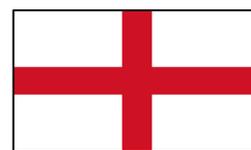




Benchmarking Network

International Comparisons of Mental Health Services for Children and Young People

Report for Sweden
August 2018



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- This report summarises the findings of research into the provision of mental health services for Children and Young People (CYP) across a number of countries. The work was undertaken by the NHS Benchmarking Network in collaboration with a group of countries who are members of either the International Initiative for Mental Health Leadership (IIMHL) or Organisation for Economic Cooperation and Development (OECD).
- An initial literature review revealed a lack of published data on international mental health system comparisons for child and adolescent mental health services (CAMHS). A process was therefore developed to invite participation in the project from a group of countries active in international mental health networks.
- A total of 13 countries took part in the project with others expressing interest in participating should future iterations of the work take place. Participant countries are all developed countries and members of the OECD, generating assurance in the project's processes and findings.
- The project explored the nature of mental health service provision for children and young people across different countries.
- All countries confirmed that children and young people's mental health services are a priority. Most countries have agreed national strategies in this area with targeted service development plans. Mental health represents the new morbidity in children's healthcare and many countries have developed clear plans for service expansion.
- The findings from the project confirmed data quality issues in some countries with a lack of readily available data in some areas.
- Most children and young people in need of mental health support will receive their care in the community setting. This model is consistent across all countries.
- The number of CYP mental health beds averages 8 per 100,000 people in the 0-18 age group.
- Admission rates for CAMHS average 116 per 100,000 people aged 0-18.
- Bed occupancy rates are below the levels reported for typical Adult mental health services in most countries and average 64% excluding leave.
- CAMHS average length of stay has a mean average of 38 days with an eleven fold range in the data from shortest average stays of 9 days to longest average stays at 98 days.
- The CAMHS workforce is typically formed from a rich multi-disciplinary team formed from specialist Clinical Psychologists, Consultant Psychiatrists and Registered Nurses working in both inpatient and community settings. Nursing staff form the largest staff group followed by Clinical Psychologists.



Introduction and background - International comparisons of mental health services for Children and Young People ⁴

- The NHS Benchmarking Network completed this project on behalf of participant countries. We are grateful for the contributions of participating countries and also for the encouragement of the International Initiative for Mental Health Leadership over previous cycles of benchmarking and mental health analytics.
- An initial literature review revealed a lack of published data on international mental health system comparisons for children's mental health services. A process was therefore developed to invite participation in the project from a group of countries active in international mental health networks. Participation was requested from countries actively involved in recognised international mental health networks. Two principle network sources were referenced.
 1. The International Initiative for Mental Health Leadership (IIMHL)
 2. Organisation for Economic Cooperation and Development (OECD)
- The IIMHL is an established forum for the dissemination of best practice in mental health services.
- The OECD are a membership body for the world's leading industrial nations and exist to promote economic cooperation and development among their 35 member countries (including the UK). The NHS Benchmarking Network presented the project's aims at the OECD Healthcare Quality Indicators Committee in November 2017, and the Committee agreed to share the project's aims and encourage participation from OECD member countries.
- The project aims to develop a consensus framework for mental health quality and performance indicators for Children and Young People. Within this overall objective the project aimed to explore a number of high value indicators to understand how CYP mental health services are provided in different contexts and explore the variation that exists between countries. The work was taken forward by the UK NHS Benchmarking Network over the period November 2017 to March 2018, and uses the most recently available data available from each participant country, generally standardised on financial year 2016/17.
- A related project on international comparisons of Adult mental health services involving the same country group will publish in June 2018. This will also include analysis of comparative national expenditure on mental health services and levels of access to mental health support.



- The countries identified on this page all helped to scope the project's content including the development of methodology and data definitions.
- The following countries provided data to the project:
 - England
 - Australia
 - Belgium
 - Canada
 - Czech Republic
 - New Zealand
 - Northern Ireland
 - Republic of Ireland
 - Scotland
 - Sweden
 - Switzerland
 - United States of America
 - Wales
- We are also grateful to the contribution made by the Netherlands and Norway to scoping the methodology and hope to be able to include their data in future collections.
- In interpreting the data in this report it should be noted that the participant group are a high performing country group drawn from the world's most developed economies. All contributing countries are members of the OECD and have advanced healthcare systems.
- A number of other countries were enthusiastic about the project but were unable to participate in the project due to a current lack of available data on children and young peoples mental health.



Process - data collection and analysis

- The countries involved in the work took part in collaborative discussions to help shape the project's scope and content. From these discussions countries agreed to focus on high level indicators that add most value to the understanding of the scale of each country's services and the models used to support demand for children's mental health services.
- The main areas of analysis were;
 1. Inpatient Care
 1. Number of beds
 2. Number of admissions
 3. Average length of stay
 4. Bed occupancy
 5. Use of restrictive practices in inpatient settings
 2. Out of hospital care – extent of community services provision
 1. Number of children accessing services
 2. Number of CYP mental health contacts delivered
 3. CYP mental health workforce
 1. Workforce levels by main professional group explored across both inpatient and community care settings
 4. Survey of extent of service models and provision from other sectors (e.g. Education)
 5. Survey of data quality in each country

The project is standardised on most recently available data, generally 2016/17 financial year for most countries.



Comparison of service models

- The countries involved in the project were invited to provide summary details of the main elements of their service models for supporting children and young peoples mental health. This included describing a number of themes including; the extent to which health services are the main providers of CYP mental health care, the extent of provision in other sectors (e.g. Education), and the focus of CYP mental health services i.e. the extent to which services focus on primary prevention, early intervention, community care, and inpatient care.
- The following describes the main emphasis of services in each country (where data was available):
 - Australia – Health and school based services in use, as well as internet services and telephone counselling. Increase in mental health promotion in education and GP training in CAMH, National Mental Health and Suicide Prevention Plan in place and reviewed annually (2017 = 5th plan), state based mental health strategies.
 - Belgium – A large inpatient care sector exists for both children's and adult mental health services.
 - England – Services have a community based care focus, with an inpatient sector provided by statutory and independent sector providers. A new strategy is in development with enhanced focus on school based mental health counselling and interventions. This model includes care provided across both health and education sectors, a model proposed in the Transforming Children and Young People's Mental Health Green Paper.
 - New Zealand – Many community based initiatives have been developed including targeted youth primary mental health funding. Primary care service models for CYP mental health, specific focus on community care, national strategy to minimise the use of restrictive practices in the inpatient environment. Mental health services in New Zealand for children and adolescents are provided through District Health Boards for both inpatient and community services. Predominantly in practice this means community services. There is a strong emphasis on NGO services in the community (30% of NZ mental health services are provided by NGO's) and primary mental health services through primary health organisations. New Zealand has a strong emphasis on reducing suicide and self-harm amongst youth; culturally appropriate services and reducing the use of seclusion and restraint. There is a small private sector with private psychiatrists and psychologists
 - Northern Ireland – Community based care and inpatient beds provision in line with wider established NHS models of care.



Comparison of service models

- Republic of Ireland - The *Vision for Change* policy set out a programme for the development of comprehensive mental health service for young people up to the age of 18 years. To achieve this goal required sustained development of services and extending the age range of services already in place. The National strategy includes a commitment to expanding access to community based care and reducing the number of children admitted to inpatient facilities.
- Scotland – Community based care and inpatient beds and a clear national strategy for CYP mental health including monitoring of access times.
- Sweden – Have implemented a number of Education based initiatives, includes public funds for CYP mental health projects and school programmes, use of Youth health clinics to provide services, shift of services from hospitals to community based mental health facilities (established policies since 2010) Historically, mental health care for children and young people has been provided by specialist CYP teams but there is an ongoing shift towards primary care. Education provision is a key component. By law the student shall have access to a school nurse, a school doctor, a school therapist, a school psychologist and a specialist pedagogue. These professionals promote mental health and prevent mental ill health on an organization level, a group level and on an individual level. But also in a minor capacity attend to students in need of support. The student's access to these services are limited in many schools.
- Switzerland – Focus on community care and referrals to community rather than inpatient mental health services. There isnt a specific national children and young people's mental health strategy. Services are organised differently between Cantons.
- Wales – Community based care focus, a minimal inpatient sector with some additional beds bought from the private sector, acknowledged multi-agency focus for CAMHS with collaboration across health, education, and youth justice systems. The 'Together for Children and Young People' plan was launched in 2015 <http://www.goodpractice.wales/t4cyp> . Led by the NHS in Wales, this multi-agency service improvement programme is working at pace to reshape, remodel and refocus the emotional and mental health services provided for children and young people in Wales, in line with the principles of prudent health and care. T4CYP is based on a human rights approach and is committed to embedding the 7 Core Aims for children and young people under the United Nations Convention on the Rights of the Child (UNCRC).
- USA – The provision and scope of children's mental health services varies at a State level. For example, 11 of the 50 State Mental Health Authorities are responsible for Developmental Disorders but for the other 39 states, other State departments administer these services. 6 of the 50 State Mental Health Authorities are responsible for autism services and an additional 15 SMHA share the responsibility for autism services with another state agency.



