

The NSW Association for Adolescent Health Inc.

Funded by NSW Health



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Homelessness Green Paper Submissions
PO Box 7442
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Dear Staff and Panel Members,

Re: NAAH - Green Paper Submission June 2008 “Putting Youth Health on the Agenda”

The NSW Association for Adolescent Health (NAAH) and its members thank you for the opportunity to provide a submission in response to the Australian Governments Green Paper on Homelessness, titled “Which Way Home? A New Approach to Homelessness”.

This submission details NAAH’s recommendations for dealing with the issue of homelessness and ensuring that the health needs of disadvantaged young people are incorporated into the Australian Government’s response to homelessness. Essentially, it highlights the importance of providing access to targeted youth health services that are modelled on an evidence-based response to the socio-health needs of disenfranchised youth.

We would be happy to discuss any of the issues we raise in our submission with you. Please feel free to contact us should you wish to further discuss this submission.

NSW Association for Adolescent Health (NAAH)

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**Response to the Australian Government Green Paper
“Which Way Home? A New Approach to Homelessness”**

Putting Youth Health on the Agenda

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The NSW Association for Adolescent Health Inc.

The NSW Association for Adolescent Health Inc. (NAAH) is the peak body committed to working with and advocating for the youth health sector in NSW to promote the health and well being of young people aged 12-25 years. NAAH aims to assist the youth health sector to strengthen and maintain its ability to provide relevant and evidence-based health services to young people aged 12-25 years.

NAAH works closely with the State's seventeen youth health services and with the NSW Centre for the Advancement of Adolescent Health (CAAH). Most of NAAH's work focuses on providing the youth health sector with support and training, government liaison and lobbying, policy and resource development, and community sector networking.

Within NSW, Youth Health Services are funded through **The Innovative Health Services for Homeless Youth (IHSHY) Program**, introduced as a pilot program in 1991, in response to the Human Rights and Equal Opportunity Commission's (1989) 'Our Homeless Children' (Burdekin) Report. This report found that homeless young people exhibit chronic health problems but are reluctant to seek treatment through mainstream services which they regard as judgemental and unsympathetic to their needs and life situations.

The IHSHY Program is jointly funded between the Australian Government and the State and Territory Governments and aims:

'to improve the health outcomes of homeless and otherwise at-risk youth aged 12-24 years and their dependents through the provision of specialised health services and improved access to mainstream health services.'

About NSW Youth Health Services

Youth Health Services in NSW are community-based health services which offer a diverse range of programs such as counselling, health promotion, primary health care clinics, alcohol and other drug services, case management, outreach and drop in health services to young people aged 12-24 years. Some services are non-government organisations and others are provided through the various Area Health Services in NSW. The primary target group for youth health services are young people identified as 'at-risk', disenfranchised, homeless or at-risk of homelessness, often with a history of abuse and neglect, and who are unlikely to access mainstream services. Some youth health services also work with young people and their families/carers to support their health and well-being.

There are seventeen youth health services in NSW which provide medical treatment, education, counselling, case management, health promotion and community development programs with various populations of young people throughout NSW and with different funding sources, budgets, staffing levels and resources. Of these, some specialise in alcohol and other drug services, whilst others provide reproductive and sexual health services. Eight youth health services are partly funded through the IHSY Program. These IHSY-funded services receive the remainder of their funding from their community auspice agency, other grants or from their local Area Health Service. The remaining nine services are fully funded by IHSY, however seven are administered through Area Health Services, and the remaining two through by non-government organisations. Occasionally, youth health services also receive one-off grants for components of specific projects but do not have staff dedicated to grant-writing or fund-raising (see also Appendix 1 for a brief overview of the Illawarra-based Youth Health Service, CHAIN).

Youth Health Services target marginalised young people (and often also work with their families) who are homeless or at risk of homelessness due to family breakdown, disengagement from education, unemployment, living with a mental illness or engaging in behaviours which place them at risk such as underage /unsafe levels of drinking or unprotected sex. The health status of these young people is often compromised by a range of identifiable high risk factors and difficulty in accessing mainstream services due to a variety of reasons (socioeconomic, lifestyle or inappropriate service responses).

