should involve professionals working alongside one another, working in concert during assessment, integrated care planning, shared decision-making, clear communication and collective responsibility for outcomes.

The final Standards should therefore establish clear expectations for coordinated multidisciplinary practice and identify responsibility for ensuring that children and families experience this as a consistent, seamless service rather than a collection of separate professionals.

### **Mental healthcare should not be overly medicalised**

AsIAm welcomes the Draft Standards' recognition that mental health and wellbeing are influenced by a wide range of factors beyond clinical intervention. This is important for many Autistic children, whose difficulties may arise from environmental barriers, unmet support needs or navigating structural barriers.

Services should therefore seek to understand what is contributing to distress before determining the most appropriate intervention. Clinical and therapeutic interventions should be considered alongside communication supports, sensory

accommodations, educational adjustments, family supports, community participation and opportunities for social connection for the young person being supported.

This approach helps to ensure that CAMHS remains focused on supporting wellbeing and participation rather than expecting the child to change who they are, particularly where their autistic characteristics do not cause harm or distress to themselves or others.

### **Continuity and coordination improve outcomes**

Continuity and consistent relationships are particularly important for Autistic children and young people, many of whom may find changes in professionals, environments or routines stressful and create additional anxiety and disrupt their confidence in the system.

The final Standards should therefore require clear arrangements for coordinating care, including the identification of a named professional who can act as a point of contact for the child and family and information sharing between professionals supporting the young person. Where changes happen between professionals, teams or services, children should be supported through a structured handover process that minimises any disruption or uncertainty.

## **Theme Five – Transitions, Continuity of Care and Lifelong Mental Health Support**

### **Continuity of care should not end when childhood does**

AsIAm welcomes the focus placed throughout Theme Five on continuity of care and the transition between CAMHS and Adult Mental Health Services (AMHS). For Autistic young people, transition often happens alongside other significant changes. Moving into adulthood may coincide with finishing school, entering further or higher education, seeking employment, changes in family supports, developing personal relationships and receiving greater independence and freedom to make decisions for themselves.

For many young people, these cumulative changes can increase anxiety, emotional distress and vulnerability to mental ill-health if they are not supported.

Transition should therefore be understood as a process rather than an administrative transfer between services. The success of a transition should be measured by whether the young person continues to be supported throughout these changes, rather than simply whether a referral has been completed.

The final Standards should require that transitions be planned, coordinated and individualised, with a greater focus on maintaining continuity of relationships, flexibility and the young's readiness to take the next step forward and navigate change with confidence.

### **Autistic young people should only transition to Adult Mental Health Services when Ready**

One of the most significant barriers experienced by Autistic young people is the sudden transition that often occurs when they reach eighteen years of age, and they begin to age out of CAMHS and children's disability services. Despite the arbitrary nature of this age threshold, many services continue to operate on the assumption that adulthood begins immediately upon reaching a particular birthday.

For many Autistic young people, this approach fails to reflect their individual circumstances. While some young people may feel confident and prepared to transition to adult services before they turn eighteen, others may require additional time and support to develop trusting relationships with new professionals, understand changes in service delivery or adjust to increased expectations of independence.

AsIAm believes the final standards should make clear that transitions should be determined by whether the young person's feels safe and supported to make the transition to Adult Mental Health Services. Services should adopt flexible approaches that recognise the diversity of young people's experiences and avoid creating unnecessary disruption at a time when stability may be particularly important.

Turning eighteen should never result in a sudden loss of trusted relationships or interruption to essential mental health supports. Instead, transitions should be gradual, predictable and individually tailored, ensuring that young people feel confident and supported throughout the process.

### **Planning to move to Adult Mental Health Services should begin well before transition occurs**

AsIAm strongly welcomes the draft standards' recognition of the importance of planning. Effective transitions cannot be achieved through referrals made shortly before discharge. They require meaningful preparation over an extended period, allowing young people to understand what will change, ask questions and gradually build relationships with future services.

Transition planning should begin well in advance of any proposed transfer to Adult Mental Health Services. Plans should be developed collaboratively with the young person and, where appropriate, their family or chosen supporters. They should identify the young person's aspirations, communication preferences, sensory needs, reasonable accommodations and any concerns they may have regarding transition.

Importantly, transition plans should be living documents rather than administrative checklists. They should be reviewed regularly, adapted as circumstances change and remain centred on the young person's expressed will and preferences.

Young people should also receive accessible information explaining how adult services differ from CAMHS, what supports will continue, what new expectations may arise and who they can contact if difficulties emerge during the transition process.

### **Keeping strong, trusted relationships with professionals supports Autistic people's mental health and wellbeing**

For many Autistic young people, trusting relationships with professionals develop gradually over time. Continuity of these relationships often plays a significant role in supporting emotional wellbeing, engagement with therapy and willingness to seek help.

