17

There is a clear link between homelessness and a series of health issues. Mental health issues and drug and alcohol addictions and substance abuse are experienced by a significant group of young people in the homeless population, and often co-occur. Family breakdown is often accompanied by trauma, grief and a disturbed emotional state. Being homeless involves a lifestyle with many health risks. Youth-specific health services, many designed under the Innovative Health Services for Homeless Young People (IHSHY) program, have been demonstrably successful. The gaps in drug and alcohol and mental health services for young people particularly affect homeless youth, where obtaining stable accommodation is necessary for progress in any longer-term health treatments. Current systems have difficulty in handling young people with high and complex needs and co-morbidity. Regional, rural and remote health care problems are due to sparse populations, large distances and the higher costs of providing services. The NYC recommends that the successes of the IHSHY be extended more broadly to achieve a rational national deployment of services tailored to the needs of homeless young people.

Chapter 17 | Health

The risks for these young women are duplicated for their unborn children. Exposed to the elements, stress, and poor nutrition, they are prone to contracting communicable diseases – from colds and gastritis to influenza. Infants born into the disadvantage being experienced by homeless young women are particularly vulnerable. We all recognise just how tiring pregnancy can be, and the need for healthy living throughout pregnancy. What must it be to be alone and homeless facing the prospect of birth?[1]

Introduction

17.1 Young people, workers and services offered the Inquiry an intimate and detailed view of the health of young homeless people and of the systems available to respond to young peoples' needs.

17.2 The accounts given to the NYC of young people's struggles with addiction and mental illness were disturbing. The way these issues affect the lives of young people has been examined in more detail in Chapter 10 Mental Health and in Chapter 11 Alcohol and other Drugs. In this chapter, mental health and substance abuse are discussed in terms of the evidence about the availability, adequacy, appropriateness and timeliness of health services to support young homeless and at-risk people with health problems.

17.3 Witnesses to the Inquiry also provided evidence about the effect of trauma and grief in the lives of many young homeless people and how there can be a continuing effect on emotionality.[2] Also, some testimony on the effect of traumas has been provided in the earlier chapters, which dealt with the causes and the experience of homelessness. The Inquiry heard that experiences such as losing family members, parental addiction and parental mental illness, multiple failed out of home placements, rejection, abuse at home and abuse once homeless can have a devastating impact on young people. In this chapter, those emotional issues are cast in terms of young people's need for counselling

and other support to achieve a stable emotional life and better mental health.

17.4 The Burdekin Report gathered evidence about the risks to life and general health experienced by young homeless people.[3] The evidence provided to this Inquiry confirms that those risks continue. Services and young homeless people presented accounts of malnutrition[4], dental problems[5], tissue injuries[6], sexually transmitted infections[7], disability[8], and debilitating conditions[9]. The Inquiry also heard a great deal of evidence about young pregnant women and young parents. Significantly, AIDS was not raised as a particular problem in this Inquiry, as might have been expected from some of the predictions aired in the Burdekin Report.[10]

Innovative Health Services for Homeless Youth

17.5 Brisbane Youth Service, on behalf of a group of Queensland services, highlighted the fact that the Burdekin Report[11] provided the first real recognition of the specific healthcare needs of young homeless people and resulted in the introduction in 1991 of the Innovative Health Services for Homeless Youth Program, or IHSHY, as a pilot program.[12] IHSHY was and is jointly funded by the Australian and state and territory governments and has the specific aim of improving health outcomes for homeless and at-risk 12 to 24 year-olds and their dependents.[13]

17.6 IHSHY funds a range of health services across Australia, a number of which provided evidence to the Inquiry about the work they do, the evolution of the program and the healthcare needs of at-risk and homeless young people.[14] A 2003 review of the program by Community Link Australia found that IHSHY services have a high impact in relation to the size of the program and the funds allocated to it.[15] That finding is consistent with the evidence submitted to the Inquiry.

