Healthcare Improvement Scotland is committed to equality and diversity. We have assessed these standards for likely impact on the nine equality protected characteristics as stated in the Equality Act 2010 and defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. A copy of the impact assessment is available upon request from the Healthcare Improvement Scotland Equality and Diversity Officer.
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1 Introduction to integrated care pathways for child and adolescent mental health services

Mental health problems in children and young people are more common than many realise. The Public Health Institute for Scotland Needs Assessment Report on Child and Adolescent Mental Health (2003), often referred to as the SNAP report, states that about 10% of children and young people ‘have mental health problems which are so substantial that they have difficulties with their thoughts, their feelings, their behaviour, their learning, their relationships, on a day-to-day basis’.

Specialist child and adolescent mental health (CAMH) services comprise multidisciplinary teams with expertise in the assessment, care and treatment of children and young people experiencing mental health problems. The wider multidisciplinary and multi-agency team around the child also has a key role in supporting children and young people with any mental health problems they may be experiencing. Integrated care pathways (ICPs), in their simplest terms, tell service providers, children and young people using services and their parents/carers what should be expected at any point along the journey of care. Using ICPs as the basis for CAMH service delivery will help to ensure that:

- assessment, care planning and care delivery are centred on the child or young person and positive outcome-focused
- care and treatment is in line with the available evidence base
- effective care partnerships are developed and sustained between agencies, children, young people and their parents/carers
- relevant and useful information is shared appropriately and in a timely way with children and young people and their parents/carers and between professionals and agencies, and
- any variations to planned care are captured, analysed and acted upon.

Through the development and application of ICPs as a basis for service provision, and through the use of the data that they generate, NHS boards, and their partners, will be able to demonstrate robust and responsive CAMH services. This will support reflective practice and continuous cycles of quality improvement. ICPs promote systems and processes which are:

- fully embedded in a culture that supports the delivery of care that is centred on the child or young person
- safe and effective, and
- can be applied to all universal and specialist CAMH services.


2 CAMH services in Scotland – an overview

In Scotland, CAMH services are generally delivered through a tiered model of service organisation (see Figure 1 below and Appendix 4 for more detail).

Figure 1: CAMH services Tiers 1–4

Children and young people who are experiencing difficulties that could be related to their mental health are usually first identified within Tier 1 services, for example by a teacher, GP or health visitor. Similarly, parents/carers who identify that their child is experiencing difficulties will usually first seek help from services at that level. Children and young people with an identified need may be subsequently referred into specialist CAMH services (falling within Tiers 2–4) for assessment and intervention if necessary.

Many children and young people accessing CAMH services will not have a definitive diagnosis. We have tried to reflect this within the standards by highlighting the need to also consider and record assessment and formulation information. These standards advocate the use of evidence-based therapies and treatments. We recognise, however, that the evidence base in CAMH is currently limited. There are some therapies that do not have a strong evidence base but are commonly accepted practice and may benefit some children and young people. Delivering care through an ICP should not stifle innovation; the clinical judgement, experience and knowledge of the CAMH practitioner will always have a bearing on any decisions regarding the best treatment option for a child or young person. ICPs use variance analysis as a tool for service improvement. It is important to acknowledge that not all variance is bad, for example in the context of clinical judgement in the assessment and treatment process.

Children and young people who are experiencing mental health problems may be in contact with a number of services and practitioners, often spanning more than one service tier. Practitioners within Tier 1 services are generally in more regular contact with the child or young person. This is particularly the case for education staff, as most children and young people spend a significant proportion of their time in school. It is important that mechanisms are established for specialist CAMH services to input to the care and support of the child or young person. This may be through liaison, consultation, support and training for staff working in Tier 1.
Additional complexities must also be considered. These can include children and young people with both mental and physical health conditions, those with a primary diagnosis of learning disability and those who are looked after. Services also have to be aware of, and provide appropriate services for, any children and young people who are subject to the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000 which is applicable to people aged 16 years and over who lack capacity to act or make some or all decisions for themselves because of mental disorder or inability to communicate due to a physical condition.

We also recognise that the age range for referral to, and treatment by, specialist CAMH services varies across NHSScotland, and within NHS boards. In recognition of this, these standards make no specific reference to age.

2.1 Involvement of children, young people and their parents/carers

Children and young people with experience of mental health services, and their parents/carers were involved in the development of these standards. They helped us to make sure that the standards are centred on the child or young person and reflect what they, and their parents/carers, see as important and helpful.

To help us to contextualise how it feels and what helps from the perspective of those accessing CAMH services, we asked a wider range of children and young people about their experiences. Thirty young people, from across Scotland, aged between 7–18 years of age, completed our ‘Your Story’ consultation tool. A separate report of the feedback received will be produced.
Standards for integrated care pathways for child and adolescent mental health services

3 The policy context


The Healthcare Quality Strategy for NHSScotland outlines a shared aim for NHSScotland to become a world leader in healthcare quality. The Healthcare Quality Strategy includes three quality ambitions that relate to providing care that is person-centred, safe and effective. The quality ambitions are:

1. ‘mutually beneficial partnerships between patients, their families, and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
2. there will be no avoidable injury or harm to people from the healthcare advice they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times, and
3. the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

Implementation of ICPs within CAMH services will support the achievement of these quality ambitions. A number of national patient safety programmes are under way or in development. As mandated in the Healthcare Quality Strategy, Healthcare Improvement Scotland is leading on the development of the Scottish Patient Safety Mental Health Programme. This programme will cover the whole age spectrum in mental health and ICPs will be central to the programme’s development and delivery. The paediatric and primary care patient safety programmes will also have interfaces with the CAMH ICP work.

In the last 10 years, numerous new policies, practice models and improvement programmes that apply to health, education and social care providers have been introduced (see the separate background reading document). Common themes emphasise the importance of the emotional well-being and mental health of children and young people and the importance of placing the child or young person and their parents/carers at the centre of all decision-making and every care encounter. Key to this is a need for:

- better communication and sharing of information between practitioners and services
- more integrated services with joined-up planning processes, and
- reciprocal support arrangements.

The standards for ICPs for CAMH services relate primarily to NHSScotland and the resultant ICPs will be NHS-based. However, ICPs provide a framework which promotes care centred on the child or young person and highlights the points on the pathway where information should be routinely shared with the child or young person, their parents/carers, where appropriate, and between agencies and practitioners. Integral to this are the rights of children and young people with regard to their own personal information and how this is managed and shared. This needs to be balanced against parents/carers’ information requirements and child protection issues.
ICPs also outline where support, liaison, and consultation are required to allow the multi-agency workforce to best meet the needs of the child or young person and their parents/carers.

The other national drivers with most significant links to ICPs for CAMH services are outlined below.

3.2 NHSScotland Specialist CAMHS Balanced Scorecard

The draft NHSScotland Specialist Child and Adolescent Mental Health Services Balanced Scorecard\(^5\) provides a common core set of key performance indicators for use across all NHS boards in Scotland. The balanced scorecard will be used to monitor the success of NHS boards in implementing CAMH policy and to support national data benchmarking of CAMH services across Scotland. Development of ICPs is included explicitly within the balanced scorecard as one of the key development areas that will contribute to achievement of the following high level objectives:

- good clinical outcomes, and
- person-centred services.

Development and implementation of ICPs for CAMH services also feature within a number of the key performance indicators. It is intended that the key performance indicators will be useful in three ways:

1. they will provide data which will support decision-making relating to local CAMH service redesign
2. they will provide data which will support national implementation monitoring and will identify where further national focus and support activity is required, and
3. they will provide benchmarking information which will be helpful to individual NHS boards and to all those with an interest in gaining a better understanding of the national position relating to CAMH service provision.

3.3 HEAT Targets

Health improvement, efficiency, access and treatment (HEAT) targets\(^6\) are a core set of Ministerial objectives, targets and measures for NHSScotland. The targets reflect Ministers’ priorities for the health portfolio and are refreshed and revised, usually every three years. There are a number of mental health specific HEAT targets which are applicable to CAMH services. We have worked with colleagues in Scottish Government, NHS Education for Scotland and the Information Services Division of NHS National Services Scotland to ensure that, where possible, ICP development and implementation delivers against the HEAT targets in mental health. ICPs are an important tool to support NHS boards to deliver against these mandatory targets.


The SNAP Report\(^1\) outlines the strategic vision for the mental health of children and young people in Scotland. It emphasises that all agencies and organisations have a role in supporting mental health and well-being across the whole continuum – from mental health promotion, through preventing mental illness, to supporting, treating and caring for those children and young people experiencing mental health difficulties of all ranges of complexity and severity.
3.5 The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)

The Framework was developed to support services to implement the recommendations of the SNAP report. It is intended to be used by health, education and social work services to aid planning and delivery of integrated approaches to children and young people’s mental health services. In essence, it is intended to promote and shape coherent, interagency planning.

The Framework fits within, and endorses, the vision for an integrated approach to children’s services planning and delivery set out in For Scotland’s Children, which assumes a holistic approach with the child at the centre. It also links strongly with the fourth edition of Health for All Children in Scotland (Hall 4). Hall 4 recommends a holistic approach to child health screening and surveillance with an emphasis on health promotion, primary prevention and targeted active intervention with vulnerable families. NHS boards and their planning partners have been tasked with implementing the Framework by 2015.

3.6 Getting it Right for Every Child (GIRFEC)

Getting it Right for Every Child (GIRFEC) is a set of guiding principles and a fundamental way of working that provides the foundation for work with all children and young people. GIRFEC builds from universal health and education services. It drives the developments that will improve outcomes for children and young people by changing the way adults think and act to help all children and young people grow, develop and reach their full potential (see Table 1). GIRFEC is an evolving process and will be updated over time as new thinking and practice emerges.

