



An Ghníomhaireacht um
Leanaí agus an Teaghlach
Child and Family Agency



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

JOINT PROTOCOL FOR INTERAGENCY
COLLABORATION BETWEEN THE HEALTH
SERVICE EXECUTIVE AND TUSLA – CHILD AND
FAMILY AGENCY TO PROMOTE THE BEST
INTERESTS OF CHILDREN AND FAMILIES

Contents

1.0 HSE/Child and Family Agency Joint Working Protocol Group	4
1.1 Introduction	4
1.2 Terms of Reference	5
2.0 Background	6
3.0 Protocol Purpose	8
4.0 Legal and Policy Context	9
5.0 Overarching Principles	11
6.0 Core Operating Principles	13
7.0 Joint Working at Local level for Individual Cases.....	15
7.1 Principles.....	15
7.2 Purpose and Function of Joint Working on individual cases	18
7.3 Communication	19
7.4 Confidentiality and Information Sharing.....	20
7.5 Identifying lead agency and co-ordinating professional.....	20
7.6 Management of costs	21
7.7 Application to HSE Chief Officer/ Child and Family Agency Service Director for Additional Resources.....	21
7.8 Resolution of Disputes and Differences.....	21
8.0 Joint Working at Area level	22
8.1 Purpose and function.....	22
8.2 Complex Cases	22
8.3 Terms of Reference:.....	23
8.4 Membership of Area Joint Working Group	23
8.5 Chair.....	23
8.6 Area Level Process	24
8.7 Escalation to HSE Chief Officer/ Child and Family Service Director levels	24
9.0 Joint Working at HSE Chief Officer/ Child and Family Agency Director Level.....	25
9.1 Purpose and Function.....	25
9.2 Referral pathway.....	25

9.3 Terms of Reference	25
9.4 Membership	25
9.5 Chair and authority of final decision making	25
9.6 Protocol Process	26
9.7 Escalation to relevant HSE National Director(s)/ Child and Family Agency Chief Operations Officer	27
10.0 HSE National Director(s)/ Child and Family Agency Chief Operations Officer	28
11.0 Child and Family Agency Register	28
12.0 Implementation Plan	29
13. 0 Evaluation and Audit	30
13.1 Work programme of National Oversight Group	30
14.0 Protocol Agreement Between Agencies	31
15.0 Appendices:	32
Appendix 1 - A Brief description of services including roles and responsibilities	32
A. Child and Family Agency	33
B. Health and Wellbeing Division	36
C. Primary Care Division	39
D. Social Care Division – Disability Services	42
E. Mental Health Division	45
F. Acute Hospitals Division (Paediatric Services)	48
Appendix 2 - Process Map	49
Appendix 3 – References	50

1.0 HSE/Child and Family Agency Joint Working Protocol Group

1.1 INTRODUCTION

On the 23rd April 2015, the *Disabilities Protocol Group* convened for the first of a series of meetings to bring greater clarity to the application of the *Memorandum of Understanding – Strategic Agreement between Ireland’s Child and Family Agency and the Health Service Executive (HSE) (14th January 2014)* and *Joint Protocol for InterAgency Collaboration between the HSE and the Child and Family Agency to Promote the Best Interests of Families (14th Jan 2014)*.

The group was sponsored by Marian Meany (AND Disability Services HSE), Paul Harrison (Director of Policy and Strategy, Child and Family Agency) and Fred McBride (Chief Operating Officer, Child and Family Agency). Ann O’Shea (Primary Care Manager, HSE) and Paul Braham (Senior Operations Manager Mental Health Division, HSE) joined the group in mid-August 2015. The remit of the group was then broadened to include children and young people with mental health issues. The group was attended by:

Name	Role
Pat Bennett	Chief Officer, HSE (Chair)
Mary O’ Donnell	Disability Services Manager, Galway PCCC, HSE
Ann Bourke	Disability Specialist, Social Care Division, HSE
Sinead Lynch	Aftercare Coordinator Louth/Meath, Child and Family Agency
Paul Braham	Senior Operations Manager Mental Health Division, HSE
Ann O’ Shea	General Manager, Primary Care, HSE
Lorna Kavanagh	Area Manager, North Dublin, Child and Family Agency
Éanna O Brien	Director Children’s Residential Services, Child and Family Agency

Tusla would like to acknowledge the additional work carried out by the following members of their Agency;

Name	Role
Mary Hargaden	Service Director
Barry Murray	Area Manager
Gary Kiernan	General Manager

The HSE would like to acknowledge the feedback contributions from internal consultation in CHO Areas 4 and 8 designed to strengthen this protocol. The HSE would also like to acknowledge the additional work carried out by the following members of their Agency;

Name	Role
Tim Hanly	General Manager
Tony McCusker	Principal Social Worker
Colleen Murphy	Clerical Officer

The Disabilities Protocol group would like to thank all of those involved for their application to what was a complex and protracted task and the support received from both agencies and their respective members of staff.

1.2 TERMS OF REFERENCE

The Terms of Reference for the Group were agreed as follows:

- To clarify and set out the respective roles, duties and legal requirements of the HSE and Child and Family Agency, in relation to children and young people with a disability and /or mental health issues
- To revise the current joint protocol in accordance with the above
- To establish areas of joint responsibility
- To develop pathways for increased understanding and co-operation between the HSE and Child and Family Agency
- To establish mechanisms for dispute resolution

2.0 Background

A consistent theme emerging from case reviews, inquiries and policy developments within Child and Family Services in recent years, is that services for children and young people could be improved if statutory agencies worked more effectively together (ICDRG, 2012: Cameron et al, 2012). A new approach is required to respond effectively to the significant and fundamental changes taking place with the establishment of the Child and Family Agency and the re-configuration of the wider health services into a divisional structure. Appropriate interface and referral pathways between the HSE Divisions and the Child and Family Agency are required to ensure that the needs of children and their families are at the centre of service delivery. Therefore effective, robust collaboration is essential.

It is recognised that specific challenges can present in contexts such as timely and consistent access to assessment and specialist interventions for children and young people with additional needs. The development of this joint protocol aims to provide effective guidance to personnel from both organisations, working to ensure the highest quality of care and intervention is afforded to these children and young people.

This protocol has been developed to assist staff in managing the emerging interface and to clarify the separate and distinct roles and responsibilities of both agencies and to develop and enhance a collaborative partnership between the HSE and the Child and Family Agency. This will lead to a consistent approach where services are delivered appropriately, meeting the clinically assessed, holistic needs of children and their families within available resources and in accordance with Government policies and legislative requirements. While the protocol is between the HSE and the Child and Family Agency, the principles apply equally to all entities that are funded by the HSE, i.e. Section 38 and Section 39 agencies where appropriate and relevant and to agencies that are funded by the Child and Family Agency under Sections, 56, 57, 58, 59 of the Child and Family Agency Act 2013 where appropriate and relevant. The overarching principle is that the collaborative partnership is all inclusive.

Shared principles and service delivery objectives for both statutory organisations are reinforced by a strong interagency collaborative framework. The development of this protocol sets out mechanisms to have issues such as appropriate referral pathways, information sharing arrangements and funding requirements clarified, addressed, and resolved should they arise.

The protocol will have specific relevance and application in a number of key contexts. These contexts include the needs of young people with lifelong health care support needs that require specialist services when they leave the care of the Child and Family Agency. Also this protocol has key relevance with regard to the appropriate referral to child protection and welfare services by HSE personnel, the timely access to appropriate mental health/ disability assessment and intervention for children involved with the Child and Family Agency.

The protocol provides a pathway for collaboration across HSE Divisions and the Child and Family Agency at local, individual practitioner level with appropriate escalation through the respective line management structures to Area level, and if required to National levels, when a collaborative approach, based on the needs of the individual child cannot be agreed or implemented.

