Te Hiringa Mahara
Mental Health and Wellbeing Commission

Te Huringa Tuarua 2023: Youth services focus report | Pūrongo arotahi ratonga taiohi

Admission of young people to adult inpatient mental health services

Te whakauru i ngā taiohi ki ngā ratonga hauora hinengaro pakeke ā-hōhipera

Te Huringa Tuarua 2023: Youth services focus report - Admission of young people to adult inpatient mental health services | Pūrongo arotahi ratonga taiohi - Te whakauru i ngā taiohi ki ngā ratonga hauora hinengaro pakeke ā-hōhipera

A report issued by Te Hiringa Mahara - Mental Health and Wellbeing Commission.

Authored by Te Hiringa Mahara.

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Te Hiringa Mahara - the Mental Health and Wellbeing Commission - was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: www.mental healthwc.govt.nz

The mission statement in our Strategy is "Whakawāteatia e tātou he ara oranga / clearing pathways to wellbeing for all." Te Hiringa Mahara acknowledges the inequities present in how different communities in Aotearoa experience wellbeing and that we must create the space to welcome change and transformation of the systems that support mental health and wellbeing. Transforming the ways people experience wellbeing can only be realised when the voices of those poorly served communities, including Māori and people with lived experience of distress and addiction, substance harm, or gambling harm, are prioritised.

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Kupu whakataki | Foreword

Rates of mental distress have been significantly increasing for young people over the past 10 years. We have reached a critical point in Aotearoa New Zealand where support for young people needs to change.

How the system responds to youth distress can change the lives of people for generations to come.

We want every young person to thrive and access the support they need, when and how they need it. However, we are concerned that young people experiencing acute distress are not always able to access acute care in a way that upholds their rights or mana.

This report highlights the practice of admitting young people to adult inpatient mental health services and explains why this needs to stop.

We acknowledge the contextual reasons why this practice is happening. However, the reality is that it is harming some young people and has no place in the future of mental health support in Aotearoa.

We want to see zero admissions of young people to adult inpatient mental health services. Instead, there must be investment in youth-specific acute alternatives, including kaupapa Māori services. These would include both residential alternatives to hospital-based inpatient mental health care and short-term respite care. These services can provide appropriate treatment, along with a supportive culture where young people are safe and have hope for the future.

Achieving zero admissions of young people into adult inpatient services will not be easy. We need genuine commitment, leadership, and a comprehensive plan to make this happen. It is not too late to start, but we certainly cannot afford to wait.

This report is the first of a series of monitoring reports that Te Hiringa Mahara will publish in 2023. The series, Te Huringa Tuarua, will focus on Compulsory Community Treatment Orders and kaupapa Māori services. It also includes a summary report of mental health and addiction services.

At the heart of this report are young people and their whānau and family who shared their experiences of adult inpatient mental health services. It is because of you and future generations that we stand up for a better future of mental health support.

Hayden Wano – Board Chair, Te Hiringa Mahara

Ngā mihi | Acknowledgements

Te Hiringa Mahara has developed this report with input from people who have shared their expertise and advice. We thank them for their guidance and acknowledge them here.

We are indebted to the young people with lived experience of distress and their whānau and family who have shared their views with us. We honour your feedback and will use your stories to advocate for a better mental health and addiction system.

We are grateful to the following groups and organisations who participated in hui on this issue and provided us with sage advice and guidance:

- National Youth Consumer Advisor Network (NYCAN)
- Eating Disorders Carer Support (EDCS)
- Mātanga Mauri Ora (National Māori Mental Health Leadership group).

We thank Te Whatu Ora | Health New Zealand for providing us with access to information from the national mental health data set that enabled us to prepare this report.

Finally, we extend our thanks to the reviewers:

- Georgia Butler, Take Notice
- Dr Margaret Aimer, Psychiatrist and Clinical Director.

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Whakamōhiotanga whānui | Overall summary

In this report, we shine a light on the practice of admitting young people (aged 12 to 17 years) to adult inpatient mental health services (adult services) in Aotearoa.

The 2018 Government Inquiry into Mental Health and Addiction heard concerns about the practice of admitting young people to adult services. Yet at that time, there was limited information about how this practice affects young people, whānau, and families. Through our discussions with young people, whānau, and families, we have heard that this practice may be harmful, causes a loss of hope, and does not uphold the rights of young people. We are also concerned that, with respect to rangatahi Māori, the practice does not reflect the Crown's commitments to Te Tiriti o Waitangi.

The following are among our key findings.

- The admission of young people into adult mental health inpatient services has decreased over the last decade, however, one in four young people who are admitted to inpatient care is admitted to an adult service.
- Admitting young people to adult services may cause harm and reduce their sense of hope.
- The negative impacts of this practice outweigh any potential positives, and young people and their whānau and family should not have to choose between age-appropriate services, and services close to home.
- Young people want to be involved in co-designing youth-specific acute response services across Aotearoa.

This report states our call to action: reduce the number of young people admitted to adult inpatient mental health services to zero. To achieve this, we need committed leadership and a detailed action plan. The Government should consider the following as part of that plan.

- Conduct a thorough investigation of the practice of using adult mental health services for young people, including the reasons why this occurs.
- Develop youth-specific acute options within communities to address the needs of young people experiencing acute distress. Options should include residential alternatives to hospital-based inpatient mental health care.
- Develop kaupapa Māori services as part of the network of acute options for rangatahi Māori.

We will monitor progress that Government, commissioners, and services make in addressing our call to action detailed above.

Kupu arataki | Introduction

Young people in Aotearoa are experiencing increasing levels of distress

In line with international trends, reported levels of distress among children and young people in Aotearoa are high and increasing (UNICEF, 2021). The Youth19 survey showed that the proportion of young people reporting symptoms of depression in 2019 had increased significantly since 2012. Compared with other ethnic identities, rangatahi Māori reported the highest rates of depressive symptoms, followed closely by Pacific youth (Fleming et al, 2020). The COVID-19 pandemic has caused an additional burden, with younger people disproportionately affected (World Health Organization, 2022).

It is particularly important that young people receive effective and age-appropriate supports and services when they are most distressed and in need of acute care. This report explores the practice of admitting young people experiencing acute distress into adult services.

Specialist mental health services for young people

For the period covered in this report (2012/13 to 2021/22), the Crown Funding Agreement required district health boards[1] to ensure access to a range of mental health services to meet the needs of their populations. Mental health services specifications require access to 'inpatient care for children, adolescents and youth with mental health disorders who are in need of a period of close observation and/or intensive investigation and/or intervention' (Ministry of Health, 2017a, p.2). They also require that services must promote the provision of age-appropriate settings and facilities, and where possible separate child and adolescent services from adult services (Ministry of Health, 2017b).

Despite the specifications for age-appropriate care, only three specialist units provide inpatient mental health services for children and adolescents. These units are in Tāmaki Makaurau (Auckland), Te Whanganui-a-Tara (Wellington), and Ōtautahi (Christchurch).[2] In contrast, all but one district across Aotearoa provide adult mental health inpatient services in local hospitals.

