National Policy for Child Safeguarding and Wellbeing within Adult Mental Health Services






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

National Policy for Child Safeguarding and Wellbeing within Adult Mental Health Services

DOCUMENT GOVERNANCE

Document Owner (post holder title):	HSE Children First National Office, as part of the office of the Chief Social Worker
Document Owner name:	Marion Martin, HSE Children First Lead
Document Owner email contact: (Generic email addresses only for the Repository)	childrenfirst@hse.ie
Document Commissioner(s): (Name and post holder title):	David Walsh, National Director Access and Integration
Document Approver(s): (Name and post holder title):	David Walsh, National Director Access and Integration
Lead responsibility for national implementation:	Policy implementation will be responsibility of HSE Regional Executive Officer within each Health Region
Lead responsibility for national monitoring and audit:	National Monitoring and Audit will be considered within existing quality and compliance assurance frameworks
Development Group Name:	Adult Mental Health Services Child Safeguarding and Wellbeing Enhancement Working Group
Development Group Chairperson:	Dervila Eyres, Assistant National Director, Mental Health Operations and Marion Martin, HSE Children First Lead

DOCUMENT MANAGEMENT

Date effective from:		01/05/2025	
Date set for next review:		01/05/2026	
Your Reference No: (if applicable)		Not applicable	
Current version no:	0	**Archived version no:**	N/A

VERSION CONTROL UPDATE		
Version No. (most recent version first)	**Date reviewed** (most recent date first)	**Comments** (1 sentence max, if required)
0	10 April 2025	Original publication

PUBLICATION INFORMATION

Topic:

Child Safeguarding and Wellbeing within Adult Mental Health Services

National Group:

Adult Mental Health Services Child Safeguarding and Wellbeing Enhancement Working Group

Short Summary:

The policy will equip Adult Mental Health Service clinicians to consider, assess, and be responsive to concerns for potential risks of harm to children who are in close relationship to, and/or in the care of, an Adult Mental Health Service user. It is based on a '*Think Family − Think Children*' approach.

Description:

A policy to support clinicians working in Adult Mental Health Services to identify and respond to current and potential child safeguarding concerns (either definite or suspected). The policy will provide for a standard ongoing requirement to consider child safeguarding concerns as part of service user assessment. It will also equip Adult Mental Health Service clinicians to assess and be responsive to potential risks of harm to children who are either:

- in close relationship to, and/or
- in the care of an Adult Mental Health Service user.

Contents

1. Planning

1.1 Overview and purpose of this Policy

This policy has been created to support clinicians, working in our Adult Mental Health Services, to consider child safeguarding concerns when in contact with service users. The aim of this policy is to help you as a staff member to identify and respond to current and potential child safeguarding concerns (either definite or suspected), during your practice.

This policy will help you to assess and respond to potential risks of harm to children who are:

- in a close relationship with an adult mental health service user, or
- in the care of an adult mental health service user, or
- both.

Protection and welfare of children

The HSE is committed to the protection and welfare of children. Every HSE staff member has a responsibility and duty of care to make sure that children connected to our services are safe and protected from harm. This includes:

- physical abuse
- emotional abuse
- sexual abuse
- neglect.

The **HSE Child Protection & Welfare Policy** sets out the assigned roles and ongoing responsibilities of all staff in the HSE. It details the procedures we need to follow to make sure that we protect and keep children safe. It is one of a number of policies and procedures in the HSE that contribute to the safeguarding of children and young people.

This policy is designed to sit alongside the HSE Child Protection & Welfare Policy which together protect children. This policy provides practical guidance to staff to carefully consider the potential risks to children, even when those risks are not immediately visible. In any instance where a child protection or welfare concern is identified the HSE Child Protection & Welfare Policy must be followed.

Some staff have extra responsibilities. These are called Mandated Persons and include many members of HSE Adult Mental Health Services including, but not limited to:

- doctors
- nurses
- psychologists
- social workers
- occupational therapists.

Schedule 2 of the **Children First Act 2015** details the additional legal obligations on these staff.

Identifying hidden harms

Our staff play a key role in identifying potential 'hidden harms' or risks for children in the care of the adult, including an adult mental health service user. The risks posed to children in some cases may be severe, and include risks of:

- physical abuse
- emotional abuse
- sexual abuse
- neglect.

This is covered in the **Children First: National Guidance for the Protection and Welfare of Children (2017)**.

Children rights and the best interests of the child

The following general principles are informed by Children First National Guidance and legislation and the UN Convention on the Rights of the Child and these inform best practice within the HSE.

- Children have the right to be recognised, respected, and protected from child abuse, harm or exploitation.
- All children must be treated equally and have the right to be protected from discrimination, intolerance, harassment and bullying; all in line with the Equal Status Acts 2000-2018, and without discrimination.
- Children have a right to be heard, listened to and to be taken seriously. Taking account of their age and understanding, they should be consulted and involved in all matters and decisions that may affect their lives.
- Parents have a right to respect and should be consulted and involved in matters that concern their children. However, a balance must be struck between protecting children

and respecting the rights, needs and duties of others, including HSE staff, parents and families. Where there is conflict, the child's best interests must come first.

- The safety and welfare of children is everyone's responsibility.
- The best interests of the child must be paramount.
- Early intervention is essential for better outcomes.
- Child safeguarding and protection is a multi-agency, multidisciplinary activity. Agencies, professionals and staff must work together in the interests of children.
- Every staff member must be aware of their role and the roles of others in safeguarding and protecting children. Staff are more likely to effectively prevent, detect and respond to child abuse, harm or exploitation, when they have completed Children First training and are clear about their responsibilities.

Think Family – Think Children

As members of our HSE Adult Mental Health Services, we might not meet the children who are in the care of, or have a close relationship with, an adult mental health service user. However, we should have a '*Think Family − Think Children*' approach to the way we work. We all need to understand:

- how important it is to recognise potential concerns relating to children, and,
- the possible need for family support, based on the presentation of an adult service user.

If we recognise needs early and intervene as necessary, we may enhance the safety, health and wellbeing of the adult service user and any connected child.

In this policy we acknowledge that behaviours by adult mental health service users linked to issues such as mental illness, domestic abuse and addiction have exposed some children to harm[1]. This is shown in a number of high-profile incidents where significant harm or fatalities to children have taken place.

We also acknowledge that these concerns do not apply to most adult mental health service users. However, we cannot overlook the possibility of hidden harms to children and young people as a result of certain behaviours.

A *Think Family − Think Children* approach[2] recognises and promotes how important it is to use a systemic whole-family approach. Some staff can find it challenging to confront issues relating to potential child protection concerns with service users.

1 HSE Child Protection and Welfare Policy (2.1, 19/01/2024) 8.3 Concerns about an adult who may pose a risk to children, 48.

However we must consider how children's safety and best interests may be impacted by the behaviours of the adults who are caring for them, or with whom they have close contact.

At this stage, we are not asking all services to adopt a full '*Think Family − Think Children*' model. Instead, we are introducing this approach to reinforce its importance for safeguarding children and how it connects to your role. This is not about additional tasks but about adopting a mind-set of curiosity, and consistently asking, *'What about the children?'*. This policy will help you to consider, assess, and respond to any concerns about a child's health or welfare being at risk. It will guide you to any additional supports the family may need.

Evidence base for *Think Family – Think Children* / Family Focused Practice

In 2009, a concept was developed in the UK called 'Think Family (Think child, think parent, think family)'. At that time the Social Care Institute developed a **guidance document for professionals working with families impacted by parental mental illness**.

Family-Focused Practice (FFP) is a way of delivering care that emphasises the family as the focus of attention as opposed to addressing only an individual's care needs. (Grant et al, 2018; Foster et al, 2015).

FFP provides psycho-social supports to the family as a unit. This may be through working directly with the service user living with mental illness and/or with the child or children, partner or other family members. (Foster et al, 2012)

Overall, the aim of FFP is to:

- improve the emotional and psychological wellbeing of the family as a whole
- enhance the home environment
- improve recovery outcomes for the individuals involved.

2 Think child, think parent, think family: a guide to parental mental health and child welfare. Social Care Institute for Excellence (2009)

What research tells us about *Think Family – Think Children* and Family-Focused Practice

Research in relation to the effectiveness of the 'Think Family (Think Parent, Think Child)' and Family Focused Practice found the following.

Overall benefits of family focused practice
This family focused approach:

- improved outcomes for parental mental illness
- reduced the subjective and objective burden of care for families
- provided a preventative and supportive function for children. (Foster at al., 2012, p.7)

Reduced chance of relapse, hospitalisation
The family approach reduced the likelihood that parents would experience a relapse of their mental illness. (Pischel-Walz et al., 2006)

Reduced need for hospitalisation
The family approach reduced the need for hospitalisation for treatment of their mental illness. (Hylan, Hoey, Finn & Whitecross, 2008)

Better overall outcomes
A 2006 Cochrane Review of the effectiveness of Behavioural Family Therapy reported that individual family approaches resulted in:

- a reduction in relapse rates
- reduction in hospital admission rates
- better adherence with medication
- reduced costs of care. (Pharoah, Mari, Rathbone and Wong, 2006)

Evidence of reduced risk of children developing same illness as their parents
A meta-analysis was carried out of 13 individual, group, and family interventions for families with parental mental illness. It found that the family approach reduced the risk of children developing the same illness as their parents by 40%. (Siegenthaler et al, 2012)

These interventions have been found to:

- increase parenting skills
- strengthen knowledge of parents' mental disorders
- strengthen resilience factors among adolescents. (Siegenthaler et al, 2012)

NICE recommendations
The 2014 **National Institute for Health and Care Excellence** (NICE) guidelines in relation to the treatment of psychosis and schizophrenia in adults recommends family treatment as a core treatment. It recommends that family intervention is offered as early as possible and that it can be started during the acute phase.

Reviews of rare fatal outcomes

Reviews of (albeit rare) cases where there were fatal outcomes for children highlight the co-existence of domestic abuse, substance misuse and poverty as strong indicators for negative outcomes for children.

These reviews highlighted the importance of effective communication with families and other professionals. A 2022 analysis of 235 serious case reviews stated that 'good communication involves listening as well as explaining, and is a basis for sensitive practice, effective information exchange, skilled challenge, clear analysis and planning'. (**Dickens et al's** 2022, p.11).

Similarly the **2014-17 Triennial Review of Serious Case Reviews in the UK Child Protection system** emphasised the need for 'authoritative practice'. This should combine supportive, relationship-based engagement with families alongside respectful challenge. (Brandon et al, 2020 p.109)

Please see Appendix 1 in relation to the literature setting out the evidence base for a Think Family – Think Children / Family Focused Practice Approach

It is important that we follow this policy as well as the HSE Child Protection and Welfare Policy and its procedures.

1.2. Scope

This policy applies to all staff working in HSE Adult Mental Health Services and relevant HSE funded services.