There are a number of associated processes in place, or being developed which will assist collaboration for example

- Children and Young People's Services Committees¹ - a service delivery framework² which will govern the routing of referrals to and through the Child and Family Agency
- National Leaving Aftercare Policy and Implementation Plan³ - outlining the Agency's commitment to and provision for the preparation of young people for leaving and Aftercare

¹ DCYA is promoting the development of Children and Young People Services Committees to ensure one is established in every county in the next 12 months. The Interagency Protocol for Joint Working has been considered within that development.

² Child and Family Agency has developed a service delivery Protocol which determines the route of referrals from the point of entry to the final outcome. An element of this will be local Area pathways with considerable reliance on community services and non statutory providers. The Interagency Protocol for Joint Working has been considered in light of this development.

3.0 Protocol Purpose

The objective of this protocol is to specify a pathway and associated responsibilities for children and families whose needs cross between health service Divisions and the Child and Family Agency. This seeks to ensure that services are:

- Child and family centred
- Vulnerable adult centred
- Not duplicated or fragmented
- Clear in relation to roles and responsibilities
- Of high quality with positive outcomes for children and families
- Transparent
- Fair and equitable for both service users and providers
- Based on shared funding across HSE Divisions and across agencies, where necessary
- Based on flexible allocation and usage of resources commensurate with assessed needs as set out in the care plan
- Based on best value for money

³ The Child and Family Agency's National Leaving and Aftercare Policy Implementation Plan recommends that an Aftercare Steering Committee will be established in each of the 17 areas. The Terms of Reference for the Aftercare Steering Committee is to receive and manage referrals of young people with complex needs aged 16+ who are in care, through a multidisciplinary forum led by Child and Family Agency. All relevant services, as committee members, will proactively engage in a joint aftercare planning process for young people leaving care.

4.0 Legal and Policy Context

This protocol reflects and is consistent with the following (not exhaustive and subject to change):

- [Assisted Decision Making \(Capacity\) Act 2014](#)
- [Better Outcomes Brighter Futures](#)
- [Child and Family Agency Act 2013](#)
- [Child and Family Relations Act 2016](#)
- [Child Care \(Placement of Children in Residential Care\) Regulations 1995](#)
- [Child Care \(Placement of Children in Foster Care\) Regulations 1995](#)
- [Child Care \(Placement of Children with Relatives\) Regulations 1995](#)
- [Child Care Acts 1991 – 2011](#)
- [Child Care Amendment Act 2015](#)
- [Children First – National Guidelines for the Protection and Welfare of Children 2011](#)
- [Children First Implementation Plan for the HSE \(Draft August 2014\)](#)
- [Children's Act 2001](#)
- [Commission to Inquire into Child Abuse \(Amendment\) Act 2005](#)
- [Data Protection Acts 1988 and 2003](#)
- [Disability Act 2005 \(including provisions for Assessment of Need\)](#)
- [Draft National Standards for Special Care Units \(HIQA\) 2014](#)
- [Early Years Standard Operating Procedures for Early Years Services](#)
- [EPSEN Act 2005](#)
- [Freedom of Information Act 2014](#)
- [Future Health - A Strategic Framework for Reform of the Health Services 2012-2015](#)
- [Health Acts 1970 and 2007](#)
- [Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2015](#)
- [High-Level Policy Statement on Supporting Parents and Families 2015](#)
- [Home Sharing in Intellectual Disability Services in Ireland 2016](#)

- [HSE Child Protection and Welfare Policy 2016](#)
- [Mental Health Acts 2001 and 2008](#)
- [National Policy and Procedure Document, Leaving and Aftercare Services: 2011](#)
- [National Children's Strategy \(Our Children - their Lives\) 2000](#)
- [National Disability Strategy 2004](#)
- [National Standards for Children's Residential Centres 2001](#)
- [National Standards for Foster Care 2003](#)
- [National Standards for the Protection and Welfare of Children \(HIQA\) 2012](#)
- [Nurses and Midwives Act 2011](#)
- [Ombudsman for Children Act 2002](#)
- [Our Duty to Care - The Principles of Good Practice for the Protection of Children & Young People 2002](#)
- [Policy on Access to Services for Children and Young People with a Disability or Developmental Delay 2016](#)
- [Policy on Domestic, Sexual and Gender Based Violence 2010](#)
- [Primary Care Strategy, A New Direction 2001](#)
- [Progressing Disability Services for Children and Young People Programme 2013](#)
- [Protection of Children \(Hague Convention\) Act 2000](#)
- [Registration Process for Service Providers – Child Care Act 1991](#)
- [Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures 2014](#)
- [Supporting Access to Early Childhood Care and Education for children with a disability 2015](#)
- [The Protection of Persons Reporting Child Abuse Act 1998](#)
- [United Nations Convention on the Rights of the Child 2010](#)
- [United Nations Convention on the Rights of Persons with Disabilities 2008](#)
- [Value for Money and Policy Review - Disability Services 2012](#)
- [Vision for Change 2006](#)

5.0 Overarching Principles

Children in state care⁴ or known to child protection services or in need of clinical intervention will be appropriately prioritised. Due regard will be had to their clinical need and additional vulnerability status by virtue of their circumstances of being in care or having a disability, mental health issue or having a life limiting medical condition. The HSE's response to the recommendations of the Child Death Review Group 2012, stated that the, *".....State has a positive duty to then discriminate positively towards children received into its care through the provisions of that Act (Child Care Act, 1991), or indeed those actively known to the Child Protection Services"*. It added that where children in care or children known to the Child Protection Services are in need of disability services or Child and Adolescent Mental Health Services (CAMHS), they will be appropriately prioritised having regard to clinical need, and additional vulnerability status. The Ombudsman's Report August 2011 recommended that children with special needs in foster care be prioritised over other children in care. Further clarification provided since confirmed this recommendation relates to children with moderate to profound special needs in foster care, many of whom present with disabilities or life limiting medical conditions. The following principles will also apply:

- No child or young person with a mental health and/or disability issue should be taken into state care as a consequence of insufficient disability /mental health services or support.
- While receiving a child formally into state care should be seen as a measure of last resort, if parents have effectively abandoned parental duties, the best interests of the child must be the guiding principle to ensure their interests and welfare are being appropriately protected.

⁴ *State care refers to children formally received into the care of the Child and Family Agency under provisions of the 1991 Child Care Act by virtue of care proceedings or voluntary parental consent. Formal state care is separate from arrangements/placements such as residential provision solely to meet a child's disability care needs that to date are not subject to statutory regulation.*

- Children with a disability or mental health issue in state care should access disability, mental health or specialist services in the same way as other children. The person who is carrying out parental duties should have no bearing on a child's eligibility or access to services. In other words, Tusla is not responsible for funding required disability services generally provided by other agencies any more than any parent.
- Joint and effective management of the transition of young people with a disability and / or complex mental health issues from State care with associated supports is required to address identified need. Early intervention and timely assessment of need is critical for this cohort of children.
- The Child Care (Amendment) Act 2015 provides for a right to aftercare planning by Tusla - not service provision. Accordingly, aftercare planning should be used by Tusla and the HSE to effectively manage the transition from child to adult disability services, based on assessed need.

Reference:

Correspondence dated 27th May 2016 by Ms Liz Canavan (Assistant Secretary General, Department of Children and Youth Affairs) to Mr Fred McBride (CEO, Tusla – Child and Family Agency). This correspondence articulates that it would be helpful to develop a policy position agreed between the Department of Children and Youth Affairs and the Department of Health regarding the provision of services to children in care and adults leaving care that are vulnerable by virtue of intellectual disability, physical disability, autism and/or mental health issues.