Note that across mental health services, no particular age definition of a child or adolescent is in use consistently. In this report we focus on those aged 12 to 17 years

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[1] From 1 July 2022, district health boards were replaced by Te Whatu Ora | Health New Zealand and Te Aka Whai Ora | Māori Health Authority. Te Huringa Tuarua 2023 reports on the period leading up to 30 June 2022.
[2] This report excludes youth forensic and intellectual disability services.

because that fits with the definition of a child (a person under the age of 18 years) used in the United Nations Convention on the Rights of the Child (UNCROC) (Office of the High Commissioner for Human Rights, 1989).[3] However, specialist mental health services for adolescents generally include people up to 18 years old. Services may also use their discretion with the age of transition to adult services. (Access and Choice youth services are available to young people up to 24 years of age.) The recently published Oranga Hinengaro System and Service Framework states that 'in line with recent evidence about human development … youth will not be required to transition to adult services until their 25th birthday and will have the choice to do so from the age of 20' (Ministry of Health, 2023).[4]

One reason for admitting children and young people to adult inpatient services is proximity to their whānau and community, especially if the admittance is anticipated to be short. Other reasons include timeliness of access to youth-specific services and issues around transport time in acute situations. However, as will be discussed further, we do not consider that operational and geographical constraints are sufficient reasons for young people to be placed with adults.

Concern about young people in adult mental health settings

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) highlighted concern about the practice of admitting children and adolescents to adult mental health settings (Government Inquiry into Mental Health and Addiction, 2018). Media coverage of this issue has also grown over recent years.[5] However, despite public concern, limited information is available publicly about the scale of this practice and there has been very little research in Aotearoa about its impacts on young people as well as whānau and family.

One Aotearoa-based study reviewed clinical records of children and adolescents who were admitted to an acute adult general psychiatric inpatient unit from 2002 to 2007 (Park et al. 2011). Findings pointed to high use of the Mental Health (Compulsory

[3] New Zealand ratified UNCROC in 1993. UNCROC sets out principles and standards for the status and treatment of children in international law.
[4] This text is taken from one of the changes under Critical Shift 4 in the Framework (Get in early to support whānau wellbeing). It reads in full: 'Services for the young adult age range will be developed in line with recent evidence about human development which recognises that adulthood does not begin until the late 20s, so youth will not be required to transition to adult services until their 25th birthday and will have the choice to do so from the age of 20. Age range eligibility criteria for all services must be flexible to respond to the strengths, preferences and needs of individuals and whānau at any stage of their life.'
[5] For example, see Children admitted to adult mental health wards (Keogh, 2017).

Assessment and Treatment) Act 1992 (Mental Health Act),[6] over-representation of rangatahi Māori in those units, and use of seclusion in the adult unit (sometimes to separate young people from adult service users experiencing severe distress). In 2009 the Ministry of Health issued guidelines for district health boards on best practice in circumstances where such admissions happen (Ministry of Health, 2009).

Aotearoa is not alone in grappling with this challenge. Recently, in December 2022, the Mental Welfare Commission for Scotland raised concern about the rise in numbers of young people admitted to adult units for mental health treatment. We note that England prohibited the practice of admitting children and adolescents under 16 years to adult mental health wards in December 2008 (McDougall et al, 2009). Since then, a significant programme of work has focused on ensuring child and adolescent inpatient services work within integrated care systems, as well as making 24/7 mental health crisis provision available for children and young people, which includes crisis assessment, brief response, and intensive home treatment functions (NHS England, 2019).

Monitoring agencies have called out breaches of rights for young people

While all people in Aotearoa are entitled to human, civil, and political rights and freedoms to protect them from unlawful discrimination, legislation acknowledges and upholds specific rights for young people.

UNCROC enshrines the rights of children under 18 years of age in international law. Article 37(c) requires:

> Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances (Office of the High Commissioner for Human Rights, 1989).

Although Aotearoa ratified UNCROC in 1993, the Government made a reservation to complying with Article 37(c) 'in circumstances where the shortage of suitable facilities makes the mixing of juveniles and adults unavoidable' (Ministry of Justice, 2020).

[6] Use of the Mental Health Act is likely related to level of acuity. In Park et al's (2011) study, causes of admission for those admitted under the Mental Health Act (204/332) were summarised into three categories: self-harm or suicidal behaviour (184/332, 55%), mental health deterioration (84/332, 25%) and aggression/violence (60/332, 18%). The Act was significantly more likely to be used if the cause of admission was a deterioration in mental health status (67/84, 80%) or aggression (45/60, 75%)."

The United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment undertook an inspection in Aotearoa. In the report that followed it states that this reservation ‘compromises the right of juveniles to be accorded treatment appropriate to their age’ (Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2017).

More recently, the New Zealand Children’s Commissioner, Judge Frances Eivers, has raised concerns about the continued lack of compliance with Article 37(c) (Children’s Commissioner, 2022). The Office of the Children’s Commissioner has highlighted this as the principal ongoing concern to come from its statutory monitoring of youth inpatient mental health services. The Children’s Commissioner acknowledges the complexity of this issue, and in particular the value in some circumstances of placing young people in local adult inpatient settings for brief admissions so they can be close to whānau and family. However, she has emphasised that operational and geographical constraints are an insufficient reason for placing young people with adults in services where they have no access to specialised care and treatment.

Rights of young people within the health and disability system

Young people using mental health services have rights established under the Code of Health and Disability Services Consumers’ Rights. This specifies the duties of providers to ensure that consumers are treated with respect, have dignity and independence, can give informed consent, and receive services that are of an appropriate standard and provided in a manner that minimises potential harm, among other rights.

Young people subject to the Mental Health Act have rights and additional protections specific to children and young people (contained in Part 8 of the Act). Section 86 of the Mental Health Act (1992) states, “Wherever practicable, an assessment examination of a proposed patient who is under the age of 17 years shall be conducted by a psychiatrist practising in the field of child psychiatry.”

Few studies have looked at outcomes for young people admitted to adult facilities

The research literature does not explore the topic of young people admitted to adult mental health inpatient services extensively. Most commonly in this area, international studies report the numbers of young people admitted to such facilities (Frith, 2017; McGilloway et al, 2000; McRae, 2019; Park et al, 2011). A small amount of literature covers the care young people receive when admitted to adult mental health inpatient services (Murcott, 2016). However, studies on the outcomes for young people admitted to such facilities are rare.

An exception is McRae's (2019) study of adolescent admissions to adult psychiatric units in Ontario, Canada, which assessed several outcomes. This study found adolescents admitted to an adult psychiatric unit had a significantly shorter stay compared with those in youth-specific facilities and were more likely to be discharged against medical advice. The author concluded further research was needed to determine the extent to which admissions to an adult psychiatric unit affected clinical and wellbeing outcomes for young people. Undertaking this research is likely to be challenging given the lack of systematic monitoring of performance and outcomes noted around the world (Murcott, 2016; Greenham and Persi, 2014).

Admission of young people to adult mental health services is an important and complex issue

There is a need to balance a range of factors in promoting the best interests and preferences of young people experiencing distress and their whānau and families. These factors include ensuring access to, and choice of, appropriate youth-focused supports and treatments, and making best use of constrained mental health resources and workforce, while complying with rights that young people have under legislation.

Although we have highlighted concerns that He Ara Oranga and monitoring agencies have expressed, how to resolve this issue has not received appropriate attention. There is limited awareness of the scale of this practice, and insufficient understanding of how it impacts on rangatahi Māori, young people, whānau, and families.