17.7 The Child and Adolescent Health Service in the Western Australian Department of Health told the Inquiry that IHSHY services have been particularly successful in reaching marginalised young people, including Indigenous young people:

> *These clients typically have complex physical and mental health issues and related social issues. If they are not supported, these needs exacerbate leading to presentations at emergency departments and an increased burden on hospitals and other services.*[16]

17.8 Brisbane Youth Service also the emphasised vital importance of IHSHY:

> *[It] is inarguably one of the most significant and useful programs targeting young homeless people that continues to promote positive health outcomes and combat the negative environmental and behavioural determinants for young people and their dependents experiencing homelessness.*[17]

17.9 Currently, Australian Government funding is provided to the states and territories for the program on a matched basis.[18] The NSW Association for Adolescent Health, the peak body for the youth health sector in that state, told the Inquiry that the current funding received by NSW is insufficient, that some locations have no IHSHY services and that existing services have experienced an erosion in funding, with an impact

on staffing levels.[19] The Child and Adolescent Health Service in the Western Australian Department of Health advised the Inquiry that its state contributes extra funding to the program.[20] The Victorian Government expressed its concerns that the purchasing parity of the program has declined.[21]

Primary Health Services

17.10 The National Youth Commission received evidence that homeless young people experience a variety of health problems.

17.11 A nurse from the Young People's Health Service in Melbourne told the Inquiry about internal research that had identified the top five presenting problems for young homeless people using the service:

> *Sexual health and viruses and also soft tissue injury related to violence, which is quite common, unplanned pregnancy, mental health issues are quite high on the list and ever increasing, drug and alcohol ...*[22]

17.12 JIGSAW Young Person's Health Service in Geelong (Vic) told the Commission that young people are presenting to its GPs with Hepatitis C, sexual health issues, high numbers of pregnancies, smoking-related difficulties and, in about 60 per cent of cases, emotional problems.[23]

17.13 The Inquiry heard that locating bulk billing GPs who understand youth homelessness is very difficult. Attracting GPs and retaining them within youth health services is also a significant problem. The Young People's Health Service in Victoria, outlined some of the issues:

> *[A doctor] earned $50 an afternoon, working in Frontyard, hardly worth his while ...*[24]

17.14 The Inquiry was advised that young people have trouble accessing mainstream health services. In addition to the problem of GP remuneration mentioned by Frontyard, other witnesses advised the Inquiry that:

- lack of Medicare cards; [25]
- concerns about confidentiality; [26]
- consent issues; [27]
- lack of housing; [28]
- poverty; [29]
- lack of transport; [30]
- lack of doctors in general and bulk-billing doctors in particular; [31]
- fear of stigma; [32]
- needs of teens to have support with navigating the system; [33]
- problems coping with appointment based systems; [34]
- can all contribute to making mainstream general practices and other mainstream healthcare services difficult for young homeless and at-risk people to use.

17.15 Non-mainstream health services have developed in response to the needs of homeless and at-risk young people. Jigsaw Young Person's Health Service in Geelong (Vic) is one example. It incorporates mental health services, drug and alcohol services, sexual health services and links with youth-friendly GPs and is located in the Corio shopping centre:

> *The idea being that I guess young people do tend to congregate in shopping centres and it had ease of access and ... public transport and that seems to be working reasonably well.*[35]

17.16 The Street Doctor service in Perth offers a different model. It is run by a division of general practice, but provides GP, nursing and outreach services from a mobile van, visiting high-risk schools and locations where young homeless people frequent.36 Another interesting example is the Quarry Street General Practice, which is also in Western Australia. Quarry Street is a free general practice for young people, where there is no requirement for a Medicare card.[37]

17.17 The NSW Association for Adolescent Heath advised the Inquiry about a decline in public dental services, noting that few youth health services offer dental health treatment. The Association told the Inquiry that there are no incentives for private dental practices to provide dental care for marginalised people:

> *The links between oral and general health are well known. Given that homeless and marginalised young people often have poor oral health, it is important that potential barriers to receiving treatment are minimised wherever possible. Poor oral health exacerbates the disadvantage homeless young people are already experiencing, limiting their social networks due to shame and embarrassment, damaging their self-esteem and limiting their ability to secure meaningful employment.*[38]

Pregnancy and parenting

17.18 The National Youth Commission was advised about the difficult circumstances faced by young homeless women who are pregnant and young parents, and of the increasingly high numbers of young parents that certain services are seeing.[39]

17.19 Witnesses spoke of young pregnant women suffering quite shocking levels of abuse from members of the public, which suggests that services which require them to mix with older pregnant women and older mums are unlikely to be perceived as friendly, welcoming environments.[40] In Perth, the Adolescent Mothers Support Service spoke of the reality of delivering health services to pregnant teenagers and the importance of being able to offer outreach services:

> *... adolescents being adolescents their problems are manifold and they are frequent poor attenders and they are also late attenders to healthcare. They don't attend GPs and they don't actually find out that they are pregnant or actually say they are pregnant until very late sometimes. I had two girls who had Down Syndrome babies last year, because they didn't present until they were 36 weeks gestation. Now, there is then nothing to do for them apart from support them and then link them into some very high cost services for a long, long time and that's their first baby.*[41]

This single-worker service advised the Inquiry of the high level of demand for outreach antenatal care. The Inquiry was concerned about sustainability in terms of human resources. The need being addressed is demonstrable but the funding does not appear to be established in a recurrent form.