Youth Health Services aim to provide marginalised young people with developmentally appropriate programs as well as multiple and easy 'soft' points of access to health and related services, acknowledging the varying needs, referral pathways and engagement preferences of young people. The Services are based in community settings to promote access and undertake early intervention activities with hard-to-reach young people whose access to mainstream health services may be limited. Accessibility and timeliness of services is essential, both in terms of physical location and environment, and issues such as minimal waiting times, maintaining confidentiality and the ability to access services without requiring payment or a Medicare or health care card. Services may be on an individual, group or population health basis, such as capacity building programs providing professional development opportunities for local residential (refuge) workers in relation to assessments and referral pathways.

About the IHSY Program

The IHSY Program was a result of the community sector's effort during the Human Right and Equal Opportunity Commission Inquiry into Homeless Young People, funded as a joint Commonwealth/State Agreement through the Youth Social Justice Strategy as a response to the findings of that Inquiry. The Youth Health Services funded by IHSY were intended to be closely connected or attached to youth homelessness services and this was a positive and innovative new approach. Importantly, it still remains a successful and effective program today.

However, since the implementation of IHSY there has been a deterioration of the core program, no funding increases to match Consumer Price Index (CPI), and the impact of applying the efficiency dividend to community programs has resulted in the reduction of core funding which has also resulted in reduction of services. In the last two years there has been high level insecurity around the IHSY program, and since July 2007 the program has been extended six months at a time. This is an inefficient and stressful way to manage programs. It causes low staff morale, high staff turnover, inability to build a long-term service and community infrastructure, inhibits planning and most importantly does not create a basis for providing ongoing health service delivery to young people.

This is extremely problematic, as Youth health Services are experiencing increasing requests for services and waiting lists are growing as the numbers of young people and families experiencing disadvantage grows. Yet funding and the ability to fund and provide positions and programs diminish. The recent NSW Area Health Service restructure has left many services, not just in youth health, with gaping holes in staffing levels, for example, as Area Health Services' recruitment and selection processes are lengthy and convoluted due to advertising processes which prioritise the relocation of 'internally displaced persons'. Staffing at Youth Health Services is frequently reduced through maintaining vacant positions in name only where the position exists, is not approved for recruitment and is left vacant, often for several years in order to come under budget. In some cases the full-time equivalent hours of a position are reduced when there is staff turnover resulting in few full-time equivalent positions providing services.

As a result of no increase in funding levels to IHSY-funded services, despite growing demands on these services, almost all programs offered by Youth Health Services have been cut to some degree. Within one service, for example, the medical, counselling, dental, visual arts and health promotion services are all staffed at significantly lower levels than ten years ago (in some cases less than half). However, the demand remains steady and there are now waiting lists as long as two weeks for a medical appointment and more than four weeks for a dental check-up. There are also limitations on the days services are available, creating an additional barrier for young people.

The integrity of the youth health model is seriously compromised by reducing the scope and availability of services due to reduced staff numbers and lower program budgets. In addition, quality health service provision through service follow-ups with clients is made more difficult when clients know they have to wait so long. Due to depleted funds for Youth Health Services, the funds available to purchase items that provide a small but necessary and much appreciated service for clients are no longer easily accessible. One youth health service used to have a fruit bowl available in the waiting area. Clients who usually wouldn't go near anything other than greasy takeaway food would devour readily accessible apples, grapes and bananas. Staff saw it as a great way to promote healthy eating

choices and demonstrate the service's concern about their needs. Since the restructure, the system has changed and many (government) services no longer have petty cash available to make small purchases such as fruit for clients even though clients continue to approach services for food, whilst they're accessing the services for their other health-related needs.

Youth health services managed by Area Health Services also have great difficulty seeking approval to spend funds allocated to their service as budgets appear to be shared and money transferred to other facilities that may be over-budget. In many cases, services never know whether spending will be approved, which consequently makes responding to client's needs quickly and planning for both core business and innovative projects difficult. As a result, many services are forced to seek external funds for what used to be considered core business such as paying for glasses, private optometrists, orthodontists, specialist doctors, gynaecological services, equipment and materials for arts-based programs and so forth. In addition, preparing funding submissions is very time-consuming and takes staff away from their primary role.

NAAH strongly recommends that the Australian government supports an improved response to homeless young people as an essential part of the effort to combat homelessness in Australia. Specifically, the IHSHY Agreement should be formally supported, expanding the funding base and extending the program for five years as part of the new arrangements.