Table 1: Scottish Government (2008). Modified from ‘the guide to getting it right for every child’

<table>
<thead>
<tr>
<th>For children, young people and their families GIRFEC means:</th>
<th>For practitioners GIRFEC means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• they will feel confident about the help that they are getting</td>
<td>• putting the child or young person at the centre and developing a shared understanding within and across agencies, and</td>
</tr>
<tr>
<td>• they understand what is happening and why</td>
<td>• using common tools and processes, considering the child or young person as a whole, and promoting closer working where necessary with other practitioners.</td>
</tr>
<tr>
<td>• they have been listened to carefully and their wishes have been heard and understood</td>
<td></td>
</tr>
<tr>
<td>• they are appropriately involved in discussions and decisions that affect them, and</td>
<td></td>
</tr>
<tr>
<td>• they can rely on appropriate help being available as soon as possible.</td>
<td></td>
</tr>
</tbody>
</table>

The ability to share information about children and young people, to aid decision-making around their needs, is fundamental to GIRFEC. Over the coming years, the national eCare framework will be developed to further support information-sharing in relation to this. In the future, practitioners will be expected to record information using shared language, structured round a standard practice model, sharing key relevant information through the eCare framework.
The GIRFEC practice model (see Figure 2) and associated tools have been designed to be used locally to complement practitioners’ own materials and processes to improve practice, and ultimately secure better outcomes for children and young people.

**Figure 2: GIRFEC practice model. Scottish Government (2008). Reproduced from ‘the guide to getting it right for every child’**

3.7 Education (Additional Support for Learning) (Scotland) Act 2009

This 2009 Act makes certain amendments to the Education (Additional Support for Learning) (Scotland) Act 2004.

The 2009 Act reinforces the concept of ‘additional support needs’ as referring to any child or young person who, for whatever reason, requires additional support for learning. Such needs can arise from any factor which causes a barrier to learning including social, emotional, cognitive, linguistic disability, or family and care circumstances.

The 2004 Act imposes duties on education authorities and others. It provides a framework for local authorities and other agencies to support all children and young people who have identified additional support needs. Of particular relevance, the Act stipulates that:

- ‘education authorities must seek and take account of advice and information (including formal assessments) from other agencies (eg health, social work services), and
- ‘other agencies have duties to help each education authority discharge its duties under the Act… For the purposes of the Act other agencies include any other local authority, any health board or any other agency specified by Scottish Ministers.’
4 Overview of the standards for integrated care pathways for child and adolescent mental health services

The standards for integrated care pathways for CAMH services have three main elements.

Process standards

The process standards are aimed at supporting NHS boards and partner agencies to lay essential foundations on which to develop their ICPs. The standards are also designed to ensure the involvement of all stakeholders including children, young people and their parents/carers. They outline the infrastructure which must be in place in order to develop, implement and use ICPs successfully: the key tasks to be undertaken, and who is responsible.

Generic care standards

The generic care standards describe the interactions and interventions that must be offered to all children and young people who access CAMH services and their parents/carers. Children and young people referred to specialist CAMH services may already have been included in local staged intervention processes. It is important to take full account of these when delivering care through an ICP.

CAMH services might provide consultation to the wider workforce around the child in relation to children and young people with additional support needs. Consultation could involve giving advice and support/training to the workforce around the child and/or supporting further planning and interventions. A generic ICP is suggested as the main framework for child and adolescent mental health care. Condition-specific elements can be added for children and young people with a specific diagnosis.

Service providers should ensure that children, young people and their parents/carers are fully engaged with CAMH services. It is recognised that ‘services should be offered as near to home as possible and in a number of settings to take account of the different needs and choices of children, young people and their parents/carers and the required intervention. This could include locations such as schools, homes and family centres, which may be perceived as less stigmatising, as well as traditional clinical settings14.

For children and young people, it is important that the ‘services provided should be appropriate for their age, gender, sexual orientation, physical and developmental ability and cultural background15.

NHS boards and partners should develop a local plan to ensure that children and young people, already receiving care from specialist CAMH services, will have their care delivered through an ICP in the future.
Service improvement standards

ICPs should significantly contribute to continuous quality improvement, and will help NHS boards and partner agencies to consistently deliver care that is ‘person-centred, clinically effective and safe, for every person, all the time’.4

The service improvement standards are designed to help ensure that ICPs are being implemented and actively used for variance analysis, service redesign, training analysis and, ultimately, demonstrating a positive impact on care. It is acknowledged that not all variance is bad, for example in the context of clinical judgement in the assessment and treatment process.
5 Standards for integrated care pathways for child and adolescent mental health services

5.1 Process standards

Standard 1  Named ICP leads
Standard 2  Stakeholder involvement
Standard 3  Process mapping
Standard 4  Links to local governance systems
Standard 5  Training needs assessment
Standard 6  Recording and analysis of diagnostic or assessment information
Standard 7  Recording and sharing of information
Standard 8  Variances
Standard 9  Referral and triage
Standard 1: Named ICP leads

Standard statement 1

A senior clinician or lead practitioner in a strategic leadership role, in partnership with a named ICP co-ordinator, is responsible for driving ICP development and implementation.

Rationale

A named strategic lead and an ICP co-ordinator are both important for the process of developing and implementing a multi-agency and multidisciplinary ICP. The organisation needs to support these individuals to fulfil their roles.

Criteria

1a A named strategic lead is allocated responsibility for driving ICP development and implementation and is accountable at NHS board level for this.

1b A named ICP co-ordinator is allocated operational responsibility for supporting ICP development and implementation.
Standard 2: Stakeholder involvement

Standard statement 2

Systems are in place for engaging with, and involving, key stakeholder groups in ICP development and thereafter raising awareness and educating all stakeholders about ICPs.

Rationale

For the successful development and implementation of ICPs, it is crucial to include everyone who is involved in a child or young person’s care. Successful implementation requires the full involvement of the wider children’s workforce\(^1\). Particular attention also needs to be paid to involving children, young people and their parents/carers.

Criteria

2a Systems are in place to involve the following stakeholders in the ICP development process:

- multi-agency and multidisciplinary workforces (including advocacy services and voluntary organisations), and
- children, young people and their parents/carers.

2b Systems are in place to involve all stakeholders in awareness-raising, promotion and education sessions about ICPs.
**Standard 3: Process mapping**

**Standard statement 3**

A process mapping exercise is conducted in the early stages of ICP development.

**Rationale**

ICPs are a tool for improving care. In order to focus improvement work on the right areas, and identify the improvements that will have the biggest impact, it is important for all stakeholders to have a firm understanding about what actually happens in day-to-day practice. Process mapping identifies and examines the existing journeys of care from the perspective of children, young people, their parents/carers and the children’s workforce. Services can begin to see where changes or improvements can be made by identifying gaps, overlaps, strengths and weaknesses of the current service provision and processes. This exercise alone can help to build good team working and develop shared goals and responsibilities. Process mapping should be carried out early on in the ICP development process.

**Criterion**

3a A process mapping exercise should:

- identify current patterns of service delivery and available resources
- examine the journey of care for children, young people and their parents/carers
- establish the strengths and weaknesses of current service provision
- quantify demands on the services
- identify the gaps in services
- identify gaps in staff skills and competencies, and
- identify how the journey of care can be improved.
Standard 4: Links to local governance systems

**Standard statement 4**

NHS boards and partner agencies can demonstrate that local governance systems support ICP development and implementation.

**Rationale**

To ensure safe and effective practice, the involvement of clinical governance (or care governance for jointly managed services), is essential to the development of ICPs\(^\text{16}\).

**Criteria**

4a The relationship between local governance arrangements and the development, implementation and review of ICPs can be demonstrated.

4b A local plan, which includes timescales, is developed and agreed, and details how:

- the organisation will deliver care using ICPs for children and young people who are accessing services for the first time, and
- children and young people currently accessing services will have their care delivered through ICPs in the future.
Standard 5: Training needs assessment

**Standard statement 5**

Training and supervision needs are identified and acted upon.

**Rationale**

Strategic leadership and planning are key factors in promoting and developing multi-agency and multidisciplinary training to ensure a competent workforce is in place across all relevant services; particularly health, education and social services.

There should be systems for reviewing children, young people’s and their parents/carers’ needs against available resources, staff skills, attitudes and capabilities. Knowing who needs which services, and monitoring whether their needs are met, offers a real opportunity to improve both the care and the quality of life for children, young people and their parents/carers.

**Criteria**

5a  There are systems in place to monitor and demonstrate that the training and supervision needs of the workforce around the child are acted upon and that training is actively promoted.

5b  There are systems in place to ensure that these training and supervision needs and requirements are incorporated into the organisation’s workforce development plans and/or local governance arrangements.

5c  There are systems in place and the organisation can demonstrate training in the competence framework for child and adolescent mental health services.
Standard 6: Recording and analysis of diagnostic or assessment information

Standard statement 6

In each NHS board area, systems are in place to record and analyse the category of diagnostic or assessment information.

Rationale

Many children and young people accessing CAMH services do not have a definitive diagnosis. NHS boards should have a mechanism for bringing together anonymised data to identify the total number of children and young people with a diagnosis or presenting problem who are accessing services. Information should be recorded using a multi-axial system of assessment\(^{18}\), in accordance with the NHS National Services Scotland, Data Recording Advisory Service’s national information requirements. This information should also be available by local authority area\(^{16}\).