17.20 Health Connections for Youth(HCY) a non-clinical youth health service in Darwin told the Inquiry that young parents now comprise 60 per cent of HCY's client group:

> *As a result of us having such a large majority of young people with pregnancy and parenting issues, we developed a program or a project that was to provide antenatal education and support to young parents, and this was a really successful project that ceased in 2006, and it was Commonwealth funded. It was through the Stronger Families and Communities Local Answers funding. We actually provided support and education to over 110 young parents in that two-year period. ... Seventy-four percent of our parents who went through those programs took on breast feeding, which I am informed by midwives throughout the health system is huge.*[42]

This program was not refunded by the Commonwealth Government.

17.21 The needs of young Indigenous and refugee women were also highlighted. The Inquiry heard that pregnancy numbers are increasing within these groups and that there are opportunities to provide pregnancy and parenting information provided adequate funding is forthcoming.[43]

Behavioural support services

17.22 The Inquiry was told that young homeless disabled people who are not considered sufficiently disabled by disability services miss out on much-needed help, including behavioural support,[44] in spite of the reality that they often have lifelong support needs.[45]

17.23 In terms of behavioural support services, Shopfront Youth Legal Centre in NSW compared the contrasting outcomes for two individuals with broadly similar issues, 'Jack' and 'Simon'. Jack had a mild intellectual disability and had experienced abuse while growing up:

> *With the involvement of some good youth services, Jack managed to attain a degree of stability, including housing. .... However, Jack still has unresolved issues, which need to be addressed through counselling and cognitive behavioural therapy. One of the most pressing issues is what is commonly referred to as "anger management" - in particular, learning to manage his responses to stressful situations such as police contact.*[46]

However, Shopfront was not able to satisfy the Department of Ageing, Disability and Home Care that Jack had a developmental disability, and no other suitable service could be found to fill the gap.

17.24 Simon, on the other hand, was accepted into the intensive program:

Simon is 19 and has a moderate intellectual disability. His parents had very high expectations of him and refused to accept that he had a disability. This eventually led to a breakdown in their relationship and Simon went to a refuge when he was about 16. Since then, Simon has come to the attention of the police a few times, mainly for being involved in fights, once for being a passenger in a stolen car and once for being in possession of a weapon. On most of these occasions it appears that he was "led astray" by older and more sophisticated friends. Fortunately Simon has received excellent support from both government and non-government services. He has stable, semi-independent accommodation through the Salvation Army. He has received case management from The Crossing, an intensive case management and support service run by Mission Australia. Significantly, he was successfully referred to DADHC, where he has a caseworker and has also received assistance from the Behaviour Intervention Service.[47]

In terms of the practicalities of their lives, Jack and Simon both have serious issues to deal with. But in Simon's case a range of support services, including, importantly, supported accommodation, is available, while Jack has been unable to access the same level of services. There may be issues in the way the Department makes assessments or it may be a case of serendipitous difference. The extent to which these young men have been able to access services seems to be the deciding factor in what has changed for them.

Drug and alcohol services

17.25 The Inquiry heard from workers across the homelessness sector that the number of young people with illegal and legal drug abuse seems to be increasing.[48] Witnesses presented evidence about some excellent and innovative drug and alcohol services, but many spoke and wrote of service gaps across Australia. Unsurprisingly and somewhat understandably, many rural and remote communities do not have drug and alcohol services; more worrying, and less understandable were the service gaps in regional centres and smaller cities which mean that for young people access is highly problematic and dislocating.