6.0 Core Operating Principles

In order to adhere to good practice standards in relation to service provision generally and interagency working in particular, a set of core principles have been developed to act as a foundation for that partnership. They include:

- Full and early involvement of each partner within a co-operative culture, based on a shared responsibility and collaborative approach
- Adherence to the Equity of Care principle ensuring that all children in care are afforded the same standard of care provision
- Responsible and effective leadership
- Service delivery through integrated working, unimpeded by organisational boundaries
- Clarity regarding the roles and responsibilities of service providers as set out in Appendix 1
- Recognition of the financial and other constraints faced by partners
- Acknowledgement of the interdependence and joint interests of the partners, and that the dialogue is between partners of equal status
- Communication is appropriate, timely, and ensures that any development by a partner of internal processes, guidelines or reconfiguration that may impact on the relationship between services and service providers, is proactively communicated
- Commitment to appropriate consultation when one partner is planning action that impacts on the other partner within the Child and Family Agency or the HSE, in order to improve outcomes for service users
- Information sharing as good practice including listening to the views of the service user/children within a family or service perspective
- Partners will seek assessment and intervention from the public sector in the first instance
- Identification of agreed resource pools where appropriate
- Identification and delivery of appropriate training on a shared basis where appropriate

- Agreement of clear processes for the planning, delivery, monitoring and evaluation of services
- Having due regard to the need for confidentiality and to share information and data within the context of legislation and relevant policy requirements
- Having a process for the resolution of any issues arising

7.0 Joint Working at Local level for Individual Cases

7.1 PRINCIPLES

In implementing this joint protocol it is imperative that staff in the respective organisations fully commit to proactively engaging in joint working regarding clinical meetings and service provision, dealing with issues, etc.

Primary Care and Specialist Services

In Primary Care, all children will have their health and social needs met within the primary care network where appropriate and the primary care team will work jointly with other services as determined by the needs of the child and family. Where the children's assessed needs require specialist care, they are referred to the appropriate specialist services e.g. mental health, disability, palliative care, children and family services and acute hospitals. It is acknowledged that some HSE primary care services may not immediately be aware of a child in state care and further liaison work as part of implementation may be needed regarding appropriate sharing of data.

Children with very Complex Needs and/or Impairments

All children with identified child protection or welfare needs fall within the remit of the Child and Family Agency. However it is recognised that children with complex needs, particularly those with mental health issues and/or moderate, severe or profound disabilities, require additional specialist services and expertise which are not available in the Child and Family Agency. Joint working between the Child and Family Agency, HSE Mental Health Services, Disability Services and Primary Care Services is therefore necessary. A collaborative approach is required to achieve a positive outcome which meets the needs of the child and family. It is also recognised that some individuals with mild disabilities have complex needs therefore joint working between Disability Services, the Child and Family Agency, Mental Health Services and Primary Care Services is vital. A collaborative approach is the key to achieving a positive outcome which meets the needs of the child and family.

Care planning for young people in care presenting with complex needs aged 16 to 18 years will involve all relevant HSE professional/service providers in the Child and Family Agency's Local Aftercare Steering Committee. Care planning in advance is a priority for these young people transitioning to adulthood to ensure the necessary supports are in place on discharge from statutory care. As per the Child and Family Agency's National Leaving and Aftercare Policy and Implementation Plan, planning should commence, with referral to the Local Aftercare Steering Committee, on the young person's 16th birthday⁵. This process provides a forum for highlighting those in most need of services post 18 years and informs services of budgetary provision and resources required in advance. Also, both agencies need to collaborate closely when private sector placements are being sought for children and young people with additional complex health care needs. Late entrants to care post 16 years of age with complex health needs may pose a planning challenge and will require a timely interagency response.

HSE Social Care Division Disability Services provide access to a range of specialist services and supports for children with a disability, including those with an intellectual disability, assessed in the moderate, severe or profound range. It is recognized, however, that some individuals with mild disabilities have complex needs which require joint working between Disability Services, the Child and Family Agency, Mental Health Services and Primary Care Services and a collaborative approach is the key to achieving a positive outcome which meets the needs of the child and family.

Some young people turning 18, who have been in foster or residential care, may be especially vulnerable due to the impact of a disability, mental health difficulties, addiction issues etc. A strong multi agency collaborative approach is essential for this cohort including, appropriate notification of abuse concerns for vulnerable young people leaving the child in care system to the relevant HSE services and the HSE Safeguarding and Protection Team (SPT). It is important that this collaborative approach in aftercare planning process incorporates the capacity of the Tusla aftercare service to co-ordinate safeguarding planning and share information on any

⁵ See Appendix 2 – Process map for consideration in cases concerning the ongoing welfare and support needs of a young person entering adult services.

known safeguarding risks factors about their current/proposed carers or living arrangement.

Effective collaboration and information sharing would also include children turning 18 years subject to a child protection plan who would be deemed a vulnerable adult post 18 years of age. Sharing of information may also include young people known to Tusla who may pose a safeguarding risk to vulnerable adults (i.e. in the family home).

Interagency Collaboration

Early proactive engagement of staff in HSE Divisions and the Child and Family Agency in the best interests of children and their families is a prerequisite for managing individual cases. Informal consultation for advice and direction in regard to specific expertise must be provided as appropriate by practitioners and colleagues in HSE Divisions and the Child and Family Agency. Where a practitioner has concerns or identifies a need for intervention from another Division or from the Child and Family Agency, she/he must liaise with the relevant practitioner and agree a process for engagement. In the event of specific issues such as High Court cases, HIQA inspections; Ombudsman recommendations, etc., the appropriate managers will act in collaboration to address the required service improvements.

Experience identifies that most interagency issues can be resolved by this early engagement and it can also act as an early warning system which ensures that appropriate actions are taken. The emphasis here is on early engagement and requests for interagency discussions must be prioritised and a meeting arranged, if agreed to be appropriate, following discussion. Joint working is governed by the requirements of Children First. When issues of child welfare and protection arise, early engagement should be as immediate as the same working day where harm has occurred, or within one week where an emergency child protection plan is required or Court matters need to be addressed. The fundamental principle is that both organisations are committed to optimal engagement, in the best interests of the child, and the minimisation of avoidable pre-emption, by other parties regarding applications to the Court for direction.

An interagency meeting can be called by **any** Division/ Child and Family Area to develop joint care plans and review processes. The process will include:

- Identification and agreement as to the Lead Agency and key co-ordinating professional
- Identification of treatment interventions that can be delivered
- If there is a need which cannot be met, to advise line management
- Where line management cannot resolve the issue e.g. due to lack of resources or some other impediment, the matter should be escalated to the next level in accordance with this protocol

The Care Plan or an addendum thereto, should clearly show which Organisation/Division is dealing with each part of the intervention(s), the actual intervention/service being provided, resources, costs, and the funding Organisation/Division. This document then forms part of the clinical and general governance and performance management process.

7.2 PURPOSE AND FUNCTION OF JOINT WORKING ON INDIVIDUAL CASES

Professionals will engage in joint working where one or more Divisions/ Child and Family Agency Areas are involved with a child and/or a practitioner requires advice or intervention to achieve the following:

- Co-ordination of appointments/engagement between the various services and the families/carers

This will streamline contact and ease the pressure on families to engage with a multiplicity of staff and support/facilitate professionals in multi-disciplinary, cross divisional/agency working.

- Multi-agency input co-ordination

To enable all stakeholders, including voluntary providers, representatives from statutory teams, health care divisions, and other services (i.e. educational support staff, etc.) to engage in joint working - this is to ensure timely outcomes in the best interests

of the child and family. The HSE CHO level Residential Services Executive Management committees to be formed in 2017 will have a key role in any future requested disability residential placements.

- Communication:

Professionals will agree locally on the process to ensure that relevant and key information is communicated to the appropriate personnel in a safe, timely and effective manner. Arrangements will vary between local areas and even on a case by case basis, depending on how data is stored, which professionals are involved, etc.