Systems should be developed to ensure that information can be shared in a way which satisfies both the legal and professional obligations of the services involved in care delivery, and the legitimate expectations of children, young people and their parents/carers. Local governance arrangements will define data management systems, usage and procedures.

This information is essential to allow NHS boards to make informed decisions regarding service planning to ensure that provision is based on demand and needs.

Criteria

6a There are systems in place to record the number of children and young people accessing specialist CAMH services.

6b There are systems in place to record diagnostic and/or assessment information which should allow for the recording of multiple values.

6c There are systems in place to record the number of children and young people receiving care through an ICP.
Standard 7: Recording and sharing of information

Standard statement 7

Systems are in place to enable the recording and sharing of information.

Rationale

Information-sharing between the multi-agency workforce around the child is important for the provision of co-ordinated care. It is central to demonstrating what services have been delivered, and what outcomes have been achieved. The GIRFEC\(^{16}\) practice model will ensure a common structure for assessing the needs of children and young people and recording of information.

There is a need to obtain consent from children, young people and their parents/carers, as appropriate, to share information outwith the staff group providing the care. NHS boards and their partners should build on their existing data sharing partnership agreements and develop information-sharing systems to enable this to happen. Service providers must be aware that young people under the age of 16 who are deemed capable of giving consent have the same right to confidentiality as an adult\(^7\). This can mean that, in the best interest of the child or young person, professionals working with them will maintain their privacy even when a parent/carer or other professional requests information\(^{19}\).

Issues of consent and confidentiality should not prevent the development of a positive partnership between practitioners and the parents/carers of older children. There should be a clear understanding of what is expected of a practitioner if a parent/carer asks for information. Organisations providing mental health services should ensure that their workforce receives and offers training and support in working through these issues. Children, young people and their parents/carers should have clear information about:

- safeguards for information
- giving consent to share information, and
- identifying circumstances where aspects of information that they might prefer to keep private might need to be shared; for example, where a child or young person is considered to be at risk themselves or poses a risk to others.

Criteria

7a There is a secure system in place that allows for the recording of, and access to, information in the child or young person’s care record.

7b Information is recorded and transferred in accordance with the Health and Social Care Data Dictionary (http://www.datadictionary.scot.nhs.uk) and the NHS National Services Scotland, Data Recording Advisory Service (http://www.isdscotland.org/isd/6464.html) and includes:

- national information requirements
- current recommendations on consent, confidentiality and record-keeping standards, and
- the capacity to share demographic, assessment and planning information electronically within and across partner agencies.
Standards for integrated care pathways for child and adolescent mental health services

**Standard 8: Variances**

**Standard statement 8**

Systems are in place to record, analyse, share and act upon ICP variances.

**Rationale**

Care delivered through an ICP enables the care team to reflect on individual and grouped variations from planned care\(^16\).

**Criterion**

8a There are systems in place for:

- recording
- collating
- analysing
- reporting, and
- acting upon variances.
Standard 9: Referral and triage

Systems are in place to manage referrals into specialist child and adolescent mental health services.

Rationale

There are likely to be a number of options available locally to make a referral\(^{16}\). Agreed referral criteria\(^{20}\) help referrers to make a decision as to what is the most appropriate service for a child or young person to be referred to.

Provision of good quality referral information can expedite the decision-making process, and help ensure that children, young people and their parents/carers access the most appropriate services. Agreed referral criteria also provide a framework which helps to ensure that potential service providers are given the most useful and appropriate information regarding the child or young person’s circumstances, and the reason for referral.

Referral algorithms allow children, young people, and their parents/carers to be signposted to the most appropriate service and help reduce the waiting time for access to treatment\(^6\).

A referral management system is important to:

- enable prompt and accurate identification of the needs of children, young people and their parents/carers,
- determine urgency, and
- conduct a preliminary assessment of risk.

Criteria

9a There is an agreed decision-making system to support referrals into specialist CAMH services.

9b Service care providers have an agreed system on how referrals are managed within their specialist CAMH service, including:

- agreed referral criteria
- administrative response times (eg agreed timescales for notification of appointments, follow-up correspondence, etc.)
- consultation processes
- initial screening arrangements
- active monitoring
- triage assessment, and
- signposting to required service according to complexity of need.
5.2 Generic care standards

Care assessment standards

Standard 10 Holistic assessment

Standard 11 Assessment and management of risk

Standard 12 Diagnosis

Standard 13 Suitability for psychological and/or psychosocial interventions

Care planning standards

Standard 14 Care centred on the child or young person

Standard 15 Child or young person’s mental health care plan

Care delivery standards

Standard 16 Recording medication decisions

Standard 17 Inpatient admission and discharge

Standard 18 Managing transitions

Outcome standard

Standard 19 Measurement of outcome
Standard 10: Holistic assessment

Standard statement 10
A holistic assessment is undertaken with the child or young person and their parents/carers.

Rationale
For children and young people entering specialist CAMH services, a holistic assessment is always necessary. If the child or young person already has a GIRFEC\textsuperscript{10} single plan, the information contained in this should be used to inform the holistic assessment. Any additional assessments carried out should build on the information already contained in the single plan.

Criteria

10a A holistic assessment is carried out with the child or young person, and their parents/carers, where appropriate. Where there is a child or young person’s single plan, information that is already available should be considered. A holistic assessment identifies:

- current difficulties and previous mental health history
- personal, family and social circumstances
- family history
- physical and developmental history
- current and past interventions used (including outcomes, adverse reactions and side effects)
- risk
- the child or young person’s strengths and aspirations
- the needs of the child or young person
- the needs of parents/carers, where appropriate
- capacity to consent to care and treatment
- additional vulnerabilities and/or co-morbidities
- educational/vocational status
- partner agency involvement, and
- legal and/or looked after status.

10b A target time for completion of the holistic assessment is recorded.

10c Service providers can demonstrate that the views of children and young people are routinely sought and recorded as part of the assessment process.
Standard 11: Assessment and management of risk

Standard statement 11

A risk assessment and management process is carried out and routinely updated.

Rationale

Ongoing risk assessment and management is essential for delivering high quality professional care. Some children and young people will have particular immediate vulnerabilities due to their presenting mental health condition. For these groups, additional risks need to be assessed and managed as they present. Care needs should be balanced against risk.

Professionals need to be alert to the risk to children and young people of abuse and/or neglect by others as well as the risk of harming themselves or others. These risks may change as children and young people develop physically and emotionally. This requires an awareness of, and adherence to, local and national child protection guidance \(^{21-22}\).

The risk assessment process should be used noting the scope of the resilience matrix from the GIRFEC\(^{10}\) practice model.

Services also have to be aware of, and provide appropriate services for, any children and young people who are subject to the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003\(^{3}\) or the Adults with Incapacity (Scotland) Act 2000\(^{3}\).

Criteria

11a  Within CAMH services, there is a record of the child or young person’s vulnerabilities and risks, in relation to:

- risk to self and others, and
- care and protection.

11b  The risk assessment leads to the generation of a risk management plan that identifies roles and responsibilities, and is:

- developed with the child or young person and their parents/carers, where appropriate
- communicated to all those involved, including partner agencies, where appropriate
- reviewed at agreed regular intervals, and
- amended as necessary, based on ongoing assessment of need.

11c  Critical incidents or significant adverse events are reported in accordance with agreed local single agency and multi-agency governance arrangements.
Standards for integrated care pathways for child and adolescent mental health services

Standard 12: Diagnosis

Standard statement 12
Where there is a diagnosis or diagnoses, it/they should be recorded.

Rationale
A particular diagnosis may suggest the use of certain treatments and/or the likely course and outlook for the child or young person. Information on how the diagnosis or diagnoses was/were reached should be included in the care record.

A diagnosis or diagnoses should be recorded and explained\textsuperscript{16} to the child or young person and their parents/carers, where appropriate. The explanation should include access to information about the condition including the range of treatment options available, as well as the support and resources that may be available in the community.

Any diagnosis given should be reviewed regularly taking into account the developmental growth of the child or young person. The views of the child or young person and/or their parents/carers, where appropriate, should also be taken into account.

Criterion
12a Where there is a diagnosis or diagnoses, the mental health care record shows:

- the diagnosis or diagnoses
- information on how the diagnosis or diagnoses was/were reached following established diagnostic criteria, where available
- the formulation
- confirmation that the diagnosis or diagnoses has/have been explained to the child or young person and their parents/carers
- that the information is shared, where appropriate, with partner agencies
- that information on the condition has been given, and
- that where the child or young person and/or their parents/carers disagree with the diagnosis or diagnoses, there is a system to record this.
Standard 13: Suitability for psychological and/or psychosocial interventions

Standard statement 13
The need for structured psychological and/or psychosocial intervention for the child or young person is assessed.

Rationale
In specialist CAMH services, structured psychological/psychosocial intervention is usually the first-line treatment position for children and young people, and may be delivered alongside other treatment options.

On behalf of the Scottish Government, NHS Education for Scotland has produced guidance for NHS boards on the local delivery of evidence-based psychological therapies. The Psychological Therapies Matrix\textsuperscript{23}, has been designed to ‘deliver the range, volume and quality of psychological therapy for the effective treatment of common mental health problems’\textsuperscript{23} and supports ICP implementation.

Evidence of the effectiveness of psychological therapies is based on the person delivering a therapy having been trained and accredited, and practising within a framework of supervision, support, audit and review\textsuperscript{16}.

Criteria

13a The assessed need for psychological and/or psychosocial interventions and/or alternative treatments is recorded.