17.26 The director of one of the youth peak bodies in Queensland spoke of having only four detoxification beds for youth in that state and of the measures resorted to by workers:

What a lot of youth workers are doing in the suburbs is attempting detoxing and into some sort of quite dangerous stuff but on their own backs. So things like allowing people to sleep in the youth worker's car or taking them out of suburbs, it's a common practice [49]

17.27 In Darwin, the Drug and Alcohol Intensive Support for Youth, DAISY, described not having a residential rehabilitation service for young people and spoke of referring young people to adult residential rehabilitation services locally, and on several occasions sending young people to Melbourne. Melbourne was chosen because it was the only place where DAISY could locate a service that was willing to accept referrals from the Northern Territory:

It took a bit of doing, like they said, "No, no it's too difficult. What about repatriation should it not work out? What about family visits and things like that?" There were a lot of teleconferences and stuff like that before we were able to refer our first young person.[50]

17.28 In Launceston, a crisis accommodation service told the Inquiry that there are no appropriate detoxification or rehabilitation services for the young people they work with, not even a suitable home detoxification service. When asked by one of the Commissioners about how they managed that service gap, one of the workers exclaimed:

Ah, harm minimisation. That is really about all we can do.[51]

17.29 Where mainstream drug and alcohol services exist in a locality, young homeless people often have no access to those services. The Inquiry was told that in Darwin, 18 and 19 year-olds were being turned away from adult services for being too young.[52] Where services existed and were theoretically willing to accept homeless young people, service practices sometimes presented unreasonable barriers. The Shopfront Youth Legal Centre in Sydney told the Inquiry:

Residential detoxification services are very difficult to get into, waiting lists are long and prospective applicants are often required to telephone frequently (sometimes daily) to maintain their place on their waiting list. … many detox services are area-based and are not available to people who cannot demonstrate that they live in a particular area. Long-term rehabilitation services are similarly difficult to access, particularly as many require a period of detox first.[53]

17.30 The Youth Drug and Alcohol Service (Sydney West Area Health Services) offers a hospital-based, inpatient, statewide withdrawal service for 12-20 year-olds:

… we have actually admitted people to hospital, much to the displeasure of the medical officers, who haven't needed to be admitted to hospital because we've had nowhere else to manage them at all, and it's impossible for them to address their drug use when they're on the street.[54]

17.31 Where accessible residential adolescent specific services exist, the Inquiry heard that they are in great demand.[55]

17.32 Homeless and at-risk young people need a range of timely drug and alcohol service options, which offer incremental engagement with trusted service providers. Without exception, the Inquiry was advised that young people up to the age of 25 need adolescent specific services. The minimum recommended service pathway seemed to include socially inclusive harm minimisation programs, residential detoxification programs, detoxification respite, residential rehabilitation, and post-rehabilitation supported housing options. What was not raised by witnesses, was early intervention for at-risk young people in terms of the support needs of non-drug-using family members, and whether such interventions could act to reduce family breakdown.

17.33 The Inquiry was pleased to hear that when workers have the resources to persist with young people there are some extraordinary success stories. The Youth Substance Abuse Service in Geelong (Victoria) provided an example of a young girl with whom it had worked:

... she was on the street and had been under the bridges, you know, pulling her out from

under the bridge chroming last year. Every day we tried to get her home and no one knew what was going on, and we told her about YSAS [Youth Substance Abuse Service] and after a while, she decided that yes, she did have a drug and alcohol problem. She went into YSAS, and from there they referred her on and decided she needed more.

... she was under 16 so there was nowhere in Geelong so it was rehab. She came home from that and battled with her issues and continued with the support, and the long and short of it is that she came out about November I think last year. It was a real battle to hold her through Christmas. We did. YSAS offered her respite again to go back, because she was really battling but since then, in the meantime, she's got herself a … job. She had to fight like hell to get back to school because the school did not want to know her, I promise you. Went to the Education Department and she's now been back for six weeks, and one of the main head people there who absolutely refused to have her on the place, is now saying it's a pleasure to have her. She is doing Year 8, Year 9. She's doing physics, chem, psychology, maths, English and graphics and starring on every single one.[56]

Mental health services

17.34 Witnesses to the Inquiry spoke and wrote about young people who are homeless and at risk of homelessness needing a range of mental health service responses. The range included services to meet the emotional needs of a population that has often experienced significant trauma[57], services for young people with specific mental illnesses, services for those who have serious mental health problems that are not easy to define or diagnose; and services for young people with a number of concurrent problems.