This policy is designed to sit alongside the HSE Child Protection & Welfare Policy which together protect children. It aims to compliment the HSE Child Protection and Welfare Policy but is not intended to serve as a summary or to substitute it. Each policy provides distinct and necessary guidance, and adherence to both is essential.

1.3. Outcomes

This policy aims to equip Adult Mental Health Service professionals to embrace an ongoing *Think Family − Think Children* approach. This means we should consider and assess the needs of children in a close relationship and/or in the care of the adult service user, and respond to any risk of harm to their health, development or welfare.
In this policy, we emphasise the support needs of the family unit. Considering the family's needs has a positive impact on recovery outcomes for the individual service user.

1.4. Disclosure of interests

No conflicts of interest were disclosed.

1.5. Supporting evidence, documents and useful resources

Legislation, guidelines, procedures and policies
Children First Act 2015
Children First; National Guidance for the Protection and Welfare of Children (2017)
Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012
Domestic Violence Act 2018
HSE Children First website
HSE Child Protection & Welfare Policy
HSE Code of Conduct

HSE Data Protection Policy
HSE National Consent Policy
HSE National Records Retention Policy
HSE Procedures on Protected Disclosures of information in the workplace
Other resources
A Guide for the Reporting of Child Protection and Welfare Concerns
Child Protection and Welfare Practice Handbook 1
Child Protection and Welfare Practice Handbook 2
Data Protection Commission: Children Front and Centre: Fundamentals for a child-oriented approach to data processing
Tusla Child and Family Support Network Coordinators
Tusla Parenting24seven – Key messages for what works best for children and families at different ages and stages
Tusla Prevention, Partnership and Family Support Programme – Meitheal for help when difficulties have arisen
Tusla Prevention, Partnership and Family Support Programme – Parenting information (General information)
Tusla Web Portal User Guide
Training
All mandatory training assigned to staff through HSeLanD

2. Definitions

Child protection

Protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect.

Child protection concern

This term is used when there are reasonable grounds for believing that a child may have been, is being or is at risk of being physically, sexually or emotionally abused or neglected.

Child safeguarding

Child safeguarding is how we look after children in our society, to protect them from:

- harm
- abuse
- neglect
- exploitation.

Child safeguarding aims to prevent harm and address potential issues before they escalate into more serious concerns. It involves protecting children from harm and promoting their overall welfare.

This includes recognising child welfare concerns that may warrant assessment and support, but may or may not require a child protection response.

- Child **safeguarding** prevents and protects.
- Child **protection** responds and protects.

Child welfare concern

This is a problem experienced directly by a child, or by the family of a child, that negatively impacts the child's:

- health
- development
- welfare.

This problem warrants assessment and support, but may or may not need a child-protection response. An example of child welfare concern is when a parental mental illness is having an impact on a child's health or well-being, because the parent is not able to care for the child properly.

Harm

This is defined in the Children First Act 2015. Harm in relation to a child is defined in two ways

1) Assault, ill-treatment or neglect of the child in a way that seriously affects or is likely to seriously affect the child's health, development or welfare.

2) Sexual abuse of the child, whether caused by a single act, omission or circumstance or a series or combination of acts, omissions or circumstances, or otherwise.

For more details and practical guidance, please see:

- Chapter 2 Children First: National Guidance for the Protection and Welfare of Children (2017).

Whether harm is significant is determined by the child's health and development compared to what would be reasonably expected of a child of similar age. The threshold of significant harm is reached when the child's needs are neglected to the extent that their well-being and/or development are seriously affected.

HSE Child Protection and Welfare Reporting Procedure

Included as part of the HSE Child Protection and Welfare Policy, this procedure outlines the key stages and considerations in relation to reporting a child protection or welfare concern in the HSE. All stages in the reporting procedure should be considered.

Mandated Person

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

(Schedule 2 of the Children First Act 2015 provides a **full list of Mandated Persons**).

Mandated Persons have two main legal obligations under the Children First Act 2015:

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

You should be aware that the legal obligation to report mandated concerns rests with the Mandated Person and you cannot discharge your duty to report these concerns on to someone else.

A report can be made jointly with any other person who shares your concerns.

As a Mandated Person if your concern does not reach the threshold for mandated reporting, but you have reasonable grounds for concern about the welfare or protection of a child, you should still report that concern to Tusla.

Mandated Report

A Mandated Report is the report sent by a Mandated Person to Tusla – Child and Family Agency. It must be sent without delay, when they have any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed, or is at risk of being harmed. This includes where a child discloses their belief to a Mandated Person that they have been, are being or are likely to be harmed. The Mandated Person ticks the box on the Tusla report form to indicate that it is a mandated report.

Reasonable grounds for concern

Reasonable grounds for concern exist where a child may have been, is being, or is at risk of being abused, harmed, exploited or neglected. For example:

Injury or behaviour
There may be evidence of an injury or behaviour that is consistent with abuse and is unlikely to have been caused in any other way.

Sexual abuse
You may be concerned about possible sexual abuse.

Emotional or physical neglect
There may be consistent signs that a child is suffering from emotional or physical neglect.

A Child's behaviour
The child may say or indicate in other ways that they have been abused.

Admission of alleged abuse
An adult or child may admit or indicate that they have committed alleged abuse.

Eye witness
A person has given an account of seeing the child being abused.

Service user file

This is a comprehensive and centralised record maintained for each adult mental health service user. It contains all:

- relevant clinical notes
- assessment forms
- other relevant documentation.

This file is the main place to store the user's:

- mental health history
- treatment/care plans
- progress notes
- any interactions with healthcare professionals.

Other names for service user file
The service user file ensures there is continuity of care and facilitates effective communication among the healthcare team. This file is also known as a:

- clinical file
- medical record
- patient record.

Child Safeguarding Action Plan

When there is a concern for a child due to their relationship with the adult service user clinicians need to identify, as part of the adult service user's Individual Care Plan or, when in place, the Individual Recovery Care Plan (IRCP), the actions needed to protect the welfare of a child. These actions are designed to protect the welfare of the child when a concern for their safety or welfare arises. These are concerns that arise due to a child's access with or relationship with the adult service user.

Actions should include:

- taking immediate safety measures
- reporting to and/coordinating with relevant agencies
- recording and putting in place steps for a broader child safeguarding plan
- providing ongoing support
- monitoring to ensure the child's safety.

Collateral information

Collateral information is an important part of a specialist mental health assessment. It is information clinicians gather about the service user from someone other than the service user. We may be given this information from the service user's family members, friends, carers or supporters – information that you may not get from the service user's self-reports.

We will consider and use this information as appropriate to inform actions, treatments or interventions for the service user.

3. Guiding principles for this Policy

3.1 Children's safety and welfare is everyone's responsibility

The safety and welfare of children is everyone's responsibility. The best interests of the child must be paramount. The safety, welfare and development of children and young people are core objectives and key priorities for the HSE.

3.2 Key definitions, signs and reporting thresholds must be known

All staff working in HSE Adult Mental Health Services need to know and understand the definitions of:

- harm
- a child protection concern
- a child welfare concern.

These definitions are set out in the **HSE Child Protection and Welfare Policy**. They are informed by the **Children First Act, 2015** and the **Children First National Guidance for the Protection and Welfare of Children, 2017**.

Staff should know the definitions, signs and reporting thresholds of abuse and neglect.[3]

3.3 Mandated Persons need to know their legal responsibilities

Staff who are Mandated Persons should know their legal responsibilities under the Children First Act 2015.

3.4 Prevention and intervention help

Early prevention and intervention are vital for better outcomes.

3 HSE Child Protection and Welfare Policy Appendices ' Abuse and neglect: Definitions, Signs and Reporting Thresholds

3.5 Every contact presents an opportunity to identify a potential risk

As part of our practice, we undertake a core bio-psycho-social assessment with a service user when they first come in contact with our services. During this assessment, we should consider if there may be any child welfare concerns and any child protection or safeguarding risks arising.

Each subsequent contact, with a service user is a chance for us to identify a potential child safeguarding risk. We should always have the best interests of the child in mind when assessing an adult service user and any of their additional support needs.

3.6 The value of family involvement should be reviewed throughout the service user's recovery journey

We should consider with the service user the value of involving family at the initial assessment, and throughout their recovery journey.

Keep the *Think Family − Think Children* approach in mind as part of the recovery culture. This encourages family members to engage with the service as part of the assessment and as part of recovery culture.

Collateral information is important. This is information we gather about the service user from someone other than the service user. We may be given this information from the service user's family members, friends, carers or supporters – information that we may not get from the service user's self-reports. We can consider the importance of this information to inform, as appropriate, actions, treatments or interventions for the service user.

Seeking collateral information from a service user's family or designated person is an important part of a specialist mental health assessment. We should look for the service user's consent before you look for this information. However, if they do not wish to consent, you can still accept collateral information from family and/or a designated person without the service user's consent.

For more information about consent and confidentiality, please see:

- the **HSE National Consent Policy 2022**
- their professional ethics guidance, for example **Guide to Professional Conduct and Ethics for Registered Medical Practitioners 9th Edition 2024**.

3.7 Service users should receive appropriate treatment and interventions

Where possible, all service users should receive appropriate treatment and interventions. This includes family-focused therapies and interventions. This will help you and the service user achieve the desired outcomes from their individual treatment plan.

The type and details of any specific treatment or intervention are not considered within the scope of this policy.

3.8 Balanced approach is needed

We must strike a balance between protecting the rights and welfare of children, and respecting the rights, needs and duties of others, including:

- parents or carers
- families
- HSE staff.

If there is conflict, the paramountcy principle applies – the best interests of the child must come first.

3.9 Appropriate sharing of service user's information

Child safeguarding and protection is a multi-agency, multi-disciplinary activity. Agencies and professionals must work together in the interests of children. There are certain circumstances when we may need to work with and to share a service user's information with other HSE staff and agencies, such as:

- Tusla[4]
- An Garda Síochána.

We may share this information as long as it is shared in a proportionate 'need-to-know' basis, for the protection and welfare of any children. Agencies, professionals and staff must work together in the interests of children.

4 Tusla Child & Family Agency. An Ghniomhaireacht um Leanai agus an Teaghlach

3.10 Protecting personal information

The **HSE Data Protection Policy** sets out the requirements of the HSE relating to the protection of personal data. All staff need to comply with this data protection law. However, we should always give precedence to child protection measures over data protection considerations.

The General Data Protection Regulation (GDPR) makes allowances for when we need to share information to protect a child and ensure their welfare.

This is covered in the Data Protection Acts 1988 to 2018. Articles 6(1)(c) Compliance with a Legal Obligation and 6(1)(d) Vital Interest, of the General Data Protection Regulation (GDPR).

Important: The data protection rules in the GDPR and the 2018 Act (irrespective of whether childrens' or adults' personal data is at issue in any given situation) are not a barrier to safeguarding. It is in the 'best interests' of children to be protected from violence, abuse or interference/control by any party.