Transitions that involve abrupt changes in clinicians, environments or approaches can undermine these relationships and increase anxiety at precisely the time when additional support may be required.

Wherever possible, the standards should encourage overlap between CAMHS and Adult Mental Health Services, including joint appointments, shared care planning and opportunities for young people to meet future professionals before formal transfer occurs. Such approaches help reduce uncertainty while promoting continuity and confidence.

Similarly, CAMHS should not discharge a young person until adult services have formally accepted responsibility for their care and arrangements are in place to ensure uninterrupted access to mental health support.

The success of a transition should therefore be measured not simply by the completion of administrative processes, but by the young person's experience of continuity, stability and ongoing support.

### **Supported decision-making should underpin every transition**

AsIAm welcomes the emphasis placed throughout the draft standards on involving young people in decisions relating to their care. This principle is particularly important during transitions between CAMHS and Adult Mental Health Services.

Transition planning should reflect the young person's own aspirations, preferences and priorities. Young people should receive accessible information about available options and sufficient time to consider decisions regarding their future care. They should be supported to participate actively in planning rather than being passive recipients of decisions made on their behalf.

For some young people, supported decision-making may involve additional time to process information, accessible communication, visual supports or the involvement of trusted supporters. These supports should be viewed as enabling their autonomy facilitating their right to make decisions relating to their wellbeing.

Family members frequently play an important role in supporting young people during transition. However, their involvement should continue to be guided by the young person's will and preferences, recognising that autonomy and family support are complementary rather than competing principles.

The standards should therefore explicitly require transition planning to uphold the young person's right to legal capacity under Article 12 of the UNCRPD throughout every stage of the process.

### **Mental healthcare should not end because organisational responsibility changes**

A transition between services should never result in a gap between mental health services. Young people should not lose access to support because eligibility criteria change, a waiting list begins again or responsibility transfers from CAMHS to Adult Mental Health Services.

CAMHS should not discharge a young person until appropriate arrangements for ongoing support have been confirmed. Where adult services cannot immediately provide this support, interim arrangements should remain in place. When a young person's needs do not align neatly with existing service structures, organisations should collaborate to develop solutions rather than leaving young people without support.

### **Transitions should extend beyond healthcare**

While the primary focus of the standards is the transition between CAMHS and Adult Mental Health Services, AsIAM believes that mental health services should also recognise the wider transitions occurring in young people's lives.

Leaving school, entering further or higher education, commencing employment or training, moving towards independent living and changes in family circumstances all have the potential to influence mental wellbeing. These life transitions may be particularly significant for Autistic young people, who often benefit from predictability, routine and continuity.

The standards should therefore encourage CAMHS and Adult Mental Health Services to work collaboratively with education providers, disability services, primary care, employment supports and community organisations to ensure that mental healthcare is integrated within broader transition planning.

Supporting young people through adulthood requires recognising that mental wellbeing is influenced by much more than healthcare alone.

## **Theme Six – Leadership, Governance, Accountability and Continuous Improvement**

### **Good standards require meaningful accountability**

AsIAm warmly welcomes the inclusion of a dedicated theme on leadership, governance and continuous quality improvement within the Draft National Standards. While the preceding themes establish an ambitious vision for child-centred, rights-based and accessible mental healthcare, Theme Six recognises that these young people's experiences will only improve where services are supported by strong leadership, effective governance and are accountable for implementing them.

For Autistic children and young people, this is particularly important given that their experiences of CAMHS can differ considerably depending on where they live, service capacity and the knowledge and confidence of individual professionals. The final Standards should therefore establish measurable expectations and transparent mechanisms for assessing whether services are delivering accessible, rights-based and neuro-affirmative care in their area.

### **Leadership should create cultures of rights, respect and inclusion**

Leadership within CAMHS should extend beyond organisational management. It should actively promote cultures in which children's rights are respected, diversity is valued and continuous learning is encouraged.

For Autistic children and young people, organisational culture has a profound influence on their experiences of care. Services that prioritise listening, flexibility, accessibility and collaboration are more likely to build trusting relationships and improve mental health outcomes. Conversely, cultures characterised by rigid procedures, poor communication or limited understanding of neurodiversity may inadvertently create barriers to participation and undermine children's confidence in mental health services.

AsIAm therefore welcomes the standards' emphasis on leadership responsibility for quality and safety. We recommend strengthening this further by requiring leaders to actively promote neuro-affirmative practice, supported decision-making, trauma-informed care and disability inclusion throughout organisational policies, workforce development and service delivery.

Leadership should also foster environments where staff feel supported to reflect on practice, learn from feedback and continuously improve services. Creating psychologically safe workplaces for staff is essential to delivering psychologically safe services for children and young people.