To better understand the impacts of this practice, we have reflected on perspectives and insights we have gained from discussions with young people as well as whānau and family who have shared their lived experience of specialist mental health services. To determine the scale of this practice and current trends, we have analysed data on admission to inpatient mental health services of young people aged 12 to 17 years over the past decade. Appendix 1 provides an overview of our approaches to gathering and analysing these data.

Ngā kōrero a ngā taiohi me ngā whānau | What young people and whānau have told us

Young people experience harm and loss of hope when admitted to adult services

Adult and youth inpatient services are fundamentally different

Young people, whānau, and families see adult and adolescent inpatient mental health services as having entirely different cultures and practices.

Young people in our focus groups talked about how youth services felt safer and more contained than adult services. Youth services seemed more able to practise in a way that includes whānau and family, is holistic, and focuses on recovery.

In contrast, young people experienced the culture of adult services as less nurturing and supportive. Whānau and rangatahi Māori emphasised the importance of feeling welcomed and connected to services. Further, a lived experience service advisor highlighted the potential for rangatahi Māori to experience a dual impact on identity when placed in an adult unit—with disconnection from both te ao Māori and youth culture.

Young people felt adult services had a greater expectation for them to be independent and self-managing, and relied more on diagnosis and

> There are completely different approaches, different expectations, policies and procedures and it can be very overwhelming to be thrown between those services, having that inconsistency.
> - Young person, Lived experience hui

> Get someone there to greet them, to sit with them, because it can be overwhelming.
> - Whānau representative, Whānau hui

> It was very hard to feel safe and connected in that environment.
> - Māori peer support worker, online survey response

> There might be treatment interventions, but they're not really specific to the young person, and they might just be more focused on getting the medication right.
> - Youth consumer advisor, NYCAN

> They are given the same overall treatment as the adults even though adults and youth need very different things to support their mental wellbeing.
> - Peer support worker, online survey

medication regimes. Adult services, whose teams do not include specialists trained in youth mental health, offer fewer (if any) supports and treatment options specifically tailored for young people, such as family therapy. Young people felt that days lacked structure and meaning, without the regular group programmes and routines of youth services.

Those under the age of 18 years in adult units can be placed under a one-to-one staffing ratio.[7] Some told us that this can lead them to feel that they were being watched over and some said they felt claustrophobic and institutionalised. Young people described becoming over-reliant on that ongoing support, with the result that they felt frightened and doubted their ability to cope when one-on-one staffing ended.

Unlike youth services, adult services do not provide on-site education or have processes in place to support connection to schools and continuing education.

> Good communication and liaison with school is so important.
> - Youth consumer advisor, NYCAN

> Within the adult service, they don't really care about your education, they don't have any support for it. You're just left to your own devices.
> - Young person, Lived experience hui

Whānau and family told us they were not sufficiently involved in care within adult settings and felt 'brushed aside'. All people using mental health services have a right to have their whānau and family involved, and for young people, keeping connected with whānau and family can be especially important.

Exposure to negative influences and experiences in services may cause harm

People we talked with felt that the culture of youth inpatient mental services was more focused on ensuring safety of young people, providing greater protection, and shielding them from potentially harmful events or influences. We received a clear message that young people placed in adult mental health units can experience distress and harm from exposure to behaviours and situations that they haven't encountered previously.

> In those (adult) wards, we started seeing a lot of violent outbursts, fights, and arguments and we were exposed to people trying to escape, people harming themselves. A whole range of different traumas that we'd never seen before.
> - Young person, Lived experience hui

[7] Having anyone aged under 18 years in an adult unit requires special reporting to the Director of Mental Health, and safe oversight and rationale for this is required.

Examples people mentioned included witnessing: violence and fights; smoking/vaping, alcohol, or other drug use; self-harm behaviours and suicide attempts; attempted escapes; and predatory behaviours.

> There is a lot of stuff that you see on the adult ward that would be hidden away on the youth unit and they would be trying to stop the young people from seeing that stuff. Whereas on the adult ward, it's very much just out there in the open.
> - Whānau member

Young people felt they didn't belong in adult units—they missed the sense of connection and the opportunity to form friendships and mutually supportive relationships with peers going through similar experiences, at a similar stage of life. We heard that young people on adult wards can feel that their own experience of distress and the impacts it has on them are invalidated. For example, this might occur if someone compares the young person's experience with that of an older person who has lost a house, job, or relationship as a result of their distress.

We heard that young people as well as whānau and family may experience a range of harmful short- and long-term impacts of admission into adult services. Youth consumer advisors, who are involved in providing services, told us that as a result of these experiences the young person's distress can increase and their symptoms can deteriorate. Longer-term impacts include long-term trauma after their discharge, as well as loss of trust and a fear of returning to adult services in future.

Services are not aligned with a rights-based perspective

Young people expressed significant concern about ways in which adult services were not upholding their rights. They identified several ways in which admission to adult psychiatric settings undermined their sense of dignity, respect, and other rights. For example, the one-on-one staffing ratio discussed earlier felt demeaning to them, reducing their potential for independence, and compromising their privacy.

> The person actually has no informed decision because they have no idea what's out there. They have no idea what's available, and we generally have no idea what we're getting into.
> - Young person, Lived experience hui

People felt that processes relating to informed choice and consent were not always adequate for young people admitted to adult services. Notably, such services did not have enough information tailored to young people, particularly about any alternative options to admission that might be available. Whānau and family were particularly

concerned that services did not always communicate well with them about their young person's treatment.[8]

The right to freedom from coercion was a prominent issue in discussions. Young people were concerned that services might invoke the Mental Health Act if they did not comply voluntarily with proposed admission plans.[9] Being subject to a Compulsory Treatment Order potentially has lifelong impacts, including potential difficulties with securing visas for entry to some countries or with being allowed to practise law in Aotearoa.

> There are long-term impacts to being admitted or threatened with MHA [Mental Health Act] as a young person, that can continue to impact on relationships with self and services for years to come.
> - Youth consumer advisor, NYCAN

Whānau and family expressed particular concern about coercion in these circumstances. In one example, a parent felt pressured to give consent for their teenager to be admitted voluntarily to an adult psychiatric unit because of an implicit risk that otherwise the service might seek a Compulsory Treatment Order or the parent might even losing custody.[10]

> Even a threat of coercion is coercion in itself.
> - Youth consumer advisor, NYCAN

Loss of trust and hope

A powerful underpinning theme emerged in our focus groups: that young people often experience an intense loss of hope as a result of being admitted to adult mental health inpatient services.

> You're surrounded by people who are struggling, and I always think—why am I even bothering if I'm just going to be in the same place in 40 years? What's the point when it doesn't seem like it ends?
> - Youth consumer advisor, NYCAN

[8] Ngā Paerewa, Health and Disability Services Standard (2021) requires that people are informed of their rights, that treatment provided complies with those rights (including the right to make an informed choice and give informed consent), that people are treated with respect, that there be effective communication, and that the person (and their whānau) are involved in the development of their care plan.

[9] Criterion 1.5.1 of Ngā Paerewa Health and Disability Services Standard (2021) states that "[Tāngata whaiora] shall receive services free of discrimination; coercion; harassment; physical, sexual or other exploitation; abuse; or neglect."