All staff must explain the limits of confidentiality to service users at the earliest opportunity, including the legal requirement to report concerns to Tusla or An Garda Síochána.

4. Procedure for Adult Mental Health Service teams to support clinicians to implement this policy

For Adult Mental Health Services to identify and appropriately manage any potential child safeguarding concerns, the following steps should be followed.

4.1 Amend the Core Bio-psychosocial Assessment

The Core Bio-psychosocial assessment template, currently used within the service, should be amended to ensure that a *Think Family − Think Children* approach is taken by all clinicians.

The assessment should:

- collect information on the service user's current level of care for, and access to, children
- include guidance on potential questions and cues to help the clinician to identify potential child welfare concerns and/or safeguarding risks
- include into the overall risk assessment an assessment of child safeguarding to address any child protection or welfare concerns.

Appendix 3 details a sample of a standard core bio-psycho-social assessment template which includes the above elements:

- Section on 'Current child-caring/parenting circumstances' (template page 8) sets out how to capture information on the service user's current level of care for, and access to, children
- This section, together with guidance on potential questions and cues (noted on page 8) will support clinicians to gather relevant information and identify such risks. The assessment should also help identify wider family support issues that may need to be referred for other internal or external interventions.
- Section on 'Risk Assessment' (template page 12) details how the risk assessment should, as standard, include assessment of any possible child protection or welfare concerns. It also includes potential prompts and questions for clinicians to consider in undertaking the risk assessment - reference **Royal College of Psychiatrists – Rethinking risk to others in mental health services** (published May 2017).

4.2 Equip clinicians with tools to support identification of potential concerns at follow up clinical assessments

Appendix 4 of this policy sets out guidance to support clinicians to identify potential child safeguarding risks during a follow up clinical assessment. Clinicians should be made aware of these questions/cues to use at a service user's follow up clinical assessment.

4.3 Create an ALERT section in the service user file

Adapt the service user file structure to include a clear 'ALERT' section. In this section, brief notes and observations on any specific concerns identified about the service user should be included. This should include a dedicated section for any child protection or welfare concern, or suspicion of potential concern that needs to be monitored. Any actions needed to assure protection of the child, should also be included.

See Appendix 5 for further details on the ALERT section of the service user file

4.4 Consider importance of multi-disciplinary work

Teams should consider the importance and value, where possible, of a multidisciplinary approach to clinical reviews with service users. For example, this may include using peer support where available.

Feedback from teams whose standard practice is to have a social worker or occupational therapist or psychologist (or other relevant health and social care professional) attend all out-patient clinics indicates the value this brings in embracing the *Think Family − Think Children* approach.

It also enables timely and efficient decision making around the service user's overall treatment plan.

4.5 Advocacy

Make service users aware they can avail of advocacy services where appropriate.

4.6 Posters

Consider putting up information posters that remind clinicians and service users of the value of a *Think Family − Think Children* approach. These posters should be put up in all clinic room settings where mental health assessments are carried out.

5. Procedure to implement policy within a service setting

To identify and appropriately manage any potential child safeguarding concerns, the following specific steps should be followed

Flow diagrams in Appendix 2 set out the process in visual format

5.1 Initial presentation of a service user

There are three ways a service user may access Adult Mental Health Services during initial presentation:

1. To Community Adult Mental Health Services following referral by a General Practitioner (GP)

2. To an Acute Hospital Emergency Department (ED) either following a GP referral or as a self-referral
3. Admitted to an Approved Centre– either voluntarily or under the Mental Health Act 2001.

NOTE: GP Referrals to Adult Mental Health Services

A GP referral to Adult Mental Health Services may include information about child protection or welfare concerns. This information should be noted when the referral is triaged by the Adult Mental Health Services team. The referral should be managed according to the level of risk assessed. At the triage stage the Adult Mental Health Services team need to prioritise:

- assessment
- review by the multidisciplinary team

The following steps should also be taken when GP referrals to Adult Mental Health Services indicate child protection or welfare concerns:

Immediate review by Adult Mental Health Services social worker
When we get a GP referral that indicates a child protection or welfare concern, the HSE Adult Mental Health Services social worker needs to immediately review the case so they can support any immediate interventional actions needed.

The Adult Mental Health Services social worker should be involved in completing the core bio-psycho-social assessment.

Working with the GP
It is important to engage with the GP to get more details and to find out if they have sent a report to Tusla.

IMPORTANT!
Providing information around a child protection or welfare concern as part of a referral to Adult Mental Health Services does not in any way replace the GP's responsibility as a Mandated Person under the Children First Act. If the concern meets the threshold for mandated reporting and the GP has not submitted a report to Tusla, you should remind the GP of that responsibility, but also submit a report as soon as possible.

Complete core-bio-psycho-social assessment

In all cases, and regardless which of the three ways that the service user initially presents to Adult Mental Health Services, we must assess their needs and risk, so we can support their recovery. This is done through a standardised, specialist and, comprehensive mental health bio-psycho-social assessment.[5]

A trained mental healthcare professional skilled in the assessment and in management of this service user group carries out this assessment.

Following the (amended) core bio-psycho-social assessment template take a *Think Family − Think Children* approach and consider if any child welfare concerns and/or safeguarding risks can be identified.

Gather information

You, as the clinician undertaking the core bio-psycho-social assessment, should collect information about any child in the care of the service user or within their immediate living or caring environment. You should always use a *Think Family − Think Children* approach. You must assess the probability of potential child safeguarding concerns.

Always explain the limits of confidentiality to service users at the earliest opportunity, including the legal requirement to report concerns to Tusla and/or An Garda Síochána.

Follow sections 5.3 onward of this policy to respond to any child protection or welfare concerns appropriately.

5.2 Follow up assessments and reviews

Follow up assessments and reviews of service users should always appropriately reassess and consider potential child safeguarding risks.

Child safeguarding issue may arise at any stage

The service user will receive treatment and interventions as set out in their treatment plan/ individual care plan that will support their recovery goals. You as a staff member may identify a possible child safeguarding concern at any stage in the service user's journey. This could be when they are assessed, treated or reviewed. It may be when they are

5 The core bio-psycho-social assessment is an overall assessment designed to understand an individual service user's level of needs and risk and includes collection of collateral information.

receiving treatment or reviewed:

- by a member of the Community Adult Mental Health Services team
- at an approved centre
- within an acute hospital setting.

Examine ALERT section in relation to any child protection or welfare concern

You should review the service user's treatment/care plan. You should pay specific attention to any child protection or welfare concern (definite or suspected) as noted in the ALERT section of the service user's clinical file.

If there is information on a previously noted concern, this should inform your assessment and updates. You may need to change how to manage the adult's mental illness to safeguard the child. You should note this in the service user treatment or care plan and within the service user file ALERT section.

If you find there is evidence to resolve, fully address or close a risk you should also document this on the service user treatment and/or care plan.

Must Take *Think Family – Think Children* approach

Even if there has been no previous concern identified, you should take a *Think Family − Think Children* approach. This will help to keep you alert to the potential fluctuating nature of mental health challenges and their impact on increasing or diminishing risk in terms of any possible child safeguarding concerns.

Appendix 4 provides guidance on potential questions and cues to show the clinician how to identify such risks during a follow up clinical assessment.

5.3 Respond to any concern identified

The following steps should happen if you as a staff member identify a child protection or child welfare concern (definite or suspected) at either stage:

(5.1) Initial presentation of the service user, or
(5.2) Follow-up assessment of the service user.

5.3.1 Report child protection concerns

Anytime you identify a child protection or welfare concern (see definitions), follow the clear obligations set out under the Children First Act 2015 and **HSE Child Protection and Welfare Reporting Procedure**.

Always ensure to inform Tusla whether any family member (other than the service user) has been notified of the concerns, so that they can take appropriate action as part of their safety planning.

If there is immediate and serious risk, you should ensure the immediate safety of the child by phoning the Tusla Dedicated Contact Point[6]. Where Tusla is unavailable, you should contact An Garda Síochána.

5.3.2 Let service user know you are concerned

When dealing with any child protection or welfare concern you should aim to let the service user know you are concerned. However, you should not do this if it could:

- put the child, or someone else, at risk
- impact the ability of Tusla or An Garda Síochána to assess or investigate the concern.

When letting the service user know you are concerned about a child, you should make sure they understand the potential risk. You should also explain why any action will be carried out and how it is valuable to involve other family members and carers in the treatment plan. This type of communication is part of the *Think Family − Think Children* approach.

5.4 Signpost in the 'ALERT' section

In the 'ALERT' section of the service user file add brief notes and observations about any specific concerns you have identified about the service user. This should include any child protection or welfare concern, or suspicion of potential concern that needs to be monitored.

The ALERT section should clearly flag where the detailed record of the concern and actions identified to assure child safeguarding is held in the service user file. You should check this ALERT section for any concern at least at each clinical assessment, or contact, or both.

Opportunities to do this include:

- ward rounds
- case conferences
- out-patient clinics.

6 Tusla has Dedicated Contact Points available throughout the country that can be contacted to discuss any child protection or welfare concerns.

Record details

You should record the details of the concern, including applicable notes and observations, in the ALERT section of the service user's file.

5.5 Prepare a Child Safeguarding Action Plan

If you identify a concern at the service user's initial presentation or at a follow-up assessment, you must include how you plan to manage this concern in the treatment or care plan. You should do this even if it is only a suspicion of concern.

Child Safeguarding Action Planning

Action plan content

You must identify and document in the service user's treatment or care plan any actions necessary to protect the child, including:

1) All treatments, interventions and actions

The child safeguarding action plan should include recommended:

- treatments
- interventions
- actions.

2) Who will take action

The care plan should say who will:

- manage the child safeguarding concern
- take immediate action to notify Tusla or An Garda Síochána
- carry out any follow-up actions identified together with Tusla or Garda Síochána (or both) if applicable.

3) Who is involved

The plan should say who is involved in referring the child to other services and agencies for the child and family.

4) Status of all actions

As appropriate all actions should be:

- tracked
- reviewed
- escalated
- closed.

You need to do this as the service user continues on their journey through the service.

Time and place should be taken into account

Child safeguarding action planning should cover what is practical at that time. For example, a plan developed at 3am in an Emergency Department by a Non-Consultant Hospital Doctor (NCHD) may only be able to plan for the next 24-48 hours.

However, a plan identified as part of a bio-psycho-social assessment undertaken at a routine clinic appointment may encompass actions over a significantly longer period of time.

Actions should be appropriate

The child safeguarding action plan should consider actions that are appropriate and proportionate to the level of concern that is identified.

Plan should clearly state if a report was made to Tusla – Child and Family Agency

The plan should say:

- whether a referral or report was made to Tusla
- where a copy of the report is held
- if the ALERT section was updated

Concerns should be flagged in the ALERT section

If there is a concern, it should be flagged in the ALERT section of the service user file.

