

# The NSW Association for Adolescent Health Inc.

Funded by NSW Health



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22 June 2007

Dear Major Eldridge

## **Submission to the National Youth Commission into Youth Homelessness**

The NSW Association for Adolescent Health (NAAH) and its members thank you for the opportunity to provide a submission as part of the National Youth Commission into Youth Homelessness (NYC).

These comments expand on the feedback NAAH provided to the NYC hearing on Monday 16<sup>th</sup> April 2007. We sincerely ask you to consider the matters we have raised for, like you, we seek opportunities to address youth homelessness and related issues facing young people who are at-risk of homelessness.

### ***About the NSW Association for Adolescent Health Inc<sup>1</sup>***

The NSW Association for Adolescent Health Inc. (NAAH) is the peak body committed to working with and advocating for the youth health sector<sup>2</sup> 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 fifteen 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.

<sup>1</sup> The NSW Association for Adolescent Health Inc.'s website: [www.naah.org.au](http://www.naah.org.au)

<sup>2</sup> The Youth Health Sector includes any service/agency that works towards the betterment of the health and wellbeing of young people.

## **About NSW Youth Health Services**

Youth health services are community-based health services which offer a diverse range of programs such as counselling, health promotion, medical / nursing clinics, alcohol and other drug services, outreach and drop in health services to young people aged 12-25 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 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, 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 for young people, whilst others provide reproductive and sexual health services to young people. Eight youth health services are partly funded through the Innovative Health Services for Homeless Youth (IHSY) Program (a Commonwealth government initiative) introduced in response to the 1989 Burdekin Report. These IHSY-funded services receive the remainder of their funding from other grants or from their local Area Health Service. The remaining nine services receive the majority of their funding from Area Health Services (eight services) or, from their lead non-government organisation (one service). 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.

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 (socio economic, 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.

The vast majority of regional and rural areas remain without a designated Youth Health Service. One Area Health Service has retained its individual Youth Health Coordinator position. The other two designated positions in the State were 'lost' as a result of the NSW-wide Area Health Service amalgamation. Youth Health Coordinators oversee the development of collaborative processes with mainstream health services and generalist youth services such as NGOs, to bridge this gap in the absence of youth-specific health services. Uniquely, there is a new Youth Health Coordinator position in Sydney West Area Health Service (SWAHS) that will bridge the gap in the absence of youth specific health services within the western zone of

SWAHS and will also provide strategic direction for the two youth health services in the eastern zone of SWAHS and professional consultation for organisations who provide services to young people. This new position was developed to advocate for youth health issues, particularly within the SWAHS structure and will be valued for creating a recognised Youth Health profile.

Youth Health Services are motivated to undertake intersectoral collaboration based on the understanding that health is more than merely the absence of disease, recognising the broader social issues such as housing, education, employment, racism and poverty, some of the social determinants of health, which impact on the choices and subsequent health status of young people. Youth Health Services approach young people's health in a holistic manner through a multidisciplinary approach and employ appropriately qualified and experienced staff who are skilled in accessing and working with young people. Furthermore, most government-funded youth health services are partly funded, managed or located within community health structures where there is a strong focus on early intervention and prevention.

### ***Access to health services by marginalised and at-risk young people***

NAAH and its members believe it is imperative to incorporate a social view of health into service planning and delivery when working with young people. A social view of health advocates for interventions which change those aspects of the environment which are promoting ill-health, rather than to continue to simply deal with the illness after it appears, or continue to expect individuals to change their attitudes and lifestyles when in fact the environment in which they live and work gives them little choice or support for making such changes.<sup>3</sup>

With this in mind, youth health services (government or non-government) aim to provide 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. The services promote engagement to health services, particularly focussing on hard-to reach young people and are often made accessible despite the young person's lack of a Medicare Card. Not all localities in NSW have youth health services and furthermore, not all services are funded equally or resourced adequately. Hence, the model of youth health service provision may include medical officers or nurses providing health outreach service in generalist youth services through service agreements, or a lone worker facilitating youth health promotion programs or building the capacity of the wider community/health sector to provide accessible health services and information to young people.

The reality for some young people is that the factors in their environment are not always easy to change/ or take considerable time to change. 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).

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, 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, disengagement from society and increasing their employment opportunities and sense of belonging.

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<sup>3</sup> South Australian Health Commission (1988) A Social Health Strategy for South Australia. SAHC: Adelaide.

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. 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.<sup>4</sup>

Services continue to promote privacy of information and confidentiality information to clients. A few organisations refer to a privacy information brochure 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.

However, the expansion of some information management systems and the introduction of Healthelink now means that young people's presentations are being uploaded and may be accessed by approved hospital staff, GPs, community health workers and the clients themselves online. This may challenge young people's perceptions that confidentiality is maintained within the service itself and also raises concerns for workers regarding engaging with young people. As one worker said:

'We're dealing with really sensitive client issues in some cases, and knowing that their confidentiality will be kept within the centre is really important to building rapport.'