### **Quality improvement should be informed by children's experiences**

Quality improvement requires organisations to understand not only what services deliver, but how children and young people experience that care. While waiting lists, referrals or service activity are important, they do not necessarily indicate whether children feel listened to, whether they understand decisions about their care or believe services have improved their wellbeing.

The final standards should therefore encourage services to routinely measure outcomes that matter to children and young people themselves, particularly as they are experts in relation to their mental health and what care meets their needs.

This should include consideration of questions such as:

- Did the child feel safe during appointments?
- Did they understand the information provided?
- Were reasonable accommodations offered?
- Did they feel involved in decisions about their care?
- Did they feel that decisions made regarding their healthcare supported their right to autonomy and feel empowered to work with clinicians on an equal basis?
- Did they believe professionals understood their communication needs?
- Has the support improved their participation in everyday life?

### **Feedback should drive meaningful change**

AsIAm warmly welcomes the standards' recognition that children, young people and families should have opportunities to provide feedback on their experiences of CAMHS.

However, children should be able to see how their experiences influence service improvement.

Many Autistic children experience barriers to providing feedback through conventional consultation methods. Some may prefer written responses, visual supports, online engagement or alternative communication methods. Others may only feel comfortable sharing feedback after relationships with services have concluded.

The standards should therefore require multiple accessible mechanisms for gathering feedback, ensuring that every child can participate in ways that reflect their communication preferences and support needs.

Equally important is demonstrating how feedback has informed change. Organisations should routinely publish summaries outlining what children and families have told them, what actions have been taken and how improvements will be monitored. This

"You Said, We Did" approach promotes transparency, builds trust and demonstrates that participation has genuine influence.

### **Data should support equity and accountability**

The final Standards should clearly specify the information that CAMHS services are expected to collect, analyse and publish.

From an Autism perspective, services should routinely monitor:

- waiting times from referral to assessment and intervention;
- access for Autistic children and other disabled children;
- use of restrictive practices;
- transitions between CAMHS and Adult Mental Health Services;
- uptake of reasonable accommodations;
- complaints and compliments;
- children's reported experiences and outcomes.

Where possible, this information should be disaggregated by disability, ethnicity, gender, age and geographical location to identify inequalities in access or outcomes.

Collecting data should lead to action. Services should be expected to use findings to identify gaps, implement improvements and demonstrate progress over time.

### **Workforce development should support consistent implementation**

The principles highlighted throughout these Standards cannot be implemented consistently without an appropriately trained and supported workforce. AsIAm therefore recommends that workforce development should become an explicit component of governance and quality assurance.

Services should assess staff training needs, monitor completion of relevant education and provide ongoing opportunities for supervision, reflective practice and multidisciplinary learning. Workforce development should include autism, neuro-affirmative practice, disability rights, accessible communication, reasonable accommodation, supported decision-making and trauma-informed care. People with lived experience should have opportunities to contribute to training and workforce development.

### **Co-production strengthens governance**

Co-production should extend beyond individual care planning to also inform service design, governance, policy development and strategic decision-making across CAMHS.

Children and young people, including Autistic young people and those from other marginalised communities, should be represented in advisory structures, quality improvement initiatives and service development. Meaningful co-production requires investment, accessible engagement methods and ongoing support to enable participation, including preparation and reasonable accommodations. When implemented effectively, it strengthens accountability, improves service quality and ensures that mental health services continue to evolve in response to children's needs.

### **Recommendations**

AsIAm welcomes the significant progress represented by the Draft National Standards for Child and Adolescent Mental Health Services. Throughout this submission, we have highlighted the strong foundations established within the draft framework, including commitments to child-centred care, accessibility, trauma-informed practice, multidisciplinary working, participation and continuous improvement.

However, for these standards to deliver meaningful change for Autistic children and young people, they must move beyond principles alone and establish clear expectations for implementation, accountability and measurable improvement.

Standards are most effective when children and families can experience their impact in everyday interactions with services.

The recommendations below bring together AsIAM's key recommendations across the six themes of the draft standards.

**Recommendation 1:**

The final standards should explicitly recognise that autism is not a mental illness and require CAMHS services to distinguish between autism, psychosocial disability and mental health difficulties, trauma and distress.

**Recommendation 2:**

The final standards should embed neuro-affirmative practice as a core competency across all CAMHS services, with clear guidance on what this means in practice, including:

- recognising Autistic communication styles;
- understanding sensory processing differences;
- avoiding deficit-based interpretations of Autism or Autistic characteristics;
- recognising Autistic burnout, masking and cumulative stress;
- supporting autonomy and participation.

**Recommendation 3:**

All CAMHS staff, including clinical and non-clinical staff, should receive mandatory training as part of their training and professional development in autism and neurodiversity, disability rights, trauma-informed practice, supported decision-making, and accessible communication.