- Flagging System:

Professionals will flag cases of concern to other relevant Divisions/ Child and Family Agency Areas, where there is a reasonable expectation that cases will require cross-divisional/service input. The process for identifying children in care or in the community that need to be flagged, should be agreed locally, for young people aged 16 to 18 years in statutory care via the Child and Family Agency Local Aftercare Steering Committees.

7.3 COMMUNICATION

Clear and professional communication standards enhance joint working. The local professionals involved in joint working will determine the process and protocols needed with regard to communication, which will be based on existing local arrangements/systems and take cognisance of local, area, regional and national requirements. Information handling policies and data protection regulations will be adopted under agreed terms of reference to support this protocol in each local area.

Referrals between professionals will be acknowledged and engagement, response or decision will commence within agreed timelines from receipt of the referral. Where a decision has been made regarding the most appropriate service provider this decision will be communicated to the referrer and copied to relevant Division / Area without delay, detailing the rationale for the decision. If the service provider to whom the referral is made is not in a position to provide services which are considered critical to

the safety of the child and family, that service provider must notify the referrer immediately and the case must be escalated appropriately

Later sections in this document regarding implementation and evaluation, set out future work that is envisaged for the National Oversight Group to strengthen and clarify the local collaborative requirements.

7.4 CONFIDENTIALITY AND INFORMATION SHARING

Each service will ensure that the highest professional standards are maintained in relation to confidentiality, and any information sharing will have the appropriate informed consent. In this regard, all relevant personnel will be cognisant of the requirements under Children First, HSE Safeguarding Vulnerable Persons at Risk of Abuse policy and other obligations in relation to freedom of information and data protection.

7.5 IDENTIFYING LEAD AGENCY AND CO-ORDINATING PROFESSIONAL

A lead agency and co-ordinating professional must be mutually agreed. The lead agency will most likely be identified firstly and will normally be the service which has the largest involvement in a case. There will be recognition that the co-ordinating professional and lead agency may change over time depending on the circumstances of the case. Consideration will be given to which professional/ service provider will be the long term care provider and a decision will be made in this regard. As agreed with the Lead Agency, all professions and agencies are obliged to remain involved in the management of the case and to actively contribute to the required service solutions. There are times when a joint co-ordination approach may be required on certain complex cases.

The Local Aftercare Steering Committees will provide a forum for discussion and review of young people over 18 years who require short-term and long-term supports up to 21 years. These children will be referred to the forum from their 16th birthday.

7.6 MANAGEMENT OF COSTS

At the individual client level, interventions will be provided from existing resources and all services identified in the Care Plan will make provision for the service within the allocation of their resources. Where a child is transitioning from Tusla child care to HSE adult care, Tusla will if required, continue to fund the placement costs for an agreed time limited period not exceeding eight weeks **with effect from 1 January, 2018.**

7.7 APPLICATION TO HSE CHIEF OFFICER/ CHILD AND FAMILY AGENCY SERVICE DIRECTOR FOR ADDITIONAL RESOURCES

Where significant additional resources are required and needs cannot be met within existing resources, (and alternatives have been explored), the local practitioners can refer the case through their respective line management structures to their HSE Chief Officer/ Child and Family Agency Regional Service Director for resolution. A business case must be provided to the appropriate manager at HSE CHO/ Child and Family Service Director Level with details of the issues, actions to date, options and costing where appropriate, and signed by all relevant parties. Where additional funding requirements cannot be met at this level, further escalation is required to HSE National Directors/ Child and Family Chief Operations Officer.

7.8 RESOLUTION OF DISPUTES AND DIFFERENCES

In situations where differences arise in relation to the management of a case and a local joint decision cannot be agreed, the practitioners from the different HSE Divisions/ Child and Family Agency Areas must make every effort to resolve them so that appropriate interventions can proceed. Where this cannot be agreed e.g. due to lack of resources or some other impediment, the matter must be escalated through the respective line management structures to the HSE CHO/ Child and Family Agency Regional Service Director level.

8.0 Joint Working at Area level

8.1 PURPOSE AND FUNCTION

The purpose and function of the Area Joint Working Group is to ensure that joint working at a local level is effective and efficient to improve outcomes for children and families. It also acts as an early warning system where senior managers in partner services are alerted to issues at the earliest possible opportunity.

The Area Joint Working Group ensures that actions taken are in line with national policy.

Objectives:

- Identify most important priorities and ensure that HSE Divisions and the Child and Family Agency Areas coordinate their efforts and develop shared responses
- Identify what each Division/ Child and Family Area is doing in their area with associated gaps and blockages and agree solutions
- Ensure individual complex cases unresolved by local joint working are managed appropriately i.e. referred back to local practitioners with recommendations for further resolution or addressed by the Area Joint Working Group in regard to specific issue, -e.g. decision on funding / resources or approach to Court
- Ensure joint issues such as aftercare will be routed through this process
- To identify gaps in service provision with a view to informing strategic planning in both organisations

8.2 COMPLEX CASES

Practitioners involved in joint working on individual complex cases can refer unresolved matters for advice or submit a business case agreed locally in accordance with this protocol.

8.3 TERMS OF REFERENCE:

- Provide oversight and appropriate co-ordination of specific cases, e.g. where more than one Division/ Child and Family Agency Area is involved; cases involving Court proceedings, the Ombudsman, HIQA; etc.
- Identify children already known to other services
- Agree priority recommendations
- Identify lead agency and co-ordinating professional(s)
- Ensure associated local assessment process and guidelines are adhered to
- Clarify management of resources and budget
- Agree priority recommendations and roles especially for a young person transitioning to adult services where there may be any safeguarding issues

8.4 MEMBERSHIP OF AREA JOINT WORKING GROUP

An Area Joint Working Group consisting of representatives from the Child and Family Agency, Mental Health, Disabilities, Primary Care services will meet on a monthly basis or less as referral rates indicate to discuss unresolved cases escalated to it. Staff representatives at the appropriate levels will be identified from each of the Divisions/ Child and Family Agency as follows:

- Disability: Disability Manager
- Child and Family Agency: Area Manager
- Mental Health: Business Manager
- Primary Care: Operations Manager/Community Health Network Manager nominee

8.5 CHAIR

Joint Chair: Area Manager, Child and Family Agency and HSE CHO Head of Service i.e. Mental Health, Social Care (Disabilities) and Primary Care.

8.6 AREA-LEVEL PROCESS

- Monthly meetings will have minutes taken and shared as appropriate, with a mechanism for addressing emergencies
- Referral as appropriate to other agencies for specific cases
- Care options to be explored based on consideration of the business case including presentation of clinical need
- Recommendations made for local practitioners to implement
- Management of costs/joint budgets – existing resources
- Review mechanism will be established

8.7 ESCALATION TO HSE CHIEF OFFICER/ CHILD AND FAMILY REGIONAL SERVICE DIRECTOR LEVELS

There is an expectation that decisions will be made at local team level regarding the provision of access to appropriate, available services. If this is not possible for whatever reason then a business case must be prepared, identifying options and costing where appropriate, and signed by all relevant parties.

The business case will be progressed to respective HSE Chief Officer and Child and Family Agency Regional Service Director for decision. In exceptional cases, where agreement cannot be reached, representations may be made to national management level.

9.0 Joint Working at HSE Chief Officer/ Child and Family Agency Director Level

9.1 PURPOSE AND FUNCTION

The overarching role of the CHO Joint Working Group is to provide a mechanism to address capacity issues (resources human or financial); for dispute resolution; to ensure an early warning system is in place; and to ensure actions taken are in line with national policy.

9.2 REFERRAL PATHWAY

Referrals to the HSE CHO/ Child and Family Group are received in regard to unresolved issues at Area level.

9.3 TERMS OF REFERENCE

- Oversight of costs/joint budgets
- Review of individual cases where issues cannot be addressed at Area level
- Sharing and dissemination of good practice
- Review and action as appropriate of reviews/reports (HIQA, Ombudsman, etc.)