[10] Our analysis has found that over the 10 years from 2012/13 to 2021/22, among those aged 12 to 17 years who were admitted to mental health services, involuntary admissions occurred for 17 per cent of those in child and adolescent services and a similar 18 per cent of those in adult services.

Being around much older adults who are very distressed can leave young people feeling they will never recover, never live the lives that they value, and never be able to stay out of inpatient services in the future. Lack of support for maintaining access to education, usual routines, and social connections can cause young people to doubt whether they could return to life as usual. They felt doors could shut for their futures because of the potential lifelong impacts of being admitted under the Mental Health Act.

> It can be incredibly overwhelming, it zaps that hope that you might have a future where you are well, where you can live your own life.
> - Young person, Lived experience hui

In addition to losing hope, young people admitted to adult services can lose trust in the services that are intended to support them and become fearful of returning to adult services in the future.

The negative impacts of this practice outweigh any potential positives—'it is not the answer'

Young people acknowledged that being admitted to adult services has potential benefits in the current context, in which Aotearoa has few youth acute services and those that exist are in locations distant from many parts of the country. In particular, young people recognised that adult inpatient admission offers care closer to their homes, whānau, families, and communities. It also supports whānau and family involvement and community connection, and helps the young people to return to their usual life as smoothly as possible. Avoiding long-distance travel to an inpatient service is important, particularly when a short admission is likely.

> It's well and good to say that it would be ideal for young people to not have to go into adult inpatient services. But then what are the alternatives?
> The alternative might mean that young people don't get the care that they need. So, if we're going to get rid of it, there needs to be something else in place that will replace it, and be better rather than worse.
> - Youth consumer advisor, NYCAN

> If even one child is harmed by that process, do not do it at all.
> - Family advocate, Whānau and family focus group

Given the limited capacity of the three child and adolescent services, admission to an adult unit may support a young person to receive earlier intervention at a time of acute distress. Although not tailored to offer youth-specific interventions, adult services are often larger in scale and offer potential links to other services in the local area. However, young people also told us that admission to a general hospital ward could feel calmer, safer, and more supportive than admission to an adult mental health inpatient unit. We note that this would not necessarily be a better option for young people requiring a short admission or waiting to access child or adolescent services as a general hospital ward does not have appropriately trained staff.

> It is no place for a kid who's going through something. No place.
> - Whānau member, Whānau and family focus group

Young people offered a pragmatic view, emphasising the need to have appropriate alternative options for acute service provision in place before stopping this practice.

In contrast, the whānau and family we met with stated unequivocally that young people should never be admitted to adult psychiatric units. The National Māori Mental Health Leadership group echoed this view.

> Young people (especially for first admissions) should not be placed in adult mental health services. The service needs to be oriented specifically for young people, especially rangatahi Māori.
> - Survey response, Mātanga Mauri Ora (National Māori Mental Health Leadership group)

Young people want youth-specific acute response services across Aotearoa

Young people wanted to see more homely residential options in communities as alternatives to child and adolescent mental health care in hospital inpatient settings. They wanted more youth-focused, short-term respite services, as well as kaupapa Māori options designed specifically to meet the needs of rangatahi Māori experiencing acute distress and their whānau. They wanted services to understand and respond to needs of young people in different rural areas. They emphasised that it is important for them to be involved in co-designing and co-producing services.

Young people as well as whānau and family also advocated for the development of a network of wraparound services that offer 24/7 acute support for young people experiencing high levels of distress within their communities.

Young people called for an emphasis on peer-led and peer-supported options and whānau-and family-focused services. (These include services that could accommodate whole families staying together and that focus on safety planning in a preparatory, instead of reactive way.)

Within the network of acute options, other community-based services could include day programmes and more options for young people to receive acute intensive support safely at home. The facilities for existing child and adolescent hospital inpatient mental health services should be upgraded and more eating disorder treatment services developed.

Ngā whakamārama mai i ngā raraunga | What the data tells us

The number of young people admitted to inpatient services has reduced

As Table 1 shows, over the last 10 years, the number of young people admitted to inpatient mental health services has decreased. In 2021/22, 662 young people aged 12 to 17 years were admitted to all inpatient services, compared with 773 young people 10 years earlier (2012/13). Note, that numbers admitted over the period 2019/2020 to 2021/22 may have been affected by the COVID-19 pandemic.

Table 1: Number and percentage of those aged 12 to 17 years admitted to inpatient mental health services, 2012/13 to 2021/22

Year	Total number admitted to all services	Number admitted to child and adolescent services	% of total admitted	Number admitted to adult services	% of total number admitted
2012/13	773	509	66%	264	34%
2013/14	721	494	69%	227	31%
2014/15	825	513	62%	312	38%
2015/16	837	542	65%	295	35%
2016/17	748	481	64%	267	36%
2017/18	747	512	69%	235	31%
2018/19	748	531	71%	217	29%
2019/20	681	501	74%	180	26%
2020/21	786	563	72%	223	28%
2021/22	662	503	76%	159	24%

The average annual number of young people admitted to adult services has decreased over time

Over the three years from 2019/20 to 2021/22, an average of 710 young people received inpatient mental health care each year (either from an adult or a child and adolescent unit).[11] During this three-year period, about 74 per cent of young people admitted to an inpatient unit received care from child and adolescent services—an average of 522 young people per year.

Over this same three-year period (2019/20 to 2021/22), an average of 187 young people aged 12 to 17 years were admitted to adult services each year. This is a

[11] The average annual number, calculated using the last three years of data, is used to smooth year-on-year variation.

reduction from the average of 268 per year admitted during the first three years of the decade (2012/13 to 2014/15). Despite this reduction, over the three-year period 2019/20 to 2021/22, one in four young people admitted to inpatient care was admitted to adult services.

The rate of young people admitted to inpatient services has reduced over the last decade

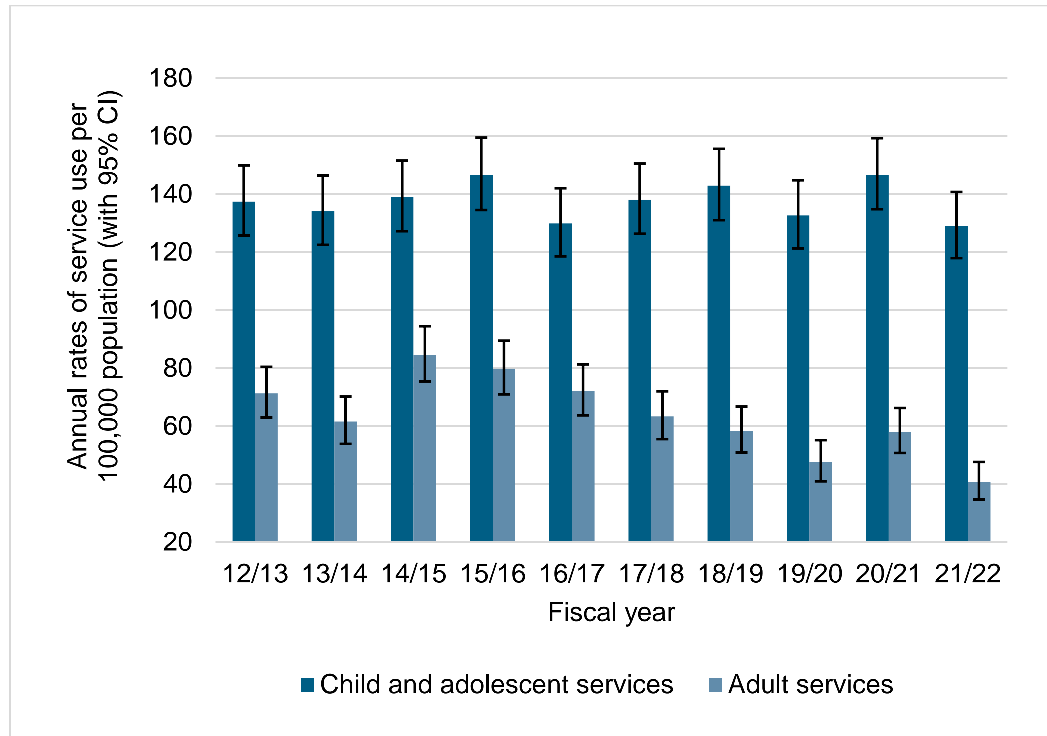
Between 2012/13 and 2021/22 the annual rate of all inpatient service use (child and adolescent services and adult services) for people aged 12 to 17 years decreased by 19 per cent.[12]