13b Where needs have been identified, there is a record that:

- children, where appropriate, young people and their parents/carers have been offered information and guidance (including educational, social, lifestyle advice), and
- the information is shared, where appropriate, with partner agencies.

13c There are systems for the provision of psychological and/or psychosocial therapies including:

- recording unmet need
- review of the individual child or young person’s progress, and
- recording of outcome.

13d Psychological therapies are delivered by appropriately trained and accredited staff under practice supervision.
Standard 14: Care centred on the child or young person

Standard statement 14
There is a record that children, young people and their parents/carers have been actively involved in the planning of their care.

Rationale
It is recognised that children, young people and their parents/carers engage better with services when they are active participants in their own care planning\textsuperscript{15}. Promoting recovery in mental health puts the process of outcomes of care as a joint partnership involving children, young people and their parents/carers.

Care that is centred on the child or young person should ensure that assessments, care planning and care delivery are based on the outcomes identified and agreed with the child or young person and their parents/carers. The care provided should be planned with the child or young person and their parents/carers on the basis of assessed needs.

Children and young people and their parents/carers should be provided with a range of information about the outcome of the assessment, the diagnosis or formulation, treatment options, outcomes, risks, side effects and their rights on an ongoing basis.

Children and young people should be regularly consulted on whom they want to have access to their care plan\textsuperscript{24}. Children and young people will receive mental health care guided by the Millan Principles\textsuperscript{25}.

Care planning involves a regular review of the ongoing care delivery and should be consistent with the GIRFEC practice model\textsuperscript{10}.

Criteria
\begin{itemize}
\item \textbf{14a} The care record shows that care is planned and agreed with the child or young person and their parents/carers, where appropriate.
\item \textbf{14b} The care record shows that, where appropriate, advice has been provided to the child or young person, and their parents/carers on sources of further information and support, for example voluntary organisations and advocacy services.
\item \textbf{14c} The care record shows evidence of regular review.
\end{itemize}
Standard 15: Child or young person’s mental health care plan

Standard statement 15

There is one mental health care plan which meets the needs of the child or young person and manages any identified risks.

Rationale

The child or young person’s mental health care plan should be based on a multidisciplinary assessment of needs and risks co-ordinated by a lead CAMH professional. Appropriate gathering of information from other agencies is essential to identify all needs and risks and to ensure continuity of care and support. The agencies involved should work collaboratively to make best use of existing relevant information from other sources. This also reduces the likelihood of children or young people and their parents/carers, where appropriate, being repeatedly asked to give the same information.

With the consent of the child or young person and their parents/carers, where appropriate, relevant information from the mental health care plan should be shared with other agencies involved in the child or young person’s care.

Children or young people, and their parents/carers, where appropriate, should be actively involved in the development and review of their mental health care plan. This should include agreeing the goals and outcomes that are important to them, and the interventions being considered to help achieve these.

Care planning information should be made available, where appropriate, to children or young people with regard to their mental health difficulties and the interventions being used or considered. Information should also be available, where appropriate, to parents/carers to support them to care for their child.

Criteria

15a The child or young person’s mental health care plan records a nominated lead CAMH professional.

15b The child or young person’s mental health care plan:

- is based on a multidisciplinary assessment of strengths, risks, needs, and past experience
- considers relevant information available from families and other agencies
- identifies the specific goals of the child or young person and their parents/carers, where appropriate
- specifies tasks, treatments and interventions
- states timescales for review
- identifies risks and how they will be managed
- records the other agencies involved in the child or young person’s care and support, and how information will be shared with them (with appropriate consents)
• identifies key transitional points in the child/young person’s journey of care, including any planned discharge from CAMH services, and how these will be managed
• includes a record of the desired outcome of the child or young person and their parents/carers (self-directed outcome), and
• includes a system to record any disagreement between the child or young person and their parents/carers regarding the mental health care plan.
Standard 16: Recording medication decisions

Standard statement 16
There is a record of all medication decisions.

Rationale
There should be a firm evidence base for all medication decisions. National licence conditions, where available, govern the indications, dosage and contra-indications for each available medication\textsuperscript{16}. ‘There are few drugs specifically licensed for use in children and adolescents’\textsuperscript{26}. When medication is prescribed off-licence, this should be under specialist supervision. ‘Prior to prescribing, the licensing status of a medication should be checked in the current version of the British National Formulary’\textsuperscript{27}. Service care providers should have agreed protocols consistent with national guidelines which provide guidance on medication, dosage, length of treatment, review requirements, side effects, and assessment of the effectiveness of medication. ‘A shared care protocol, where appropriate, should be adopted between primary and secondary care’\textsuperscript{27}.

‘The potential balance of risks and benefits from any pharmacological treatment needs to be considered for each individual child, and discussed, where appropriate, with them and their parents/carers, so that they can make an informed decision’\textsuperscript{26}.

Criteria
\textbf{16a} The care record shows the decision-making process, including when to initiate, review, change, maintain or end medication, and the range of treatment options considered.

\textbf{16b} Where medication needs have been identified, there is a record that:

\begin{itemize}
  \item children, where appropriate, young people and their parents/carers have been offered information and guidance (including educational, social, lifestyle advice), and
  \item the information is shared, where appropriate, with partner agencies.
\end{itemize}

\textbf{16c} The care record allows for:

\begin{itemize}
  \item review of the individual child or young person’s progress, and
  \item recording of outcome.
\end{itemize}
**Standard 17: Inpatient admission and discharge**

**Standard statement 17**

The reasons for, and the length of inpatient admission are recorded and discharge is planned.

**Rationale**

Careful consideration should be given to alternative services capable of meeting the needs of the child or young person including intensive community treatment services, where available. However, there will be occasions when inpatient admission is the most appropriate course of action. When inpatient admission is required, this should be as brief as necessary, and the aims of the admission stated and agreed. In the event of emergency admission, reducing the risk of harm to the child or young person is paramount. Due to the nature of emergency admissions, it may not be possible to carry out a specialist mental health assessment at this time. Wherever possible, the child or young person should have access to appropriate care in an environment suited to their age and development.

When a child or young person is unavoidably placed on a paediatric or adult mental health ward there should be collaboration and joint working between child health, adult mental health and CAMH professionals. The shared aim should be to ensure a timely and appropriate placement, if required, in a child or adolescent inpatient unit.

Discharge from hospital or transfer of care from one setting to another are areas where the continuity of care can break down, especially if inadequate information is transferred. Discharge planning should begin as early as possible from the time of admission and should involve the multi-agency and multidisciplinary team around the child or young person and their parents/carers.

Discharge and/or transfer should be a seamless process, ensuring that appropriate services are in place to support the child or young person. Discharge and/or transfer plans need to be well co-ordinated based on the child or young person’s assessed needs, reviewed regularly, and include ongoing risk assessment and management. This can only be done through effective planning and communication.

**Criteria**

17a When a child or young person’s admission to hospital is planned, the care record shows:

- the reasons for inpatient admission
- any alternative options considered (including Tier 4 intensive community treatment services, joint approaches with partner agencies, etc)
- if the child or young person has any known communication or cognitive difficulties
- the aims of admission
- the expected and actual length of the inpatient stay
- how the child or young person will continue to access full entitlement to education
• how the child or young person will continue to access their family, friends and peer group (and in as normal an environment as possible)
• how the links between the inpatient and community team will be maintained and information shared while the child or young person is in hospital, and
• the plan for discharge.

17b When a child or young person’s admission to hospital is unplanned, the care record shows why it was not possible to note the aims and duration of inpatient stay.

17c When a child or young person is unavoidably placed in an inappropriate setting (eg a paediatric or adult mental health ward), there should be mechanisms in place for their safe management including:

• a shared care protocol between CAMH services and the inpatient provider outlining the support that will be provided while the child or young person is in hospital, and
• risk assessment and management.
Standard 18: Managing transitions

Standard statement 18

The workforce around the child or young person takes a consistent and structured approach to transitions and involves children, young people and their parents/carers, where appropriate, in planning at key transition points.

Rationale

‘Children and young people are more vulnerable to mental health problems at times of important change in their lives. For example, change of home or household, when they are transferring from primary to secondary school, from school to other settings, from care settings to independent living, and between services for young people and those for adults’.7.

Young people and their parents/carers should experience a smooth transition from CAMH services. The young person’s existing ICP should provide the necessary link to adult services. At this transition point, there will be more emphasis on the support that can be provided outwith families and within communities. Young people’s needs should be seen in terms of what they require, what can be offered and who can support them. Young people need to be fully involved in any decisions made to help them. Those young people who leave school and are not in education, employment or training schemes and are too young to be referred to adult services, may be particularly vulnerable at this time. ‘Young people must get the support they need to find out about, engage with and sustain education, employment and training options’28. At this stage, it may be useful to consider vocational readiness assessment.

‘Careful and early collaborative planning is required across agencies and boundaries, to minimise distress and, where appropriate, ensure continuity of care. Careful planning is particularly important where transitions involve a child or young person with additional support needs’7.

Criteria

18a There is a consistent and structured collaborative approach to planning at key transition points that is appropriate to the age and developmental stage of the child or young person.

18b When developing a care plan, service care providers consider long term outcomes in terms of well-being, as well as short term targets for children and young people. Partners to the care plan should agree what actions are necessary to achieve these aims.