9.4 MEMBERSHIP

- Child and Family Agency Regional Service Director
- HSE Chief Officer or nominee
- HSE Primary Care Head of Service
- HSE Social Care Head of Service
- HSE Mental Health Head of Service

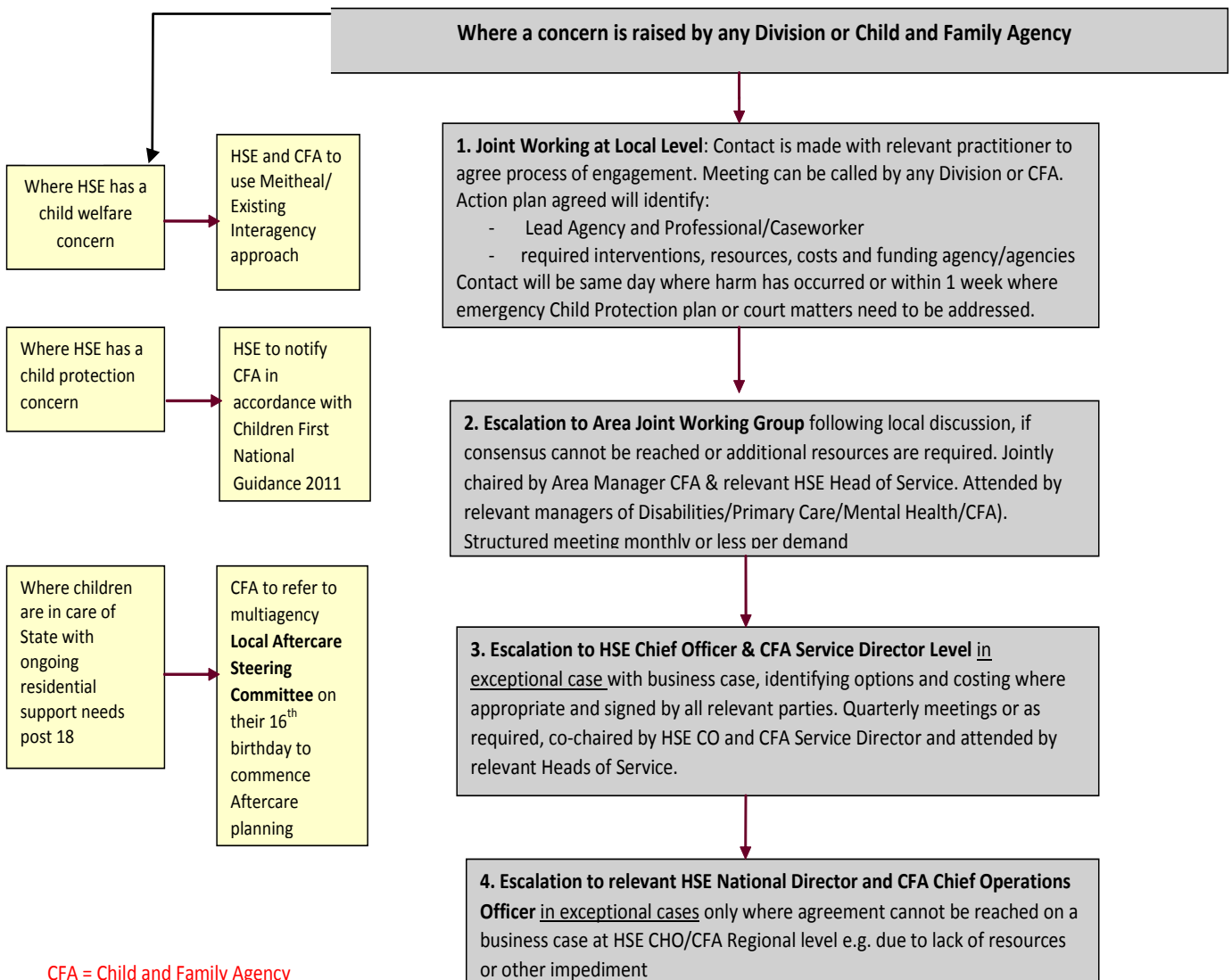
9.5 CHAIR AND AUTHORITY OF FINAL DECISION MAKING

Joint Chair (Child and Family Agency Regional Service Director and HSE Chief Officer or nominee)

9.6 PROTOCOL PROCESS

The following diagram represents the working protocol as a flow chart. As part of the process there will be quarterly meetings, minutes taken, and shared as appropriate, with a mechanism for addressing emergencies

Joint Working Protocols HSE / TUSLA



9.7 ESCALATION TO RELEVANT HSE NATIONAL DIRECTOR(S)/ CHILD AND FAMILY AGENCY CHIEF OPERATIONS OFFICER

The business case will be progressed to the respective HSE Chief Officer and Child and Family Agency Regional Service Director for decision. In exceptional cases, where agreement cannot be reached on a business case submitted to the HSE CHO/ Child and Family Agency Joint Working Group, the case should be escalated to the relevant HSE National Director(s) and Child and Family Agency Chief Operations Officer.

10.0 HSE National Director(s)/ Child and Family Agency Chief Operations Officer

Responsibility in this exceptional case will rest with the relevant HSE National Director(s) and Child and Family Agency Chief Operations Officer to agree a resolution on unresolved disputes.

11.0 Child and Family Agency Register

The Child and Family Agency will retain a register regarding children in care with a disability. HSE will be notified by the Child and Family Agency when a child is 16 so that appropriate planning can be made for onward care as required. The Child and Family Agency may notify sooner than 16 years where necessary.

There is a broader requirement for HSE to be aware of the numbers of young people in the Child and Family Agency's care requiring onward residential or long term adult family placement (based on appropriate assessment of their disability needs) so these costs can be factored in to the estimates for HSE.

12.0 Implementation Plan

In order to embed this protocol into everyday practice staff must be made sufficiently aware of its existence. Each Area/Region will take responsibility to implement the protocol at operational level with clear endorsement by HSE CHO Chief Officer's senior management groups and the Child and Family Agency Service Directors.

In addition an implementation plan will be developed which addresses the following:

- HSE Chief Officers and Tusla Area Managers to jointly organise implementation workshops with relevant stakeholders and staff personnel
- Relevant ongoing training to be provided to encourage collaboration and relationship building
- Identification of additional resources required to support implementation of the local cross divisional resolution structures and the remaining of the 17 Local Aftercare Steering Groups
- Identification of additional resources required to support young people with disabilities moving to appropriate adult accommodation and provision after their 18th birthday
- A joint National Oversight Group will be convened with an agreed work plan to oversee implementation of the protocol

13. 0 Evaluation and Audit

Ongoing evaluation and review of the protocol will be necessary to ensure success and evidence that it is meeting its intended objectives.

The Joint National Oversight Group convened by National HSE Management Team in partnership with the Child and Family Agency will meet three months after roll out of this Joint Working Protocol and on a three-monthly thereafter to monitor, assess and recommend revisions as necessary based on analysis and the experience at local level. The Group will also provide on-going support nationally to local CHOs/ Tusla areas. The Joint National Oversight Group should include HSE cross divisional representation from Social care, Primary care and Mental Health Divisions. This group will also take into consideration further development work, identified through consultation sessions held in HSE CHO areas 4 and 8 in January 2017 as well as the written submission of the Louth HSE Children's Services Group.

13.1 WORK PROGRAMME OF NATIONAL OVERSIGHT GROUP

Initial work programme to include:

- Track roll out of implementation plan including briefings and workshops at local level. Audit levels of engagement and collaboration at local level and measure if protocol is working effectively at front line in a consistent and standardised manner.
- Available to advise Joint Area Working Groups on how interagency challenges in areas such as child protection/welfare threshold criterion, role clarification, referral responses and capacity constraints could be addressed.
- Consider future joint learning opportunities and further work in relation to the interagency challenges and opportunities.
- Consider further developments to strengthen local collaboration.