17.35 Iona House, a young women's shelter in Townsville, spoke to the Inquiry about levels of self-harming behaviours in the young women the shelter supports:

Seventy-five per cent of our young women who come to the shelters are self-harmers. We put strategies in place to help them work through that, but it would be really good to see some service where they can actually go and talk about those issues.[58]

17.36 While the recent addition of new Medicare items for psychological and allied health services would, at first glance, seem to offer some help for homeless young people, initial indications are that as a general population young people under 25 have not been taking up these referral opportunities.[59] As discussed earlier in this chapter, there are a variety of reasons why homeless and at-risk young people have particular difficulties accessing GPs and they may therefore face additional barriers to benefiting from these new referral opportunities.

17.37 For many young homeless people, the trauma they have experienced or the poor state of their mental health means that they have service needs beyond the general practice level.

17.38 In many ways the evidence about the situation for young homeless and at-risk people with mental health problems closely paralleled, and intersected with, the evidence about the situation for those with substance abuse problems. Witnesses provided some

examples of exemplary services, but the weight of evidence presented dealt with service gaps and the inappropriateness of mainstream services for young homeless people with mental health problems.[60]

17.39 What distinguished the evidence about mental health services was the level of creative thinking that appears to have taken place in the field, especially outside the major cities. Some of this appears to have arisen organically as members of communities get together to find local solutions to their issues.[61] On the other hand some of it seemed to have been stimulated by the framework and funds provided under the new National Youth Mental Health Foundation, Headspace. It is far too early to make any statement about the potential effectiveness of Headspace, other than to note the fact that its existence has stimulated some new combinations of community consortia on the ground.[62]

17.40 Headspace made a submission to the Inquiry containing a number of criticisms of the current healthcare system's response to the mental health needs of at-risk and homeless young people. In particular, Headspace drew the Inquiry's attention to the problem of the division of services according to age, which sees 18 to 25 year-olds serviced by the Adult Mental Health Services instead of the Child and Adolescent Mental Health Services, and questioned the accessibility, appropriateness and perceived friendliness of the current system.[63]

17.41 The Inquiry heard from other witnesses about a lack of adolescent-specific in-patient crisis services and residential rehabilitation services. Where adolescent-specific mental health crisis services didn't exist, young people in crisis could find themselves in general wards with adults.[64] Southern Youth and Family Services in Wollongong told the Commission that:

> *…there are almost no residential youth mental health services, and certainly none in our area.*[65]

17.42 In Townsville, Child and Youth Mental Health Services told the Inquiry that without adolescent in-patient facilities young people have to be placed in the adult psychiatric ward or sent to Brisbane:

> *We have to send them all down to South-East Queensland which as you can imagine is difficult and challenging for these young people because they have then disconnected from family and from their community.*[66]

17.43 Campbell Page, which runs a broad range of youth services on the South-West Coast of NSW, faced a similar problem:

> *There is one crisis bed in the Eurobodalla Shire for people - and that's including adults - who have mental health services crisis issues. That's it. The closest psychiatric hospital is Goulburn and that's a very scary place for most of our young people to know they're going to ...*[67]

17.44 There also appeared to be a problem with homeless young people accessing mainstream adolescent specific mental health services. A SAAP worker in Bondi in

NSW, located near the largest adolescent mental health service in NSW complained that:

> *… the best response we get from mental health services to our adolescent residents who are in need is when there's been a crisis that has seen them delivered to the emergency ward by an ambulance. Then there will be a response.*[68]

17.45 In Tasmania, the Salvation Army had no issue with the quality of adolescent mental health services, but had trouble accessing them:

> *One of the issues we found particularly in our women's services is the waiting list, the long waiting list to access some of those services, and the protocols around, often not having a parent assigned or a guardian assigned to actually take on some of that role that service might be prepared to do.*[69]

17.46 The witness went on to speak of waiting periods of up to six months. Complaints about waiting lists were echoed in Geelong in Victoria.70 In Adelaide, the Inquiry was told about six to eight week waits even for young people with suicidal tendencies.[71]

17.47 The Inquiry was told about young people reaching out to mental health professionals for help. While mental health professionals often seemed well intentioned, they did not always appear to appreciate the complexity of the lives of the young people who presented. YWCA Darwin spoke about mental health professionals consistently underestimating a young woman's mental health problems:

> *Recently, we have had ... an expectant mum who has tried to access mental services. The young [woman] had issues related to self-harm and was also threatening to harm others. She was severely depressed, and had previously sought mental health services in another state prior to coming back to Darwin. So, basically, [she] tried to access mental health services, went in, had an assessment and the assessment didn't go well, they said, "No, you're fine. You don't need to go on medication," and, you know, "We need to talk. We're not going to prescribe some medication", even though she needed that, as she may have harmed herself or others. So basically, [we] contacted on-call after hours, and didn't receive any support from the on-call team. Ended up going into accident and emergency department at the hospital. Still did not get the appropriate service that she wanted and left in tears, and there is a good side to this story. It was actually through a GP, through our system, we located a GP who was able to -- willing to prescribe some medication, some antidepressant medication, and she's doing well now and is very, very happy with the service that she got from the GP, and was really wanting to share her story today.*[72]

17.48 Where suitable, residential mental health services existed, the Inquiry heard that they do work effectively. Collins Place, a residential psychosocial rehabilitation service in Geelong (Victoria) described the nature of the service it provides:

> *We have capacity for ten, five dual occupancy cottages here in Geelong West. The age range is 16 to 24. The criteria for admission is a diagnosed mental illness, case management and live in the region obviously. The young people stay with us for up to two years and the purpose of the program is to support people through their wellness*

with the idea of living independently post discharge.[73]

Embracing complexity

17.49 Services and young people repeatedly drew the Inquiry's attention to the necessity of facing up to and embracing the complex needs of individuals and the extreme difficulty of doing so in a divisive health system, where one aspect of health need is treated in isolation from another. Witnesses used phrases to describe young people's complexities such as high and complex needs and talked, not incorrectly, of the prevalence of young people with co-morbidities and dual diagnoses. The Inquiry was told that young people are being denied healthcare services because they have more than one health problem.

17.50 In Hobart the Coordinator of Annie Kenney, a young women's refuge, voiced her frustration about dealing with single-focused healthcare services:

... if you tell an agency this client has drug and alcohol issues, they'll want to know about mental health, and then vice versa, so it's sort of fighting from agency to agency to get that help …[74]

17.51 The Youth Substance Abuse Service in Geelong (Vic) spoke to the Inquiry about the complex needs of one young person who had been supported by the service. This young man was homeless, has drug problems, had a history of family trauma and out of home placement, suffers from extreme anxiety, and has a congenital spinal condition. YSAS talked about the challenge of finding the best approach when single-issue interventions fail to cope with complexity:

That [case] is not uncommon, that is a really common sort of combination of factors. So that's the way we certainly look at it at YSAS from a social model and health perspective that takes into account lots of issues that are affecting young people and how they all combine through the young person's development to bring it to this place.[75]

17.52 The Inquiry also received evidence that young people at the other end of the spectrum were missing out on services. While a young person's mental health problems might be serious enough to affect their ability to maintain accommodation, or even be accepted into a youth refuge, it may not be considered sufficiently serious to attract the help they need. One health worker told the Commission that:

… a youngster might have a serious kind of functional problem, but if they don't have a ... disorder, schizophrenia or bipolar disorder, or be [in a] seriously life threatening situation, [but] they've got some sort of personality disorder, then they don't attract case management.[76]

17.53 Mission Australia spoke of the need to deal pro-actively with complexity:

What works is actually understanding and being prepared to deal with the complexity of issues that impact on young people who are homeless or young people generally. So the education at the same time dealing with the housing, the health, the family, the drug

and alcohol and mental health, particularly relevant that they are done together for homeless young people. The best practice internationally would say that intensive long-term support is required that is specifically targeted for young people.[77]

17.54 Mission Australia identified for the Inquiry several youth-based initiatives as examples of good practice. The organisation's own Triple Care Farm in New South Wales was nominated:

> *Triple Care Farm is an holistic, residential alcohol and other drugs rehabilitation program for young people aged between 16 and 24 years. This specialist three-month program assists young people to address complex alcohol and other drug issues, homelessness, mental illness, abuse and trauma, in a rural setting in the NSW Southern Highlands. The program offers individual and group counselling, case management support, accredited and non-accredited vocational training, music, arts and media programs and trade programs. The program also offers six months of aftercare support as programs participants re-enter the community. This after-care is a critical factor in the success of the program.*[78]

17.55 The Inquiry was also told about a number of services emerging from the new National Youth Mental Health Foundation, Headspace, which aims to develop new youth-friendly models for delivering mental health services to young people.[79] The Riverina Division of General Practice in NSW had received funding from Headspace to develop a community of youth service:

> *It's more about having one approach to deal with youth in terms of their mental health, co-morbidities, homelessness, education and other things that are dealt with up to the age of 24. So what we've been doing is actually working on this idea around a community of youth service, and that means that youth are able to enter the service through any organisation that they would normally feel happy to access. However, once they are in the system, they are then able to move around within that system and get the help that they need and they would be case managed by the most appropriate provider who is the lead case manager.*[80]

Regional, rural and remote healthcare

17.56 The challenge of providing healthcare services in rural, regional and remote Australia goes beyond the needs of homeless young people and young people at risk of homelessness, but the consequences of failing to meet that challenge weigh particularly heavily on this vulnerable section of the Australian community.

17.57 Witnesses from different parts of the country gave evidence about service gaps that ranged from not having any suitable services in a region to having under resourced services or an incomplete range of services. In Alice Springs, the Inquiry heard of psychiatric services only being available on a '... fly in fly out' basis.[81] The NSW Association for Adolescent Health told the Inquiry that '... the vast majority of regional and rural areas remain without a designated Youth Health Service'.[82] Southern Youth

and Family Services, which is based in Wollongong in NSW, advised the Inquiry that there was no youth specialist drug and alcohol residential program in their area:

> *… young people have to leave the area. The closest is Sydney or Canberra. Most young people do not complete the programs, at least in their first few admissions.*[83]

17.58 Earlier in this chapter, examples were given of young people being flown across state boundaries for drug and alcohol treatment because of a lack of services.

17.59 Services in regional, rural and remote areas sometimes work cooperatively to overcome the particular challenges they face. In Darwin, a school nurse told the Inquiry about Taminmin High School helping students to access mental health support by organising transport, using welfare staff to drive students to appointments or liaising with other organisations to facilitate access.[84]

17.60 Aisbett, Boyd, Francis and Newnham surveyed a number of young rural people in Victoria and found that the lack or reliable transport to mental health services, the lack of qualified professionals within their own region who specialised in child and adolescent mental health, long waiting lists, the lack of after-hours services, and the negative impact of stigma and social exclusion all worked together to create barriers.[85] Co-location of mental health services with general health services was suggested as one way to reduce the stigma.

17.61 North East Support and Action for Youth, which services eight local government areas in north-east Victoria, told the Inquiry that youth health services should only be co-located with other youth services, as young rural people will not access general community health services for sensitive matters such as pregnancy, mental health support and substance use problems.[86]

17.62 In the context of the Aisbett, Boyd, Francis and Newnham findings, Dr Leanne Craze spoke at the Canberra hearings in support of the co-location concept.[87] She advised the Inquiry that in many towns:

- mental health services are unsustainable in terms of services for adults, let alone young people;

- health teams have impossible caseloads and are highly visible in the community;

- burnout is high and expectations are unrealistic.

Dr Craze voiced her concerns about the provision of fly-in or drive-in services as a solution and instead advocated for better support for local community members struggling to complete training in allied health fields and community sector work.

17.63 Dr Craze voiced doubts about whether comprehensive mental health services could ever be established across all rural and remote areas of Australia and advocated investigating creative alternatives. She drew the Inquiry's attention to a concept for rural and remote regions that is similar to the new Personal Helpers and Mentors Program

under the COAG National Action Plan on Mental Health (where people from a range of backgrounds are employed to support people with severe functional limitations resulting from severe mental illness).[88] The idea Dr Craze raised involves developing regional field education support networks aimed at building an alternative rural mental health workforce. Dr Craze described the two-fold approach the network would require. The first involves identifying existing national policy initiatives that require support workers; identifying the rural areas where these programs are entering; identifying appropriate courses and training providers for these rural support workers; and asking those providers to undertake an audit of field placements, including identifying any placement problems. The second involves providing better student support through locating, pro-actively developing, and supporting placements and student supervision; negotiating secondments and position transfers to facilitate the take-up of placements; and brokering for targeted training areas.[89]

> *The difference that that would make ... and I say it quite seriously, that I actually think that positions like those [involving skilled up locals], a workforce like that, in rural towns, would actually make the difference between a young person seeking treatment and staying engaged in treatment and also it would make the difference between a mental health professional not quitting, because it would take a significant load off mental heath professionals.*[90]