Youth Health & Homelessness

As highlighted within 'Which Way Home', young people aged 12 - 24 experience high levels of homelessness in Australia, consisting of 'more than 1 in 3 people' of all population groups, with SAAP services assisting over 13,200 unaccompanied whilst under 17 years in 2005-6. The report also acknowledges that causes of homelessness are complex and that there are many interrelating factors, many of which have been mentioned throughout this document and include mental health, family conflict, substance use, unemployment and housing issues (such as cost, eviction, etc). Health issues as an effect of homelessness are also briefly addressed as a concern for all population groups, stating that 'rates of acute mental illness and chronic health problems amongst homeless people are high and include poor dental health, infectious disease, STI's, etc)' (Australian Government, 2008).

Homelessness has serious and long-lasting health implications for young people in Australia. These marginalised youth suffer increasingly from the negative health and social affects associated with housing instability, including greater risk of exposure to physical and sexual assault and much lower levels of nutrition and hygiene (AIHW, 2007). Disadvantaged young people are also more likely to live in substandard or overcrowded dwellings, are more likely to have mental health issues, are more likely to abuse drugs and alcohol (including injecting drug use), and to have suffered from at least one traumatic event. In addition, homeless young people also suffer from 'asthma, bronchitis, HIV infection and tuberculosis, and have a higher likelihood of being a victim of crime' (AIHW, 2003).

Although risk-taking is a characteristic of adolescence, evidence of greater risk-taking behaviours amongst marginalised and homeless young people is high and the resulting health concerns are alarming. Strategies that specifically target at-risk adolescents are required due to the high level of vulnerability and risk of harm. Homeless or at risk young people are susceptible to engaging in crime, self harming, suicidal tendencies, unprotected sex or sex work, adolescent pregnancy, passivity, low motivation, behavioural issues, high levels of aggression/violence, associations with anti social peers, social isolation, alcohol and other drug dependencies (including injecting drug use), depression, early school drop out, and low education.

In addition, there are a number of emerging health issues facing at-risk and homeless young people which also require adequate responses. These include:

Medicare and access to GPs

Access to Medicare is needed for all young people, as are streamlined processes for services to advocate for access to Medicare for homeless people have limited personal identification, and for those who are likely to have difficulties in maintaining their details and Medicare card number.

The number of youth-friendly and experienced general practitioners (GPs) in local areas is frequently very limited. Marginalised and/or at-risk young people often experience poor physical health and may find it difficult to access private GP services either due to cost or not having a Medicare card. In addition, the complex health needs and health conditions of these clients frequently require long and detailed consultations which many mainstream GP services usually cannot offer. If young people are indeed able to access a GP then they are better able to establish a relationship as well as a medical history with one doctor and begin

to have quality experience and care (NAAH 2007). The provision of professional development and training for GPs and fee structures that support provision of long consults is required.

It is worth stating that there are a number of examples of youth services in the NGOs sector partnering with youth friendly GP's in an attempt to provide programs in areas where gaps in services exist. However, the sustainability of these programs is in doubt due to the limited resources available for adequate administration and follow up of young people who are often transient or are difficult to engage unless they have the back up support of an existing Youth Health Service that is well resourced can provide the necessary administration.

Dental Health

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. Access to dental services for clients of youth health services has decreased considerably since the release of the original Burdekin report due to the general reduction in publicly-funded dental services. Few Youth Health Services offer a dental service, and those that do have seen the service progressively reduced. Initial dental consultations provided through a youth health service allows young people who do not have a Medicare or Health Care card to be referred to dental hospitals for treatment. Currently, there are no free dental treatment options available for young people who do not have a Medicare and Health Care card. In addition, even youth health services that offer a dental service are extremely limited in terms of referral centres. There are no government incentives for private practices to provide services to marginalised community members. Furthermore, youth health services have reported that even when their service has covered the costs of dental services for clients, few private dental practices take up their offer, raising concerns about prejudice or young people once again being placed in the "too hard basket". These factors combine to create significant barriers to treatment for those that need it most. 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.

Mental health and Drug and alcohol/ dual diagnosis

There is very limited numbers of accommodation services who will accept young people with dual diagnosis. Often the exclusion criteria is so regimented that it does not allow for high-risk clients to be able to access appropriate accommodation (if any at all). Many people working with young people find that the 'siloes' of health services structures mean that care is not coordinated and often they are referred between Mental Health and Drug and alcohol services for individual treatment which is not joined up and well coordinated. Referral pathways for young people with mental health issues are not standard and are complex in nature. Given the difficulties of engaging marginalised young people in health services, complex referral pathways create barriers to mental health services, increasing the likelihood that clients will be lost through the referral process. A further problem is that the onus is on clients to engage with services, even when a clear need for active intervention exists (NAAH 2007).

