A Vision for the Health and Wellbeing of Children and Young People in Ireland

A collaboration of:

- National Clinical Advisor and Group Lead for Children and Young People
- National Clinical Programme for Paediatrics and Neonatology
- National Child Health Public Health Programme

Contents

Executive summary

Investing in children is one of the most important things a society can do to build a better future (WHO, 2023). This document sets out a vision for the health and wellbeing of Children and Young People (CYP) in Ireland. Rather than just focusing on service delivery, this vision is informed by the distinct and evolving needs of CYP. It is a collaboration of the National Clinical Advisor and Group Lead, Children and Young People, the National Clinical Programme for Paediatrics and Neonatology and the National Child Health Public Health Programme, Health Services Executive (HSE).

Approximately 25% of the population is under the age of 18 years, with 33% under the age of 24 years. Infants, children and young adults have distinct health needs according to their developmental stage. The HSE has an important role in supporting and delivering the high quality, equitable and accessible care required for health and wellbeing, particularly for children, and as described in the Health Acts.

The overarching vision is that all Children and Young People (CYP) in Ireland will be enabled to live their best, healthiest life.

This will be achieved when:

- The environment and services are **configured** around their distinct **needs**.
- **Responsibility and accountability** for CYP population health and healthcare is clear.
- The **social, commercial and environmental determinants** impacting the health of the population are considered and acted on.
- Relative needs are the basis for **service configuration, integration, governance, outcomes, and resource allocation** for the population.

This short document describes a framework for holistic consideration of the health and wellbeing needs of CYP living in Ireland and informs a population health management approach to address those needs. It describes health and wellbeing need across key population segments (health categories and age bands).

Recommendations

1. Develop a **unified governance structure** at HSE centre, the aim of which is to support the development and lead implementation of national planning to support CYP health and wellbeing. This structure would provide appropriate national health functions and provide a framework to support regional areas. It would also enable cross sectoral collaboration for CYP.
2. Develop a HSE National **Integrated Care Plan for CYP** that focuses on the delivery of optimal prevention, early intervention and healthcare aligned with the HSE Corporate Plan 2021-24. The Integrated Care Plan should be based on the distinct need of the CYP population and their families.
3. New Health Regions should use this **population health management approach** to plan, develop and integrate local services to better meet the needs of their CYP population and CYP specific governance should be clearly defined within each Health Region with a clinical lead appointed and supported to implement this vision.

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1 Introduction

Health is defined by World Health Organisation as 'not just the absence of disease, but a state of complete physical, mental and social wellbeing'.

This document aims to describe a structure for holistic consideration of the health and wellbeing needs of children and young people (CYP) living in Ireland to inform a population health management approach to address those needs. The purpose is to support service delivery by focussing on what is required and desirable for CYP growing up in our country. With governance and alignment within and between all organisations that design, plan or resource services for CYP, these needs can be appropriately addressed. Organised and strategic active supports and interventions for CYP and their families are required to ensure that children achieve their best health and well-being. Just as clean water does not happen by chance, good health requires coordination, governmental investment and governance.

1.1 Overarching vision

The overarching vision is that all children and young people in Ireland will be enabled to live their best, healthiest life. This will be achieved when:

- The environment and services for children and young people are **purposefully and actively configured** around the holistic, **bio-psycho-social needs** of the CYP population and all its segments/cohorts.
- **Responsibility and accountability** for the health and healthcare of the whole CYP population of Ireland is clear within the relevant organisations/ regions.
- The **social, commercial and environmental determinants** impacting the health of the population are considered and acted on.
- Health and social care work together when planning and implementing **service configuration, integration, governance, outcomes, and resource allocation** for CYP.

This vision for the health and wellbeing of CYP in Ireland recognises the need for a 'Children in All Policies' approach nationally and regionally, with all agencies working together to enable optimal health and social outcomes from the perspective of children and families.