Action Plans should be regularly reviewed and updated

Any Adult Mental Health Services clinician who interacts with the service user should review and update the plan on an ongoing basis. Note all updates, including:

- action taken
- actions outstanding
- engagement with other family members.

This is needed so the HSE Adult Mental Health Services social worker can support the assessment of any concern and the involvement of Tusla with their associated risk management actions.

If a report has been made to Tusla it is important to verify that Tusla have undertaken a child protection assessment of the concern and that a safety plan is in place. Continue to monitor the situation. Also, never assume Tusla have all information, so if any new information on an existing concern or any new concerns related to the welfare or protection of the child are identified at follow up assessments, these must also be reported to Tusla. The child safeguarding action plan should continue to be monitored and updated.

Actions plans should be supervised by a consultant

A consultant psychiatrist should supervise the plan as it is:

- developed
- put in place
- closed out.

The plan should only be closed out when all individual risks noted have been closed or fully addressed. There should also be liaison with Tusla, if they are involved.

Appendix 6 provides guidance to support Child Safeguarding Action Planning

5.6 Notify HSE Adult Mental Health Services social worker

The HSE Adult Mental Health Services social worker has a particular expertise in working:

- systemically with families
- within teams
- with other agencies.

They provide guidance about managing child protection or welfare concerns.

Where you identify a child protection or child welfare concern, you should notify the HSE Adult Mental Health Services social worker and ask them to get involved in the care and treatment plan. You should note additional updates to the service user's treatment or care plan. This should be based on any interventions and actions that the HSE Adult Mental Health Services social worker initiated.

Further actions and interventions should be documented in the service user treatment and/or care plan.

5.7 Multidisciplinary Team review of concerns

Any child protection or welfare concern should be reviewed at the next Multidisciplinary Team (MDT) meeting. Additional updates to the service user treatment or care plan should be noted. This should be based on interventions and actions initiated by any member of the MDT and/or by the Tusla social worker if applicable.

We recommend that all new service user core bio-psycho-social assessments are discussed and reviewed by MDT at their next meeting. This is to provide assurance that all child safeguarding concerns identified (definite or suspected) will be:

- reviewed by the MDT
- flagged to the adult mental health social worker for consideration.

If the HSE Adult Mental Health Services social worker is not present at the MDT meeting, a written communication should be sent to them. This will make sure they know of the concerns and actions taken. For example, they will know if a report to Tusla has been made or not.

Never assume that just because Tusla may already be involved in a specific case, that Tusla already has all the information. Always consult with Tusla about any extra information about an existing concern or any additional concerns that may emerge at follow-up assessments with the service user.

5.8 Risks that arise during service user's journey

Sometimes a possible child protection or welfare concern is identified at a later point in the service user's journey.

In these circumstances, we need to plan actions that will protect the child from risk. You should document these actions in the service user treatment and/or care plan.

The MDT should raise or review any concerns and flag them to the HSE Adult Mental Health Services social worker. This is needed even if there has been a referral to the HSE Adult Mental Health Services social worker in the past.

Both of these actions should be documented in the service user treatment or care plan. This is in addition to any responsibilities that staff have under the **HSE Child Protection and Welfare Policy**. For example, all staff need to report concerns to Tusla, if there are reasonable grounds for concern. Mandated Persons must make a mandated report if the concerns reaches the threshold of harm.

5.8.1 When Tusla needs to be involved

If Tusla needs to be involved, the MDT should ensure a named individual from their team coordinates interagency collaboration, to help achieve the best outcome. This should be noted in the service user's treatment and/or care plan. If the named individual is unavailable, an alternative individual should be delegated to maintain coordination as required.

5.8.2 Tusla is lead agency for child protection

In the case of a child protection concern, Tusla is the lead agency. Staff from Tusla will be responsible for leading a child protection assessment of the concern. They would typically be the ones to engage with a child directly. It would be unusual for HSE Adult Mental Health Services to directly engage with children unless it was part of family-based interventions.

Effective communication with Tusla or any other agency when managing any risks is essential to ensure the best outcome. Working together may include a series of scheduled interagency child protection and welfare strategy meetings. These should involve multiple members of the Adult Mental Health Services team and different contacts within Tusla or other agencies.

You must always keep records relating to child protection and welfare (notes and reports) in perpetuity as detailed in the HSE National Records Retention Policy.

5.9 Information sharing

Refer to the HSE Child Protection and Welfare Policy and its Information Sharing Framework for guidance on understanding when it is appropriate to share information for child safeguarding purposes.

Always explain the limits of confidentiality to service users at the earliest opportunity, including the legal requirement to report concerns to Tusla and/or An Garda Síochána.

Protection of a child comes first
The best interests of the child must be paramount. You must share information for the immediate protection of a child in a proportionate 'need-to-know' way whether or not you have the service user's consent. You should say why you need to share this information in the service user file.

Always tell Tusla about child protection concerns

You must always report child protection concerns to Tusla – even if you do not have the service user's consent. You do not need to get consent to make a report to Tusla if your report is made in good faith. Mandated Persons must make a report if a child is at risk of harm, in line with the Children First Act 2015.

Always ensure to inform Tusla whether any family member (other than the service user) has been notified of the concerns, so that they can take appropriate action as part of their safety planning.

When a report has been made to Tusla it is important to verify that Tusla have undertaken a child protection assessment of the concern and that a safety plan is in place. Continue to monitor the situation. Also, never assume Tusla have all information, so if any new information on an existing concern or any new concerns related to the welfare or protection of the child are identified at follow up assessments, these must also be reported to Tusla. The child safeguarding action plan should continue to be monitored and updated.

5.9.1 Getting consent to share information

If you aim to get family members involved in the service user's treatment, you should always try to get the service user's consent first. You should also share relevant information as needed.

Consent is an ongoing process
Consent should be an ongoing process during the service user's care journey. This is especially important when you are considering sharing information related to child welfare or protection concerns.

5.9.2 When service user at first refuses consent

If the service user initially refuses consent for family involvement in their treatment, it is important to revisit the consent conversation if a child welfare or protection concern arises. As much as you can, make sure the service user understands the risk identified and its seriousness. Explain the potential for:

- heightened concerns
- the need to intervene early
- welfare support.

Tell the service user that without family support, the concern may escalate. This could lead to child protection and safety concerns that may need to be reported to Tusla and/or An Garda Síochána.

When service user will not give consent and a concern for a child arises
If the service user refuses to allow information sharing with family members, assess if you need to report the concern to Tusla. If unsure, have an informal and anonymised consultation with Tusla. You should note this in the service user file.

How is a family member or the carer of a child to be informed of a concern if the service user refuses consent
Where there is a clear and immediate child protection or welfare risk, proceed to share information without consent, in a proportionate 'need-to-know' way.

If the risk is not immediate, always consider the safety and welfare of the child as paramount when making a decision on whether it is appropriate for you to share information. Giving information to a person who has a bona fide 'need-to-know' for the protection of a child is not a breach of confidentiality or data protection, where the best interests of the child or young person require it.

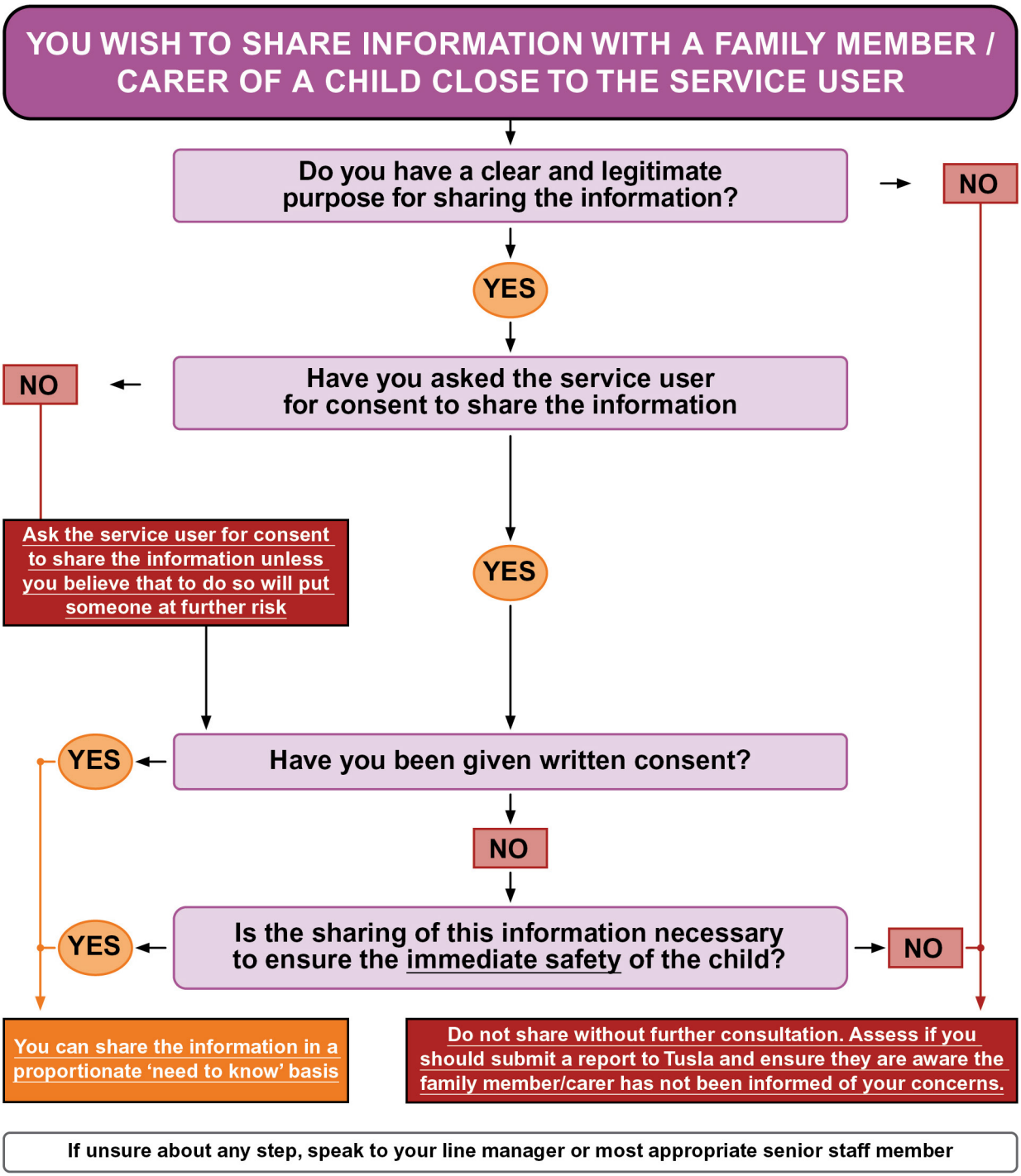
Any information shared must be reasonable and proportionate.