Pregnancy termination

Clinics that provide safe and free terminations for 'at risk' pregnant women who are unable to pay have been closed (namely the Bessie Smyth Foundation at their Powell Street Clinic and the "under 20's" (for young women under 20 year olds) clinic at KGV Hospital in Camperdown). There is a limited service provided at Nepean Hospital offering only two free places per month. The remaining termination service providers operate on a fee for service basis in addition to requiring a Medicare care and/or Healthcare Concession Card (or payment of a higher fee if these aren't available). This includes Marie Stopes who have taken on the Powell Street Clinic facilities. The youth health sector is concerned about the lack of access to free terminations, which is particularly problematic for young women who are homeless and unable to afford to have either a termination or the networks and support to provide for a child.

In an effort to tackle these health problems, Youth Health Services design and implement practical support programs that address these health concerns and improve health behaviours of at-risk young people. For example, many offer a breakfast program, shower and laundry facilities; or innovative health promotion and education projects to engage young people to improve knowledge and behaviours in relation to sexual health, self-esteem, risky behaviours that harm (such as binge drinking and drug use), parenting skills, budgeting, bullying, healthy eating & cooking programs to name some. Youth Health Services also help to end the cycle of homelessness, hence removing young people from environments that may place them at risk.

To ensure positive and effective outcomes, SAAP and homeless services are key services to support the engagement of these young people and the service delivery in these areas. In regards to mental health, all services need to be properly staffed to be able to support young people with mental health conditions, especially where they are not yet engaged in treatment or specialist supports. Behaviours need to be managed as they can be unpredictable and at times risks the safety of staff and others.

In an improved response to homelessness, SAAP and other such services need increased specialist supports such as after hours mental health supports (not just assessment), improved access to psychologists and psychiatrists on-site, and specialist behaviour management staff.

To improve responses to homeless young people, additional funding is required for IHSHY and Youth Health Services to increase the hours of health service provision so that the complex health needs of at risk young people can be addressed. Access to primary health care, health promotion, counselling and case management supports outside of normal Monday to Friday hours is required. During the initial stages of the IHSHY program, some services did extend hours, however reduced funding has also caused this to be reduced. Opening hours of youth health services from 7.30/8am until 8pm and for week-end services would be a positive thing for homeless young people.

The Current Youth Health Model – Why does it work?

Providing access to Youth health Services is paramount for young people who are marginalised and difficult to reach (Kang, et al, 2005). Youth Health Services play an important role in supporting young people to make informed health choices, meeting them at the point where they are currently (with younger clients in particular) and supporting them to make their own decisions around their health care (which can take time).

Youth Health Services have an early intervention focus which assists in the early detection of causes and effects of homelessness such as developing mental health issues, alcohol or other drug problems, family relationship issues or breakdown, abuse, neglect, and poverty. Through the assessment process the Youth Health Services are able to identify underlying issues and assist in making appropriate referrals to services such as SAAP, Reconnect or other specialists as well as providing health service interventions from Youth Health Services.

Furthermore, Youth Health Services' social view of health promotes services and programs that develop resiliency in young people through the provision of a supportive environment which focuses on their strengths and abilities, the promotion of supportive structures and environments which promote connectedness within families and the local community, and that enhance intrapsychic strengths and adaptive coping skills. Youth Health Services deliver excellent primary health care, adding to young people's understanding of their health, equipping them with information and support to make more informed choices, and giving them support to remain in school or educational programs, reducing their risk and disengagement from society as well as increasing their employment opportunities and sense of belonging.

The youth health model (i.e. the provision of accessible and holistic health services through multidisciplinary teams) was developed in response to this social view of health and feedback from clients themselves about the need for stand-alone services which provide a one-stop shop of professional, youth-friendly health services (see also Appendix 1). A key principle is that the services are community-based and are accessible alternatives to mainstream health services, which marginalised young people may find intimidating or difficult to access. It has long been recognised that a significant barrier to young people seeking help is a concern about confidentiality and trust, as well as knowledge of services available and how to access them (NSW Centre for Advancement of Adolescent Health, 2002).