1.2 Principles of Healthcare for Children and Young People

Every person has human rights. CYP have further, specific rights in line with their vulnerability and dependency on others. The internationally accepted standards to be applied to basic human rights for children are provided for in the United Nations Convention on the Rights of the Child and reinforced in the EU Child Guarantee within Ireland's National Action Plan 2022 and Ombudsman for Children Office, Annual Report 2022.

It is clearly understood that '*the foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health to educational achievement and economic status.' (*Marmot, 2010).

The principles underpinning healthcare for CYP are:

- CYP have health and social care needs that are distinct from those of the adult population.
- Healthcare for CYP should be developmentally appropriate and child- and family- centred.
- Strategic, organised and proactive prevention and early intervention programmes in healthcare services for our child and adolescent population are necessary to optimise their physical and mental development and sustained lifelong health.
- Need must be the basis of all considerations for health and well-being planning, including the social needs and other wider determinants of health. This approach will help identify inequity in the provision of health and other services that have an impact on health outcomes and may inform resource allocation to address these.
- CYP and their families should be able to access necessary appropriate information, advice, support and care as close to home as possible, to move between clinical and other health services seamlessly and to be supported to transition to adult services seamlessly.
- Anticipatory and responsive healthcare services for children and young adults should evolve to align with changing needs in areas such as mental health, sexual health, overweight/obesity and transition to adult services.
- Health and wellbeing of CYP is the responsibility of the whole community and requires a multi-agency and sector partnership with CYP and families.
- Children and YP live in families, environments, and communities that need to provide them with the opportunity to reach their fullest developmental potential.

1.3 Overview of children in Ireland and what determines their health

Ireland has one of the youngest populations in Europe with 24% of the population aged under 18 years representing 1.2 million CYP, (the EU average is 18%).

CYP's health needs are becoming more complex and have changed over the past decades with increasing survival of extreme prematurity and an increase in numbers of CYP with chronic disease and/or disability, as well as obesity and mental health challenges.

Approximately 50-70% of adult health outcomes are determined by non-medical factors These are the social determinants of health (SDH)[1], the conditions in which people are born, grow, live and age, and the wider set of forces and systems shaping the conditions of daily life (WHO, 2023). Most of these determinants are outside of health-care domain including early childhood development; safe, warm housing, healthy foods, family income protection, social inclusion, conflict and education. Poverty places CYP at a higher risk of marginalisation and of multiple adverse childhood experiences.

Childhood adversity and long term impact

Adversity in childhood is strongly associated with poor adult physical and mental health. The more adverse childhood experiences (ACE) that a child has, the worse the long-term effects are likely to be. Homelessness is an ACE and may be preceded by, or associated with, many other ACEs e.g., divorce, family disharmony, substance abuse. Long term effects of ACEs include adolescent risk-taking behaviours, mental illness and a high risk of suicide into adulthood, cancer, diabetes, heart disease and ultimately a shortened lifespan. Other long-term effects include loss of educational opportunities, relationship problems and reduced income potential (see Appendix A).

Strong actions on the social determinants of health across government and non-government organisations, including health, is required to prevent children's exposures to ACEs and early intervention to minimize their impact.