Figure 1 shows annual rates of child and adolescent inpatient mental health services use among those aged 12 to 17 years were relatively static across the decade 2012/13 to 2021/22.[13] However, over this same time span, the annual rate of admission to adult services fell by 43 per cent among this age group.

[12] These rates are for unique individuals, which means each person is only counted once as a service user in a 12-month period, even if they use the services multiple times during that period. All rates are per 100,000 population of the age group in question.

[13] Charts illustrating rates include confidence intervals (shown by vertical lines on the bars). A confidence interval describes the uncertainty surrounding an estimate such as a rate calculated using the estimated number of those aged 12 to 17 years in the population at a certain date. The '95 per cent' in the confidence interval represents a level of certainty about the estimate, i.e., there is a 95 per cent probability that the true value falls within the range of the confidence interval. If the confidence intervals overlap, the difference between groups is not statistically significant.

Figure 1: Annual rates of service use per 100,000 population aged 12 to 17 years in Aotearoa by inpatient mental health service type, 2012/13 to 2021/22



Rates vary between ethnic groups

Figure 2 and Figure 3 show the annual rates of service use among those aged 12 to 17 years by ethnicity.[14] All ethnic groups have higher rates of child and adolescent service use compared with adult service use. Across both service types, Māori and European/others generally have higher rates of service use than Pacific and Asian young people.

In the five years to 2016/17, Māori young people appear to have higher rates of adult service use than other ethnic groups. However, in the following five years Māori rates tended to decline and are now similar to European/other rates. Note that this analysis does not explore other factors such as where the young people live, which may affect whether they use adult services.

[14] Ethnicity data uses using total ethnicity responses categorised as: Māori, Pacific, Asian and European/other - including 'other ethnicity' and 'residual ethnicity' responses. The size of the confidence intervals shown in the charts depends on the degree of error in the population estimates. This is affected by various factors including the size of the population.

Figure 2: Annual rates of child and adolescent service use per 100,000 population aged 12 to 17 years in Aotearoa by ethnicity, 2012/13 to 2021/22

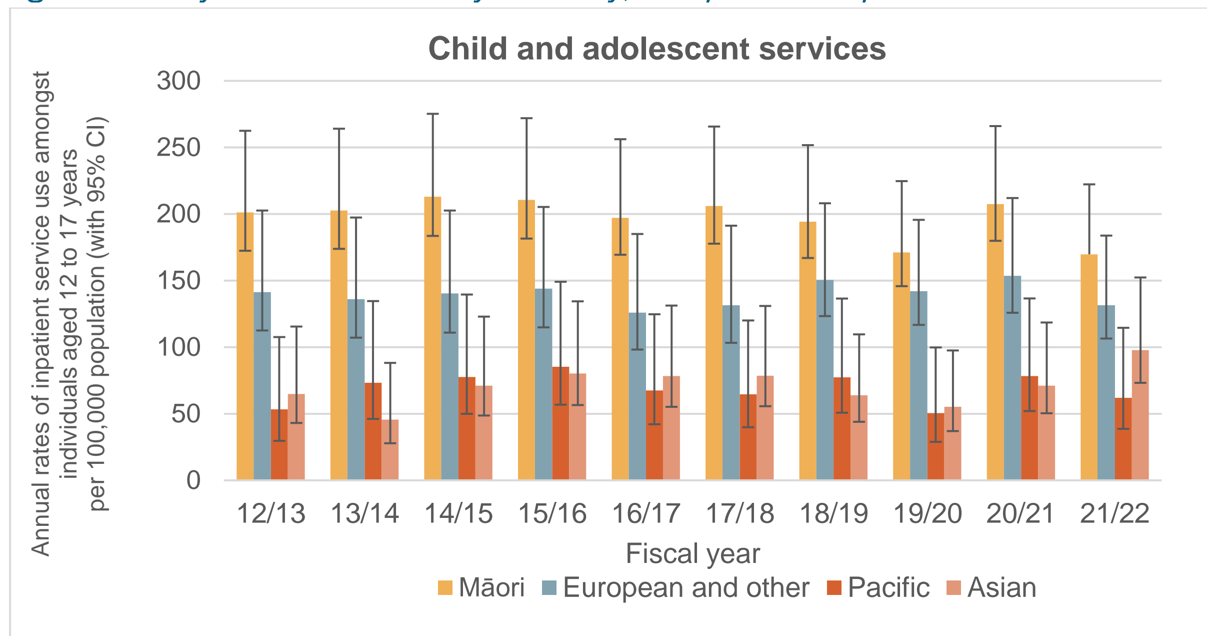
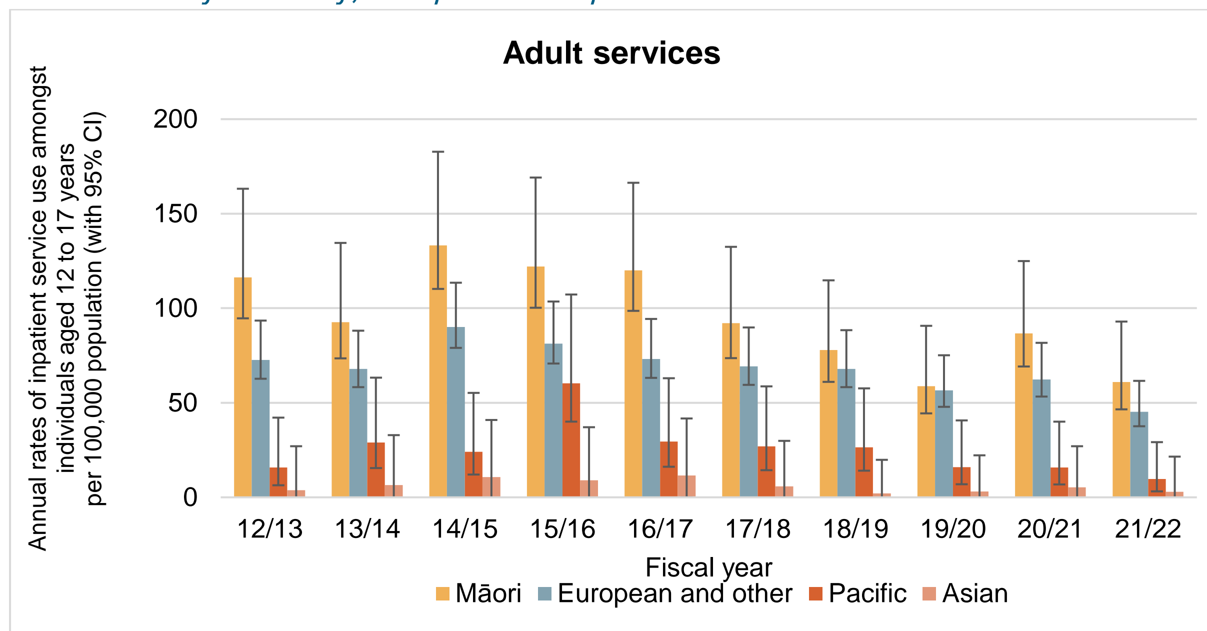