Youth Health Services promote privacy of information and confidentiality information to clients. Organisations refer to privacy information brochures which explains to clients that in order to ensure that appropriate health services are provided, the Area Health Service or other health professionals may need to share personal client information with other health professionals, ensuring the information is treated in strict confidence and is only available to health professionals directly involved in that client's care, with the consent of the client.

Youth Health Services based in the community, rather than in hospitals or alongside specialist health services, are more accessible as they are more likely to appear youth-friendly and approachable and less likely to appear adult-oriented and medically-focused, which can be discouraging for many young people. They are better able to provide services which meet a young person's physical, mental and social health needs through their diverse range of programs. Youth Health Services are client focussed and encourage young people

to access the service even if they aren't ready to seek medical help. This means that a young person may initially attend a service to participate in a creative arts group or just drop in to talk or seek advice. As the service is non-threatening and operates at the pace that the young people/person requires, they can, over time, establish a trusting relationship with the service, enabling them to access other services such as counselling or primary health care at later stages. This is particularly important as young people who have come from disadvantaged backgrounds require flexibility, and the ability to establish rapport and a level of trust, before they can feel comfortable to accept assistance.

In terms of a close connection to community-based homelessness services, Southern Youth and Family Services in Wollongong operate the IHSY Service (See also Appendix 1). The model offered provides consistent case management and streamlined access across a range of programs and services for homeless and at risk young people. This service (CHAIN) actively attracts and engages young people in the Service in order to assess and respond to their needs through a range of health, medical, welfare and other services. It includes the encouragement of positive health behaviours of clients in relation to physical, mental & sexual health. Health promotion & education that is aimed at key issues such as nutrition & healthy eating, safe sex practices, self-esteem, binge drinking & illicit drug use, & risk taking behaviours (including violence). In addition to the direct health services provided, a holistic approach is gained through case management, and other service methods such as drop-in and casual client contact to provide support and links in regards to relationships with family & friends (including parenting), as well as providing access & referral for housing, education & employment, financial support, & case management to assist in continued self-reliance & to engage clients with mainstream services.

In terms of an improved response to homeless young people this model is highly successful. However, funding arrangements need to be simplified across the homelessness service response as there is an excessive bureaucratic burden placed on community-based services that are seriously encumbered by the demands of complicated funding requirements.

General Comments About Homelessness, Community Services & Work Force

NAAH's primary interest is in responding to the health needs of homeless and at-risk young people. However, many of the Youth Health Services work closely with SAAP and other relevant services, including one IHSHY service inside a community agency that delivers a broad response to homelessness. As such, we intend to make some broader comments in addition to the main focus of our response.

Our experience of working with SAAP and homelessness services is that they do a very difficult job in an environment of inadequate resources. Many people are turned away as there are no accommodation places, which is not a result of the operational inadequacies of the Service but an indicator of high unmet demand and the need for more resources. Many of these services only have one staff member who may be working after hours, and at times as the sole worker in an organisation. They work in a way that Government Department staff or many other parts of the community sector would not tolerate. Many young people are placed in SAAP services, whereas in many cases they should be having intensive supports in a health setting for their own safety and well-being, and for the safety and well-being of others. Many SAAP services actually co-ordinate and case manage large numbers of young people with severely inadequate funds and staff numbers.

The staffing of community services is an essential ingredient to an effective and quality service delivery, and it is pleasing that this issue is mentioned in the green paper. We believe that this is an important area and increased funding must be provided to allow community agencies the ability to provide equitable wages compared to similar jobs in Government. There is a widening gap between salaries in the community sector and Government and this is not good policy in terms of quality service delivery in both sectors. Training and professional development is important but it must be done in conjunction with an immediate increase in wages and conditions for community sector salaries. SAAP and other community based programs are some of the least paid of any industry grouping.

Our experience also in the community youth sector, health and accommodation/housing sector is that there is inadequate capital funds provided for suitable properties, vehicles and other such items. This includes accommodation that is not just crisis but long-term housing, including for those young people who are discharged from hospital so they can be offered the long-term housing and ongoing support services they need. Capital funds must be provided to ensure suitable and adequate properties for supported accommodation and housing but also for appropriate office areas, counselling areas, and program and activity space. The new Federal Government has created a number of infrastructure funds, however in an improved response to homelessness there needs to be a capital infrastructure fund for community services.