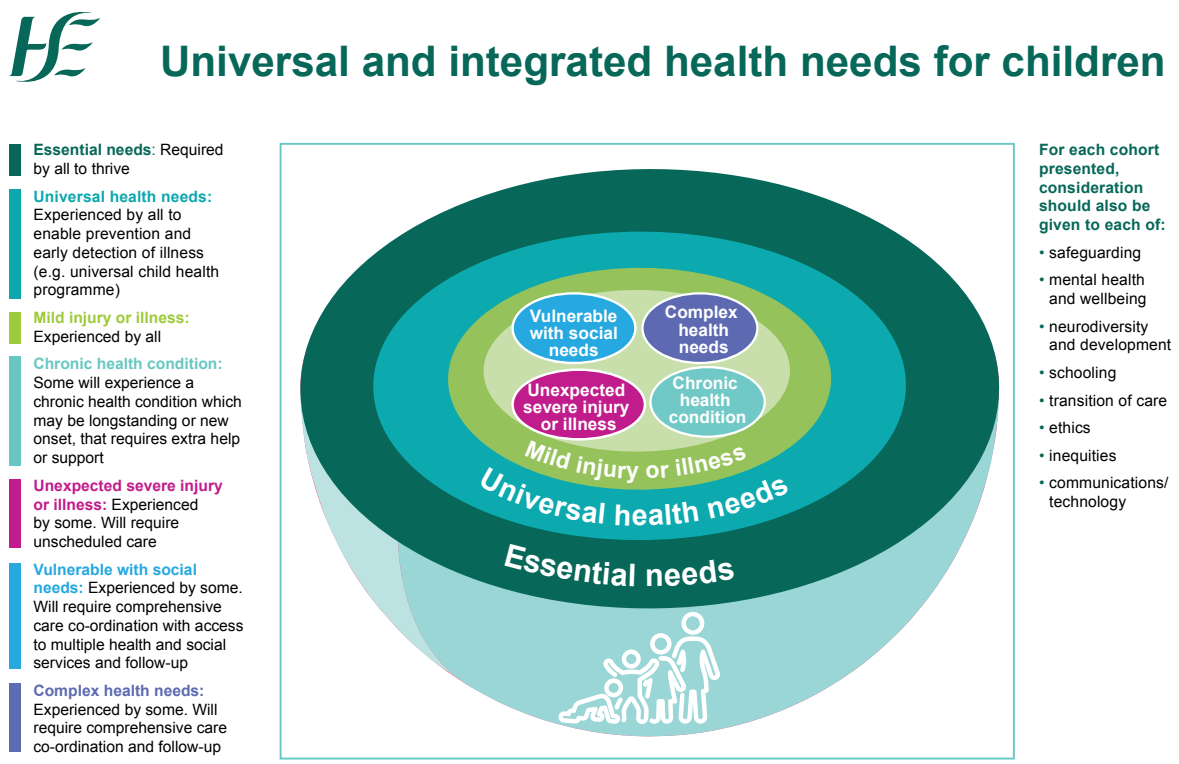
Current child health parameters in Ireland

- 7.5% of CYP aged 0-17 years are living in consistent poverty and are the age group at highest risk of poverty. (CSO, 2023).
- At end March 2024 4,170 children are currently registered as homeless in Ireland. By the end of April 21,914 CYP under the age of 18 years have arrived in Ireland from Ukraine seeking safety from war.
- Ireland's exclusive breastfeeding rates remain low with 31.7% at 3 months in 2023.
- Circa 1 in 10 CYP live with chronic illness such as asthma, diabetes, cystic fibrosis, inflammatory bowel disease, eczema, arthritis, mental health disorders and epilepsy. CYP living with over-weight and obesity is estimated to be 1 in 3 and is increasing.
- It is estimated that 4% (48,000) of children have complex disability with ongoing needs for health supports (HSE, 2009).
- 1 in every 65 school children (1.5%) in Ireland is living with Autism Spectrum Disorder. Attention Deficit Hyperactivity Disorder (ADHD) impacts approximately 5% of the population in Ireland.
- Mental health challenges are increasing in CYP e.g., Up to 17% of young women and 2.4% of young men have experienced an eating disorder by early adulthood.

1 https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health
https://www.who.int/health-topics/social-determinants-of-health
https://www.cdc.gov/about/sdoh/index.html

2 A population health management approach for CYP in Ireland

Figure 2
Children and Young People: Representation across health according to need



Population health management aims to maintain and improve the **health and wellbeing needs** of the entire population and to reduce health inequities among population groups.

While some needs will be common to all CYP, some CYP will have greater needs related to their health journey e.g., those who experience social vulnerability or chronic disease. While all CYP will have essential needs of care, food and shelter to survive, there are also universal health care needs that support CYP to thrive and to protect them from potentially serious childhood illnesses. In addition, most CYP will experience some unexpected minor illness and injury as they progress through childhood. Within the CYP population there are groups/cohorts associated with more complex disease/ injury or social needs.

A visual representation of health cohorts according to need is set out in Figure 2.0.