Figure 3: Annual rates of adult service use per 100,000 population aged 12 to 17 years in Aotearoa by ethnicity, 2012/13 to 2021/22



Rates of youth admissions for mental health care increase with age

The number of young people admitted to either child and adolescent or adult inpatient mental health services rises with age (see

Table 2). This same pattern holds for annual rates of all service use (adult, and child and adolescent combined) by age per 100,000 population (not shown).

Table 2: Number of young people admitted to either child and adolescent or adult inpatient mental health services, 2012/13 to 2021/22

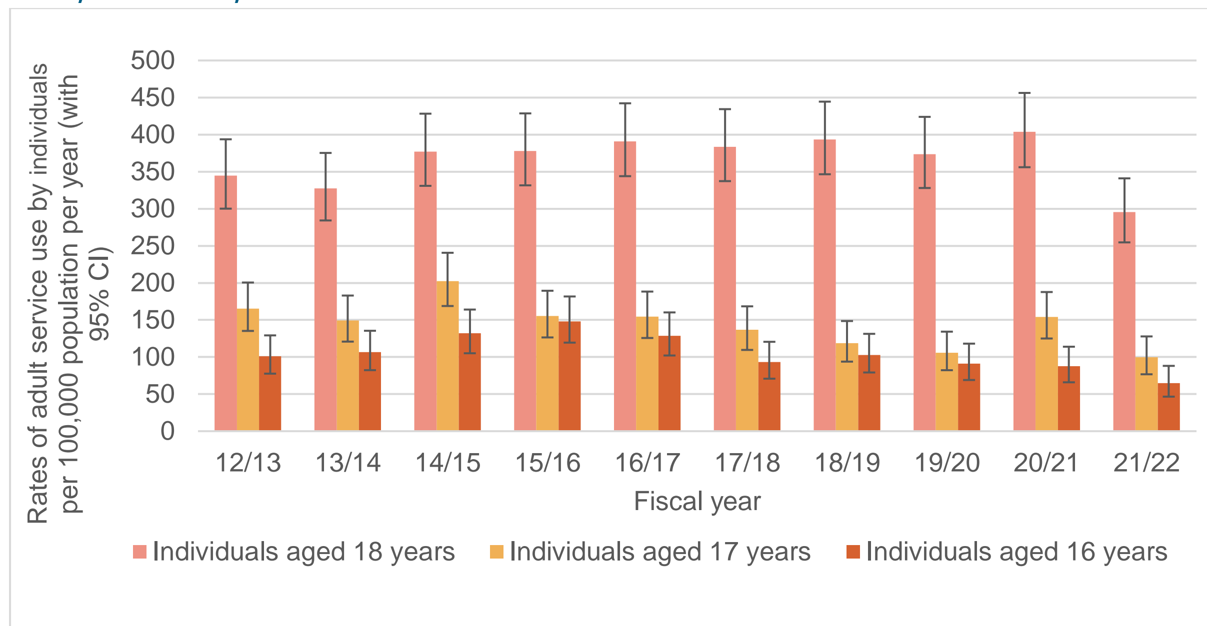
	Age (years)						
Year	12	13	14	15	16	17	Total
2012/13	12	43	97	176	211	234	773
2013/14	10	33	92	169	201	216	721
2014/15	14	49	97	153	217	295	825
2015/16	12	47	106	158	248	266	837
2016/17	16	42	87	160	204	239	748
2017/18	14	53	95	152	193	240	747
2018/19	17	35	84	150	217	245	748
2019/20	16	45	67	125	185	243	681
2020/21	19	62	100	155	196	254	786
2021/22	16	33	101	118	188	206	662

Figure 4 shows that the annual rates of admission to adult services among 18-year-olds are substantially higher than for 17-year-olds. Across the decade from 2012/13 to 2021/22, the average rate of adult service use for 17-year-olds was 61 per cent lower and for 16-year-olds was 71 per cent lower than for 18-year-olds.

Overall, 92 per cent of young people aged 18 years admitted over 2012/13 to 2021/22 went into adult services. The significantly higher likelihood of an 18-year-old being placed in adult services is notable, given that child and adolescent mental health services often include 18-year-olds. These data also stand in contrast to the feedback from young people that they are not ready at this age to transition to adult services.

In this report we have not been able to explore the factors that influence whether an 18-year-old is admitted to an adult service. Further analysis of this topic could include, for example, looking at the difference between those who had contact with services prior to being 18 years old, and those who had first contact at 18 years old, and seeing the extent to which this affects the likelihood of them being admitted to a child and adolescent service.

Figure 4: Annual rates of adult inpatient mental health service use per 100,000 population aged 16 to 18 years in Aotearoa, by age of individual at admission, 2012/13 to 2021/22