14.0 Protocol Agreement Between Agencies

This Joint Working Protocol for interagency collaboration is now finalised and agreed by the Health Service Executive and Tusla – Child and Family Agency.

This agreed Protocol will be reviewed annually by nominated representatives from the Health Service Executive and Tusla – Child and Family Agency

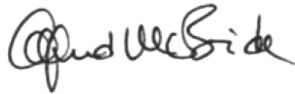


29/03/2017

Signed: _____

Date _____

Tony O'Brien, Director General, HSE



Signed: _____

Date 29/03/2017

Fred McBride, Chief Executive Officer, Tusla – Child and Family Agency

15.0 Appendices

APPENDIX 1 – A BRIEF DESCRIPTION OF SERVICES INCLUDING ROLES AND RESPONSIBILITIES

The following is a high-level overview of services provided by the HSE and Child and Family Agency. More detailed information regarding the provision of specific services, referral pathways, contact points, etc., is available at local primary care centres, other service delivery centres and offices, the internet, etc. Staff in the respective organisations will continue to have access to and avail of all the existing sources of information in relation to the range and extent of service provision.

In implementing this joint protocol, it is imperative that staff in the respective organizations fully commit to proactively engaging in joint working regarding clinical meetings and service provision, dealing with issues, etc.

A. CHILD AND FAMILY AGENCY

All children fall within the remit of the Child and Family Agency however it is recognised that children with complex needs, particularly those with moderate and profound disabilities, require additional specialist services and expertise which are not available in the Child and Family Agency. Joint working between the Child and Family Agency, Disability Services, Mental Health Services and Primary Care Services is therefore vital and a collaborative approach is the key to achieving a positive outcome which meets the needs of the child and family.

The functions of the Child and Family Agency include:

- The carrying out of investigations and assessments of child welfare or protection concerns reported to the Agency under the Child Care Act, 1991.
- The carrying out of assessments of need for children who have been identified as having welfare or protection needs related to the failure of their parents as set out in the Child Care Act 1991.
- The provision of services which might be required to secure the safety, support, welfare and protection of any child where these are in question in line with the Child Care Act 1991.
- The provision of alternative care services for those who may need them including identifying, providing or making provision for appropriate emergency, foster care, residential care or special care.
- The registration, supervision and inspection of pre-school services and the implementation of guidance and standards relating to health, safety and welfare promoting of the development of children attending pre-school or school age services.
- The provision of some pre-school and special school services such as those in special care units.
- The provision of advice and assistance to families who need such support in order to meet their parenting requirements and to ensure that the welfare and protection of a child is secured. This could take the form of training courses in community settings, one-to-one supports or supporting parents to self-refer or take up

services relating to their own mental health, addiction, domestic violence or other difficulties they are experiencing.

- The identification of need and provision of family support services including guidance to parents in respect of their parenting responsibilities; and to support them in their parenting role. This is likely to include a wider range of universal parenting supports aimed at prevention and early intervention, including community-based parenting courses aimed at the general population; teen parent support programmes, etc. It might also include occasional advice or guidance provided in the form of booklets, media utilisation and advisory leaflets for parents.
- The assessment, approval, supervision and support of persons providing foster care and other alternative care services on behalf of the Agency in accordance with the Child Care Act 1991.
- The assessment of need for services for children and young people who have been in care as they transition into adult life and the provision of any relevant aftercare services.
- The provision of services to children seeking asylum who have been separated from their parents.
- The assessment of eligibility and suitability of persons proposing to adopt for the purposes of adoption in accordance with the Adoption Act 1991.
- The provision of information, training and advice on the Children First Guidance.
- The identification of need and provision of services for children and young people who are not attending school in accordance with statutory requirements for children of school-going age. This includes a range of services which are intended to support such children in resuming or stabilising their attendance and in completing school and the development and provision of appropriate services which support and liaise with parents for them to support their own children in attending school and achieving their educational development milestones as part of programme to improve their school engagement and or attendance.
- The provision of counselling, advice and emergency accommodation services for children and parents who are the subject of abuse as set out in the Domestic Violence Act 1996.
- Sponsoring the requisite prosecutions under the Child Care Act 1991 and the Educational Welfare Act 2010.

- Services provided in accordance with the Family Support Agency Act 2001, including family support services, grant aid, research and information provision.
- Local Aftercare Steering Committees are to be established in each Child and Family Agency area. It is anticipated that in care planning for young people in care aged 16 to 18 years, who are presenting with complex needs, all relevant HSE professional/service provider will participate in the Child and Family Agency local Aftercare Steering Committees. Care planning in advance is a priority for these young people transitioning to adulthood to ensure the necessary supports are in place on discharge from statutory care. This process provides a forum for highlighting those in most need of services post 18 years and therefore informs services of budgetary provision and resources required in advance.

B. HEALTH AND WELLBEING DIVISION

The publication of Healthy Ireland – A Framework for Improved Health and Wellbeing 2013- 2025 is a major milestone for the future provision of health and social care in Ireland. It provides the structure to enable service providers to influence major change in the development, implementation and delivery of health and social care for future generations. It emphasises the need for a collaborative approach between the health sector and other areas of Government and public services to work together, to affect improvements in social protection, food safety, education, housing, transport and the environment. These are the key factors which influence health and social outcomes for the entire population. Tackling health inequalities, introducing preventative health measures and health promotion activities, to be delivered in the community, were the key messages in the consultative process which informed the publication of Healthy Ireland. It is widely recognised that these factors are economically more prudent than costly acute care and treating increasingly costly long-term chronic diseases.

The Environmental Health Service in the Health and Wellbeing Directorate undertakes inspections of early years services in accordance with a range of statutory regulations within its remit. In addition, the Environmental Health Service carry out joint inspections of early years services under the Child Care (Pre-school Services) Regulations in conjunction with the Child and Family Agency, Community Medical and Public Health Nursing staffs. These multidisciplinary teams of healthcare professionals work in partnership to meet the health needs of all children in areas of child developmental screening, child health surveillance, and immunisation programmes.

The aim of the service is:

- Early detection of, and action to address, developmental delay or abnormalities, ill health and growth impairments;
- Protection against communicable disease through high immunisation rates and reduced cases of vaccine-preventable diseases;

- Prevention of obesity and the promotion of health-enhancing behaviours for every child such as eating a well balanced diet, playing actively, and having an appropriate weight and height for their age and general health;
- To focus on neurodevelopment and emotional health as well as early detection of impairments.

All children under the age of six and those attending primary schools are eligible to avail of child health screening services and are referred to the appropriate specialist services, with free GP cards in place for under sixes providing free GP visits, assessments at age two and five and care for children with asthma. The schedule for these checks as per 'Best Health for Children' is as follows: Post natal visit, 6-8 weeks, 3 months, 7-9 months, 18-24 months, 3.25 - 3.5 years, junior / senior infants, school exit.

The service is delivered by:

- Routine developmental checks
- Referral to Child Welfare Clinics
- School screening in Infant Classes for Vision and Hearing and exit vision screening in some areas
- Immunisation programmes: neonatal BCG, school immunisation programmes in primary and secondary school
- Promotion of child health through community and public health actions

Health Promotion and Improvement is defined as 'the process of enabling people to increase control over, and to improve, their health' (WHO:1997). It encompasses building healthy public policy; reorienting health and personal social services; creating supportive environments; strengthening community action; and developing personal skills. Examples of work in this regard are as follows:

- Breastfeeding health
- Obesity; diet and nutrition and physical activity
- Sexual health and crisis pregnancy
- Health promotion and improvement
- Co-ordinate the implementation of the 'Breastfeeding in Ireland – Strategic Action Plan'

Programmes are also designed to support health promoting schools which are characterised as 'a school which is constantly strengthening its capacity as a healthy setting in which to live, learn and work' (WHO:1997).