Data inclusion criteria – additional comments

Australia	Includes child and adolescent beds (acute and non acute) for public hospitals. Does not include "youth" category.
New Zealand	Figures refer to Children and youth under 20 years of age. NGO and District Health board collections are included, but no primary care or private provider data.
England and Wales	Bed numbers include NHS (public) and independent sector provision, however remaining activity and workforce metrics are based on NHS providers only.
Sweden	Primary care is not included in the data provided. Private services is a small part of the mental health provided in Sweden except for Stockholm but most of these services are included in the data. Mental health care provided by the social services is not included, nor are mental health services within the education sector, except workforce data.





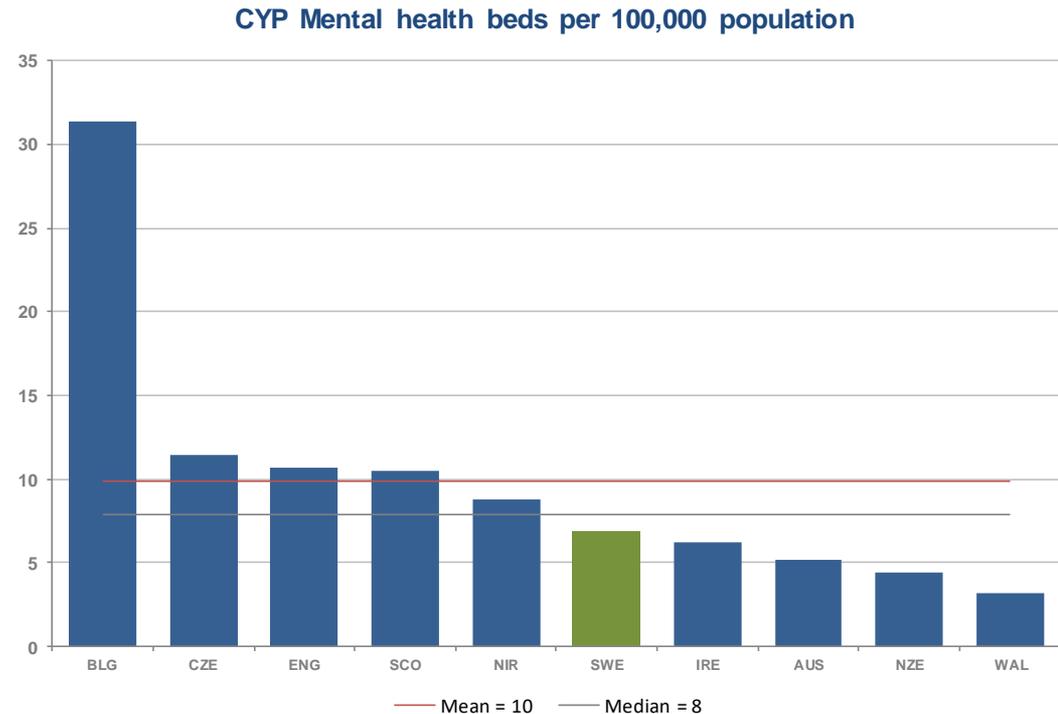
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Comparisons of Hospital Inpatient Care

Raising Standards through Sharing Excellence

CYP Mental Health beds per 100,000 population

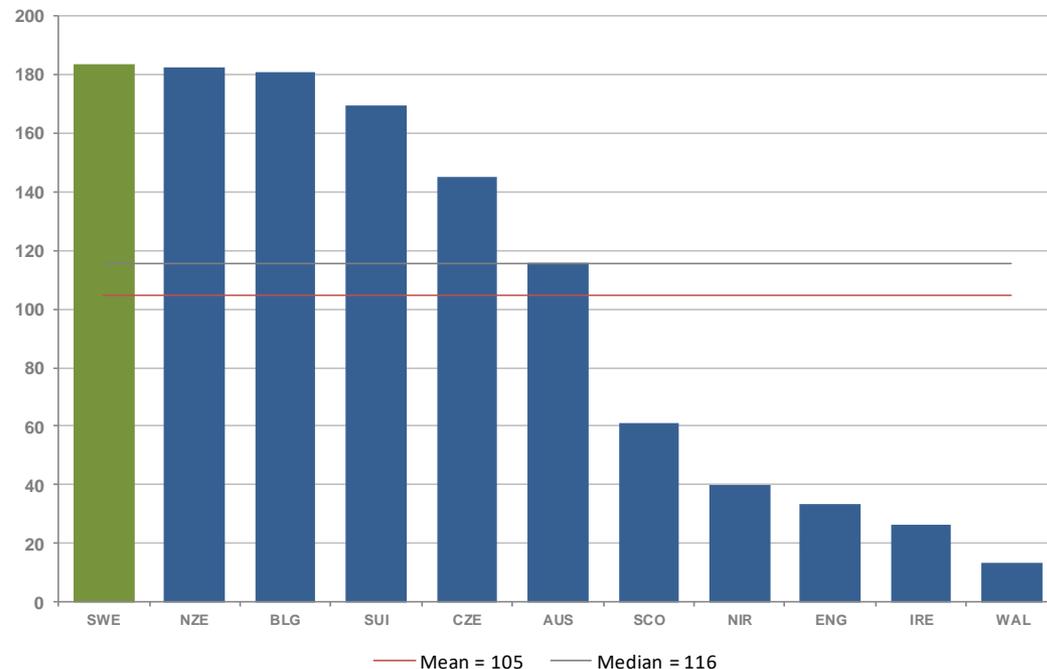
- Mental health inpatient bed capacity describes a recognisable element of a country's mental health infrastructure and informs the likelihood of patients being admitted to a bed.
- The data reveals a median average of 8 CAMHS beds per 100,000 population in the CYP age group (0-18). The mean average is skewed to 10 beds per 100,000 children by the large number of beds reported by Belgium at 31 per 100,000 (who also have high numbers of Adult mental health beds).
- The lowest bed numbers are reported by Wales and New Zealand (4 each) and Australia (5).



CYP MH Admissions per 100,000 population

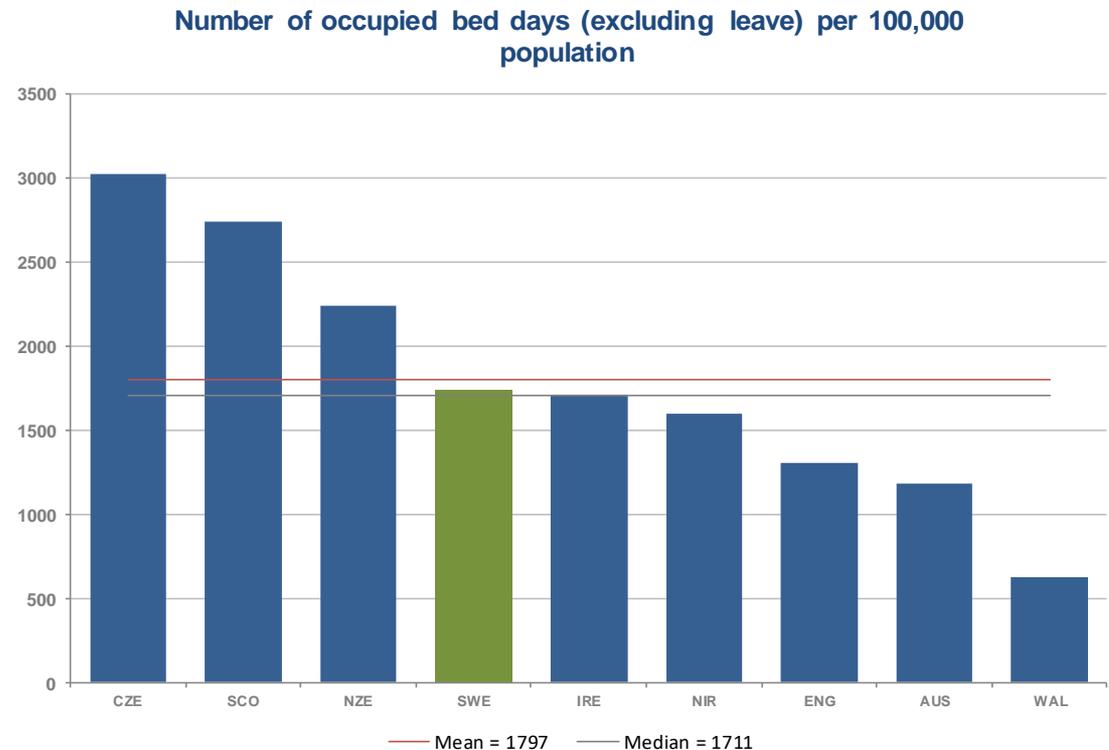
- Admission rates to beds are often shaped by the availability of beds. Countries with more beds can be expected to have higher per capita admission rates than countries with fewer beds. The other main determinant of admission rates is average length of stay, with countries with shorter stays typically generating more admissions per capita. Admissions can include multiple admissions for some patients which should also be included in any interpretation of individual country positions.
- The data reveals a median average of 116 CAMHS admissions per 100,000 population in the CYP age group (0-18). The mean average is 105 admissions per 100,000 children.
- The data splits into two broad groups with high admission rates evident in countries with high bed numbers (Belgium), and short length of stay (Sweden and New Zealand).
- The lowest admission rates per annum per 100,000 children are reported by Wales (13), Republic of Ireland (26) and England (33).
- Data on comparative admission rates over time was not provided by countries although anecdotal observations made by some countries does contain examples of growth occurring at high levels in recent years. Canada (not included on the graph) highlighted a 47% growth in admission rates for ages 5 to 24, over the 10 year period 2006 to 2016.