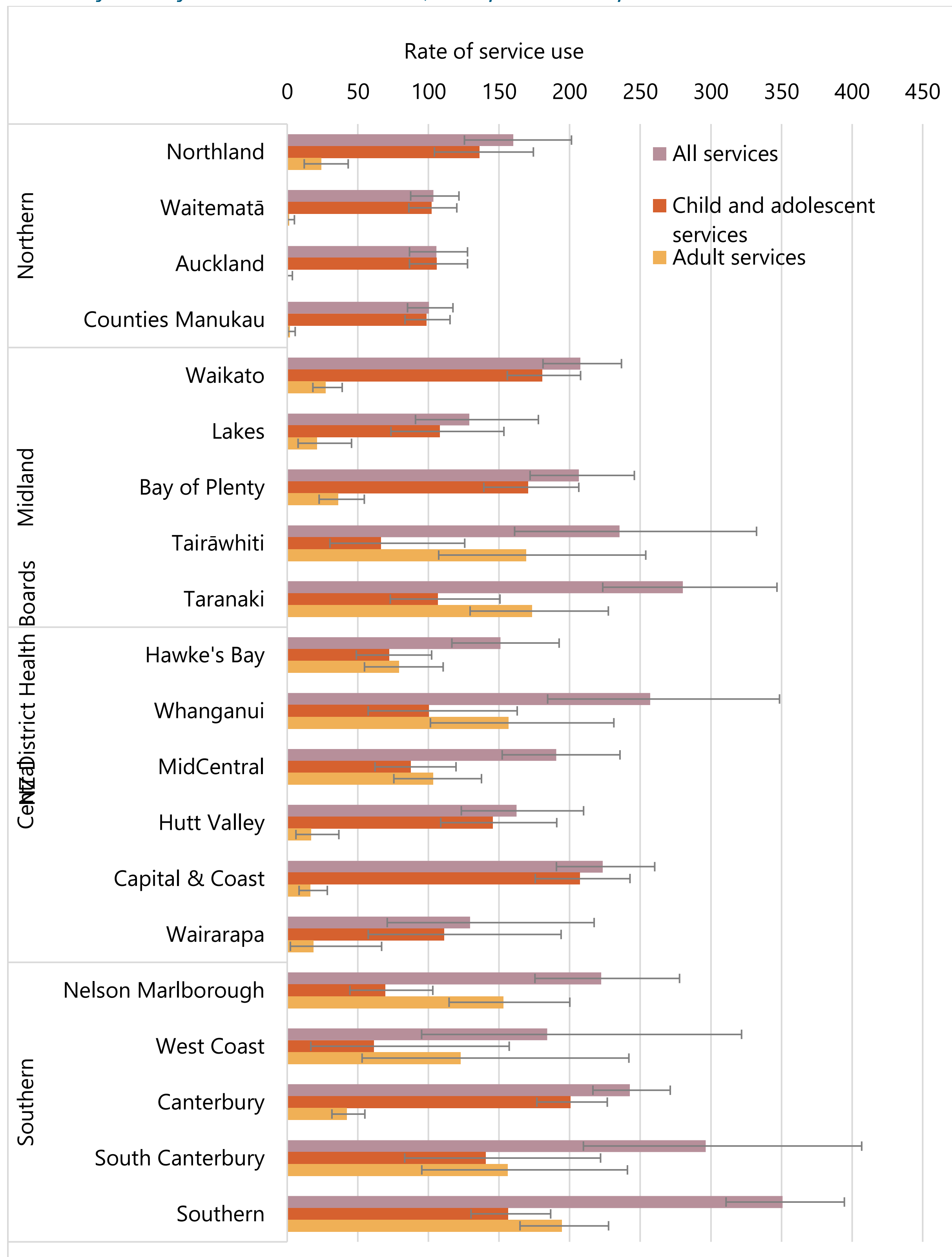


Rates vary between districts

Figure 5 shows the average annual rate of service use by (former) district health board areas over the period 2019/20 to 2021/22. Please consider these data as indicative only because the confidence intervals for some areas are large.

Very broadly, rates of young people admitted to adult services are generally lower in those areas with specialist inpatient mental health services for children and adolescents (Tāmaki Makaurau (Auckland), Te Whanganui-a-Tara (Wellington), and Ōtautahi (Christchurch)). However, this general pattern has some inconsistencies. For example, Canterbury District Health Board has higher rates of users of adult services than several district health boards that are not close to specialist services for young people. Figure 5 also shows that the three district health boards in the greater Auckland area had very low rates of adult inpatient service use, but also relatively low rates of child and adolescent inpatient service use. Further exploration of this topic could include analysis of access to youth crisis respite options across New Zealand.

Figure 5: Average annual rate of inpatient service use per 100,000 population aged 12 to 17 years by district health board, 2019/20 to 2021/22



Ngā mea me whakarerekē | What needs to change

We welcome the reduction in admissions of young people to adult inpatient mental health services that has occurred over the past decade. However, over 150 young people each year are still admitted to adult units. Through feedback, we have heard clearly that this practice is detrimental to the wellbeing of young people, whānau, and families—it is causing harm and reducing hope.

We recognise the tensions around configuration of specialist inpatient mental health service capacity for children and adolescents in Aotearoa. However, we agree with the New Zealand Children's Commissioner that operational and geographic considerations are not an excuse. We are 'making do' with an unacceptable solution for young people most in need of developmentally appropriate and effective support at incredibly difficult times in their lives.

In relation to rangatahi Māori, Te Tiriti o Waitangi places a clear obligation on the Crown to commit to achieving equitable health outcomes for Māori. This obligation includes ensuring that health and disability services are provided in culturally appropriate ways that recognise and support the expression of hauora Māori models of care (Ministry of Health, 2020). This is an important issue and we need to do better.

The feedback from young people as well as whānau and family makes it clear that the answer to this issue lies not within inpatient mental health services, but in improved access to a wider range of acute options to address the needs of young people experiencing acute distress. This thinking aligns with preliminary findings from work we have under way to better understand the community, residential, and inpatient services available in Aotearoa for people experiencing acute mental distress. We have found that few existing community acute services are tailored for young people.

Further investigation and analysis are required

We recognise that using adult mental health facilities for young people is a complex issue. In this brief report, we have examined the extent of this practice and current trends, and reflected on perspectives we have gained from discussions with young people as well as whānau and family. Further investigation and analysis are called for.[15] For example, it would be useful to explore the lengths of stay of those who may

[15] Note that Directors of Area Mental Health Services are required to report the reasons for age-mixing and rationale for 'best interests' in their quarterly reports to Manatū Hauora | the Ministry of Health. However, reporting quality varies.

have been admitted to adult services and then transferred to child and adolescent services. We also need to understand the reasons for the practice of admitting young people to adult mental health services, including the factors that influence any over-representation of rangatahi Māori.

Reduce the number of young people admitted to adult inpatient units to zero

Young people experiencing acute distress must not be admitted to adult services. This practice may be harmful and does not uphold young people's rights or mana.

To reduce youth admissions to adult services to zero, we need committed leadership and a detailed action plan. The Government should consider the following as part of that plan.

- Conduct a thorough investigation of the practice of using adult mental health services for rangatahi Māori and young people, including the reasons why this occurs.
- Develop youth-specific acute options within communities to address the needs of young people experiencing acute distress. Options should include residential alternatives to hospital-based inpatient mental health care and short-term respite care.
- Develop kaupapa Māori services as part of the network of acute options for rangatahi Māori.

We will monitor progress that the Government, commissioners, and services make in addressing our call to action detailed above.

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Āpitihanga tuatahi | Appendix one

Methods for quantitative analysis

Aim

The objective of analysis was to describe the use of acute inpatient mental health services[16] for young people aged 12 to 17 years, and for those aged 18 years. The focus was to compare admission of young people to services for adults versus specialist services for children and adolescents.[17]

Data sources

Te Whatu Ora provided an extract from the Programme for the Integration of Mental Health Data (PRIMHD), the national collection of specialist mental health service activity and outcomes data.[18] We looked at records for the decade between 1 July 2012 to 30 June 2022.

Records were linked to the NZ National Health Index (NHI) system to obtain demographic information by encrypted NHI, ensuring all service users remained anonymous.

We used census data for the NZ population by age and ethnic group (total response) to estimate denominators to calculate annual rates of intervention per 100,000 population aged 12 to 17 years.