Let Tusla know about the level of the family's awareness
When making a report to Tusla, inform them if the family or carer of the child is not involved or does not know about the concern. This is a key piece of information that Tusla

may need when assessing any level of risk. Ask Tusla to consider informing the family, as part of their safety planning process.

5.9.3 Child Safeguarding Information Sharing Framework in Adult Mental Health Services

The following flowchart is an adaptation of the HSE Child Protection and Welfare Policy Information Sharing Framework, for the purpose of applying the framework directly to this policy document.



6. Policy development

6.1 Consultation and stakeholder involvement

When developing this Policy, the working group engaged with stakeholders within the HSE. These included:

- Principal Social Worker Group
- Executive Clinical Directors
- Area Directors of Nursing
- Principal Occupational Therapists
- Principal Psychologists
- Mental Health Services Heads of Service
- Quality and Patient Safety
- HSE Children First Training and Development Officers
- Office of Mental Health Engagement and Recovery

The working group sent the draft Policy to each group of HSE stakeholders and asked for review and feedback from these groups.

The working group also engaged with external parties when developing this Policy. These included:

- Persons with lived experience
- Funded Non-Governmental Organisations (NGOs) delivering the service on behalf of the HSE (through Mental Health Reform)
- Ombudsman for Children's Office
- Tusla – Child and Family Agency

6.2 Communicating, distributing and putting plan in place

The following explains how the working group will roll out this policy to 'Adult Mental Health Services' teams.

6.2.1 Communicating the policy

When finalised, the working group will issue the policy to Adult Mental Health Services teams in the Regional Health Areas (RHAs). The working group will do this by communicating with the office of the HSE Regional Executive Officers (REOs). Each RHA will be responsible for making sure the policy is put in place. RHAs must do the following:

- notify all Adult Mental Health Service team members about this policy and its implications for the local service
- update the core bio-psycho-social assessment template to incorporate the policy guidance
- put in place the ALERT section of service user files and individual care plans
- put in place child safeguarding action planning within the service user treatment or care plan.

The working group will also send each RHA a reminder about the sample policy implementation plan template. It is in Appendix 4 of the National PPPG Template.

Staff members can get this template on the home page of the **HSE National PPPG Central Repository**. Staff members can adapt this as needed to support putting the plan in place locally.

6.2.2 Dissemination of the policy content

The working group responsible for developing the policy content will support the distribution of the policy by organising the following:

- presentation to RHA mental health service leads (or equivalent)
- presentation to Executive Clinical Directors
- recorded introductory video for all Adult Mental Health Services staff.

6.2.3 Questions related to the Policy

If you have a question or comment about this policy, please email **ChildrenFirst@hse.ie**.

6.2.4 Expected date of full implementation

The policy will become effective from 01 May 2025. Adult Mental Health Services teams are expected to implement this policy as soon as possible to the effective date.

6.2.5 Policy storage and access

The policy document can be accessed only on the **HSE National Central Repository**. It is the single trusted source for accessing, storage and document control for national Policies, Procedures, Protocols and Guidelines (PPPGs). Associated templates can be accessed via **Mental Health Services - Procedures, Processes, Guidance - HSENet Document Hub**.

There should be no duplicate copies of this policy accessible in any secondary electronic locations. Instead, staff must link to the document on the Repository from other locations. This link will automatically update in all locations if changed on the Repository.

7. Governance and approval

HSE National Mental Health Operations are responsible for the governance and approval arrangements for this policy. The Assistant National Director for Mental Health Operations, working jointly with the HSE Children First Lead, commissioned this policy.

They used a checklist to assess if the policy met the PPPG standards. This list was outlined in How to Develop HSE National PPPGs – A Practical Guide. It was signed and dated by the co-Chairpersons of the Working Group.

The HSE National Director, Access and Integration will review and be responsible for approving the policy. They will base their review on the Working Group's recommendation.

Once approved, the working group will convert the final version of this document into a PDF and upload it to the HSE National Central Repository. A signed and dated copy of the Checklist will be attached to the master copy, which will be kept by the National Director, Access and Integration.

8. Sustainability

The implementation of this policy is the responsibility of the HSE Regional Executive Officer (REO) within each health region, ensuring its integration into local service delivery. Monitoring of compliance with this policy will fall under the overall operational monitoring and compliance arrangements already established within the services. Additionally, the HSE Children First National Office (HSE CFNO) will incorporate specific assurance criteria related to this policy within the HSE Children First Compliance Assurance Frameworks and Checks; however, these checks will not occur on a regular basis.

9. Review and update

9.1 Next review date

A review of the policy will commence within one year of its publication, in collaboration with key stakeholders, to assess its effectiveness and ensure alignment with best practices and emerging needs.

If there are no amendments to the National 3PG following the review process, the date and detail of the review must still be recorded in the version control update box (page 2).

10. References

Children First Act 2015
Children First: National Guidance for the Protection and Welfare of Children (2017)
Guide to Professional Conduct and Ethics for Registered Medical Practitioners 9th Edition 2024
HSE Child Protection and Welfare Policy
HSE Child Protection and Welfare Reporting Procedure
HSE Data Protection Policy
HSE National Records Retention Policy
Royal College of Psychiatrists – Rethinking risk to others in mental health services

11. List of abbreviations

ED – Emergency Department
FFP – Family Focused Practice
GP – General Practitioner
HSE – Health Service Executive
IRCP – Individual Recovery Care Plan
MDT – Multidisciplinary Team
NCHD – Non-Consultant Hospital Doctor
NGO – Non-Governmental Organisations
NICE – National Institute for Health and Care Excellence
PPPG – HSE National Policy, Procedures, Protocols, Guidelines and Clinical Guidelines

REO – HSE Regional Executive Officer
RHA – HSE Regional Health Area

12. Appendices

Appendix 1: Evidence base for a *Think Family − Think Children* and a Family Focused Practice Approach
Appendix 2: Flow diagrams to support Adult Mental Health Services staff
Appendix 3: Standard Core bio-psycho-social assessment template
Appendix 4: Guidance on potential questions/cues to support the clinician in how to identify child safeguarding risks
Appendix 5: Guidance on structure and content of ALERT section of the service user file
Appendix 6: Guidance to support Child Safeguarding Action Planning
Appendix 7: National Monitoring and Auditing of policy
Appendix 8: Membership of Policy Development Group
Appendix 9: Policy approval and sign off

Appendix 1: Evidence base for a *Think Family – Think Children* and a Family Focused Practice Approach

The following documents include reviews of the literature in relation to the impact of parental mental illness on children and families and identify the evidence base for a Family Focused Practice and a *Think Family − Think Children* approach in Adult Mental Health Care.

- Dickens, J., Cook, L., Cossar, J., Rennolds, N., Rimmer, J., Sorensen, P., Wate, R., Taylor, J., Hallett, N., Molloy, E., & Garstang, J. (2022). Learning for the future: final analysis of serious case reviews, 2017 to 2019. Department for Education
- Brandon M, Sidebotham P, Belderson P, Cleaver H, Dicken J, Garstang J, Harris J, Sorensen P, Wate R. Complexity and challenge: A triennial analysis of SCRs 2014 – 2017.
- Holttum, Sue. "Inclusion of family and parenthood in mental health recovery." Mental Health and Social Inclusion 22.3 (2018): 114-120.
- Foster, K. P., Hills, D., & Foster, K. N. (2018). Addressing the support needs of families during the acute hospitalization of a parent with mental illness: A narrative literature review. International Journal of Mental Health Nursing, 27(2), 470-482. **https://doi.org/10.1111/inm.12385**
- Lagdon, Susan, et al. "Families with parental mental health problems: A systematic narrative review of family focused practice." Child Abuse Review 30.5 (2021): 400-421.
- Goodyear M, Hill TL, Allchin B, McCormick F, Hine R, Cuff R, O'Hanlon B. Standards of practice for the adult mental health workforce: meeting the needs of families where a parent has a mental illness. Int J Ment Health Nurs. 2015 Apr 24(2):169-80. doi: 10.1111/inm.12120. Epub 2015 Jan 26. PMID: 25619407.
- Power, J., Goodyear, M., Maybery, D., Reupert, A., O'Hanlon, B., Cuff, R., & Perlesz, A. (2016). Family resilience in families where a parent has a mental illness. Journal of Social Work, 16(1), 66-82. **https://doi.org/10.1177/1468017314568081**
- Goodyear M, Zechmeister-Koss I, Bauer A, Christiansen H, Glatz-Grugger M, Paul JL. Development of an Evidence-Informed and Codesigned Model of Support for Children of Parents With a Mental Illness- "It Takes a Village" Approach. Front Psychiatry. 2022 Jan 31;12:806884. doi: 10.3389/fpsyt.2021.806884. PMID: 35173638; PMCID: PMC8841827
- Falkov A, Grant A, Hoadley B, Donaghy M, Weimand BM. The Family Model: A brief intervention for clinicians in adult mental health services working with parents experiencing mental health problems. Australian & New Zealand Journal of Psychiatry. 2020;54(5):449-452.

Further, the Social Care Institute for Excellence (SCIE) UK document below identifies what parents and children have said they want, and how they would like to be supported.

- **Family Focused Practice in Adult Mental Health Care**
- **SCIE: Think child, think parent, think family: A guide to parental mental health and child welfare**

The 2019 **Hidden Harm Strategic Statement**, while focused on the impact of parental substance misuse on children, is a good example of Irish healthcare services promoting family focused practice and strong interagency working to protect child and enhance their wellbeing.

In the Republic of Ireland context, Mulligan et al (2021) reported that 'over two thirds of the families reported substantial benefits from participating in Family Talk, including reduced stigma, giving children and partners a voice, increased service-user confidence, and improved family communication/relationships' (p.2).

Additional studies highlight greater work satisfaction for professionals engaging in Family Focused Practice as a consequent of a more collaborative approach to working with families (Toikka and Solantus 2006; Moore et al., 2012).