18c Service care providers take a partnership approach and can demonstrate:

- that they have consulted the child or young person and their parents/carers, where appropriate, and recorded their views as part of their involvement in the transition process
- that they have consulted partners in education and/or social work, where relevant
• that they have involved other relevant partners or agencies in order to minimise gaps in service as a child or young person moves through transition, eg on discharge from inpatient or day care services

• planned transition from CAMH services to adult services

• effective transfer of information about the child or young person to the new named person in the agency assuming responsibility, and

• planned transfer of responsibility when another service care provider becomes the lead professional, or the named person resumes responsibility when a multi-agency plan is no longer needed.

It is recognised that currently there are regional variations in the upper age range for access to CAMH services.
Standard 19: Measurement of outcome

Standard statement 19
A professionally rated, validated tool is used to measure outcome.

Rationale
A professionally rated, validated tool must be used to measure outcomes\(^\text{16}\). The choice of tool or scale should be based on the presentation, age and capacity of the child or young person. The views of the child or young person and their parents/carers should be recorded when reviewing planned outcomes.

Criteria

19a The care record includes a professionally rated tool which is validated for the relevant client group to monitor outcome.

19b There are systems in place to record:

- ‘what has improved in the child or young person’s circumstances
- what if anything has got worse
- if the planned outcomes have been achieved
- if any aspects of the plan need to be changed, and
- if the plan can continue to be managed within the current environment\(^\text{10}\).
5.3 Service improvement standards

Standard 20 Systems for reviewing and analysing variances

Standard 21 Collecting stakeholder views on ICP care
Standard 20: Systems for reviewing and analysing variances

**Standard statement 20**

The information gathered through regular review of ICPs and from the analysis of variance, leads to change in practice and/or service delivery, where appropriate.

**Rationale**

There needs to be a multi-agency and multidisciplinary process for recording, collating analysing, reporting, and acting upon variances. Grouped variations may indicate where service re-design and improvement is required. Systems should be in place to allocate resources appropriately.

All variance from planned care needs to be monitored, reported, acted upon, and reviewed at:

- local service management level, including senior members of the care team, and
- NHS board and local authority directorate level\(^{16}\).

In accordance with the GIRFEC\(^{10}\) principles and the Healthcare Quality Strategy\(^{4}\), the views of children, young people and their parents/carers need to be reflected in this process.

**Criteria**

20a The multi-agency and multidisciplinary care team reviews individual and grouped variances.

20b The local management team reviews grouped variances to identify areas where service re-design can improve service delivery.

20c The NHS board and local authority care governance structures receive collated ICP variance reports.

20d All stakeholders are given feedback on the actions taken in response to variances.
Standard 21: Collecting stakeholder views on ICP care

**Standard statement 21**

Stakeholder views about care delivered through ICPs are collected and acted upon.

**Rationale**

All staff should be able to contribute to the development and updating of the ICP. Involving staff in the early stages of ICP development should be supplemented by the regular gathering of feedback from staff once ICP care is introduced. This allows for updating and improvement of the ICP in line with daily practicalities and will improve participation from frontline staff. Just as important is the gathering of feedback from children, young people and their parents/carers about their experience of having their care delivered through an ICP. As a minimum, an annual survey of staff, children, young people and their parents/carers should be conducted and the results fed into the process of updating the ICPs.

**Criteria**

21a A survey (or similar) of staff, about the ICP process is conducted at least annually and the survey results acted upon.

21b A survey (or similar) of children, young people and their parents/carers about the care they have received is conducted at least annually, and the survey results acted upon.
6 Appendices

Appendix 1 Background on Healthcare Improvement Scotland

Appendix 2 Background on mental health integrated care pathways and recent developments in Scotland

Appendix 3 Approach to development of standards for integrated care pathways for child and adolescent mental health

Appendix 4 CAMH service tiers

Appendix 5 CAMH ICP steering group membership

Appendix 6 CAMH ICP young people and parent/carer subgroup membership

Appendix 7 CAMH ICP generic subgroup membership

Appendix 8 References

Appendix 9 Glossary
Appendix 1: Background on Healthcare Improvement Scotland

Healthcare Improvement Scotland was launched on 1 April 2011. This health body was created by the Public Services Reform (Scotland) Act 2010 and marks a change in the way the quality of healthcare across Scotland will be supported nationally.

Our vision

Our vision is to deliver excellence in improving the quality of the care and experience of every person in Scotland every time they access healthcare.

Our purpose

Our organisation has key responsibility to help NHSScotland and independent healthcare providers to:

- deliver high quality, evidence-based, safe, effective and person-centred care, and
- scrutinise services to provide public assurance about the quality and safety of that care.

What we do

We are building on work previously done by NHS Quality Improvement Scotland and the Care Commission, and our organisation includes:

- Healthcare Environment Inspectorate
- Scottish Health Council
- Scottish Health Technologies Group
- Scottish Intercollegiate Guidelines Network (SIGN), and
- Scottish Medicines Consortium.

Our work programme supports Scottish Government priorities, in particular those arising from the Healthcare Quality Strategy for NHSScotland. Our work encompasses all three areas of the integrated cycle of improvement (see Figure 3) with patient focus and public involvement at the heart of all that we do.

The integrated cycle of improvement involves:

- developing evidence-based advice, guidance and standards for effective clinical practice
- driving and supporting improvement of healthcare practice, and
- providing assurance about the quality and safety of healthcare through scrutiny and reporting on performance.
Standards for integrated care pathways for child and adolescent mental health services

Figure 3: Integrated cycle of improvement

Appendix 2: Background on mental health integrated care pathways and recent developments in Scotland

What is an integrated care pathway?
An ICP is a tool that allows the comparison of planned care with care actually given. ICPs allow any variances in planned care to be recorded, analysed and acted upon. An ICP is much more than a document of care. It encompasses how care is organised, co-ordinated and governed, and embodies a system of continuous quality improvement. ICPs promote information-sharing and collaborative working between stakeholders, including children, young people and their parents/carers and partner agencies. Development of ICPs also offers new opportunities for sustained quality improvement in CAMH services.

Standards for integrated care pathways for mental health – adult services
We published standards for ICPs for adult and older adult mental health services in December 2007. We adopted a collaborative approach to develop these standards and involved a wide range of stakeholders including:

- people with experience of using mental health services
- informal carers
- healthcare managers and clinicians
- local authorities, and
- voluntary organisations.

Our adult ICP project development groups invested significant time and effort in collating and appraising the evidence base, and in development of the ICP standards. We drew on the available literature, and on the knowledge of experts in ICP development and implementation in the development of the process and service improvement standards. Guidelines published by SIGN and the National Institute for Health and Clinical Excellence provided the main evidence base for the generic and condition-specific care standards.

Support for ICP development and implementation
A package of support has been established to help NHS boards to develop and implement adult mental health ICPs. This includes:

- a team of national ICP co-ordinators
- an online ICP toolkit, and
- a national network of ICP link co-ordinators from each NHS board.

Progress with ICP development and implementation
All NHS boards have established ICP co-ordinator and ICP clinical lead posts. Since December 2007, NHSScotland has been using the ICP standards to develop and implement ICPs, and to drive quality improvement in adult mental health services. NHS boards are also incorporating the data capture elements of ICPs into their future information management and technology development plans.
Appendix 3: Approach to development of standards for integrated care pathways for child and adolescent mental health services

We held a CAMH stakeholder consultation event in March 2009. Stakeholders from across the range of agencies and organisations involved in CAMH came together to discuss the principles of ICPs and whether ICPs could add value within CAMH services. In addition to this event, our CAMH clinical advisor consulted a number of relevant national groups. The feedback from this consultation process was overwhelmingly positive with regard to applying the principles of ICPs to CAMH services. It was also agreed that a similar multidisciplinary and multi-agency standards development model would work well.

A CAMH ICP steering group was established in October 2009 (see Appendix 5 for membership). This group agreed that the adult ICP standards should be used as the basis for development of CAMH specific standards. It was agreed that work would initially focus on the development of standards for a generic CAMH pathway.

The steering group also highlighted the importance of ensuring that the standards for CAMH services can stand alone and are not seen as an ‘add-on’ to the adult work. The steering group advised that two working subgroups should be established to take forward the review and adaptation of the existing standards. We established a service user and parent/carer subgroup and a generic subgroup (see appendices 6 and 7) to take this work forward.

The members of our service user and parent/carer subgroup helped us to ensure that these standards are centred on the child or young person and reflect what they, and their parents/carers, see as important and helpful. In addition, they contributed to the design and development of the ‘Your Story’ consultation tool that was completed by 30 children and young people aged 7–18 years from across Scotland. An amended electronic version of the consultation tool and a separate ‘Your Story’ report will be produced.

Our knowledge management unit undertook a targeted literature search for up-to-date evidence and policy documents related to ICPs and CAMH services. Where no significant new evidence was identified, the adult ICP standards document, and its underpinning evidence base, is referenced within the standards for CAMH services. The subgroups appraised the relevant new literature, and comprehensive evidence and background reading tables were produced (see appendix 8 and the background reading document). The transferable aspects of the process, generic care and service improvement adult standards were updated to ensure that they fully reflect CAMH service organisation and delivery; CAMH specific standards were added as necessary. The standards for CAMH services are based on the available literature and the expertise of the subgroups and steering group members.

The steering group oversaw the work of the subgroups and the drawing together of the standards. This final version of the standards for CAMH services is a web-based interactive resource. Website address: www.icptoolkit.org
Appendix 4: CAMH service tiers


Tier 1
Child and adolescent mental health services at Tier 1 are provided by practitioners working in universal services who are not mental health specialists. This includes:

- GPs
- health visitors
- school nurses
- teachers
- social workers, and
- youth justice workers and voluntary agencies.