CYP needs also evolve with age and stages of development from before birth up to their transition into adulthood with individual variation. Tables 1.1 to 1.7 present consideration of the needs across health and age cohorts.

2.1 Conclusion and recommendations

Health services should be part of a broader continuum of agencies collaborating on the whole population health and well-being of CYP. This document can support the design of health services for CYP which should be informed by and meet the distinct needs of CYP population and their families/ guardians, rather than be developed as an extension of adult services.

This approach will support service providers to map the needs of CYP, identify opportunities for improvement, support service planning and resource allocation focussed on optimising the health outcomes for CYP and their families.

Recommendations to enable the delivery of the overarching vision of this paper, a vision that is aligned with Sláintecare, are set out below.

1. Develop a **unified governance structure** at HSE centre, the aim of which is to support the development and lead implementation of national planning to support CYP health and wellbeing. This structure would provide appropriate national health functions and provide a framework to support regional areas. It would also enable cross sectoral collaboration for CYP.
2. Develop a HSE National **Integrated Care Plan for CYP** that focuses on the delivery of optimal prevention, early intervention and healthcare aligned with the HSE Corporate Plan 2021-24. The Integrated Care Plan should be based on the distinct need of the CYP population and their families.
3. New Health Regions should use this **population health management approach** to plan, develop and integrate local services to better meet the needs of their CYP population and CYP specific governance should be clearly defined within each Health Region with a clinical lead appointed and supported to implement this vision.

Table 1.1: CYP population segmentation of needs by health status and age

Essential needs

Required by all CYP in order to thrive

Perinatal and antenatal	0-2 years	3-5 years	6-12 years	13-15 years	16-25 years
Environment • Housing • Amenities • Support circles **Positive health factors** • Relationships • Nutrition • Exercise, healthy weight • Engagement & information • Preparation for birth & parenthood • Relationships • Nutrition • Avoidance of alcohol/ smoking/ drugs • Safe home, key supports • Vaccinations **Health and social risks** • Poverty • Homelessness • Alcohol • Drugs • Smoking • Domestic abuse • Environment • Marginalisation • Maternal stress and family conflict • Post-natal depression	**Environment** • Safe warm home • Absence of violence/ alcohol/ drugs • Safe environments – enabling walking/ interact • Play spaces • Smoke-free • Early years supports • Pre-school / creche • Immunisations **Positive health factors** • Parenting and home visiting supports • Sleep • Positive parent-child relationships/infant mental health/active play/ communication • Breastfeeding/ nutrition • Limited screen time **Growth and development** • Critical time for development • Information for parents **Health and social risks** • Homelessness/ marginalisation • Live with alcohol/ drugs/ conflict	**Environment** • Safe warm home • Early years services • Pre-school/creche • Primary school • Safe environments –enabling walking/ interact • Play spaces • Early years supports • Pre-school/creche • Immunisations **Positive health factors** • Parents/caregivers included in discussion • Nutrition • Prevention of iron deficiency, • Sleep routines, play, limited screen time • Talk, communication, • Positive parent relationship • Child and parent mental health **Growth and development** • Critical development time • Information for parents • Talk and play • Parenting supports **Health and social risks** • Homelessness/ marginalisation • Live with alcohol/ drugs/ conflict	**Environment** • Safe secure home, absence of domestic violence/alcohol/ drugs • Education • Play spaces urban/rural developments • Group and team activities • Family/ other support circles • IT literate **Positive health factors** • Child included in discussion • Sleep, exercise • Nutrition and prevention of iron deficiency • Peer engagement • Safeguarding and sex education **Growth and development** • Increased self-management • Puberty - social emotional growth and development • Learning difficulties • Anxiety • Sleep hygiene **Health and social risks** • Homelessness/ marginalisation • Live with alcohol/drugs/ violence • Internet/social media/porn • Access to addictive substances including vaping • Bullying	**Environment** • Safe secure home • Education, State exams • IT literate • Sports/arts team activities • Family, friends, support circles **Positive health factors** • CYP included in discussion • Parental support • Exercise/nutrition/ sleep • Limited screen time • Peer engagement • Educated safeguarding/ sex • Vaccination – HPV **Growth and development** • Significant physical/ psychological/social change • Puberty/hormones • Confidence/body image • Information for YP/ parent • Increased independence • Transition of care and responsibility for health **Health and social risks** • Homelessness/ marginalisation • Live with addiction/ conflict • Internet/social media/porn • Alcohol/drugs/ smoking • Risk-taking behaviours • Risk of sexual assault • Self-harm/suicide/ bullying • Body image/eating disorders	**Environment** • Move from home/ independent living • Driving and transport • Education +/-pressure • State exams **Positive health factors** • Include CYP in discussions • Self-management with parental input if appropriate • Consent • Significant physical/ psychological/social change • Peer engagement • Transition of care and increased responsibility for health • Continuity of care • Contraception **Development into adulthood** • Sexual health • Parenthood • Support groups – AYA • Information for young person/parent **Health and social risks** • Alcohol/drugs/ addiction/smoking/ vaping • Self-harm/suicide • Eating disorders • Poverty • Homelessness/ marginalisation • Social media experience