**Recommendation 4:**

The final standards should define accessibility broadly require CAMHS services to proactively identify and implement reasonable accommodations from the point of

referral onwards. This should include accessible communication and information, sensory accessibility, flexible appointments, additional processing time and alternative communication methods.

**Recommendation 5:**

The final Standards should require services to demonstrate that reasonable accommodations are consistently implemented, reviewed and adapted to meet the child's changing needs.

**Recommendation 6:**

The final standards should establish that autism, intellectual disability or complexity of presentation must never be used as a reason to refuse access to mental health support where a child is experiencing mental health difficulties.

**Recommendation 7:**

The final Standards should strengthen the “*No Wrong Door*” approach by requiring CAMHS, Children's Disability Network Teams, Primary Care and other relevant services to work collaboratively where a child has mental health and disability-related support needs. Where responsibility is unclear, the child should continue to receive appropriate support while services determine the most appropriate pathway. The Standards should also recognise the importance of timely access to autism assessment, in line with the [Autism Assessment and Intervention Pathways Protocol](#), where this can help inform appropriate mental health support and treatment, support understanding of a child's needs, and reduce the risk of misdiagnosis and missed diagnosis within our community.

The Mental Health Commission should monitor referral pathways and outcomes to identify where fragmentation is resulting in delayed or denied access to support.

**Recommendation 8:**

The final standards should explicitly recognise psychological safety as a core component of safe mental healthcare and require CAMHS services to demonstrate how

they create environments where children feel listened, believed, respected, and can communicate in ways that work for them.

**Recommendation 9:**

Trauma-informed practice should recognise the impact of healthcare-related trauma, educational trauma, bullying, exclusion and repeated experiences of misunderstanding on Autistic children and young people. Services should minimise re-traumatisation by ensuring consistency and continuity of support, providing predictable processes; accessible communication and promoting the young person's right to make decisions related to their healthcare.

**Recommendation 10:**

Assessments should be strengths-based, collaborative and focused on understanding the whole child rather than identifying diagnosis alone.

**Recommendation 11:**

Assessments should consider the interaction between mental health, autism, communication, sensory needs, family circumstances, education, social inclusion and environmental factors.

**Recommendation 12:**

Every child receiving CAMHS support should have an individualised care plan which is:

- co-produced with the child and family;
- accessible and understandable;
- based on the child's own goals and priorities;
- regularly reviewed;
- clear regarding responsibilities across professionals.

**Recommendation 13:**

The final standards should strengthen expectations regarding multidisciplinary working, ensuring that CAMHS provides coordinated input from relevant disciplines, including

psychology, psychiatry, occupational therapy, speech and language therapy, nursing and social work.

**Recommendation 14:**

Services should adopt a holistic approach to delivering mental health supports, recognising that supporting mental health may require addressing environmental barriers, sensory needs, education, social connection and family support which impact the young person's wellbeing alongside clinical interventions.

**Recommendation 15:**

Transitions between CAMHS and Adult Mental Health Services should be planned well in advance and should be based on the young person's readiness, needs and preferences. Each young person should have an individualised transition plan which includes their goals and priorities, communication preferences, reasonable accommodations, identified supports and responsibilities between services.

**Recommendation 16:**

CAMHS and Adult Mental Health Services should be required to engage in joint transition planning, including shared appointments, joint care planning introductions to new professionals and structured handover processes.

**Recommendation 17:**

No young person should experience a gap in mental healthcare due to transition between services. CAMHS should not discharge a young person until appropriate arrangements for ongoing support are confirmed, with interim supports where necessary.

**Recommendation 18:**

Children and young people should be recognised as active participants and rights-holders throughout all aspects of CAMHS, including assessment, treatment, transition planning and service evaluation.

**Recommendation 19:**

The standards should require meaningful co-production with children and young people, including Autistic children and young people, in service design, governance, quality improvement and policy development.

**Recommendation 20:**

Feedback mechanisms should be accessible and reflect diverse communication needs, including alternative formats and communication methods.

**Recommendation 21:**

Services should demonstrate how feedback from children, young people and families has influenced improvements through transparent reporting mechanisms.

**Recommendation 22:**

The final standards should establish measurable indicators to assess whether services are delivering accessible, rights-based and neuro-affirmative care.

**Recommendation 23:**

Quality measurement should include outcomes that matter to children and young people, including feeling safe, understood, actively involved in decisions;

- accessibility of services;
- improved participation and wellbeing.

**Recommendation 24:**

The Mental Health Commission should require services to collect and publish data relating to waiting times, outcomes for young people and children's experiences of accessing support.

**Recommendation 25:**

Data should be disaggregated where possible to identify inequalities experienced by disabled children, Autistic children and other marginalised groups.

**Recommendation 26:**

Governance structures should include meaningful representation from children and young people, families and people with lived experience of mental health services.