In 2009, Social Care Institute for Excellence (SCIE) in UK developed a 'Think Family, Think Parent, Think Child' Guide for health care professionals working with children and adults. In 2011 SCIE recommended:

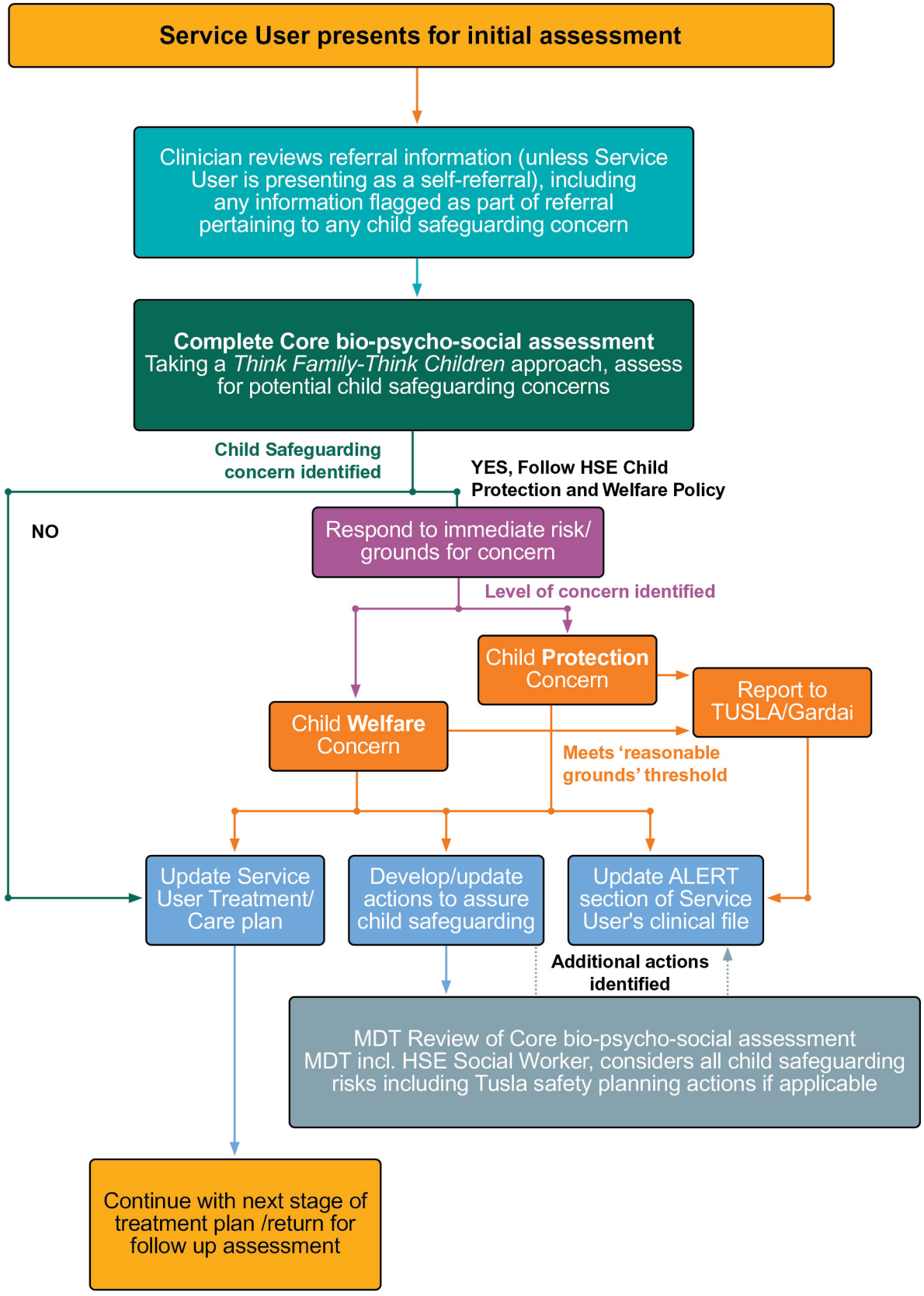
- The Family Model is a useful conceptual framework, developed by Australian child and adolescent psychiatrist, Adrian Falkov, to help staff consider the parent, the c hild and the family as a whole 'when assessing the needs of - and planning care packages for - families with a parent suffering from a mental health problem' (Falkov, 2012).

In 2007 a group of young carers in Merseyside came up with the following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems:

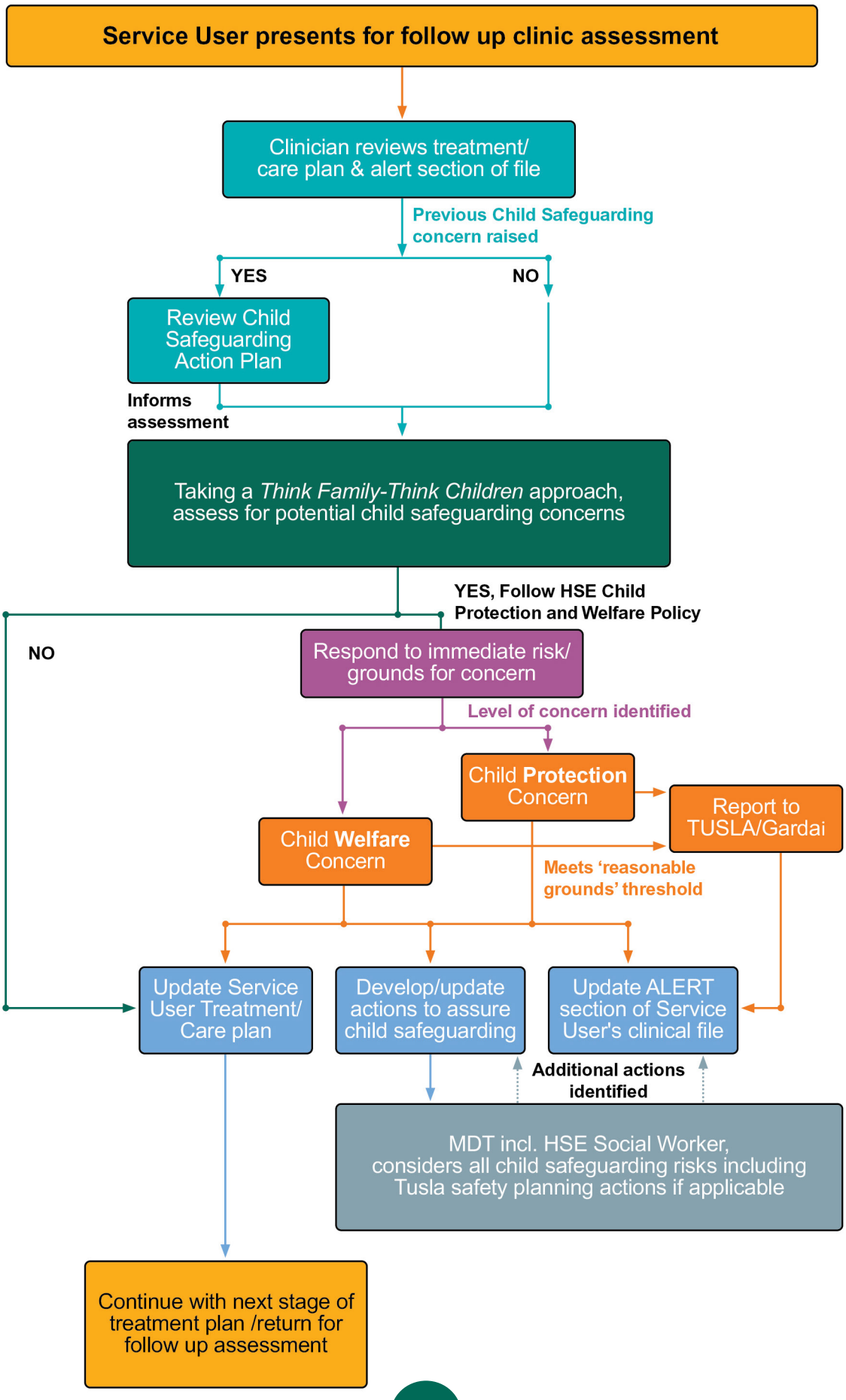
1) Introduce yourself. Tell us who you are. What your job is.
2) Give us as much information as you can.
3) Tell us what is wrong with our mum or dad.
4) Tell us what is going to happen next.
5) Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6) Ask us what we know, and what we think. We live with our mum or dad. We know how they have been behaving.
7) Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8) Please don't ignore us. Remember we are part of the family and we live there too!
9) Keep on talking to us and keeping us informed. We need to know what is happening.
10) Tell us if there is anyone we can talk to (Barnardo's 2007).

Appendix 2: Flow diagrams to support Adult Mental Health Services staff

Initial presentation of service user to Adult Mental Health Services



Follow-up assessment of service user to Adult Mental Health Services



Appendix 3: Standard Core bio-psycho-social assessment template

HSE Mental Health Services

MENTAL HEALTH ASSESSMENT

(insert service name)

FIRST NAME	DOB_____/____/_____
SURNAME	GENDER _____
ADDRESS _____	
MEDICAL RECORD NUMBER	
COMPLETE TWO IDENTIFIERS OR AFFIX LABEL HERE	

Location: _____

Date and time referred: _____ Date and time assessed: _____

RISKS/ALERTS? No ☐ Yes☐

Summary (Summarise key points from completed assessment and management plan)

_____

INFORMATION SHARING AND CONFIDENTIALITY

PROMPT: *We won't be sharing any personal information about you with your family without your consent (noting limits to confidentiality). As part of your assessment we will seek to receive/invite information from your identified supports/family as they know you best.*

Issues of information sharing and confidentiality discussed including exemptions to confidentiality (i.e. risk to self or other, and child protection issues) No ☐ Yes ☐

I the undersigned (clinician) have discussed information sharing and the exemptions to confidentiality with [insert service user name] _____

Signature [clinician]: _____ Date: _____

Signature [service user]: _____ Date: _____

DEMOGRAPHICS

Age:_____ Contact Number:_____ Marital Status:_____

Gender:_____ Occupation:_____

Mental Health Service Area/Consultant:_____ Emergency contact:

Contact Number:_____ Relationship:_____

Identified supporter (e.g. family, advocate, co-decision-maker etc.):_____

Is there a decision support arrangement in place? No ☐ Yes ☐

Contact Number:_____ Relationship:_____

GP:_____ Contact Number: _____

Ethnicity(write in description):_____

Translator No ☐ Yes ☐ NA ☐ Language:_____

ASSESSMENT DETAILS

Referred by:_____ Contact details: _____

Was this assessment conducted in a crisis situation? No ☐ Yes ☐

REASON FOR REFERRAL/PRESENTING COMPLAINT

_____

_____

_____

Sources of information (indicate if corroborative history obtained, interpreter used, details of people present at assessment)

Interview	No ☐ Yes ☐ NA ☐	GP Letter	No ☐ Yes ☐ NA ☐
Case notes	No ☐ Yes ☐ NA ☐	Carer/relative	No ☐ Yes ☐ NA ☐

Other_____

Communication issues (e.g. language or cultural barriers, sensory impairments)

_____

HISTORY OF PRESENTING PROBLEM: e.g. own understanding of current problem, onset, frequency, duration, identity, features (sleep/appetite/concentration), precipitants/triggers/current stressors, current risk. Presenting problem, predisposing factors, precipitating factors, perpetuating factors, protective/positive factors. What is your understanding of your difficulty?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAST PSYCHIATRIC/MENTAL HEALTH HISTORY: e.g. any previous involvement with the mental health services, ICD diagnosis, admissions (voluntary/involuntary), advanced healthcare directive, engagement with care, past treatments, any other professionals involved in care, past or present (community care, juvenile liaison officer), other therapeutic interventions, reasons for relapse. Have you had any help with this problem or similar problem before?