Staff also play a strong advocacy role on behalf of their clients in youth health services. For example, the recent introduction of area-wide electronic access to patient records widens the number of services who have access to a young person's file, raising concerns about confidentiality. Although staff acknowledge that the change provides clinicians with a fuller history of clients, staff in some area health services complain that their clients were not given adequate opportunities to comment on this practice and fear that this change could result in increased barriers for young people being able to trust health service providers. (For other examples of advocacy provided by youth health services, please refer to the Appendix, Case Study 1: LP).

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. This means that a young person may initially attend a service to participate in a creative arts group and over time establish a trusting relationship with the service, enabling them to access other services such as counselling or the medical clinic at earlier stages.

However, the recent (and ongoing) restructure of Area Health Services and the strong interest management have in rationalising and streamlining services means that young people's needs, particularly those of marginalised young people, rate poorly in a system focused on fiscal pressures and the need to consolidate physical resources. There is the concern that over time, many Area Health Service youth health services will be forced to co-locate with other services in facilities that are not youth-friendly or focused on the needs of young people. These are

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<sup>4</sup> NSW Centre for the Advancement of Adolescent Health. (2002) Access to Health Care Among NSW Adolescents, Phase 1 Final Report, prepared by M Booth et al. Children's Hospital, Westmead.

facilities that aim to meet the needs of a variety of population groups but which actually fail to sustain meaningful engagement with the very groups they claim to serve.

### ***The Burdekin Report and the IHSY funding program***

The Innovative Health Services for Homeless Youth (IHSY) Program was 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 IHSY 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'.<sup>5</sup>

In reality, however, the current levels of funding received in NSW by the IHSY program is insufficient. There have been no funding increases to this program to match Consumer Price Index (CPI) increases since the program's inception, placing further strains on Area Health Services and other funding sources which are then required to meet the growing demands. Where these additional funds are unavailable, service managers report that they are being required to delve into program costs to meet staff wages and infrastructure needs like equipment, running costs and rent.

For example, for one service in regional NSW, the IHSY funding in 1993, used to pay for 2 workers: a Health Education Officer (HEO) and a Reregistered Nurse. Now, in 2007, the IHSY funding this service receives just covers the salary and wages of the HEO, whilst the Area Health Service pays for the Registered Nurse. The Commonwealth funding clearly has not kept up with CPI and award increases.

In addition, the coverage of the IHSY program in NSW is limited. Whole Area Health Services (AHS) like Greater Southern AHS and Greater West AHS are without youth-specific health services or youth health coordinator positions.

### ***Increased demands and limitations on health service provision for at-risk and homeless young people***

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 diminishes. The recent Area Health Service restructure have 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 (and no doubt in other sectors such as community health) is often 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

<sup>5</sup> Source: <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-publth-strateg-youth-ihsy.htm>, viewed 7<sup>th</sup> June 2007.

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. Services try to inform clients about the free food vans/ 'restaurants', but often they have used their transport money for the day to get to the health service in the first place.

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.

***Emerging health issues facing at-risk and homeless young people and the need for adequate responses***

**Homelessness in rural settings**

NAAH members report concern about the lack of funding opportunities and initiatives to tackle the silent yet concerning number of young people who 'couch surf', staying with friends or acquaintances. They are not seen and subsequently not heard. For example, in the huge land mass covered by Greater Southern Area Health Service and the Greater West Area Health Service, there are no IHSY programs or youth health services which provide access to primary health care and early intervention initiatives for young people.

**Dental services**

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 centers. 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.

### **Medical services**

The rationale for including doctors within youth health services fits a holistic one-stop shop model, however medical services within youth health services have been significantly reduced in some services in recent years (either through a reduction in the number of hours available or through approval not being granted to recruit for vacant positions). In addition, the number of youth-friendly and experienced general practitioners (GPs) in local areas is often 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 often 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.

### **Mental health and Dual diagnosis**

It appears more resources are being invested in young people's mental health, which has been sadly neglected of late. However, accompanying the new funding drive comes concerns that there is too strong a focus on diagnosis and little contribution to promoting resilience or ways of enabling people. Also, youth health service providers indicate that young people are facing barriers in accessing mental health services as there appears to be a strong focus on early intervention and the first episode of psychosis. Many clients who have long standing and complex mental health issues are left with little support or available beds and so youth health services and other generalist counselling services tend to pick up the young people that mental health services exclude, without the appropriate facilities or resources to support them. This results in extensive waiting lists and decreased early intervention opportunities.

Dual diagnosis - defined here as the co-existence of a mental health problem/diagnosis with ongoing substance misuse or abuse, is a complex and multifaceted issue. This is further compounded when the onset so commonly occurs during adolescence when there is a range of physical, emotional and social changes occurring<sup>6</sup>. NAAH and the youth, health and community sectors continue to call for an exploration of the issues and challenges in addressing the needs of young people and their families/carers in relation to dual diagnosis. Young people continue to express frustration and disappointment about their (and their family members') inability to

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<sup>6</sup> Davis, C. (2003) CAUGHT IN THE GAP - Dual Diagnosis and Young people: a report on the issues. NSW Association for Adolescent Health Inc (NAAH): Sydney.

make the link between their alcohol and other drug use and their mental health problems. (Please refer to the Appendix, Case Study 2: SD).