Response to Options Outlined in Green Paper

The options detailed in the Green Paper are not adequate as a way forward. The way forward is a combination of many things which we will detail further on in this response. Essentially, Options 1 – 3 are inadequate because:

Option 1 - states that the 'youth' stream of support will sit with education, training and employment services. This is limiting as in no way does it reflect the various important components of a young person's life. These include family and connection, child protection, cultural and community connection, supported accommodation and housing, income, living and social skills development, health and others. Placing the response in a particular portfolio area does not guarantee an effective response in that area. All homeless people have common areas including housing, supported accommodation, health etc and so the overall response needs to be consistent and cohesive. This limited approach critically undermines the significant problems associated with young people's lives, for example health and homelessness. Improving the health outcomes of marginalised and vulnerable young people needs to be a clear, stand-alone objective, and providing access to a proven model of youth health service is essential to adequately address the needs of this population group.

Option 2 – again, this is also problematic as it is far too limiting. The SAAP response is one part of the response and it is effective, but it also needs support, enhancement and additional resourcing. This option should say build on SAAP and enhance the overall response to homelessness through a streamlined and improved system including health, housing, education, and others. For example, Option 2 as it is written in the Green Paper overlooks health altogether and undermines the significance that 'health' plays in relation to homelessness. There is a need to strengthen the existing Youth Health Services through additional investment and increasing support.

Option 3 – This option as written is unworkable. It denies the reality that for specialist groups there should always be specialist response as there is no evidence that mainstream services can respond adequately to all groups with special needs. In our suggestion below we reiterate the importance of improved responses from mainstream services, but it will always be a combination of specialist and mainstream responses. This option as it is written does not attend to the current situation where mainstream services also need to be extended to meet demand e.g. housing waiting lists, hospital beds etc. It does not address problems associated with young people's access to mainstream health services and the lack of appropriately targeted services available to the population group. Existing Youth Health Services provide access to young people based on a model that is holistic and provides multiple as well as soft/'easy' access points and multidisciplinary health services where young people's physical, mental and social health needs can be met in a strategic, one-stop fashion. As stated, a key principle is that there needs to be strong and effective community-based services that are accessible alternatives to mainstream health services, which marginalised young people may find intimidating or difficult to access. In rural and regional areas this is particularly important as mainstream services are inadequate. In addition, there needs to be professional development and training to ensure that the workforce within both the mainstream services and the community sector have the appropriate skills to successfully engage at-risk young people. Finally, mainstream providers need to have the skills and time to be able to develop successful and sustainable partnerships with NGOs and community-based providers to ensure effective and appropriate responses to at-risk young people.

NAAH Recommendations

Health for homeless and at-risk young people needs to be incorporated into the Australian Government's response to homelessness. The report states that SAAP is the Australian government's primary response to homelessness in Australia and yet this seems to miss all the other supports that add to the effort around homelessness (e.g. IHSY, Reconnect). The current approach does not adequately address the health needs of disadvantaged young people, and providing access to targeted youth health services that are modelled on an evidence-based response to the socio-health needs of disenfranchised youth needs to be expanded. This can be done in two ways – resourcing and increasing homelessness services' ability to deliver specialist youth health supports and also ensuring that youth health services for homeless young people are strongly linked to homelessness services.

As such, NAAH also recommends that the Australian Government:

1. Acknowledges health responses as essential to an overall homelessness response
2. Confirms IHSY as a long term agreement and funding stream in the overall homelessness response and confirm it with security
3. Supports existing services delivering quality programs and build on them to ensure increasing effectiveness in improving the health outcomes of homeless and at-risk adolescents
4. Explores the current youth health model as a potential option for the development of a model for homelessness health services
5. Adequately resource all community programs including IHSY so they are able to provide sufficient wages and conditions to attract and maintain a quality workforce
6. Reduce the burden of excessive bureaucracy and micromanagement of community based services, streamline contract management and make it simpler for homelessness and youth agencies to access appropriate funds
7. Develop a capital infrastructure fund for community services

NAAH also supports all recommendations in the Report *Australia's Homeless Youth* from the Independent Inquiry Into Youth Homelessness released this year, including the recommendation that:

- the Innovative Health Services for Homeless Youth (IHSY) 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;
- flexible, non-judgmental ante-natal and post-natal outreach based support services be implemented in major population centre's for pregnant and parenting young women and men;
- 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;
- 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; and

- 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.