Tier 1 practitioners are able to offer general advice and treatment for less severe problems. They contribute towards mental health promotion, identify problems early in the child or young person’s development and refer to more specialist services.

Tier 2
Mental health practitioners at Tier 2 level tend to be CAMH specialists working in teams in community and primary care settings (although many will also work as part of Tier 3 services). They can include, for example:

- mental health professionals employed to deliver primary mental health work, and
- psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Tier 2 practitioners offer consultation to families and other practitioners. They identify severe or complex needs requiring more specialist intervention, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1 level.

Tier 3
Tier 3 services are usually multidisciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. Team members are likely to include:

- child and adolescent psychiatrists
- social workers
- clinical psychologists
- community psychiatric nurses
- child psychotherapists
occupational therapists, and
• art, music and drama therapists.

Tier 4
Tier 4 encompasses essential tertiary level services such as intensive community treatment services, day units and inpatient units. These are generally services for the small number of children and young people who are deemed to be at greatest risk (of rapidly declining mental health or serious self harm) and/or who require a period of intensive input for the purposes of assessment and/or treatment. Team members will come from the same professional groups as listed for Tier 3. A consultant child and adolescent psychiatrist or clinical psychologist is likely to have the clinical responsibility for overseeing the assessment, treatment and care for each Tier 4 patient.
Appendix 5: CAMH ICP steering group membership

Dr Katherine Leighton (Chair)
Consultant Child and Adolescent Psychiatrist, NHS Greater Glasgow and Clyde

Ms Sally Amor
Child Health Commissioner, NHS Highland

Mr David Brand
Educational Projects Manager, NHS Education for Scotland

Mr Graham Buchanan
Manager – Playfield Institute, NHS Fife

Ms Laura Caven
Young Person Representative (until April 2010)

Mr Zander Caven
Parent Representative (until April 2010)

Ms Emelin Collier
Head of Planning and Development/Child Health Commissioner, NHS Western Isles

Dr Alastair Cook
Associate Medical Director, NHS Lanarkshire

Dr Nuno Cordeiro
Consultant Paediatrician, NHS Ayrshire & Arran

Ms Lee Davies
Programme Principal: Mental Health, Information Services Division, NHS National Services Scotland (Until May 2011)

Ms Lizzy Dixon
Specialist Occupational Therapist in Adolescent Mental Health, NHS Grampian

Ms Natalie Elliott
Young Person Representative (from April 2010)

Dr Fiona Forbes
Child and Adolescent Mental Health Advisor, Healthcare Improvement Scotland

Ms Margo Fyfe
CAMH Nursing Advisor, Scottish Government (until March 2010)

Mrs Mary Gallagher
Operations Manager: Children and Families, East Renfrewshire Community Health and Care Partnership

Dr Sarah Glen
Consultant Child and Adolescent Psychiatrist, NHS Borders
Dr Caroline Holms
General Practitioner, NHS Greater Glasgow and Clyde

Dr Sheenagh Macdonald
Consultant Clinical Psychologist, NHS Tayside

Mr Selwyn McCausland
Participation Development Co-ordinator, Barnardo’s Scotland

Dr Ann McFadyen
Consultant Child and Adolescent Psychiatrist, NHS Dumfries & Galloway

Ms Margaret McKinlay
Area Education Officer – North East, Education Improvement Service

Mr Graham Monteith
CAMH Nursing Advisor, Scottish Government (from July 2010)

Ms June Orr
Inspector, Her Majesty’s Inspectorate of Education

Dr Alastair Palin
Adult Mental Health Advisor, Healthcare Improvement Scotland

Mr Michael Sibley
Programme Principal: Mental Health, Information Services Division, NHS National Services Scotland (From May 2011)

Mr Neil Strachan
Regional Network Project Manager (CAMHS), North of Scotland Planning Group
Appendix 6: CAMH ICP young people and parent/carer subgroup membership

Ms Margaret Allan
Parent/carer

Ms Tracy Allan
Parent/carer

Ms Laura Caven
Young Person Representative (until April 2010)

Mr Zander Caven
Parent Representative (until April 2010)

Ms Natalie Elliott
Young Person

Ms Katherine Holdsworth
Young Person

Mr Sam McPherson
Young Person

Ms Tracey McPherson
Parent/carer

Ms Carolanne Mitchell
Young Person

Mr Dean Thomson
Young Person

Ms Fiona Thomson
Parent/carer

Mr Robin Thomson
Young Person

Ms Ruth Thomson
Parent/carer
Appendix 7: CAMH ICP generic subgroup membership

Dr Katherine Leighton (Chair)
Consultant Child and Adolescent Psychiatrist, NHS Greater Glasgow and Clyde

Mr Graham Buchanan
Manager – Playfield Institute, NHS Fife

Dr Nuno Cordeiro
Consultant Paediatrician, NHS Ayrshire & Arran

Ms Lizzy Dixon
Specialist Occupational Therapist in Adolescent Mental Health, NHS Grampian

Dr Fiona Forbes
Child and Adolescent Mental Health Advisor, Healthcare Improvement Scotland

Mrs Mary Gallagher
Operations Manager: Children and Families, East Renfrewshire Community Health and Care Partnership

Ms Jane Heslop
CAMHS Nurse Manager, NHS Lothian

Dr Caroline Holms
General Practitioner, NHS Greater Glasgow and Clyde

Mrs Sarah Lloyd
Lead Clinician, Managed Clinical Network for Children with Complex Mental Health Needs, NHS Fife

Ms Anne Marie McGovern
Head Teacher, St Benedict’s Primary School

Ms Margaret McKinlay
Area Education Officer – North East, Education Improvement Service

Ms June Orr
Inspector, Her Majesty’s Inspectorate of Education

Ms Sue Reynolds
Area Principal Psychologist, South West Area Psychological Services

Ms Chris Ridley
Health Policy and Development Manager, Scottish Government

Mr Andrew Smith
Senior CAMH Nurse, NHS Ayrshire & Arran

Dr Helen Stirling
Consultant Clinical Psychologist, NHS Forth Valley
Appendix 8: References


### Appendix 9: Glossary

**additional support needs**  
Extra support beyond what is provided to children and young people of the same age, to help a child or young person benefit from education including pre-school, school and in preparation for life after school.

Additional support needs can be both long and short term, or can simply refer to the help a child or young person needs in getting through a difficult period.

**Adults with Incapacity (Scotland) Act 2000**  
This Act safeguards the welfare of adults (aged 16 or over) who lack the capacity to take some, or all decisions for themselves. This may be because of mental disorder or inability to communicate by any means. It allows other people to make decisions on their behalf.

**advocacy services**  
An advocate can assist someone, at a time when they may be particularly vulnerable, to say what they need and want. Persons to whom the individual’s views are put by an independent advocate are still able to exercise their professional judgement about how much of the patient’s views should be taken on board. For example, where an advocate tells a medical worker a patient’s views, the medical worker will make a professional judgement based on their codes of conduct.

The new Mental Health (Care and Treatment) (Scotland) Act 2003 states that any person with a mental health ‘disorder’ has a right to access independent advocacy services. The Act places a duty on NHS boards and local authorities to secure the availability (to persons in its area with a mental disorder) of independent advocacy services, and to take appropriate steps to ensure that those persons have the opportunity of making use of those services.

**agency**  
Organisations, both statutory and voluntary, where staff work with children and young people and/or their families. May refer to any working environment, and to teams. There might be several agencies within one large organisation.

**algorithm**  
A set of agreed or binding routines by which a process can be carried out.

**allied health professionals**  
Professionals other than doctors or nurses who are directly involved in providing healthcare. This includes physiotherapists, occupational therapists and dieticians.