CYP Mental health admissions per 100,000 population



CYP MH occupied bed days excluding leave per 100,000 population

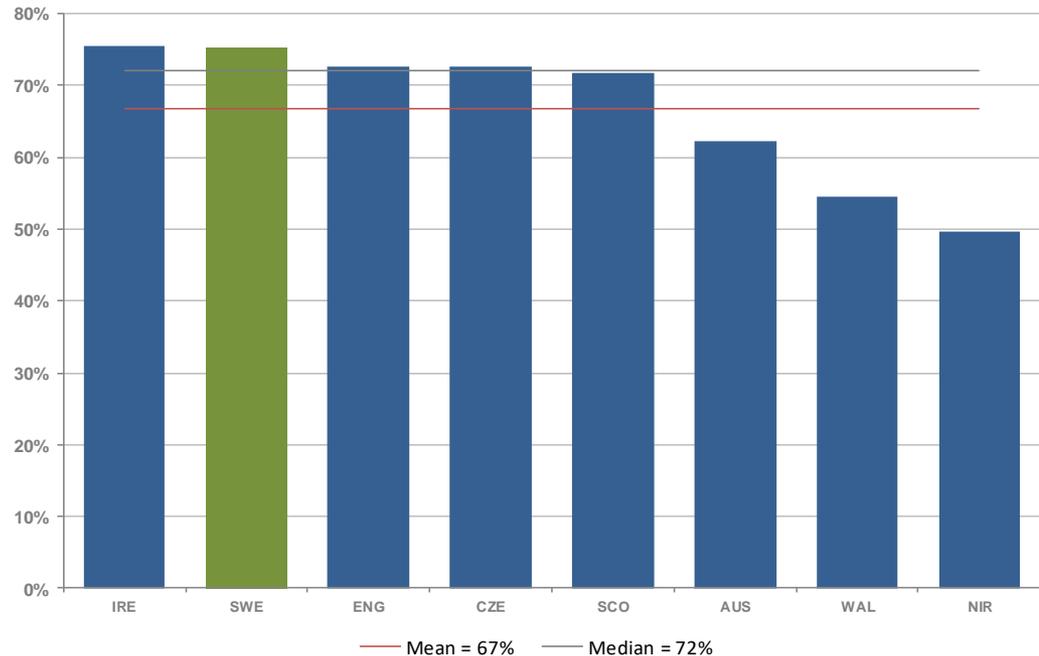
- Of the countries who could supply this metric, the Czech Republic reported the highest number of occupied bed days per capita.
- Median average figures are 1,711 occupied bed days per 100,000 population, with mean average values of 1,797 bed days per 100,000.
- Bed numbers, length of stay and bed occupancy all impact on the total number of occupied bed days a country will report.



Bed occupancy excluding leave

- While not every country was able to supply data on bed occupancy, it is interesting to see the relatively small amount of variation on this measure and the broad consistency observed on CAMHS as a specialty with relatively low bed occupancy compared to adult mental health bed occupancy.
- Bed occupancy is a mean average of 67% excluding leave, with all countries reporting bed occupancy below the 85% guide outlined by the UK Royal College of Psychiatrists.
- England's position of 72% is the 3rd highest of the group behind Ireland and Sweden at 75% and equal to the Czech Republic (72%). Northern Ireland and Wales report the lowest bed occupancy with a combined average of 52% excluding leave.
- One of the main reasons for low bed occupancy in CAMHS is the extensive use of leave days to manage patient care.

CYP Mental health bed occupancy excluding leave

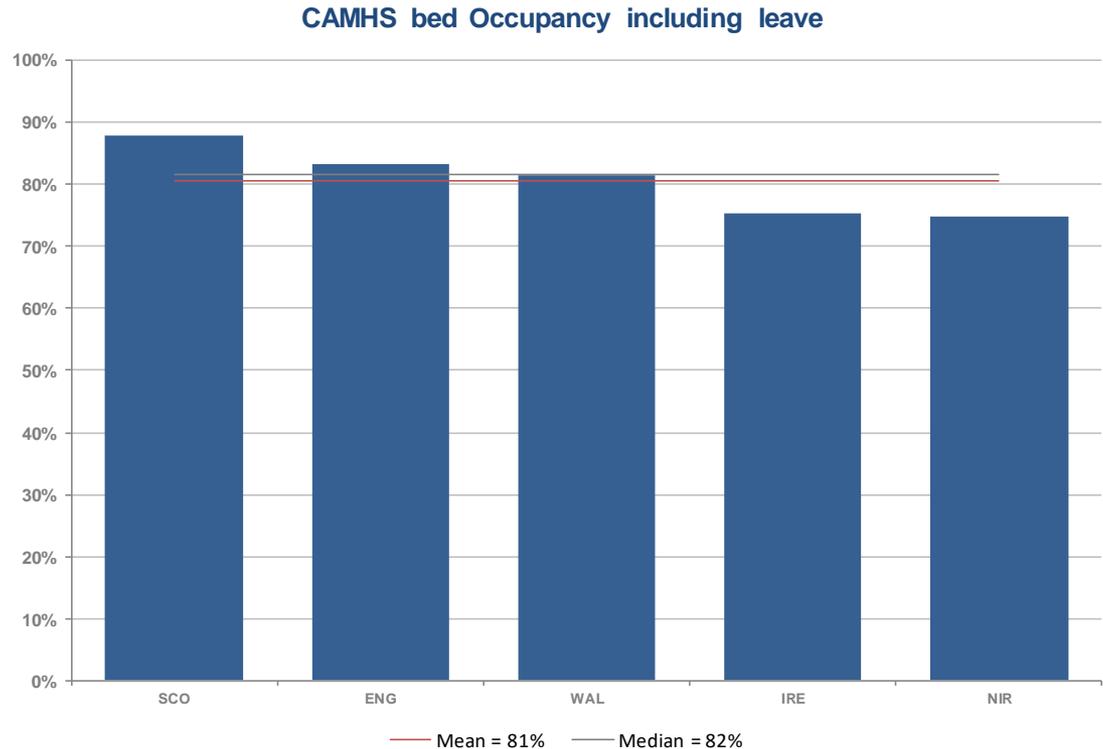


Ireland figure is including leave



Bed occupancy including leave

- When bed occupancy is calculated including leave days, mean average occupancy increases to 81%.
- UK countries and the Republic of Ireland were the only countries able to provide data on bed occupancy including leave. Average bed occupancy increased in all countries when leave days are included in the occupancy calculation. However, occupancy including leave still falls behind the 90% to 105% occupancy (including leave) figures observed in Adult mental health specialties.



Average length of stay excluding leave

- A number of factors can influence length of stay, including bed availability, patient acuity, rates of involuntary detention and models of community care.
- An 11-fold variation is evident in the data, from Sweden with the shortest stays (10 days) and Wales the longest (99 days), with England reporting the second longest length of stay (72 days excluding leave) and Wales the longest (98 days). Mean average length of stay is 41 days (median 42 days).
- Countries with higher number of beds typically report shorter average length of stay as patient acuity may be diluted. New Zealand offer an interesting short stay model (12 days ALOS) alongside low levels of beds.
- All 4 UK countries report above average length of stay.