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[16] DHB hospital-based inpatient MH services were defined using the following PRIMHD fields and codes:

- ACTIVITY_SETTING_CODE = “IP” (services provided in a hospital setting while the tangata whaiora/consumer is an inpatient for mental health and/or addiction)
- ACTIVITY_TYPE_CODE = T02 (MH intensive care or equivalent); T03 (MH acute IP or equivalent); and T04 (MH sub-acute or equivalent)
- ORGANISATION_TYPE = “District Health Board (DHB)”

[17] Type of service was defined using the ‘Team Target Population’ PRIMHD field, that categorises the age group or target population of the healthcare team providing service, with codes selected as follows:

- Specialist child and adolescent mental health services: 3 (Infant, Child and Youth Population); 4 (Child and Youth Population) and 5 (Infant and Child Population)
- Adult mental health services: 1 (Older People Population); 2 (Adult Population); and 6 (Mixed Population)

[18] PRIMHD is a living data collection, which continues to be revised and updated as data reporting processes are improved. For this reason, previously published data may be liable to amendments.

Approach

We followed Ministry of Health guidance relating to use of PRIMHD to support our analysis, in particular the PRIMHD Code Set Standard HISO 10023.3:2017 (Health Information Standards Organisation and Ministry of Health, 2019).[19]

Analysis focused on individual people in Aotearoa aged 12 to 17 years, admitted for a minimum of one night per fiscal year to either a specialist child adolescent or an adult district health board inpatient mental health service.

Counts of individuals admitted to mental health services were developed for each fiscal year, with total counts for the decade determined as the sum of counts for each of the 10-years. An individual was counted once during any fiscal year within which they were admitted to either an adult or a child and adolescent service. As such, the same individual may feature once per annum within both types of service and may feature within counts for more than one fiscal year.

We explored variation in access by sub-groups within the admitted population by:

- age – determined on the date of first inpatient admission (to either an adult or child/adolescent service) per fiscal year
- ethnicity – using total ethnicity responses categorised as: Māori, Pacific, Asian and European/other (including 'other ethnicity' and 'residual ethnicity' responses).[20]

R 4.1.0 (R Institute, Vienna, Austria) was used for statistical analysis of the PRIMHD extract to support comparison of estimates between different population groups. A Poisson framework was applied using the pois.exact R function from the epitools package. This function returns upper and lower 95% confidence intervals for a rate of count events (number of people admitted) that occur for a given population, assuming a poisson distribution, to determine annual rates of service use amongst those aged 12 to 17 years per 100,000 NZ population with exact 95% confidence intervals.[21]

To determine whether individuals were admitted voluntarily or under the Mental Health (Compulsory Assessment and Treatment) Act 1992, we matched legal status records by encrypted NHI where the legal status code represented either an inpatient Compulsory Treatment Order (CTO) (given under Sections 30 or 31 of the MH Act) or a community CTO where the service user is admitted to an inpatient service for an episode up to 14 days (under Section 29). Individuals with an 'open' CTO within any

[19] PRIMHD Code Set Standard HISO 10023.3:2017

[20] Note: There were no records for this cohort within specified timeframes with 'Middle Eastern, Latin American and African' responses.

[21] See Simple method to calculate the confidence interval of a standardized mortality ratio (SMR) (Ulm, 1990).

fiscal year were classified as being subject to 'involuntary' admission during that time period.

Measures

Numbers of people were reported with actual numbers and annual averages for the three-year period from 2019/20 to 2021/22 to reflect the most recent activity levels.

Analysis of the relative differences between groups (e.g., for Māori relative to European/other) and trends (reported as percentage changes over the 10-year period) were calculated from annual rates of service use amongst those aged 12 to 17 years per 100,000 NZ population across the decade.

Project design and methods for qualitative analysis

We sought the views of people with lived experience, including tāngata whaiora Māori, and whānau and family to hear their views on the potential impacts (both positive and negative) of young people being admitted to adult mental health services (adult services), and what they believe needs to happen to meet their expectations. To do this, we held focus groups and had an online form.

Recruiting people to focus groups

Emails were sent to everyone in our lived experience database[22] inviting people to participate in a focus group to share their views on the admission of young people to adult inpatient mental health services. The email contained information about the scope of the focus group and who we were particularly interested in hearing from, such as rangatahi and young people who have personal experience of distress and / or using inpatient mental health services and youth consumer advisors / youth lived experience advocates who know what young people want from mental health services.

For those interested in participating, we asked people to choose from a lived experience focus group, a whānau and family focus group, or a Māori focus group that would be facilitated by Māori staff. We asked people to forward the invitation onto their networks so that we could reach people we hadn't connected with before.

[22] The lived experience database consists of 250 people who have lived experience of distress, alcohol or other drug harm, gambling harm, or addiction. Some people in this database also work within the mental health and addiction sector in various roles, including within the CPSLE workforce across the motu.

Collecting the voices of tāngata whaiora, family, and whānau

Focus groups

We held three focus groups including:[23]

1. one lived experience focus group attended by three young people, including those who had their own lived experience of being admitted to an adult inpatient mental health service as a young person
2. one whānau and family lived experience focus group attended by three people, one of whom was Māori. People attending this focus group either had had loved ones who had admitted to an adult service as a young person or knew someone who had this experience
3. one focus group with the National Youth Consumer Advisor Network (NYCAN)[24] attended by seven people.

Each focus group was facilitated by two people, one of whom was a lived experience advisor.

Online form

A link to an online form was sent to people who couldn't attend a focus group, but still wanted to share their thoughts with us, as well as people who had registered for a focus group but were unable to attend. This includes everyone who registered for the Māori focus group. For consistency, the questions in the online form were the same as those asked during the focus group. In total, we received five submissions on the online form. Four of these respondents identified as Māori, including rangatahi Māori.

Focus group questions

We asked three questions, which were sent out to participants in advance. These were:[25]

1. What do you view as potential issues and challenges with the admission of young people to acute adult mental health services?

2. What are the potential advantages to the admission of young people to acute adult mental health services?

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[23] While we did organise a Māori focus group, despite early interest, it was not able to go ahead due to a lack of attendance.

[24] NYCAN is a roopū consisting of young people working in Youth Consumer Advisor roles in non-government organisations as well as Te Whatu Ora child and adolescent mental health and addiction services across the motu. NYCAN advocates for Youth Consumer empowerment by contributing to positive, youth friendly transformation within services and strategy.

[25] We did not ask questions about people's experiences because we didn't feel focus groups were the best way for us to collect these stories safety.

3. In an ideal mental health system, how would services support young people in crisis (e.g., young people currently assessed as requiring inpatient admission)?

How we made sense of what people said

We took a teams-based approach to qualitative analysis. The team comprised te ao Māori perspectives, lived experience perspectives, and people with qualitative research experience.

Data from the focus groups[26] and the online forms were analysed using a reflexive thematic analysis approach (Braun & Clarke, 2022). Reflexive thematic analysis offered flexible guidelines, rather than a set of rules to follow, and provided a rigorous approach to narrow down what was shared in the focus groups to the key themes identified in this report.

To make sense of our data, we individually familiarised ourselves with the focus groups by watching and listening to the recordings before coding[27] extracts in transcripts relevant to the report's scope. In multiple team sessions, we combined our coded data and then sorted these into groups by searching for patterns of meaning. Together, we also generated initial themes that were shared across the three focus groups and these themes were refined in our report writing process.

[26] By data, we are referring to the recordings of each focus group and their associated transcripts. Each focus group was recorded with the consent of every participant.
[27] By codes, we are referring to labels that were a couple of words or short phases that described what a particular passage or sentence was about.

Te Hiringa Mahara
Mental Health and Wellbeing Commission

Te Kāwanatanga o Aotearoa
New Zealand Government