**assessment**  
The process of measuring children and young people’s needs and/or the quality of an activity, service or organisation.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>balanced scorecard</td>
<td>This is a widely accepted method for measuring strategic performance and management that was initially developed for the private sector. It has since been adapted and used in the public sector, including health services.</td>
</tr>
<tr>
<td>British National Formulary (BNF)</td>
<td>A medical reference book which provides healthcare professionals in the UK with authoritative and practical information on the selection and clinical use of medicines.</td>
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<tr>
<td>CAMH services</td>
<td>See child and adolescent mental health services.</td>
</tr>
<tr>
<td>CAMHS</td>
<td>See child and adolescent mental health services.</td>
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<tr>
<td>care governance</td>
<td>Care governance refers to jointly managed services where governance arrangements operate across health and social work.</td>
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<tr>
<td>care plan</td>
<td>A document which details the care or treatment that a child or young person receives, and identifies who delivers the care or treatment.</td>
</tr>
<tr>
<td>care record</td>
<td>Information about the physical or mental health of a child or young person, which has been made by, or on behalf of, the care team.</td>
</tr>
<tr>
<td>carer</td>
<td>A person who looks after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.</td>
</tr>
<tr>
<td>child and adolescent mental health (CAMH) services</td>
<td>The main function of CAMH services is to develop and deliver services for those children and young people (and their parents/carers) who are experiencing the most serious mental health problems. They also have an important role in supporting the mental health capability of the wider network of children’s services. CAMH services are usually delivered by teams including psychiatrists, psychologists, nurses, social workers, and others.</td>
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<tr>
<td>child protection</td>
<td>The process of protecting children and young people from abuse or neglect, preventing impairment of their health and development. This ensures they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.</td>
</tr>
<tr>
<td>children’s workforce</td>
<td>The people working with children and young people in health, social care, education, justice and community safety, youth work, play and other related areas.</td>
</tr>
<tr>
<td>clinical governance</td>
<td>Corporate accountability for clinical performance. Ensures that patients receive the highest quality of care possible, putting each patient at the centre of their care. This is achieved by making certain that those providing services work in an environment that supports them, and that the organisation places safety and quality of care at the top of its agenda.</td>
</tr>
<tr>
<td><strong>clinician</strong></td>
<td>An expert clinical practitioner who specialises in clinical work as opposed to laboratory-based studies. Also, a healthcare practitioner who specialises in seeing, diagnosing and/or treating patients.</td>
</tr>
<tr>
<td><strong>cognitive</strong></td>
<td>Related to how a person thinks.</td>
</tr>
<tr>
<td><strong>co-morbid/co-morbidity</strong></td>
<td>The presence of two or more disorders at the same time. For example, a person with depression may also have co-morbid obsessive compulsive disorder.</td>
</tr>
<tr>
<td><strong>consultation</strong></td>
<td>A meeting with an expert, eg a clinician, to get advice and/or treatment.</td>
</tr>
<tr>
<td><strong>contra-indication</strong></td>
<td>Something that increases the risks involved in using a particular drug, carrying out a medical procedure, or taking part in an activity.</td>
</tr>
<tr>
<td><strong>criterion/criteria</strong></td>
<td>A rule/rules giving the detailed and practical information on how to achieve a standard.</td>
</tr>
<tr>
<td><strong>critical incident</strong></td>
<td>An incident relating to clinical systems or procedures, which results in harm, or an injury, or a near miss to a patient or service user or member of staff.</td>
</tr>
<tr>
<td><strong>Data Recording Advisory Service</strong></td>
<td>This service supports the healthcare data recording needs of NHSScotland staff and partner agencies. It provides expertise and advice on the use and implementation of healthcare data standards.</td>
</tr>
<tr>
<td><strong>dataset</strong></td>
<td>A collection of information. The information in the dataset must be gathered to give an accurate picture of the provision and delivery of current services, and to help improve their quality.</td>
</tr>
<tr>
<td><strong>diagnosis</strong></td>
<td>Identification of an illness or health problem by means of its signs and symptoms. This includes ruling out other illnesses and possible causes for the symptoms.</td>
</tr>
<tr>
<td><strong>discharge</strong></td>
<td>The formal end of an episode of care. Types of discharge include inpatient discharge, day-case discharge, day-patient discharge, outpatient discharge and discharge from the care of allied health professionals.</td>
</tr>
<tr>
<td><strong>Diagnostic and Statistical Manual-IV (DSM IV)</strong></td>
<td>The Diagnostic and Statistical Manual-IV is published by the American Psychiatric Association and is a handbook used by clinicians to help them diagnose a range of medical disorders. The DSM has gone through five revisions (II, III, III-R, IV, IV-TR) since it was first published. The next version will be the DSM V, scheduled for publication in 2011.</td>
</tr>
</tbody>
</table>
**eCare framework**
eCare is about better and more joined up care, advice and assistance to the people of Scotland through the use of computers and communication technology. With the individual’s consent eCare enables secure information-sharing between professionals – such as doctors, nurses, social workers and teachers – in public and voluntary agencies. Website address: www.ecare-scotland.gov.uk

**Education (Additional Support for Learning) (Scotland) Act 2004**
Provides a framework for local authorities and other agencies to support all children and young people. It came into force in November 2005 and its main provisions introduce:

- the concept of additional support needs
- new duties on local authorities and other agencies
- rights for parents, and
- resolving differences for families and authorities, mediation, dispute resolution and the Additional Support Needs Tribunal.

**Education (Additional Support for Learning) (Scotland) Act 2009**
The new Act does not change the basic purpose of the 2004 Act – it aims to strengthen some duties under the Act and clarify parts that have been confusing.

**evidence-based practice**
An approach to decision-making in which the clinician uses the best evidence available, in consultation with the child or young person and their parent/carer, to decide upon the option which suits that child or young person best.

**For Scotland’s Children 2001**
Records information gathered in the assessment process. It draws on psychological theory and research to provide a framework for describing a mental health problem and how it developed.

**formulation**
Records information gathered in the assessment process. It draws on psychological theory and research to provide a framework for describing a mental health problem and how it developed.

**Getting it Right for Every Child (GIRFEC)**
A national approach to supporting and working with all children and young people in Scotland. It affects all services for children and adult services where children are involved. GIRFEC is based on research, evidence and best practice, and designed to ensure all parents, carers and professionals work effectively together to give children and young people the best start we can, and improve their life opportunities. Website address: www.scotland.gov.uk/Topics/People/YoungPeople/childrensservices/girfec

**GIRFEC**
See Getting it Right for Every Child.

**GP**
General practitioner, also known as a family doctor.

**guidelines**
Systematically developed statements which help in deciding how to treat particular conditions.
Standards for integrated care pathways for child and adolescent mental health services

**Health and Social Care Data Dictionary**
A tool to explain and help the accurate recording of aspects of health and social care services. Website address: www.datadictionary.scot.nhs.uk

**Healthcare Improvement Scotland**
Healthcare Improvement Scotland was launched on 1 April 2011. The organisation was created by the Public Services Reform (Scotland) Act 2010 and its key purpose is to improve the quality and safety of healthcare for the people of Scotland. It builds on the work previously done by NHS Quality Improvement Scotland and the Care Commission.

Healthcare Improvement Scotland is a health body with NHS terms and conditions and includes: the Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guideline Network, and the Scottish Medicines Consortium.

Healthcare Improvement Scotland has four strategic objectives. To:

- support innovation and improvement in the delivery of high quality healthcare planned and designed with the patients, their families and the public at the centre of everything we do
- provide assurance of the safety and quality of healthcare services to the people who use them and to the public in Scotland through risk-based proportionate scrutiny of those services
- provide authoritative, evidence-based advice and guidance on high quality treatment and care, and best practice in public engagement, and
- influence national policies to improve the quality of healthcare.

**Health for All Children in Scotland (Hall 4) 2005**
This guidance emphasises the need for an integrated approach to delivering services aimed at children and their families. It signals a change in direction from a medical model of screening for deviations from the norm to greater emphasis on health promotion, prevention and targeting of children and families who are at risk.

**health screening**
See screening.

**health visitor**
A qualified registered nurse, midwife, sick children’s nurse or psychiatric nurse with specialist qualifications in community health, which includes child health, health promotion and education.

**Healthcare Quality Strategy for NHSScotland 2010**
An approach which aims to put quality right at the heart of NHSScotland. It recognises that patients’ experience of the NHS is about more than speedy treatment – it is the quality of care they get that matters most to them.
| **HEAT targets** | The core set of Ministerial objectives, targets and measures for the NHS. HEAT (Health Improvement, Efficiency and Governance, Access and Treatment) targets are set for a three-year period and progress towards them is measured through the Local Delivery Plan process. By March 2013 no-one will wait longer than 26 weeks from referral to treatment for specialist CAMH services. |
| **holistic assessment** | Takes into account all aspects of children and young people’s lives and the factors that affect them. |
| **ICD-10** | See International Classification of Diseases-10. |
| **ICP** | See integrated care pathway. |
| **implementation** | Putting into practical effect; carrying out a task or project. |
| **infrastructure** | The basic systems and services that are necessary for an organisation to run smoothly. |
| **inpatient** | A person who is admitted to hospital for observation, examination or treatment. |
| **integrated assessment framework** | A common means for all agencies and professionals to assess children and young people’s needs and to share information about them in order to ensure that interventions at any level lead to improvements in the child or young person’s life. |
| **integrated care pathway (ICP)** | An agreement by a local group of staff and workers, both multidisciplinary (nurses, doctors, psychologists etc) and multi-agency (NHS boards, education, social work etc), to provide a wide range of services to a clinical or care group on the basis of current views of good practice and any available evidence or guideline. It is important that the group of staff and workers agree on communication, record-keeping and audit processes. There should be a way to identify when an individual has not received any care set out by the pathway so that this can be acted upon and remedied. The local group should be committed to continuous improvement of the integrated care pathway on the basis of new evidence of service developments or of problems in carrying it out. |
| **intensive community treatment services** | This form of treatment provides an alternative to inpatient care or may offer post-discharge support, in order to reduce the length of stay in hospital. Intensive community treatment services, where available, are typically provided by a multidisciplinary team, comprising health and social care professionals. |
| **International Classification of Diseases-10 (ICD-10)** | Lists and groups diseases and other health problems. Website address: www.who.int/classifications/icd/en |
| **intervention** | Healthcare action intended to benefit the child or young person. |
key performance indicators

Provide a way of measuring how well an organisation is progressing towards meeting organisational goals.

learning disability

A life-long condition started before the age of 18, with a lasting effect on the individual’s development. There is less ability to understand new or complex information or to learn new skills, and to cope on one’s own.

local authority

The level of government at local level with responsibility for delivering many services not operated by national government. Each local authority is accountable to those living within its area through elected councillors. Key services delivered by local authorities include education, public housing, and social work.

looked after

As defined by the Children (Scotland) Act 1995, a child is looked after if they are: provided with accommodation by local authorities under section 25 of the Act; subject to supervision requirements following a children’s hearing; and subject to an order, warrant or authorisation under which the local authority has responsibilities for the child.

Mental Health (Care and Treatment) (Scotland) Act 2003

This law came into effect in October 2005 and deals with how people with a mental illness, learning disability or other mental disorder can be given care and treatment. It says:

- when a person can be taken to hospital against their will
- when a person can be given treatment against their will
- what rights a person has when they are receiving care and treatment, and
- what safeguards are in place to protect a person’s rights.