Finally, NAAH also supports the broad response from Homeless Australia for an option 4 including the following recommendations:

1. a 10 year increase in the supply of housing for people who have experienced homelessness
2. enhance SAAP as the foundational homelessness response, to provide longer term support to clients
3. expand on early intervention programs
4. expand the scope of National Affordable Housing Agreement to become a National Affordable Housing & Homelessness Agreement
5. development a Commonwealth Whole of Government Homelessness Strategy that will ensure various Commonwealth portfolios at different levels of government
6. build on existing State/Territory homeless strategies
7. set targets and develop a strong research agenda
8. fund strong, well resourced National and State/Territory homeless peak bodies
9. strong national leadership (through the creation of an Australian Council on Homelessness)

Appendix 1

Youth Health Service Case Study 1

CHAIN (Community Health for Adolescents in Need)

CHAIN is funded through the IHSY Program (Innovative Health Service for Homeless Youth) by NSW Health, and is auspiced by Southern Youth & Family Services based in Wollongong, NSW.

CHAIN operates on the foundation of the youth health model, based on the provision of accessible and holistic health services through a multidisciplinary team and developed in response to a social view of health.

CHAIN's program aim is to "Contribute to improving health outcomes for young people who are marginalised, homeless or at risk of homelessness by improving access to mainstream or specialised health services and directly providing a range of innovative health services including primary health and related services that respond to the complex needs of the target group (consistent with the IHSY program and the broader young social justice strategy that IHSY originated from)."

All activities are aimed at improving the health outcomes of disadvantaged, homeless and otherwise at risk youth and their dependents through the provision of specialist health services including primary health and ancillary health care and improved access to mainstream health services.

A key activity is to attract and engage young people in the Service and to assess and respond to their needs through a range of health, medical, welfare and other services. It includes the encouragement of positive health behaviours of clients in relation to physical, mental & sexual health. Health promotion & education that is aimed at key issues such as nutrition & healthy eating, safe sex practices, self-esteem, binge drinking & illicit drug use, & risk taking behaviours (including violence). In addition to the direct health services provided, a holistic approach is gained through case management, and other service methods such as drop-in and casual client contact to provide support and links in regards to relationships with family & friends (including parenting), as well as providing access & referral for housing, education & employment, financial support, & case management to assist in continued self-reliance & to engage clients with mainstream services.

Examples of Activities include: Centre-based individual case work, drop-in contact, group work, outreach work, early intervention and prevention approaches; Provide shower facilities; Provide food including the breakfast program; Provide laundry facilities; Provide information and advice; Provide referral to other youth health services; Provide referral to mainstream health services; Assistance with procuring certain essential medications; Undertaking of case co-ordination/case management treatment processes; Provide direct access to GP's, psychologists and psychiatrists through direct links with Headspace (a GP & mental health service) for medical treatment; Provide direct access to Registered Nurse for individual assessment, treatment and ongoing care (eg approval for prescriptions, administer first aid and basic treatment for minor injuries and ailments, and pregnancy testing); Address gender and cultural issues in relation to access to services and treatment provisions; Provide referral to various health and medical services, including referral to emergency treatment.

CHAIN has recently had an increase of numbers of clients using the service, increased partnerships including with GP's, increased clients accessing the Sexual Health Clinic, and many other positive developments due to demand for the service.

Bibliography

Australian Government (2008). *Which Way Home? A New Approach to Homelessness*. Canberra.

Australian Institute of Health & Welfare (2007). *Australia's Young People: Their Health & Wellbeing*. Cat No. PHE 50. Canberra: AIHW

Homelessness Australia (2008) *Response To Australian Governments Green Paper 'Which Way Home? A New Approach to Homelessness'*

Kang, M., Bernard, D., Usherwood., T., Quine, S., Aperstein, G., Kerr-Roubicek, H., Elliott, A. & Bennett, D. (2005) *Better Practice in Youth Health: Final Report on Research Study Access to Health Care Among Young People in New South Wales: Phase 2*. Sydney: NSW Centre for the Advancement of Adolescent Health, The Children's Hospital Westmead.

National Youth Commission (2008) *Australia's Homeless Youth: a report of the National Youth Commission Inquiry into Youth Homelessness* National Youth Commission

NSW Association for Adolescent Health Inc website: www.naah.org.au

NSW Centre for Advancement of Adolescent Health (2002) *Access to Health Care Among NSW Adolescents*, Phase 1 Final Report, Children's Hospital, Westmead.

South Australian Health Commission (1988) *A Social Health Strategy for South Australia*. SAHC: Adelaide