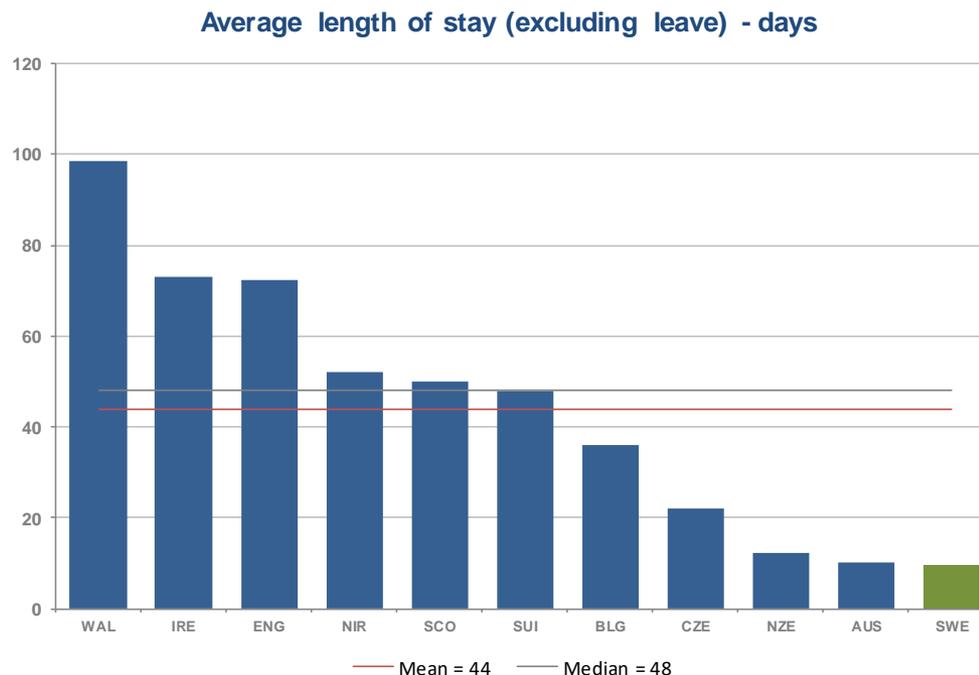


Illustration of intra-country variation

UK ALOS Variation for General CAMHS

Average Length of Stay

- The mean average length of stay in the UK (all 4 countries) for NHS General Admission CAMHS beds was 74 days (excluding leave) in 2016/17, an increase from the mean of 72 days seen in 2015/16.
- Substantial variation is evident in the data from shortest average length of stay of 10 days through to longest length of stay of 310 days.
- The interquartile ranges extend from 50 days to 74 days with the median value around 60 days. The data is skewed by the long lengths of stay demonstrated by the three providers at the left hand side of the chart who all report average length of stay in excess of 170 days.

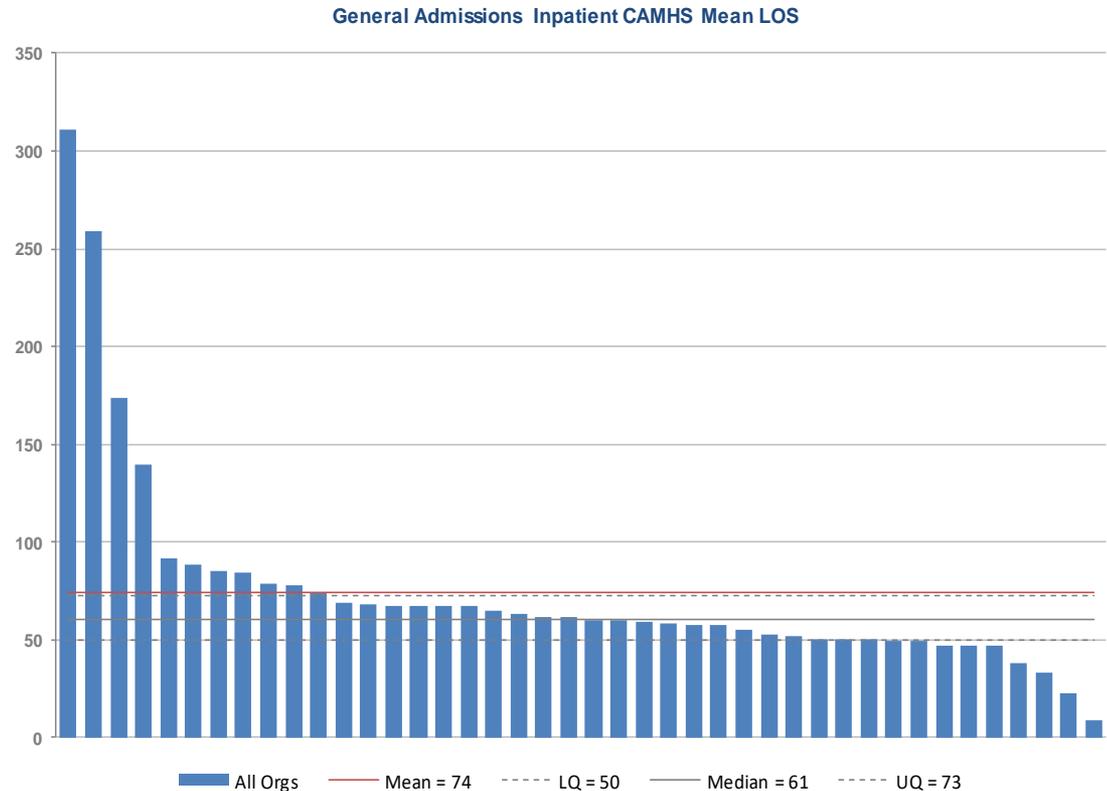
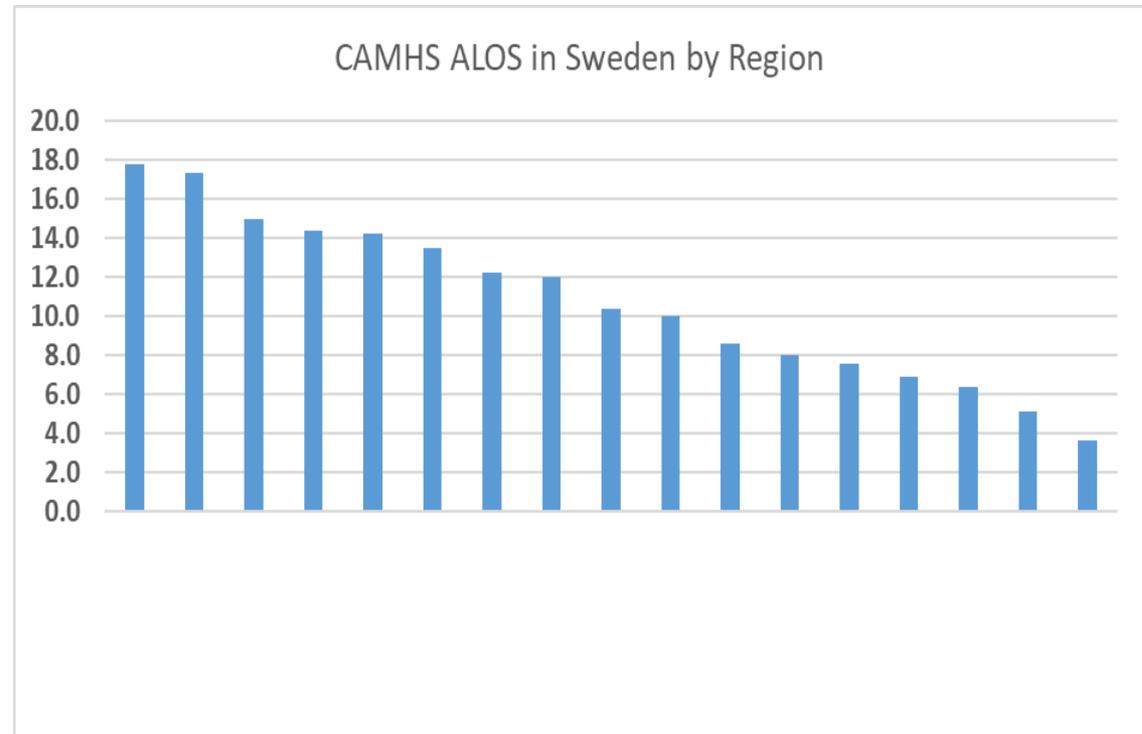


Illustration of intra-country variation

Sweden ALOS Variation for General CAMHS

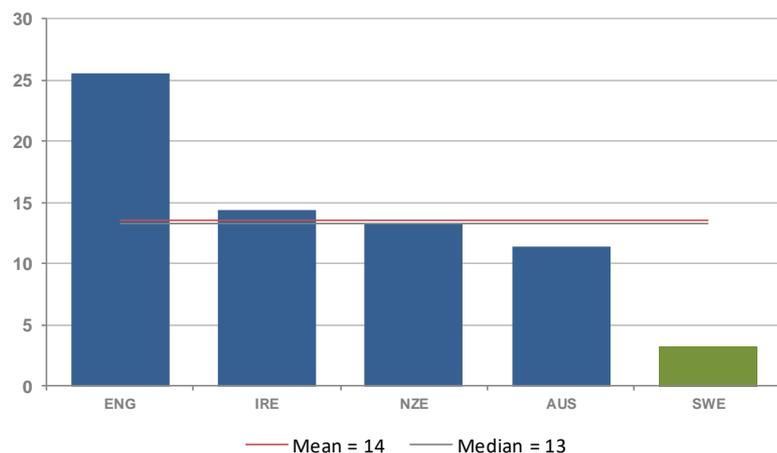
Average Length of Stay

- The chart opposite shows average length of stay for providers in each Swedish region. Mean average length of stay in Sweden is 10 days.
- Variation is evident between regions but from a smaller base length of stay.