The law is based on a set of principles, and these principles should be taken into account by anyone involved in a person’s care and treatment. Website address: www.opsi.gov.uk/legislation/scotland/acts2003/20030013.htm

Mental Health of Children and Young People – a Framework for Promotion, Prevention and Care 2005

Developed to assist all agencies with planning and delivering joined-up approaches to children and young people’s mental health.

Millan Principles

The Mental Health (Care and Treatment) (Scotland) Act 2003 resulted from the report of the Millan Committee in 2001. A central feature of the Millan Committee report was that both the law and practice relating to mental health should be driven by a set of 10 principles, especially minimum interference in people’s liberty and maximum involvement of service users in any treatment.
<table>
<thead>
<tr>
<th><strong>multi-agency team</strong></th>
<th>Different services, agencies, teams of professionals and other staff working together to provide services. See agency.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>multi-agency workforce</strong></td>
<td>The wide range of skilled people from different organisations who need to come into play in a joined-up way to provide services. See agency.</td>
</tr>
<tr>
<td><strong>multi-axial system of assessment</strong></td>
<td>When looking at a patient, this takes into account various mental disorders, their general medical condition, any psychosocial and environmental problems, as well as level of functioning. These areas may otherwise be overlooked if a single symptom is focused on. Examples of multi-axial systems of assessment are the international classification of diseases-10 (ICD-10) and the diagnostic and statistical manual-IV.</td>
</tr>
<tr>
<td><strong>multidisciplinary team</strong></td>
<td>A group of people from different fields such as medicine, nursing, and social work who work together to provide care for patients with a particular condition. Team members may come from different organisations.</td>
</tr>
<tr>
<td><strong>named person</strong></td>
<td>Someone nominated by a person to support them and protect their interests. The named person is entitled to receive certain information about the person and to act on their behalf in certain circumstances.</td>
</tr>
<tr>
<td><strong>national board</strong></td>
<td>Provides national clinical and non-clinical care and services to NHSScotland. Six of the eight national boards are special health boards: NHS 24; NHS Education for Scotland; NHS Health Scotland; Scottish Ambulance Service; State Hospitals Board for Scotland, and The National Waiting Times Centre Board. Healthcare Improvement Scotland and NHS National Services Scotland are national support organisations. For more information please see ‘How NHS national boards support the wider NHS in Scotland’ – website address: <a href="http://www.nhsnss.org/supplementary_pages/publication_detail.php?pid=118">www.nhsnss.org/supplementary_pages/publication_detail.php?pid=118</a></td>
</tr>
<tr>
<td><strong>national patient safety programmes</strong></td>
<td>In 2008, the Scottish Government launched the Scottish Patient Safety Programme to improve patient safety and reduce mortality in acute hospital settings. In 2009, the programme was expanded to include acute paediatric services. Website address: <a href="http://www.patientsafetyalliance.scot.nhs.uk/programme">www.patientsafetyalliance.scot.nhs.uk/programme</a> The Healthcare Quality Strategy for NHSScotland 2010 commits to introducing patient safety programmes for mental health and primary care services.</td>
</tr>
<tr>
<td><strong>NHS</strong></td>
<td>National Health Service.</td>
</tr>
</tbody>
</table>
**NHS board**
There are 22 NHS boards in Scotland – 14 are territorial boards responsible for healthcare in their areas. The remainder are national boards. See NHS board (territorial) and national board.

**NHS board (territorial)**
There are 14 territorial boards, the mainland being covered by 11 and the island groups (Orkney, Shetland and the Western Isles) by three. They are responsible and accountable for strategic planning, service delivery, performance management and governance within their local areas. Each NHS board uses the organisational building blocks of NHS direct care, such as community health partnerships or operating divisions, in a way which suits its geography and population. NHS boards work together in regional planning arrangements for those services which require that wider perspective.

**NHS Education for Scotland (NES)**
NHSScotland’s education and training body. It provides educational and training solutions that support excellence in Scottish healthcare.

**NHSScotland**
The National Health Service in Scotland.

**off-licence prescribing**
The prescription of a medicine outside its licensed use when there are no alternatives or where access to effective alternatives is restricted is termed off-licence use. The term ‘off-label’ is also used.

The prescription of a medicine that does not have a marketing authorisation for use in the UK is termed ‘unlicensed’ medicine use.

**outcome-focused**
Driven by the impact, or end result of services on a service user or patient’s life.

**outpatient**
A patient treated in a hospital but who does not need to be admitted to the hospital.

**paediatric**
Branch of medicine that deals with the medical care of infants, children, and young people.

**patient journey**
The pathway through the health services taken by the patient, and as viewed by the patient.

**person-centred care**
Care that has its focus on the person with an illness and not on the illness in the person.

**pharmacological treatment**
Treatment of an illness through use of drugs.
primary care
The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

process mapping
Looking at all the steps and decisions in a process to show people what their jobs are and how they should work with one another as part of that process.

psychological intervention
An approach by a professional which aims to improve the health of the patient. This type of service is provided by a wide range of professionals, for example clinical or counselling psychologists, counsellors, psychiatrists, mental health nurses, social workers, and others.

psychology
The scientific study of human behaviour and mental processes.

psychosocial
Relating social conditions to mental health.

referral
The process by which a child or young person is transferred from one professional to another, usually for specialist advice and/or treatment.

risk management
The systematic identification, evaluation and treatment of risk, a continuous process with the aim of reducing risk to organisations and individuals alike. The ‘culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.’ (Australian/New Zealand Risk Management Standard 4360: 2004).

Scottish Government
The devolved government for Scotland, whose responsibilities include health policy and the administration of NHSScotland. Previously named the Scottish Executive. Website address: www.scotland.gov.uk

Scottish Intercollegiate Guidelines Network (SIGN)
To help improve the quality of healthcare, SIGN develops national clinical guidelines aimed at reducing variations in clinical practice and in outcomes for patients. Founded in 1993 by the Academy of Royal Colleges and Faculties in Scotland, SIGN is part of Healthcare Improvement Scotland. The evidence base for many of the clinical standards has been drawn from SIGN guidelines. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Secretariat, Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA. Website address: www.sign.ac.uk
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottish Needs Assessment Programme (SNAP) Report 2003</td>
<td>This report said that all agencies and organisations have a role in meeting the needs of the mental health of children and young people.</td>
</tr>
<tr>
<td>Scottish Patient Safety Mental Health Programme</td>
<td>This programme is currently being developed by Healthcare Improvement Scotland to inform and support the implementation of an NHSScotland-wide framework for patient safety in mental health services. This includes services for children and young people, adults and older adults.</td>
</tr>
<tr>
<td>screening</td>
<td>Examination of people with no symptoms, to detect unsuspected disease.</td>
</tr>
<tr>
<td>side effect</td>
<td>An effect of treatment in addition to its desired therapeutic effect. A side effect is usually unpleasant and unwanted.</td>
</tr>
<tr>
<td>SIGN</td>
<td>See Scottish Intercollegiate Guidelines Network.</td>
</tr>
<tr>
<td>significant adverse event</td>
<td>Where there is an injury or harm related to or from the delivery of care.</td>
</tr>
<tr>
<td>signposting</td>
<td>Directing people to other sources of information and support. Signposting may include supporting service users to make initial contact with other service providers, for example the NHS, local authorities, the voluntary or private sector.</td>
</tr>
<tr>
<td>special health board</td>
<td>See national board.</td>
</tr>
<tr>
<td>stakeholder</td>
<td>An individual or group with an interest in the success of an organisation in delivering results, and maintaining the quality of the organisation’s products and services.</td>
</tr>
<tr>
<td>statutory</td>
<td>Required or created by law.</td>
</tr>
<tr>
<td>stigmatising</td>
<td>To mark out or characterise someone negatively because of certain personal characteristics. For example, their cultural or ethnic background or an illness or disorder that they have.</td>
</tr>
<tr>
<td>transition</td>
<td>Moving from one service to another, for example from CAMH services to adult services, or from primary to secondary school.</td>
</tr>
<tr>
<td>treatment</td>
<td>Aiding recovery where possible, and easing symptoms. This involves organising and managing healthcare and related services for a person.</td>
</tr>
<tr>
<td>triage assessment</td>
<td>A brief assessment to identify the seriousness of a child or young person’s problem, the urgency with which treatment is required and any immediate risk of harm.</td>
</tr>
<tr>
<td>validation</td>
<td>Demonstration that a procedure, process, and activity will consistently lead to the expected results.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>variances</td>
<td>The amount by which something changes or is different from something else.</td>
</tr>
<tr>
<td>vocational readiness</td>
<td>The stage at which a young person feels that they are ready to engage in voluntary work, education, training or paid employment.</td>
</tr>
<tr>
<td>vocational status</td>
<td>Indicates if a young person is engaged in voluntary work, education, training or paid employment.</td>
</tr>
<tr>
<td>voluntary organisation</td>
<td>An organisation whose main focus is to deliver social benefit in a variety of forms, rather than to generate profit for distribution to its members. It will usually be governed by volunteers and be independent of government.</td>
</tr>
<tr>
<td>vulnerable families</td>
<td>Families that are more easily harmed, for example because of low income, unemployment, poor housing, or belonging to an ethnic or other minority.</td>
</tr>
<tr>
<td>workforce around the child</td>
<td>The wide range of skilled people from different organisations who need to come into play in a joined-up way to provide services that meet the needs of children, young people and their parents/carers.</td>
</tr>
</tbody>
</table>
Scottish Intercollegiate Guidelines Network

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are key components of our organisation.

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