MEDICAL HISTORY: e.g. hospitalisations, illnesses (cancer, tuberculosis), known physical conditions (anaemia, epilepsy, thyroid, stroke, pregnancy, problem hormonal/kidney/respiratory/hearing/visual/mobility), head injury, dementia, recent surgery, nutritional status (diet and physical activity, including sedentary lifestyle, any health concern expressed)

History (hx) of diabetes?	No ☐ Yes ☐ Unknown ☐
Hx of Cardiovascular Disease (e.g. heart attack, DVT, stroke)	No ☐ Yes ☐ Unknown ☐
Hx of Dyslipidemia (abnormal blood cholesterol level)	No ☐ Yes ☐ Unknown ☐

"Yes" to any of the above may indicate that a more detailed assessment of metabolic syndrome is required

CURRENT TREATMENTS		
CURRENT MEDICATIONS (use generic name including complementary/herbal medicines)	DOSE/FREQUENCY/ROUTE	COMMENTS (e.g. prescriber, side effects, adherence)
CURRENT PSYCHOTHERAPY/PSYCHOSOCIAL THERAPY	**FREQUENCY**	**PRACTITONER**

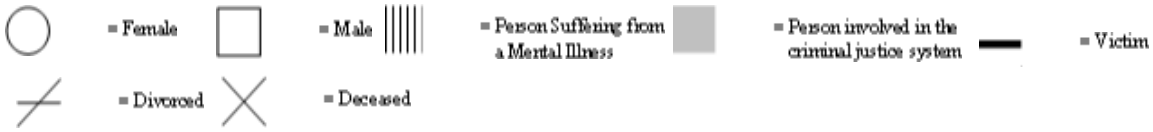
ADDITIONAL INFORMATION (e.g. medications trialled and reason for cessation, overuse of medication)

DRUGS ALLERGIES AND ADVERSE REACTIONS (including non-medication reactions, document alerts on page 1)

OTHER TREATMENTS/THERAPEUTIC INPUTS

FAMILY HISTORY: e.g. family of origin, family genogram, details of mental illness, substance misuse, dementia, details of family relationships, adoption/foster care, state of relationships, i.e. harmonious/conflicting/domestic abuse/coercive control

FHX of Mental Illness	No ☐ Yes ☐ Unknown ☐
Family History (FHX) of Diabetes	No ☐ Yes ☐ Unknown ☐
FHX of Obesity	No ☐ Yes ☐ Unknown ☐
FHX of Cardiovascular Disease (e.g. stroke, heart problems, high BP)	No ☐ Yes ☐ Unknown ☐
FHX of Dyslipidemia (abnormal blood cholesterol levels)	No ☐ Yes ☐ Unknown ☐



DEVELOPMENTAL AND PERSONAL HISTORY- SIGNIFICANT LIFE EVENTS/HISTORY OF TRAUMA: e.g. birth (mode of delivery), childhood (early development, milestones, conduct problems, frequent change of address, adverse childhood events (abuse (physical, emotional, sexual)/neglect (physical, emotional),household dysfunction(mental illness, incarcerated relative, substance misuse, parent/carer treated violently, absence/loss of a parent (divorce, abandonment, separation, death), schooling/education (learning difficulties, literacy skills bullying, exams), occupational /employment history, accidents, bereavements, other major events. psychosexual history (transgendered) & relationships (incl. most recent significant relationship

FORENSIC HISTORY: e.g. previous criminal record or charges, involvement with probation services, current pending charges and convictions for violent offences. Include contact with youth justice services and violence/challenging behaviour in school, social, disability or mental health services

CURRENT SOCIAL CIRCUMSTANCES: e.g. social supports (family, carer, voluntary agencies, home help, community centre, Neighbours) income, debts, day time activities, hobbies, interests, any recovery/rehabilitation needs, accommodation issues and housing status (who does he/she live with/nearest relative), home situation, home stressors, if homeless, current sleeping status and duration of homelessness, housing need (couch surfing, living in emergency accommodation? Do you feel part of a community/neighbourhood? Who do you spend time with?

Any children? No ☐ Yes ☐

Are there concerns about the safety of a child, young person or other dependents? No ☐ Yes ☐ ☐ Please cross reference with ALERT section in clinical file.

CURRENT CHILD-CARING/PARENTING CIRCUMSTANCES the focus of this section is to explore with the service user their parenting/caring responsibilities for children under the age of 18 and stressors. This is in the context of the HSE supporting a 'Think Family – Think Children' approach across mental health services and the importance of involving family in care and treatment as much as possible. A supportive, non-judgemental, non-leading approach should be utilised in exploring the issues in this section. Please ensure to link this part of the assessment to previous information supplied by the client e.g. regarding their own experience of being parented, their own family history and genogram

IF APPLICABLE, ALWAYS CHECK THE SERVICE USER FILE/ALERT SECTION TO SEE IF ANY PREVIOUS RISK HAS BEEN RECORDED (E.G. RISK OF HARM TO A CHILD, PREVIOUS RISK OF VIOLENCE

DETAILS OF CHILDREN AND/OR OTHER DEPENDENTS (if this part is not relevant e.g. there are no children/dependant, skip to substance use section

NAME	RELATIONSHIP	AGE (DATE OF BIRTH)	ADDRESS AND LIVING WITH WHOM (have always lived there? For how long?)

Always ask questions in a non-judgemental way and consider questions such as the following:

General questions to understand circumstances

- Do you have children?
- Do you care for some else's children?
- Do you have access to children?
- Do you find this stressful?
- Is there any particular child or issue causing you stress?
- How do you find parenting at the moment? Has this changed in recent times?
- Have you ever sought help from extended family or services

Impact of own experiences as a child (links to Development & Person History Trauma History section)

- Can you describe what your own experience of being parented was like?
- Do you feel that your own adverse childhood is having an impact on your experience of parenting now

Coping Skills (links to Premorbid Personality section)

- When you are very stressed/angry/frustrated which of your relationships does this mostly impact on?

Involvement with family support services and/or Tusla

- Have you ever sought help from Tusla's family support services, local community services or have you ever had contact with Tusla in relation to child protection concerns?

Example Think Family-Think Children Bio-Psycho-Social Core Assessment

ADDICTIONS HISTORY: e.g. substance, gambling, online, alcohol – type (beer, spirits, wine, fortified wine, cider, alcopops, others), quantity (drinks per day), frequency, drugs used (cannabis, benzodiazepines (prescribed, street, internet, multiple, other) heroin, methadone, other opiates, cocaine (powder/ crack) amphetamines, ecstasy/mdma/halluconegnics (LCD, magic mushrooms), over the counterdrugs, any other drugs (solvents/gas/novel psychoactive substances/steroids) quantity (cost per day), frequency, smoking status, tobacco (e cig), gambling types (scratch cards, lottery, casinos, slot machines, card games, bingo, horse racing), other addictions (e.g. food, cyber/on-line, etc.) quantity(cost), frequency (where, how), previous efforts to stop

Ever injected	No☐ Yes☐ NA☐
Ever shared needles	No☐ Yes☐ NA☐
Indicate if a substance use assessment completed	No☐ Yes☐ NA☐

PREMORBID PERSONALITY: including temperament, attitudes, character, hobbies and interests, ability to form and maintain relationships, coping skills

MENTAL STATE EXAMINATION

APPEARANCE AND BEHAVIOUR: e.g. physical description, level of personal hygiene, grooming, demeanour, eye contact, restlessness, motor activity (retardation/over activity), level of co-operation, aggression or hostility.

SPEECH: e.g. poverty of speech, pressure of speech, spontaneity, volume, rhythm/rate, tone.

MOOD: e.g. subjective (as described) objective, angry, euphoric, distressed

AFFECT: e.g. reactivity, appropriate, restricted, flattened, is there a subjective recent change?

THOUGHT FORM: e.g. understandability, coherent speech, evidence of thought disorder (loosening of association, circumstantiality)

THOUGHT CONTENT: e.g. delusions, overvalued ideas, preoccupations, obsessions, subject matter

THOUGHT STREAM: e.g. flight of ideas, slowing of thinking, circumstantiality, perseveration, thought block

PERCEPTION: e.g. illusions and hallucinations (type 1st 2nd 3rd, auditory, visual, olfactory, tactile, gustatory), command hallucinations.

COGNITION: e.g. orientation in time, place and person. Indicate if MMSE completed. No ☐ Yes☐ NA☐

INSIGHT, AWARENESS AND JUDGEMENT: e.g. perception of illness, need for treatment

RISK ASSESSMENT

If you are aware that there are children/young people in the care of the service user, then consider family/significant others view of the possible risk and flag that it's a normal part of our practice to talk to people who know you well and to invite them to share how they see you and what areas/issues they feel you could benefit getting help around

Please check the file/the alert section to see if a previous risk e.g. risk of harm to a child/previous risk of violence, has been recorded (links to Risk/Alerts section)

(N = No, Y = Yes, UK = Unknown	HARM TO SELF			HARM TO OTHERS		
	N	Y	UK	N	Y	UK
Significant past history of risk	☐	☐	☐	☐	☐	☐
Current thoughts, plans, symptoms suggesting risk	☐	☐	☐	☐	☐	☐
Recent change in behaviour, mood, ideation or intent	☐	☐	☐	☐	☐	☐
Concern from others about risk	☐	☐	☐	☐	☐	☐
(Assessment should include corroboration where possible)						

	N	Y	UK
Current problem with alcohol or substance misuse	☐	☐	☐
Major mental illness	☐	☐	☐
AT RISK MENTAL STATE (e.g. depression, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)	☐	☐	☐
Level of risk appears to be highly changeable	☐	☐	☐
Significant uncertainty in the assessment of the level of risk	☐	☐	☐

Overall Risk (current/immediate)

Harm to Self_____

Harm to Others (including children): _____

Prompts/Questions to consider

- Who is the primary care giver/parent for the child/children?
- Who will be looking after them while they are in hospital?
- Are they worried about any aspect of their care?
- Do they see any harm or risk to the child/children What are their hopes for the children in the future?
- Have they or ever had thoughts of harming the child?

Other *(Specify)_____

_____

_____

Protective Factors _____

_____

(Consider other risk e.g. child safety, absconding, exploitation, intimate partner violence, abuse, neglect, homelessness, falls/medical)

ADDITIONAL MEASURES e.g. routine outcome measures such as EMT/CAN/cognitive assessments/other scales, tools & attach copies.

Collateral History

Prompt: Think of family/significant others view of the possible risk. A good quality assessment should include collateral e.g. receiving/inviting information from family/supporters. It's a normal part of our practice to talk to people who know you well and to invite them to share how they see you and what areas/issues they feel you could benefit getting help around.