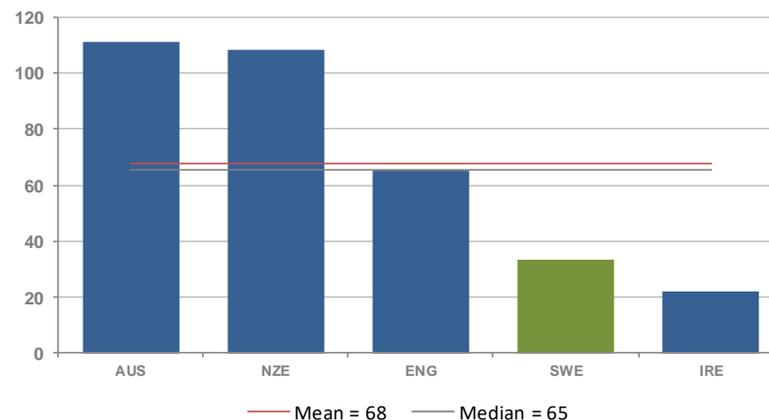


Use of seclusion

Uses of seclusion per 100 admissions



Use of seclusion per 10,000 occupied bed days excluding leave



- Seclusion is used as a technique to manage confrontational situations that can include violence, aggression, and behavioural disturbance in psychiatric services.
- Strategies to manage these circumstances through the use of seclusion need to balance the need to keep patients safe whilst respecting personal liberty and freedom. In this context seclusion is typically used as a short-term management strategy, sometimes as an alternative to restraint.
- Only 5 of the 13 countries taking part in the research study were able to adequately report on the number of incidents of seclusion (New Zealand, England, Republic of Ireland and Sweden).
- The rates reported by these countries averaged 65 (median value) per 10,000 bed days, a rate of 1 seclusion per 158 bed days. England occupies the mid-point (median value) in the distribution.
- When seclusion is compared per 100 admissions, the median position is 13. England reports the highest position on this chart at 26 uses of Seclusion per 100 admissions. England also reports the longest length of stay of the countries on these charts, therefore longer admission periods during which seclusion can occur.





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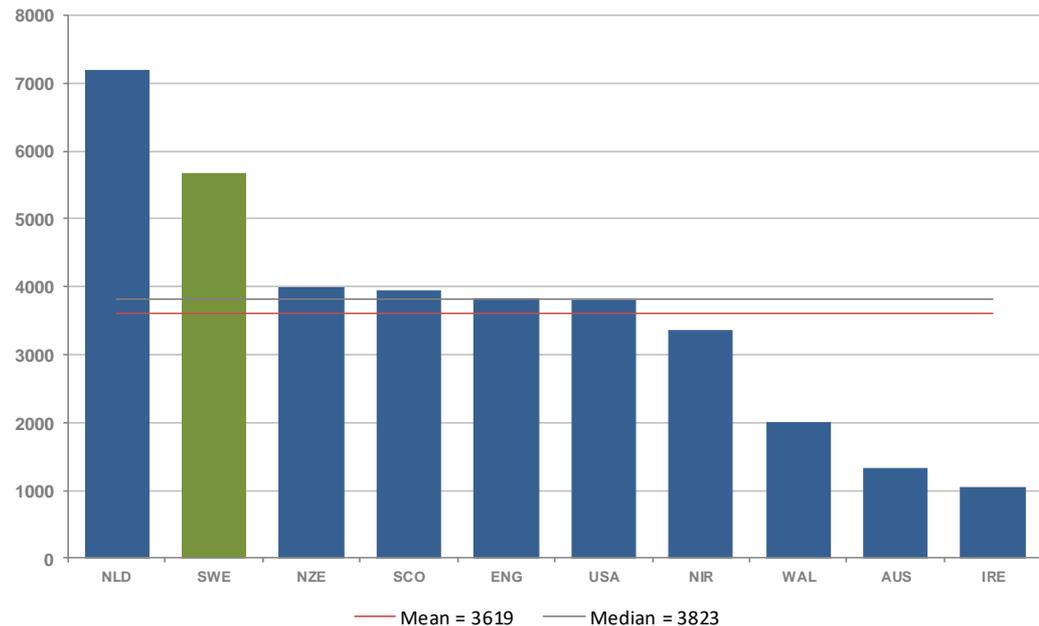
Community Care

Comparisons of out of hospital care

Children seen by community CAMHS

- Nine of the thirteen countries could quantify the level of community care provided in terms of the number of children who utilise services each year. England averages 3,837 children per annum, a position marginally above the median average position occupied by the USA and higher than the mean average of 3,221. Sweden provide the highest level of community care in terms of population coverage (5,671 children per 100,000 0-18), and Australia and the Republic of Ireland the lowest levels.
- A number of countries provided evidence of demand growth within community based CAMHS services. England, Wales and New Zealand all referenced growth in demand levels in the last 4 years. Other countries did not provide data on this issue but country based project leads confirmed an anecdotal perception that demand rates were increasing for a number of reasons with a sense that mental health forms a rising area of morbidity in children's healthcare.

Children seen by community CYP mental health services per 100,000 population



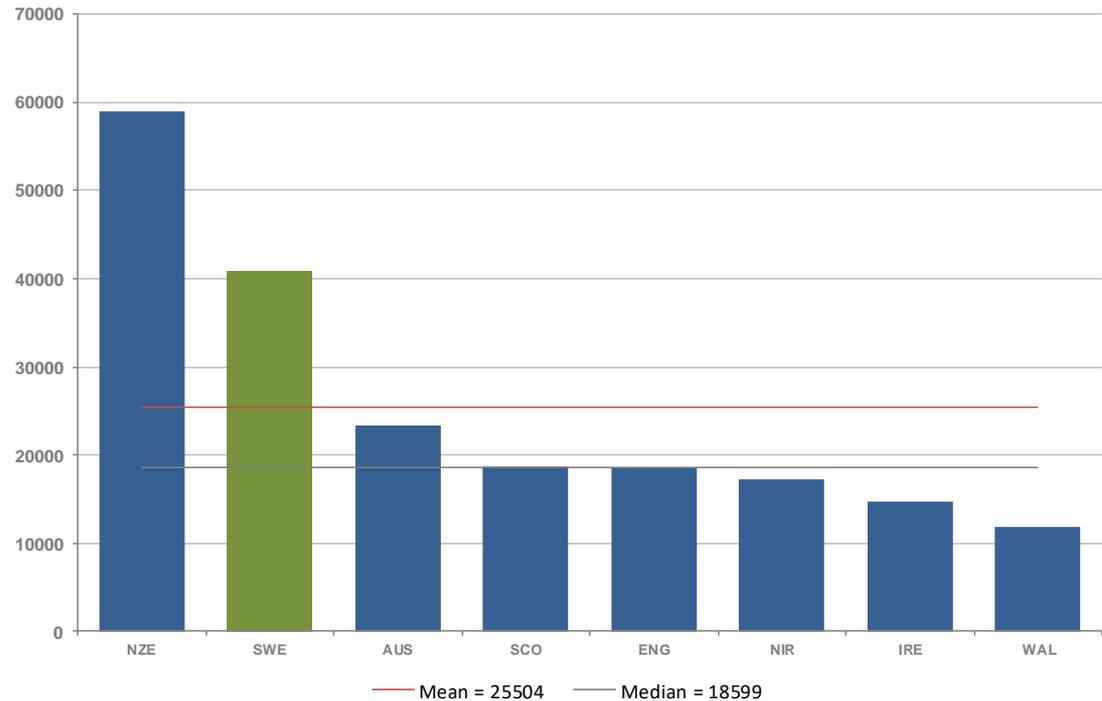
Please note that data for Republic of Ireland relates to children seen for first appointment only