Table 1.2: CYP population segmentation of needs by health status and age

Universal health needs

Required by all CYP to enable prevention and early detection of illness

Perinatal and antenatal	0-2 years	3-5 years	6-12 years	13-15 years	16-25 years
Primary/universal health care • Antenatal care • Foetal health assessment • Consideration of family history for rare diseases • Maternal weight • Alcohol/drugs • Safe maternity care in appropriate setting • Postpartum supports for mum and baby • Maternal health review for early identification complications post-partum. • Maternal weight • Alcohol/drugs **Protection/prevention** • Optimised medication e.g. folic acid, attention to any medications partners appropriate for conception and pregnancy • Regular review of infant health	**Primary/universal health care** • Newborn screening • Developmental checks, Screening, immunisation Breastfeeding and lactation support **Protection/prevention** • Health information for parents; understanding of normal development, behaviour, feeding, infections, etc • Preparation for toilet training • Parental and care giver support to manage IMH and new parental relationship • Support for process of changing carer role and return to work transition	**Primary/universal health care** • Monitoring development: • Mobility/gait • Language • Hearing & vision • Autism / Intellectual disability • Learning difficulties • Social • Accessible services & referral pathways • Family support **Protection/prevention VNB group for early intervention +++** • Information for parents – nutrition, sleep, screen time, dental, physical activity, play, socialisation, toilet training etc. • Advice, guidance for parents on self-management mild illness • Nutrition/eating • Dental • Pharmacy	**Primary/universal health care** • Soft tissue & orthopaedic injury • Urgent care **Protection/prevention** • Nutrition, exercise/ sports, • Hearing, sight, dental • Growth monitoring (height/ weight), sleep, play • Socialising with peers • Ability to learn • Safety • Anxiety/nervousness • Alcohol/drugs/etc	**Primary/universal health care** • Mental health support • Scoliosis/ hip dysplasia • Gender identity issues • Acne/ skin care • Contraception **Protection/prevention** • Information/ support YP and parent • Nutrition/ exercise • Puberty/ sex health education and support • Nutrition • Alcohol/ drugs /etc	**Primary/universal health care** • GP/ College and community services/Info AYA • Reproductive health services • Gender identity • Access to medications and advice **Protection/prevention** • Info/support YP & parent • Nutrition/exercise • Mental health/addiction • Alcohol/drugs/etc

Table 1.3: CYP population segmentation of needs by health status and age

Mild injury or illness

Will be experienced by all CYP and requires access to information for parents/CYP specific to age group on:

- Common illness and injury
- Management of illness/ red flags
- When/ where to access expertise

Management should include:

- Access to social and family history
- Identification of vulnerable families

Perinatal and antenatal	0-2 years	3-5 years	6-12 years	13-15 years	16-25 years
• Signposting to services • Access to GP/Early Pregnancy Units	• Timely access to Pharmacy/GP/OOH/ urgent care close to home • Services available in evenings • Making every contact count – development/ safeguarding/ child protection/ social issues • Transport/ parking • Post-natal depression	• Preschool / creche illnesses • Coughs, colds, cuts, falls • Timely access to Pharmacy/GP /OOH/ urgent care close to home	• Acute: Coughs, colds, cuts, gastro, rashes, • Longstanding: tummy ache, anxiety, bed wetting, behavioural, etc. • Information for parents NB – Diagnosis/symptom management/ red flags/ monitoring • Timely access to GP/ urgent care/ pharm/ rapid access clinic	• Engagement with CYP & parent/ guardian • Age appropriate & consent • Information for CYP and parent/guardian • Advice on smoking, sex health etc. • Substance abuse/ addiction • Anxiety issues etc • +/- psych issues emerging • Timely access to GP/ urgent care/pharm/ rapid access clinic/ • School nurse or other support workers	• Engagement with CYP and parent/guardian • Age appropriate & consent • Information for CYP and parent/guardian • Advice on smoking, sex health etc. • Substance abuse/ addiction • Anxiety issues etc • +/- psych issues emerging • Timely access to GP/ urgent care/pharm/ rapid access clinic/ • School nurse/college support workers

Table 1.4: CYP Population segmentation of needs by health status and age

Chronic health condition

Some CYP will experience a chronic disease which may be longstanding or of new onset. All will require:

- Early detection
- Education of YP and parents/carers
- Supported self-management
- High specialist input
- Minimise impact on education and social engagement
- Minimise burden on parents / carers e.g., costs +/- medical card – equipment medications, transport, parent missing work

Perinatal and antenatal	0-2 years	3-5 years	6-12 years	13-15 years	16-25 years
• Screening/early Diagnosis • Genetics/genomics • Early diagnostics • Additional health and social support required	**New onset:** • Early support for emerging conditions • parent/peer supports • access to and awareness of services for assessment & diagnosis • PHN/CMD • GP/specialist/HSCP • Accessible and coordinated care	**New onset:** • Education for CYP, parents, school • Early support for emerging conditions • Parent/peer supports • Access to and awareness of services for assessment and diagnosis • PHN/CMD • GP/specialist/HSCP • Accessible and coordinated care	**Longstanding**: • GP oversight • Specialist/MDT care • School engagement • Sick day plan • School continuity, equip, med, peers, sports participation • Prompt access to care • Family/self-management support **New onset:** • Access to specialist care • Diabetes/renal/ asthma • Parent/YP/School education • Optimising education continuity, exercise etc. • Care close to home where possible	**Longstanding** • Increased responsibility/ transition of care plan • GP/specialist oversight • Early intervention • Sick day plan • School continuity, equip, med, peers, sports participation • Prompt access to acute/spec svc if needed • Psychological support • Family support • Puberty/weight/ mental health • Medication adjustment **New onset:** • e.g., IBD, Mental Health • Transition of care planning	**Longstanding** • Consent • Move to self-mgt. • Transition of care support • Changes in lifestyle and behaviour impact disease mgt and progression • New living location – unfamiliar with health providers/ services • Education support **New onset:** • e.g. IBD, Mental Health • YP and parent education • Psychological and psychiatric support • Addiction

Table 1.5: CYP population segmentation of needs by health status and age

Vulnerable with social needs

Some CYP will require comprehensive care co-ordination with access to multiple health and social services & follow up because of experience of:

- Violence
- Marginalisation
- Poverty
- Homelessness
- Addiction
- New immigrant groups