C. PRIMARY CARE DIVISION

The object of the primary care services is to improve the health of the population by providing local access to multi-disciplinary Primary Care Teams and collaborating with specialised services to provide responsive and integrated care, achieved through:

- Health and personal social care personnel working collaboratively in a multidisciplinary environment
- Working collaboratively with local communities
- Identifying and addressing local needs based on local needs assessment
- Identifying and working towards removing health inequalities
- Improving access to services
- Improving performance through national care standards and development of good quality information systems

Primary Care Teams and Health and Social Networks were envisaged as the vehicles through which the strategy would be implemented and set out below are the details in relation to same:

Primary Care Teams (PCTs)

Primary Care is centered on the needs of individuals and groups of people to match their needs with the competencies required to meet them. A group of primary care providers come together to form an inter-disciplinary team known as the Primary Care Team. The teams service small population groups of approximately 3,000-7,000 people depending on whether a team is in a rural or urban setting. The team is comprised of a core unit of practitioners who provide the most common service needs in the community; these include General Practitioners and Practice Nurses, Public Health Nurses, Community Registered General Nurses, Physiotherapists, Occupational Therapists, Speech and Language Therapists, Social Workers, Home Helps and administrative support. The primary care teams are directly supported by networks which provide additional resources depending on assessed needs, such as dieticians, psychologists and diagnostic testing. The primary care network arranges referrals to other services for needs that are outside their scope and which are provided at network, CHO or national level.

In general the following children will have their needs adequately met by their local primary care network:

- Children under the age of 18
- Children with a mild physical or intellectual disability if their needs can be met by Primary Care Networks regardless of number of disciplines required.

The Primary Care Team is the main provider of support for children with non complex difficulties in functional skills/applied skill sets required for activities of daily living, learning new skills and social interactions. This may involve physical, social, emotional, communication and behavioural needs.

Primary Care/Addiction Services:

Similar to Mental Health teams, a multidisciplinary team provides assessment and intervention determined by the severity and complexity of the presenting problem(s). The risk of harm to the child may be reduced by effective treatment and support for the affected parent(s). To work effectively, a range of disciplines, skills and perspectives are required, so that the individual misusing the substance and his/her family can be offered a care and treatment package geared to their individual needs.

The aim of treatment and rehabilitation is to support abstinence, relapse prevention and the development of life and coping skills. There are different types of treatment programmes to cater for those at different stages in addressing substance misuse, for example substitution prescribing, stabilisation, detoxification, rehabilitation, step down and aftercare. These programmes can be provided by services on an inpatient or outpatient basis.

In-patient or residential treatments are based in hospitals or other treatment facilities. The level of medical support can vary depending on the residential facility and the treatment provided. Outpatient services are provided through health care or addiction treatment facilities over regular sessions where support from doctors, nurses, psychiatrists, key workers, counsellors etc. may be available. There are also a number of treatment programmes available to family members. (See www.drugs.ie)

Range of interventions:

Tier 1 interventions include the provision of drug-related information and advice, screening and referral to specialised drug treatment services. They are delivered in general healthcare settings (emergency departments, liver units, antenatal clinics, pharmacies, or in social care, education or criminal justice settings [probation, courts, prison]).

Tier 2 interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community - or hospital-based. The interventions include information and advice, triage, referral to structured drug treatment, brief interventions and harm reduction e.g. needle exchange programmes.

Tier 3 interventions are mainly delivered in specialised structured community addiction services, but can also be sited in primary care settings such as Level 1 or Level 2 GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community-based specialised drug assessment and coordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

Tier 4 interventions are provided by specialised and dedicated inpatient or residential units or wards, which provide inpatient detoxification (IPD) or assisted withdrawal and/or stabilisation. Some service users will require inpatient treatment in general psychiatric wards. Acute hospital provision with specialist "addiction" support will be needed for those with complex needs e.g. pregnancy, liver and HIV-related problems. Others will need IPD linked to residential rehabilitation units to ensure seamless care.

D. SOCIAL CARE DIVISION – DISABILITY SERVICES

Disability services are of a specialist nature and are not designed to accommodate all health and social service needs of a person with a disability. Instead, the objective is to address specific aspects of a person's needs associated with their disabling condition.

Government and Department of Health policy is clear that a person with a disability must be supported to access mainstream services and supports and accommodated on an equal basis to the able-bodied population, taking into account any specific requirements which may be addressed such as access, communication, etc. The mainstream agenda further provides that people with an intellectual disability who are not assessed to be in the moderate, severe or profound range, and who do not require access to the specialist range of provision funded through HSE disability services, should have their needs met from the wider health social and public service. It is recognised, however, that some individuals with mild disabilities have complex needs therefore joint working between Disability Services, the Child and Family Agency, Mental Health Services and Primary Care Services is vital and a collaborative approach is the key to achieving a positive outcome which meets the needs of the child and family.

Current provision of Disability Services includes:

Residential services for persons who, because of their disability, are unable to live independently without supports.

Respite and Home Supports are provided in a variety of ways including:

- Centre-based respite where a child or an adult comes into a respite residential centre for a planned short break
- Home support / family support where staff work on a one-to-one basis with the child or adult either in their own home or their local community
- Home sharing where a child or adult spends time with a host family in the community
- Contract families offer placements to individuals with additional needs such as highly medical needs

- Clubs such as homework clubs, Saturday clubs and special interest clubs such as drama, cinema, cookery etc.
- Holiday projects run during holiday times

New Directions Personal Support Services for Adults with Disabilities is implementing a radical shift in the provision of day supports to people with disabilities in line with current policy and legislation. The New Direction approach involves the provision of a set of person centred personal support services for people with disabilities. These supports are outcomes based and are delivered within a culture of person centeredness where the users of service playing a key role in the development, planning, delivery and evaluation of their service.

Rehabilitative Training provides foundation level personal, social and work-related skills for participants to enable them to optimise their level of independence and integration.

Preschools: Supporting children with a disability to access and experience mainstream pre-school and where not appropriate, to access a special pre-school.

Personal Assistant services: where the PA is employed by a person with a disability to enable them to live an independent life and promoting choice and control.

Multidisciplinary supports: provide assessment and ongoing interventions through a range of therapy including Speech and Language Therapy, Occupational Therapy, Psychology, Physiotherapy and Social Work, and Nursing personnel. Progressing Disability Services for Children and Young People Programme is currently being rolled out across the country. There are 56 multidisciplinary Children's Disability Network Teams providing for all children with complex disabilities, within a defined geographical area, regardless of their diagnosis, where they live or go to school. Remaining children's therapy services across the HSE and non-statutory agencies will be reconfigured into a further 75 teams in 2016 to provide full cover across the country.

Technical Aids and Appliances such as wheelchairs, splints and other aids to performing activities of daily living.

Miscellaneous Support Services are also provided to support people with disabilities. These include counselling, advisory, advocacy, information and general support services.

Note: The education of children between the age of four and 18 years is the responsibility of the Department of Education and Skills.

E. MENTAL HEALTH DIVISION

CAMHS Community Mental Health Teams

Community child and adolescent mental health teams are the first line of specialist mental health services, providing acute secondary mental health care in the community. The multidisciplinary team provides assessment and intervention determined by the severity and complexity of the presenting problem(s). To work effectively, a range of disciplines, skills and perspectives are provided, so that children and adolescents are offered a care and treatment package geared to their individual needs.

It is the function of CAMHS teams to provide a specialist secondary mental health service to those aged up to 18 years old who have moderate to severe mental health disorders that require the input of a specialist multi-disciplinary mental health team. The mental health disorder is also severe enough to cause substantial distress to the child/young person, their family or others, and to have a significant impact on various aspects of the child/young person's life within the domains of development, family relationships, school, peers, and leisure activity.