Contacts delivered by community CAMHS

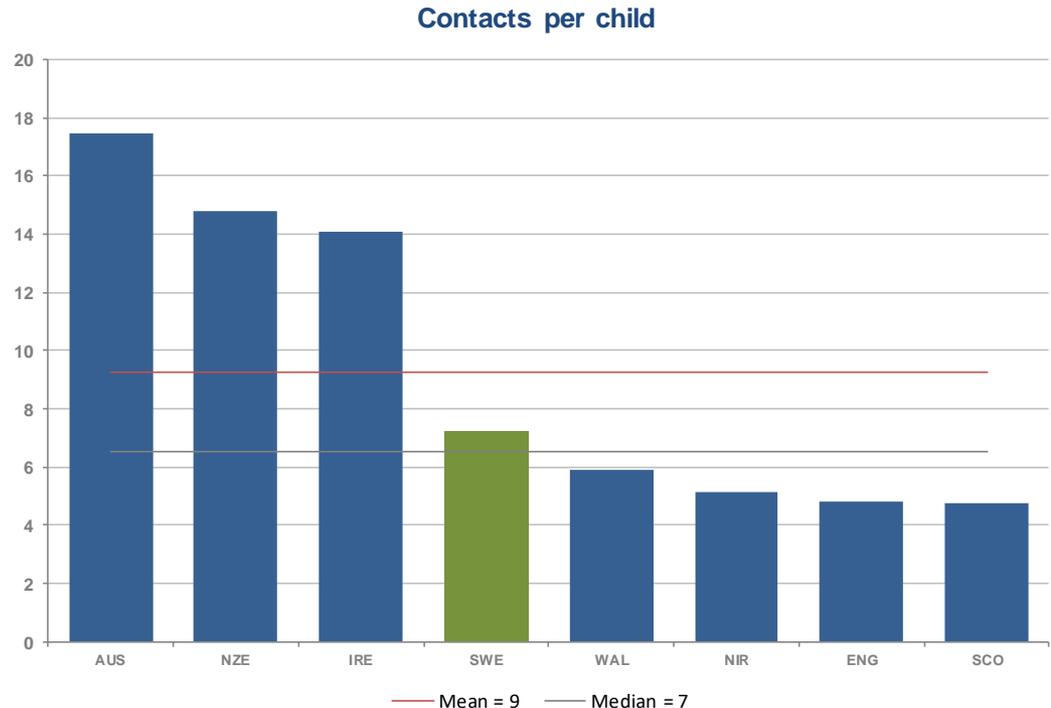
- The number of contacts per 100,000 registered population is the total of all contacts provided, including both face to face and non face to face. The mean position reported is 25,504. Locally determined policies and procedures may impact on contact levels, and there is variation in duration and frequency of contacts that a service may offer.
- It should also be noted that this data focuses on services delivered by specialist CAMHS and excludes general primary care services.
- England and Scotland occupy the median position in the data distribution with contact rates of 18,735 and 18,464 respectively per 100,000 children per annum. Wales and the Republic of Ireland provide the lowest number of community contacts.
- New Zealand (58,884) and Sweden (40,778) support the highest number of contacts in the community environment.

Community CYP mental health contacts per 100,000 population



Contacts per child

- Data on the number of contacts per child on the CAMHS caseload shows wide variation reflecting different levels of service intensity between countries.
- The mean average is 9, with Australia and New Zealand operating above this with 17 and 15 contacts per child during the year. The Republic of Ireland reports 14 contacts per child.
- All 4 UK countries have an average input of between 5 and 6 contacts per child, followed by Sweden at 7 contacts per child per annum.
- In interpreting the data on contacts per child it should be noted that this will include a range of activities including; initial assessments and ongoing interventions. Some children will require just one appointment, others will require an ongoing package of care.





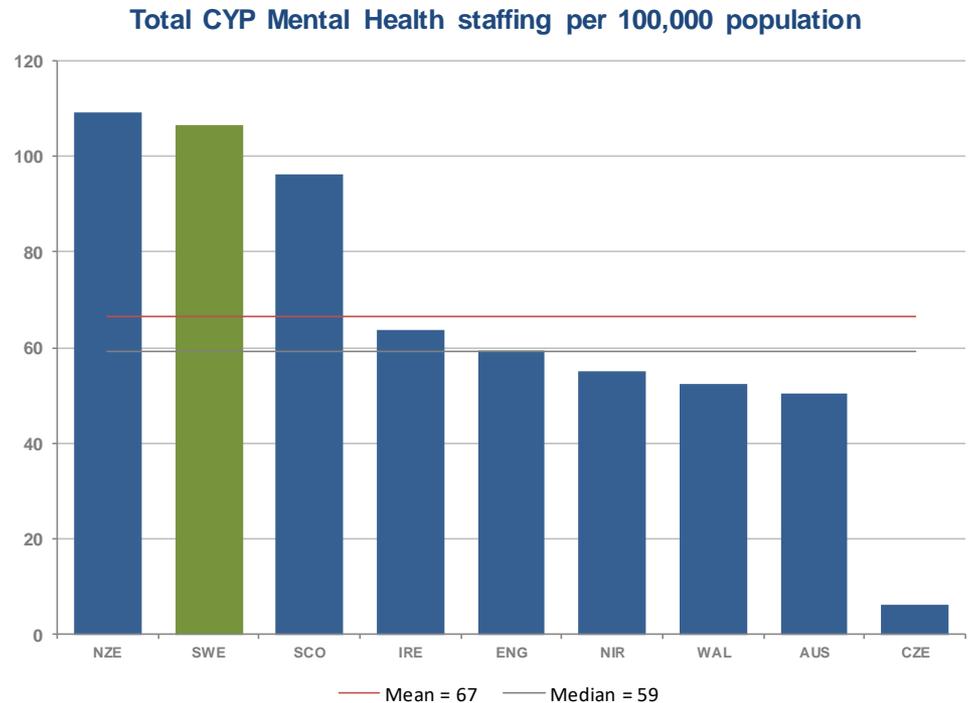
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Workforce

Raising Standards through Sharing Excellence

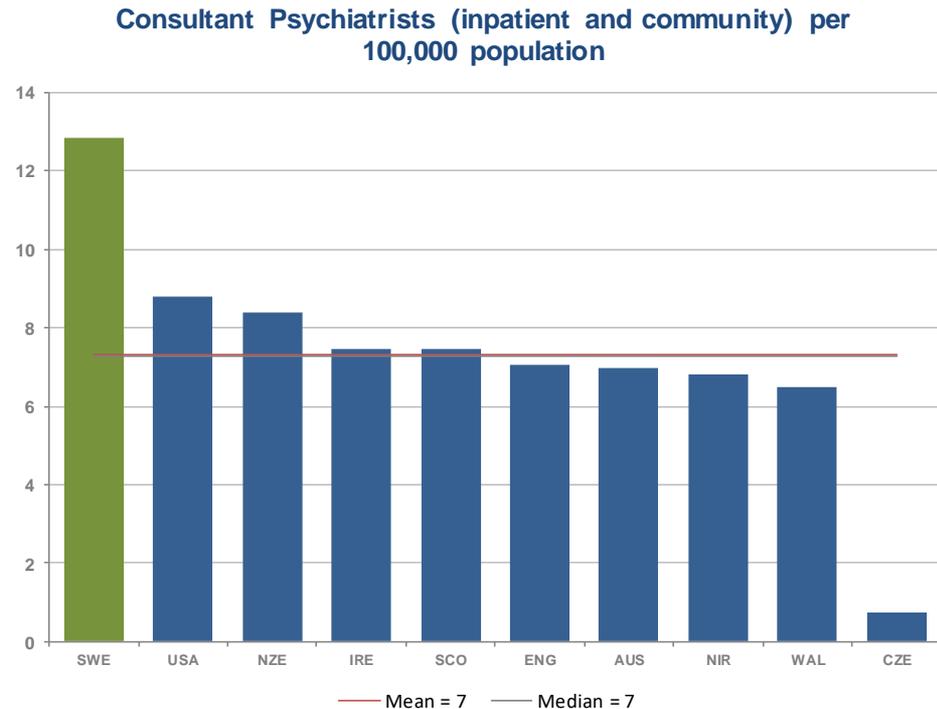
Workforce

- The CAMHS workforce is typically formed from a multi-disciplinary team involving Child and Adolescent Psychiatrists, specialist Therapists and Nurses.
- This section of the report explores the number of specialist staff deployed in each country. Of the 13 countries participating in the study, 10 were able to provide data on workforce.
- New Zealand reported the largest workforce figure at 109 per 100,000 population in the 0-18 group. This figure includes consultant psychiatrists, registered nurses, clinical psychologists and other clinical therapists and practitioners.
- Sweden reported the second highest rates at 106 per 100,000 population.
- UK countries reported workforce levels in the range from 52 WTE to 96 WTE per 100,000 population aged 0-18.
- The mean value of 67 is marginally skewed by the higher numbers of staff reported by Sweden, New Zealand, and Scotland. The median value is 59 WTE per 100,000 population aged 0-18.