Perinatal and antenatal	0-2 years	3-5 years	6-12 years	13-15 years	16-25 years
• Awareness of and access to information • Specific focus on pre-conception health • Screening • Accessible antenatal education • For both parents • Nutrition • Exercise – healthy weight • Gender identity supports • Teen pregnancy	• Information for parents/ caregivers/ creches (accessible) • Support with sleep, breastfeeding/ nutrition, child safety, communication, dental, crying, play, development, SIDs • Signposting information • Transition to community supports • Maternal mental health • Infant mental health, bonding and attachment • Developmental checks • Parenting support • Home visiting • Community groups	• Identification engaging /tracking of CYP is NB • Adverse childhood events (ACE) • Transport to school • Family/parenting support required • Nutrition/physical exercise • Additional school support • Increased responsibility/ carers • Access to multiple health and social services	• Family/parenting support required • Nutrition/physical exercise • Transport to school • Additional school support • Increased responsibility/carers • Risk taking • Increased exposure to environmental/ social issues – crime, violence, addiction, drug, sex • Access to multiple health and social services • Identification of these YP is NB • ACE history	• Identification of these YP is NB • ACE history • Transport to school • Family/parenting support required • Nutrition and food choices • Physical exercise • Education consistency • Additional school support • Increased responsibility/carers • Increased exposure to environmental/ social issues – crime, violence, addiction, drug, sex • Pregnancy/ parenthood • Social media • Behavioural issues	• Identification of these YP is NB • Care supports may come to an end e.g. foster care due to age. • Increased risk taking/ behaviours drugs, sexual, etc. • Violence – sexual/ physical • Psychiatric diagnoses • Education/ employment • Addiction • Access to multiple health and social services (child/adult) – can be challenging

Table 1.6: CYP population segmentation of needs by health status and age

Complex health needs

Which will require comprehensive care co-ordination and follow-up.

Some CYP will have complex needs requirements including:

- care co-ordination and integration
- rest of family needs
- new onset/emerging needs

Perinatal and antenatal	0-2 years	3-5 years	6-12 years	13-15 years	16-25 years
• Screening/early Diagnosis • Genetics/genomics • Early diagnostics • Additional health and social support required	**New onset:** • Early support for emerging conditions • parent/peer supports • access to and awareness of services for assessment and diagnosis • PHN / CMD • GP/specialist/HSCP • Accessible and coordinated care	**New onset:** • Education for CYP, parents, school. • Early support for emerging conditions • Parent/peer supports • Access to and awareness of services for assessment & diagnosis • PHN/CMD • GP/specialist/ HSCP • Accessible and coordinated care	• Include CYP in discuss • Regular equipment checks • Monitoring and review • CDNT/HSCP • Education supports • Peer engagement • Respite • Crisis/escalation pathway • Palliative care • Community services close to home/school/ transport **New onset:** • Timely access to assessment/diagnosis • Access to intervention • Rehab • Parenting/family support	• Regular equipment monitoring and update • May be additional diagnoses/change in health status because of development age • Increased self-management • Poor adherence • Education consistency and support • CDNT/HSCP • Education supports • Peer engagement • Respite • Crisis/escalation pathway • Palliative care • Local community services **New onset:** • Timely access to assessment/diagnosis • Access to intervention • Rehab • Parenting/family support	• Extra support as they transition to adult health services, occupation, education • Mobility, transport, independence, advocacy, accommodation/ residential • Social engagement/ isolation • Aging parents – may require additional support • Access to rehab

Table 1.7: CYP population segmentation of needs by health status and age

Unexpected severe injury or illness

Will be experienced by some CYP who will require unscheduled care which should include:

- Timely/ urgent GP/out of hours /urgent care/paediatric emergency services
- Healthcare provider expertise to recognise/stabilise/respond
- Transport
- Easy access to signposting information for parents and CYP
- Acute inpatient local/regional/tertiary services and subsequent rehabilitation or community support
- Age-appropriate care and environments where possible

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Whole population integrated child health - segmentation model (NHS UK Nov 2021)

A Population Health System (A Vision for Population Health: Towards a healthier future. Kings Fund, 2019)

Monthly Homelessness Report. January 2023. Prepared by the Department of Housing, Local Government and Heritage gov.ie /housing.

Appendix A

Preventing adverse childhood events	
Strategy	**Approach**
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality childcare • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programmes • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programmes • After-school programmes
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centred services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behaviour and future involvement in violence • Family-centred treatment for substance use disorders

Ref: Centers for Disease Control (US) website

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