Findings and Recommendations

17.64 Young homeless and at-risk people require access to specialist or youth specific healthcare services, including dental care, that respond to local conditions, such as those funded by the IHSHY program. Even if the debate about 'youth specific' and generalist health services continues, there should be no controversy about the proven value of the kind of services provided under IHSHY. Both community sector and government stakeholders told the NYC that the program is insufficiently funded. IHSHY is another example where a pilot program has yielded some highly effective and innovative service models, and yet success was not implemented more broadly. The Perth mobile clinic was supported as a flexible youth specific health service that could visit different locations more accessible for young people. This type of initiative could well be developed in other capital cities. In the context of a redevelopment of IHSHY, the scope of the program could be broadened somewhat, but the key issue is developing capacity to more adequately respond to expressed and real need.

Recommendation 17.1:

The NYC Inquiry recommends that the Innovative Health Services for Homeless Youth (IHSHY) program be continued and further developed as an important component of a national homelessness service system in order to provide more and better health services for at-risk, disadvantaged and homeless young Australians.

17.65 Mainstream antenatal, postnatal and parenting services are not suitable for pregnant and parenting youth. The evidence of how well the Adolescent Mothers Support Service is working is encouraging as is having an outreach capacity to contact

and work with this group.

Recommendation 17.2:

The NYC Inquiry recommends that flexible, non-judgemental ante-natal and post-natal outreach based support services be implemented in major population centres for pregnant and parenting young women.

17.66 The criteria to access disability behavioural support programs can be difficult for young disabled homeless people to meet.

17.67 There are widespread gaps in the provision of non-area based, adolescent specific, drug and alcohol services, including: early intervention, residential detoxification, post-detoxification respite, residential rehabilitation, and post-rehabilitation supported housing. There are links between homelessness and drug and alcohol issues as well as mental health; however, by no means are all young people who experience mental illness, or have drug and alcohol problems, homeless. For homeless young people who do have such problems getting the help they need is particularly difficult as specialist services often cannot provide accommodation or accommodation services cannot cope with a young person who is psychotic or has a hard drug habit. While it can be argued that some young people successfully access mainstream services, for highly marginalised youth, this continues to be problematic. The provision of both mental health and drug and alcohol services is uneven around Australia and the level of service provision needs to be addressed for young people generally. The Victorian Youth Substance Abuse Service stands out as an example of consolidated service capacity with near to full state coverage. Victoria was spending $15-16 million on youth drug and alcohol services and probably could reach state-wide capacity as well as provide a substantial amount of outreach for a total of $20 million at current levels of need. A fully developed national network could cost close to $100 million per year of which a significant part is already in government program budgets. For homeless youth, in particular, new combinations of services and new models and more effective linkages between programs and sectors are required to create a system that works more effectively for this group.

Recommendation 17.3:

The NYC Inquiry recommends that a national network of youth substance abuse services be established across all jurisdictions to provide an appropriate range of services that are sufficiently funded to meet current levels of need.

17.68 There are gaps in the provision of adolescent-specific and youth-specific mental health services, emergency mental health services and residential rehabilitation services. An argument was strongly put by Headspace that young people need particular attention given mainstream services are often perceived as 'unfriendly' or not understanding of young people. For homeless young people experiencing mental health issues, the issue of stable accommodation and appropriate support is critical. Treatments and therapies presume that everyday stresses are relatively stabilised and that a young person can concentrate on working through their mental health issues. Overall, some $4 billion over five years underpins the National Action Plan on Mental Health with a range of initiatives91. A question can be raised about the extent to which the needs of young

people are addressed and within that the extent to which appropriate responses have been funded that will impact on the lives of homeless young people.

Recommendation 17.4:

The NYC Inquiry recommends that all jurisdictions review the provision of mental health services for young people in terms of access, service gaps, wait times and operational efficiency in order to adequately resource support programs for young people with mental health issues and their families.

17.69 Many young homeless and at-risk people present with a constellation of health problems that need to be addressed at the same time, and effective models appropriate for homeless and marginalised youth have been developed but not extended nationally over the past 20 years. The experience of the Innovative Health Service for Homeless Youth is particularly instructive.

Recommendation 17.5:

The NYC Inquiry recommends that new models of residential programs be developed and funded which enable drug and alcohol, youth mental health and supported accommodation services to work in partnership to support homeless young people with a dual diagnosis.

17.70 Homeless and at-risk young people in rural, regional and remote communities experience additional disadvantage in relation to access to healthcare.

ENDNOTES

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