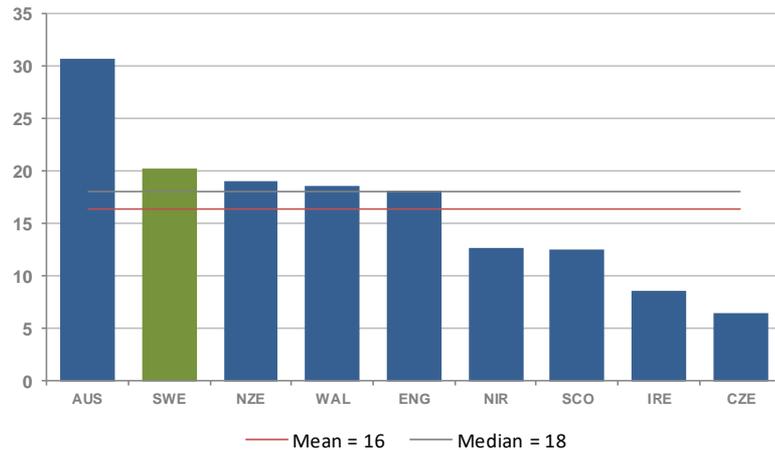
Consultant Psychiatrists – total staffing

- Consultant Psychiatrists per 100,000 population shows the WTE (whole time equivalent) number against a 0-18 year old population. Staff working in inpatient and community settings are included.
- Sweden reports the highest levels at 13 per 100,000 population, and the Czech Republic the lowest at 1 per 100,000 population.
- The remaining 8 countries report similar levels to each other, ranging between 7 and 8 WTE per 100,000 population aged 0-18.
- The mean and median positions across all countries is 7 WTE.

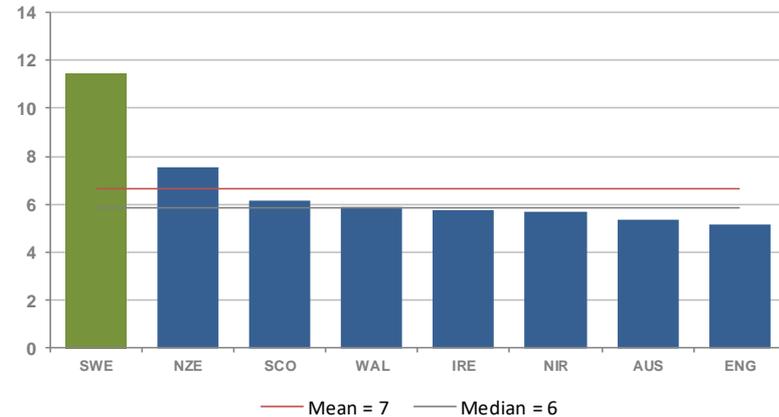


Consultant Psychiatrists

Consultant Psychiatrists per 100 beds



Community based Consultant Psychiatrists per 100,000 population

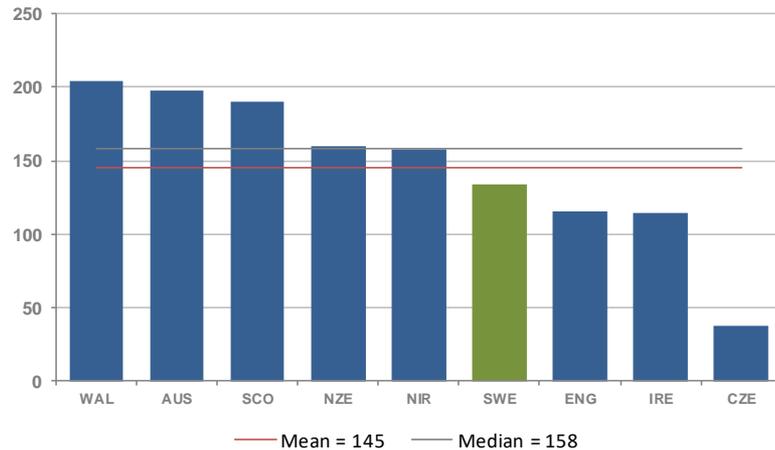


- This analysis of comparative workforce levels focuses on the number of specialist staff employed in both inpatient and community settings. In comparing staff numbers a denominator of inpatient staff per 100 CAMHS beds is used, and a community denominator of staff per 100,000 population in the 0-18 age groups is used. All staff based benchmarks are based on full time equivalent staff calculations.
- In the Inpatient context, the number of CAMHS Consultant Psychiatrists employed per 100 beds has a mean average of 20. Australia employ most staff (31 WTE) and Czech Republic the fewest (6 WTE).
- In the community context, the number of CAMHS Consultant Psychiatrists employed per 100,000 children in the 0-18 age group averages 7 whole time equivalent staff. Sweden employ the most staff (11 WTE) followed by New Zealand (8 WTE) but the other countries on the chart are largely similar reporting 5 – 6 WTE per 100,000 population

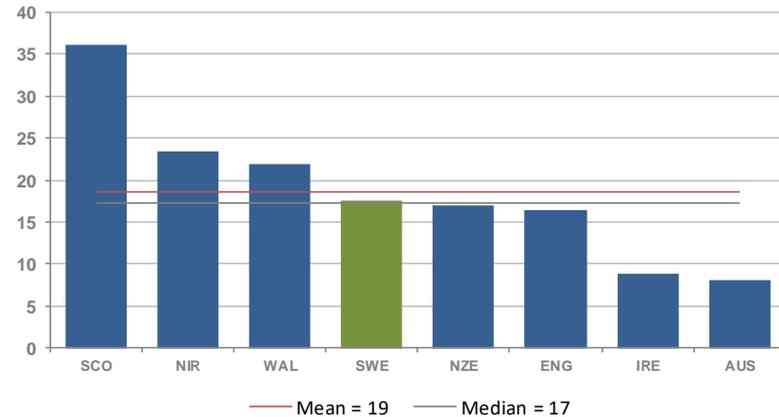


Qualified CAMHS Nurses

Registered nurses per 100 beds



Community based registered nurses per 100,000 population

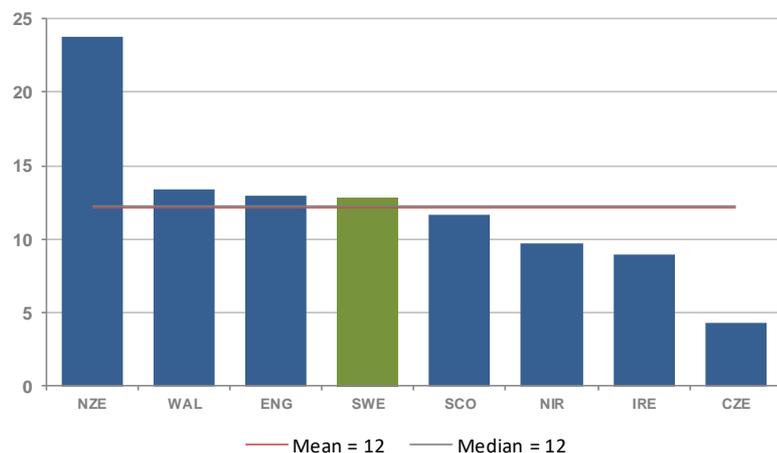


- Specialist Nursing staff in Children and Young People's mental health services can perform a number of roles. In the inpatient environment CAMHS Nurses are often employed as ward managers and also deliver interventions as part of a wider multi-disciplinary team. The analysis of the Nursing workforce only focuses on qualified / registered Nurses rather than Nursing Assistants and support workers who are also typically part of the wider CAMHS Nursing team.
- In the Inpatient context, the number of CAMHS Nurses employed per 100 beds has a mean average of 145. Wales employ most staff (204) and Czech Republic the fewest (37).
- In the community context, the number of CAMHS Nurses employed per 100,000 children in the 0-18 age group averages 19 whole time equivalent staff. Scotland employs the most staff (36 WTE) and Australia the fewest (8 WTE).