The diagnosis of Autism and Intellectual Disability remains the remit of primary care and disability services. Children with a mild intellectual disability are seen by CAMHS only when there is a co-morbid moderate to severe mental health disorder. Where the child/young person has a moderate or severe degree of intellectual disability and co-morbid mental health disorder, they should be referred to the Mental Health Intellectual Disability Services for Children and Adolescents (CAMHS-MHID).

It is recognised that children/young people with Autistic Spectrum Disorder (ASD) experience co-morbid mental health disorders. The role of CAMHS in relation to autism can then best be defined as "consultation on difficult diagnoses and specialist episodic treatment of acute mental disorders".

It is not the role of CAMHS to make recommendations that determine the provision of specific educational supports/resources as this is the responsibility of the Department of Education and National Educational Psychology Service.

The community CAMHS teams provide:

- Assessment of emergency, urgent and routine referrals from Primary Care Services, Disability Services, Adult Mental Health, Paediatricians, Child and Family Agency, NEPS, Assessment Officers and other community based clinicians (see CAMHS SOP for more detail).
- Treatment of moderate and severe mental disorders.
- Outreach services to identify severe or complex mental health need, especially where families are reluctant to engage with mental health services.
- Assessment of young people who require referral to in-patient or day services.
- Training and consultation to other professionals and services.
- Participation in research, service evaluation and development.

Child and Adolescent Mental Health Acute Inpatient Provision

There are four HSE-provided in-patient CAMHS units across the country. The CAMHS in-patient units are Approved Centres under the Mental Health Act 2001 and not statutory residential special care facilities for children. In the tiered model of CAMHS, in-patient services are located at the tertiary level.

The aim of the in-patient service is to provide an evidence-based and cost-effective service for children/young people with severe and often complex mental illness. The in-patient programme offers a comprehensive recovery-focused treatment approach and education programme operating within a therapeutic milieu. There should be the provision of a therapeutic and nurturing environment with developmentally appropriate evidence-based treatment approaches. The service should be able to provide a range of therapeutic interventions.

The in-patient service provides appropriate assessment and treatment which will bring about the change necessary to affect the child/young person's discharge home to the care of their local community CAMHS team as soon as it is clinically appropriate in line with his/her ICP.

The CAMHS in-patient service must be accessible and be provided for a catchment area specifically so that the child/young person can be as near home as possible. Therefore, each of the CAMHS units has a regional remit based on the administrative areas of the HSE as outlined in Table 1.

Unit Name	Unit Location	Bed Numbers	Primary Catchment Area
Eist Linn	Cork-CHO 4	20	CHO 4 & 5
Merlin Park	Galway – CHO 2	20	CHO 1 (partial) ^a , 2 & 3
Linn Dara	West Dublin – CHO 7	24	CHO 6,7 & 8 (partial) ^b
St Joseph's	North Dublin – CHO 9	12	CHO 9, 1 (partial) ^c , 8 (partial) ^d

Fig2. Table 2.

a) Sligo-Leitrim, Donegal

b) Laois/Offaly/Longford/Westmeath

c) Cavan/Monaghan

d) Louth/Meath

In addition in-patient CAMHS teams:

- Promote and improve mental health of children and young people
- Enable families, carers and other professionals to positively support children and young people, by providing them with appropriate strategies and skills to improve mental health
- Provide timely assessment and interventions appropriate to the needs of each individual child and their family

National Office for Suicide Prevention

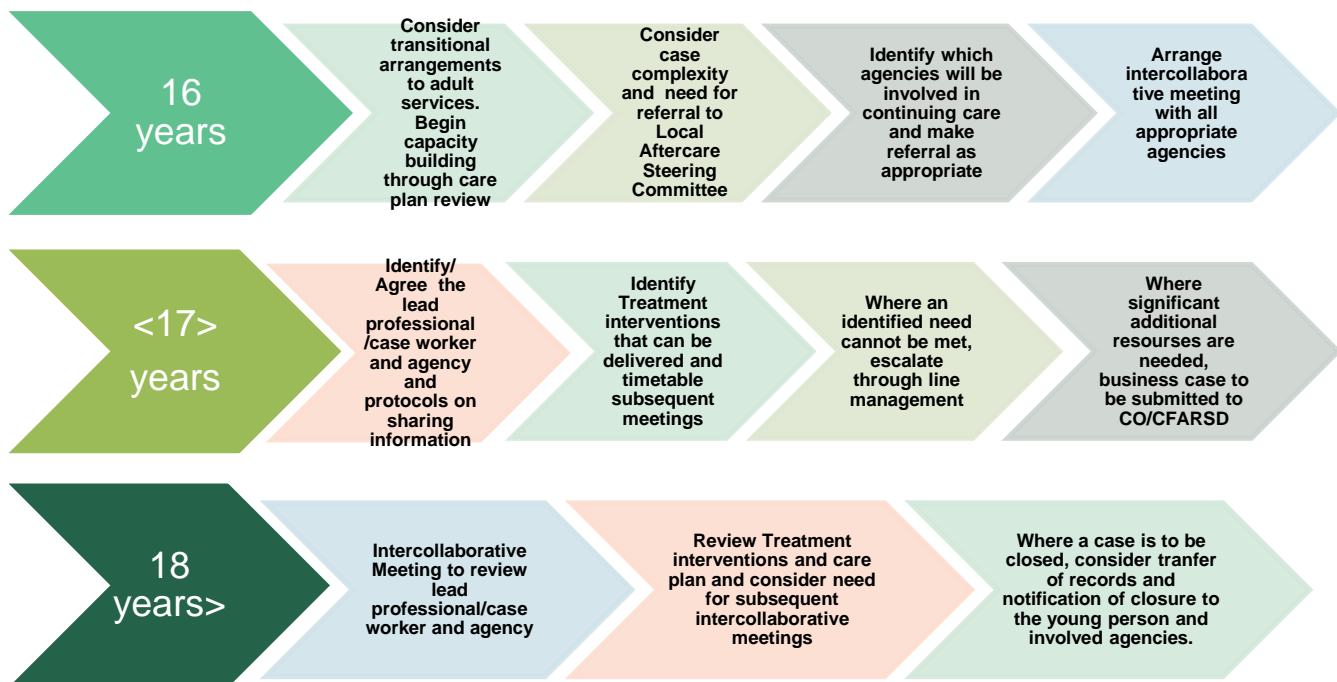
The main function of the National Office for Suicide Prevention (NOSP) is to oversee the implementation, monitoring and evaluation of 'Reach Out', the National Strategy for Action on Suicide Prevention 2005-2014. The NOSP publishes an annual report in order to meet the requirements of the Health (Miscellaneous Provisions) Act 2001.

F.ACUTE HOSPITALS DIVISION (PAEDIATRIC SERVICES)

Acute hospital services for children are being restructured under the Children's Hospital Group Board. This Hospital Group is made up of Our Lady's Children's Hospital, Crumlin (OLCHC), Temple Street Children's University Hospital, (TSCUH) and the National Children's Hospital, Tallaght. Services provided include specialist secondary and tertiary paediatric national services and secondary paediatric services to local catchment areas in the greater Dublin area. St Clare's and St Louise's Child Sexual Assault treatment centres are sited within this Hospital Group and referrals to those units come from Child Protection Social Workers. Details of the referral pathways, access arrangements and the range of paediatric services provided outside the Dublin area are available from the Acute Hospitals Division.

APPENDIX 2 – PROCESS MAP

Process map for consideration in cases concerning the ongoing welfare and support needs of a young person entering adult services



APPENDIX 3 – REFERENCES

Cameron, A., Lart, R., Bostock, L. and Coomber, C. (2012) Factors that promote and hinder joint and integrated working between health and social care services (Research briefing 41). London: SCIE.

Shannon, G, and Gibbons, N. (2012) Report of the Independent Child Death Review Group; <http://www.dcy.gov.ie/viewdoc.asp?DocID=2172>.