FORMULATION/OVERALL CLINICAL IMPRESSION (predisposing precipitating perpetuating, protective factors, current, longer term risk; document any Alert/Risks on Page 1)

PROVISIONAL DIAGNOSIS e.g. ICD-10

INITIAL MANAGEMENT PLAN

Has the plan been discussed with a Consultant Psychiatrist/Senior Clinician? Yes ☐ No ☐ N/A ☐

Has the plan been discussed and agreed with the Service user? Yes ☐ No ☐ N/A ☐

Name:_____ Date:_____ Time:_____

Communication received about the smoke free campus	No☐ Yes☐ NA☐

COMMUNICATION UNDERTAKEN			
Prompt: If child safeguarding concern has become apparent during this assessment or this section, it is good practice to tell the person that you are contacting Tusla/making a Tusla referral. "I will always endeavour to tell you when I am making contact with Tusla and what I am sharing with them".			
Collateral (during assessment)	Name	Contact details	Comment
Primary carer/family Yes ☐ NA☐			
GP Yes ☐ NA☐			
Community Mental Health Team/Other(specify) Yes ☐ NA☐			
Copies (sent to)		Date, if yes	Comment
File	No ☐ Yes ☐ NA☐		
Community Mental Health Team	No ☐ Yes ☐ NA☐		
GP	Letter No ☐ Yes ☐ NA☐ ECP No ☐ Yes ☐ NA☐		

ASSESSMENT COMPLETED BY: **NAME (BLOCK CAPITALS)**	**PROFESSION:**
SIGNATURE	**DATE:**

Appendix 4: Guidance on potential questions/cues to support the clinician in how to identify child safeguarding risks during a follow up clinical assessment

The following sets out guidance to support an Adult Mental Health Services clinician to identify child safeguarding risks during a follow up clinical assessment.

Prior to service user assessment (Pre-Review):

- Review case file with particular attention to ALERT Section and any additional updates e.g. information from relative/GP/PHN/Tusla.
- Discuss with key worker if indicated and consider joint review with key worker if indicated.

During review with service user:

The following should be captured:

- Date and location of the Out Patients Clinic.
- Age, gender, marital status, living arrangements (e.g. who is at home with you?)
- Diagnosis.
- Medication.
- Assessment of current concerns/complaints.
- Additionally, if involved in caring for children, ensure person is asked about children. Below are sample questions:
    - How are the children doing?
    - How are you coping with the children at the moment?
    - Who supports you to look after the children?
    - Have you any concerns about how your illness may be impacting on the children?
    - In what ways do you think your illness impacts most on the children?
    - Have you ever had thoughts about harming your child?
    - How aware do you think the children are of your mental health problem and how it affects you?
    - Are there particular times or situations that you find most difficult? What supports would help you then? If concerns are raised/noted regarding the welfare of a child

or young person, more detailed assessment is required. This needs to include child safeguarding action planning. This plan should be documented in the service user treatment or care plan.

- Review/update of any previous mental health and/or medical concerns.
- Current use of substances.
- Current social circumstances (see Appendix 3 Standard Core bio-psycho-social assessment template for sample questions).
- Adherence to care and recovery plan interventions including medication.
- Mental State examination (see Appendix 3 Standard Core bio-psycho-social assessment template for sample mental state examination)
- Risk assessment (see Appendix 3 Standard Core bio-psycho-social assessment template for sample risk assessment.
- Collateral history. Important that this is reviewed and updated but most especially when a child welfare concerns raised/noted.
- Summary/formulation.
- Care plan agreed including Child Safeguarding Risk Management Plan with actions appropriate to the level of concern that has been identified and plan overseen by the Consultant Psychiatrist.

Post review with service user:

Following completion of the review with the service user the following should be undertaken:

- Update ALERT section of file.
- Letter to GP/other relevant agencies.
- Discuss at next MDT and notify team social worker.

Appendix 5: Guidance on structure and content of ALERT section of the service user file

Guidance for completing the ALERT Section of the HSE Adult Mental Health Service User's Clinical File

The file for every service user should include a clearly signposted ALERT section. This should be populated with brief notes/observations of specific concerns when identified about the service user that should be highlighted for attention. It should also note where the detailed information about that alert is documented and detailed. Clinicians should check this ALERT section for any concern and/or risk in advance of each contact with a service user.

Record the service user's name, date of birth and file reference number

Sections to be completed:

Note each section (1-5) of the template should be completed for any concern/risk being flagged.

1 State reason for ALERT:

- Record the current concern and/or risk and provide a brief description
- Child Safeguarding Concern/Adult Safeguarding Concern/Violence/Aggression Risk/ Suicide Risk/Other

2 Name of Reporting Clinician:

- Record the name and signature of the reporting clinician

3 Date Reported:

- Record the date reported and to whom person/agency/service internal or external service.

4 Status of ALERT:

- Record the status of ALERT open or closed. If open, record level of alert high, medium or low as assessed by reporting clinician

5 Detailed Records:

- Reference the location in the file of the detailed records and reports regarding the concern and/or risk.

Please note: This template should be reviewed by the clinician at each service user assessment to ensure information on ALERTs is current and records archived once ALERTs are closed.

Template for ALERT Section of the Adult Mental Health Service User's Clinical File

(Template to be adapted by each AMHS Team depending on team decision on which types of alert to capture, in addition to Safeguarding alerts)

BE ALERT TO THE FOLLOWING ABOUT THIS SERVICE USER

Please note that some of the ALERTs MAY remain open even after other ALERTs are closed

Name:		**Date of birth:**	**File Reference:**	
Please state reason for **ALERT:**	Name of Reporting Clinician: *Print, sign, date*	Date reported: *Date and to whom; person/ agency/*service	Status of ALERT: *Open: **High**/**Medium**/**Low*** *Closed (add date closed)*	Case records/reports: *Please reference location in file of records and detailed reports*
Child Safeguarding Concern: Brief description of concern Is Tusla involved? Yes/No				
Adult Safeguarding Concern: Brief description of concern				

Violence/Aggression Risk: Brief description of risk				
Suicide Risk: Brief description of risk				
Other: Brief description of concern or risk				

Note: This ALERT page should be kept up to date at all times. If this alert page is full or need to be replaced, please ensure to transfer any relevant information to a new ALERT page and file this page in an archive of ALERTs section in the service user's file.

Appendix 6: Guidance to support Child Safeguarding Action Planning

In the event that a child safeguarding concern (definite or suspected) is identified, the Adult Mental Health Services clinician should identify appropriate actions to assure the safety and welfare of the child is protected. These actions should form part of the adult service user's Individual Care Plan, or when in place the Individual Recovery Care Plan (IRCP).

The following provides guidance to the Adult Mental Health Services clinician in development of comprehensive and appropriate actions to protect the child:

- Actions should be informed by the specific concerns identified and any assessed risk(s) and should specify **WHO** is at risk and **WHY** (including detailed description of the risk and the indicators or evidence of potential harm or neglect). These should be noted in the ALERT section of the service user file.

- Actions should describe **WHAT** should be done, and **HOW**, with consideration of the adult service user's needs in relation to their capacity to safeguard the child – for example:
    - Immediate actions need to be taken to ensure the safety of the child including identification of staff member responsible
    - What reports need to be made to external agencies (Report to An Garda Síochána (immediate risk) and/or Tusla (follow HSE Child Protection & Welfare Reporting Procedure)
    - Other supports and management that is needed such as support services needed for the child, referrals to additional support programmes for the adult service user (e.g. substance abuse treatment, parenting programmes, etc.)

- Actions should consider timing of **WHEN** they should be reviewed and evaluated (date and by whom)

Appendix 7: National Monitoring and Auditing of policy

The implementation of this policy is the responsibility of the HSE Regional Executive Officer (REO) within each health region, ensuring its integration into local service delivery. Monitoring of compliance with this policy will fall under the overall operational monitoring and compliance arrangements already established within the services. Additionally, the HSE Children First National Office (HSE CFNO) will incorporate specific assurance criteria related to this policy within the HSE Children First Compliance Assurance Frameworks and Checks; however, these checks will not occur on a regular basis. The document owner is the HSE CFNO under the governance of the Chief Social Worker, ensuring oversight of the policy's content and applicability.

A review of the policy will commence within one year of its publication, in collaboration with key stakeholders, to assess its effectiveness and ensure alignment with best practices and emerging needs.

National Policy for Child Safeguarding and Wellbeing in Adult Mental Health Services Policy - Compliance Assurance Criteria

	To be included as part of Operational and Compliance Arrangements Established	To be included as part of Operational and Compliance Arrangements Established
Assurance Criteria 1 Amendments made to local AHM Team's Core Bio-Psy-cho-Social Assessments: Ensure that the assessment template includes child safe-guarding considerations and identifies potential risks related to the service user's relationship with children	Yes	Yes (check for section in Assessment template and declaration of use)

Assurance Criteria 2 Use of Alert Sections in Service User Files: Implementation of a dedicated ALERT section in service user files to document child protection or welfare concerns, ensuring concerns are tracked and addressed	Yes	Yes (check for ALERT Section template and declaration of use)
Assurance Criteria 3 Child Safeguarding Actions Plans: Development and implementation of action plans within the service users care plan to address identified risks and outline protective measures	Yes	No
Assurance Criteria 4 Child Protection or Welfare Reporting: Staff report concerns promptly to Tusla or An Garda Síochána, where necessary, and maintain records	Yes	No
Assurance Criteria 5 Multidisciplinary Team (MDT) Reviews: Child Safeguarding concerns and actions plans regularly reviewed as part of MDT meetings	Yes	No

Appendix 8: Membership of Policy Development Group

	Membership of Child Safeguarding and Wellbeing Enhancement Working Group
Name	**Role and position**
Dervila Eyres (Co-Chair)	Assistant National Director, Head of Operations, HSE Mental Health Services
Marion Martin (Co-Chair)	National HSE Children First Lead, Children First National Office
Dr Anne Cullen	Executive Clinical Director, Mayo Mental Health Service
David Timmons	Area Director of Nursing, National Forensic Mental Health Service
Eileen O'Brien	HSE Children First National Office
Kerry Cuskelly	Principal Social Worker (CHO Dublin North City and County) – to July 2024
Mary G Killion	Principal Social Worker (Galway/Roscommon Mental Health Services)
Michael Ryan	General Manager Mental Health Engagement and Recovery and Person with Lived Experience
Michelle Mansfield	HSE Children First National Office
Patrick Bergin	Head of Service, National Forensic Mental Health Service

Paul Braham	Senior Operations Manager (Area DON), HSE Community Operations - Mental Health Services
Colette McLoughlin	Service Director, National Office Services & Integration, Tusla, Child and Family Agency
Ken Stanley	Project and Change Management Specialist, Centre for Effective Services (CES)

Appendix 9: Policy approval and sign off

Name	Role and position
David Walsh	National Director, Access and Integration

Name: (print)	David Walsh
Title:	National Director, Access and Integration
Signature: (e-signatures accepted)	
Registration number: (if applicable)	