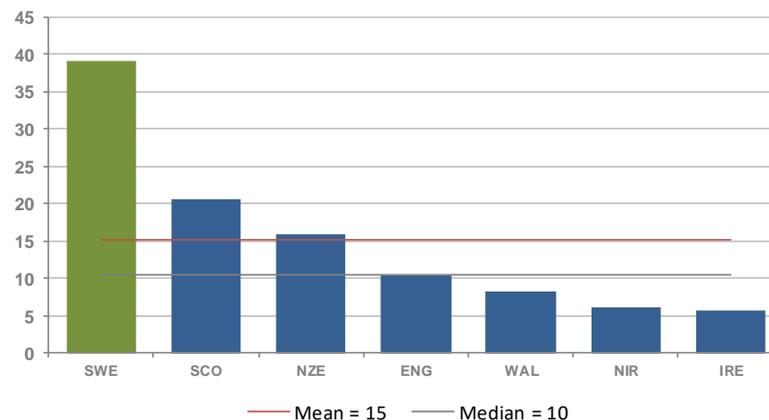


CAMHS Clinical Psychologists

Clinical Psychologists per 100 beds



Community based Clinical Psychologists per 100,000 population



- Children and Young People's mental health services typically have a broad therapy offer which will include contributions from Psychologists, Psychiatrists, and other specialist therapists including Occupational Therapists. Participants expressed an interest in exploring Clinical Psychology as the main therapy area within CAMHS. In the inpatient environment Clinical Psychologists deliver interventions as part of the wider CAMHS multi-disciplinary team and may have a particular focus on recovery. The analysis of the Clinical Psychology workforce only focuses on qualified staff and is expressed in full time equivalent numbers.
- In the Inpatient context, the number of CAMHS Clinical Psychologists per 100 beds has a mean average of 12. New Zealand employ most staff (24) and Czech Republic the fewest (4).
- In the community context, the number of CAMHS Clinical Psychologists employed per 100,000 children in the 0-18 age group averages 15 whole time equivalent staff. Sweden employs the most staff (39 WTE) and Northern Ireland and the Republic of Ireland the fewest (6 WTE).



Conclusions

- We would like to express our thanks to the countries that participated in this research project. The project's work has been interesting on a number of levels and has engaged countries in the debate about children's mental health services, mental health data, definitions, interpretation and analysis.
- The aspiration of undertaking international children's mental health service comparisons has been advanced and interesting variations have emerged in the comparative data. The reasons for this variation are numerous and include issues around; data completeness, data quality, ability to produce data in line with the project's definitions, the contextual position of each country's health system, resource levels, and performance variations that might exist both within and between countries.
- The project's findings show coherence on a number of areas. All countries cited children and young people's mental health services as a priority and many could demonstrate this in the form of explicit national strategies.
- In inpatient care we noted variation in the number of beds provided, with countries at different positions in their commitment to inpatient models. Several countries cited a position of aiming to focus predominantly on community based care with an ambition to reduce bed numbers over time.
- Each participant country recognised community based care as being the main delivery route for children and young people's mental health services. Demand for community based care is rising in many countries.
- Approaches to community based care differ in terms of the number of children able to access services, and the intensity of services provided. Sweden has the broadest offer in terms of the number of children accessing services. This model includes care provided across both health and education sectors, a model proposed in England in the Transforming Children and Young People's Mental Health Green Paper. All UK countries have a broad community based offer with the NHS being the main delivery route.
- Comparisons of the CAMHS workforce also show variation across countries. CAMHS services are typically delivered by a skilled multi-disciplinary team involving Child Psychiatrists, Nurses and specialist Psychological Therapists.

Dissemination of findings:

- This report will be published via the NHS Benchmarking Network website. Other participating countries will also receive local versions of this report.
- The findings from the project formed part of a wider discussion that took place at a two day seminar in Stockholm on 28th and 29th May 2018, hosted by the International Initiative for Mental Health Leadership.





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Appendix 1

Data Specification

Children and Young People's Mental Health	
Defining "Children's Mental Health"	
Which of the following are categorised as children's mental health in your country?	
Antenatal / perinatal support for mothers	Yes/No
Early years support for infants e.g. attachment issues	Yes/No
Parenting programmes	Yes/No
Emotional disorders	Yes/No
Conduct / behavioural disorders	Yes/No
Developmental disorders	Yes/No
Autism / Spectrum Disorders	Yes/No
Hospital Care	
	Inpatient psychiatric beds for children / young people
Number of hospital beds for children's mental health	
Number of admissions 2016/17	
Number of available bed days 2016/17	
Number of occupied bed days (excluding leave) 2016/17	
Number of occupied bed days (including leave) 2016/17	
Average length of stay (excluding leave) - days	
Average length of stay (including leave) - days	
Number of incidences of use of restraint 2016/17	
Number of incidences of use of prone restraint 2016/17	
Number of incidences of use of seclusion 2016/17	
Do you feel demand has been increasing, decreasing or staying the same in the last 10 years? Please provide data relating to numbers of admissions or changes in bed numbers if available.	
Community Care	
If you have specialist mental health services for children in the community:	
number of children who accessed specialist community mental health support during 2016/17	
number of contacts delivered to children in the community during 2016/17	
Median average waiting time from referral to assessment	
Median average waiting time from referral to start of treatment	
Do you feel demand has been increasing, decreasing or staying the same in the last 10 years? Please provide data relating to numbers of referrals or activity if you have this.	



Education					
Please describe the role education (schools / colleges) play in children's mental health provision e.g. detection, mental health promotion, in-house counselling. This may be a formal requirement or a widely adopted approach.					
Suicide		Comments			
Number of suicides for 0-18 year olds inclusive (2016/17 or most recent 12 months available)		Whole population suicides for this age group, not just in children known to mental health services.			
Suicides per 100,000 population aged 0-18 inclusive (2016/17 or most recent 12 months available)		Please provide latest available annual data position.			
Please detail if these are confirmed or suspected, and the time period being reported.					
Workforce					
Proportion of primary schools have an in-house counsellor / other mental health professional					
Proportion of secondary schools have an in-house counsellor / other mental health professional					
Number of FTE working in children's mental health	Hospitals	Specialist community care	Schools / education	Other	Total
Consultant Psychiatrists					
Registered nurses					
Clinical Psychologists					
Other Clinical Therapists and Practitioners					
Workforce metrics	Hospitals	Specialist community care	Schools / education	Other	
If available, please provide details relating to challenges or successes in relation to workforce metrics over the last 10 years, such as recruitment and retention, vacancies, skills shortages					





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Appendix 2

Additional resources

Country	Title	Link
Canada	The Mental Health Strategy for Canada: A Youth Perspective	https://www.mentalhealthcommission.ca/English/initiatives/11849/mhs-a-youth-perspective
England	Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf
Switzerland	Swiss national public mental health strategy	https://www.psychiatrie.ch/fmpp/spezielseiten-newsletter-fmpp/nationale-strategie-psychische-gesundheit/
Switzerland	Swiss national association for quality development in hospitals and clinics	https://www.anq.ch/en/
New Zealand	Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017	https://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017
Scotland	Mental Health Strategy 2017–2027 – a 10 year vision	http://www.gov.scot/Publications/2017/03/1750
Wales	Together for Children and Young People	http://www.goodpractice.wales/t4cyp
Wales	Mental Health (Wales) Measure	https://www.rcpsych.ac.uk/pdf/Code%20of%20Practice.pdf
Sweden	Current situation and challenges of student health	https://www.uppdragpsyiskhalsa.se/skola-och-elevhalsa/



Country	Title	Link
Australia	Prevention and Early Intervention	http://www.health.gov.au/internet/main/publishing.nsf/content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/\$File/pla2.pdf
Australia	EPPIC (Early Psychosis Prevention & Intervention Centre)	https://oyh.org.au/our-services/clinical-program/continuing-care-teams/eppic-early-psychosis-prevention-intervention
Australia	Prevention of depression and anxiety in Australian schools	https://www.blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/prevention-of-depression-and-anxiety-in-australian-schools.pdf?sfvrsn=2
Australia	Physical health and mental wellbeing	https://nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Physical%20health%20and%20wellbeing%20-%20final%208%20Apr%202016%20WEB.pdf
Australia	Principles for health and wellbeing	http://www.education.vic.gov.au/Documents/about/department/principlesforhealth.pdf
Australia	Tell them they're dreaming: work, education and young people with mental illness in Australia	https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Work-Education-Young-People/tell-them-theyre-dreaming-view?ext=.
Australia	National standards for Mental Health services	https://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/\$File/servst10v2.pdf
Australia	Guideline for the transition of care for young people receiving mental health services	https://www.health.qld.gov.au/_data/assets/pdf_file/0020/151085/gh-gdl-365-5.pdf
Australia	Transition of Young People with Complex and Chronic Disability Needs from Paediatric to Adult Health Services	https://www.racp.edu.au/docs/default-source/advocacy-library/transition-of-young-people-with-complex-and-chronic-disability-needs.pdf



Country	Title	Link
Northern Ireland	Child and Adolescent Mental Health in NI	http://www.niccy.org/media/2810/niccy-scoping-paper-mental-health-review-apr-2017.pdf
Northern Ireland	Mental Health in Northern Ireland: Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services	http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf
Republic of Ireland	Delivering Specialist Mental Health Services	https://www.hse.ie/eng/services/publications/mentalhealth/hse-mental-health-division-delivering-specialist-mental-health-services.pdf
	CAMHS Standard Operating Procedure	https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/publications/