There are also a dearth 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). The question of what services, in general, are available for these young people remains unanswered. Many youth health workers find that alcohol and other drug services refer clients to mental health services only to see the client referred back. It is an extremely frustrating situation for the young person and the services trying to support them.

Many youth health services offer primary care in mental health, however referral networks have diminished since the original Burdekin report and psychologists and social workers face a range of inefficiencies in referral pathways to psychiatrists. The referral pathways for young people with mental health issues are not standard and are complex in nature. For example, in referring to mental health services, an initial intake assessment appointment is required, and a client is then required to attend a follow up appointment up to two weeks later. In other cases, the referring service must page the relevant mental health service then liaise back and forth with the client for appointment times. Given the difficulties of engaging marginalised young people in health services, such 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.

In the case of some clients from refugee backgrounds with a significant history of trauma and complex needs, mainstream mental health services may not be equipped to provide appropriate interventions for these young people. In addition, mainstream adult mental health services are also often ill-equipped to deal with younger adult clients, especially those from marginalised backgrounds. Youth health services often cater to young people up to 24 years, and many of their clients require youth-appropriate mental health services. The lack of such an option presents a significant barrier to service.

### **Centrelink allowances**

The programs and eligibility criteria for benefits has changed dramatically since the original Burdekin report, resulting in numerous impacts on individual clients of youth health services. An increased emphasis on recipient obligations for participation and maintaining eligibility means it has become easier for recipients to be breached, resulting in accumulation of debt. Increased scrutiny and surveillance of benefits are making it difficult for young people meet the requirements. Young people who are homeless will often not have a mail address where they regularly receive mail. As a result, notifications of appointments, impending breaches or other important information is often not received until it is too late. Eligibility for the independent rate and Austudy has been tightened, resulting in greater levels of financial hardship. Centrelink debts have the potential to become part of a wave of problems with long-term negative impacts. (Please refer to the Appendix, Case Study 3: LA).

### **Accommodation & housing**

There are not enough services to provide accommodation for all the young people who present without a place to stay. Often services will turn away a young person based on drug or alcohol use or mental health concerns. There are even fewer services which will support young people with these issues. The housing needs of young people with dual diagnosis are even greater with very few services able to provide appropriate housing support for this group.

The squeeze in the private rental market, with current vacancy rates around 1.5% and rents at record levels, means that not only can young people in crisis (financial or other) often not afford private rental, even if they could there are many landlords who refuse to offer them a lease

when demand is so high. Department of Housing services are extremely difficult to access for both young people and service providers. There is a lack of transparency and clarity around roles and eligibility requirements, meaning that a young person (and services which support them) are often forced into a situation where they have no choice but to accept crisis accommodation while they wait for community or supported housing while remaining on long-term waiting lists for Department of Housing. If crisis accommodation is unavailable, young people may be forced to rent rooms in private boarding houses which are often inappropriate for their needs. Young people also increasingly report being forced to share rooms with older people they do not know, a situation which may place them at risk (particularly if they are already vulnerable). This process is counter-productive for young people who have overcome challenges in their life and require accommodation through circumstances beyond their control. It is also disempowering to young people who are capable of living independently with some tenancy support from organisations able to provide this.

### **Emerging communities**

There has been a significant increase in the number of refugees from African backgrounds in areas of metropolitan NSW, in particular from countries such as Sudan that have experienced protracted civil wars. Many of the refugees from these areas have been subject to war-related trauma such as being drafted as child soldiers and witnessing or experiencing high levels of violence. As a result, many suffer ongoing trauma and family separation or breakdown. Many members of these communities have specific and complex needs including mental health and literacy issues, requiring timely and intensive support. This support could be delivered in an intensive case-work model involving working with the young person, the family and the wider African community. Services such as STARTTS are well-placed to provide direct service delivery and training to other services, however they are insufficiently resourced to meet demand. A coordinated service approach is also required, as many people from these communities move around a great deal, crossing service agency boundaries in the process. Innovative arts-based programs have been demonstrated to be very successful in engaging these communities. Partnerships between these types of programs and services that offer intensive casework/counseling and other health services, or a service that offers all of these services in a 'one-stop shop' offer real promise for future program delivery. To date, however, 'one-stop shop' youth health services have not been not been resourced to properly meet the intensive case-work needs of these young people who engage in their services. (Please refer to the Appendix, Case Study 4: NG).

### **Alternative education**

A number of models for retaining and re-engaging young people excluded or at risk of exclusion from mainstream high schools have been developed since the last Burdekin Inquiry. In particular, Links to Learning programs, based in youth services and in partnership with local high schools, support young people who are at risk of leaving school early. The Partnership Outreach Education Model (POEM) uses a distance education framework in a youth service setting to enable young people to complete their secondary education if they have left school early or had severely interrupted schooling.

### **Transit fines**

Young people are often not eligible for concession cards because the courses that they are doing are not deemed to be full time, thus meaning they have to pay full fare, creating additional financial hardship. Also, at-risk young people are often transient and do not receive their concession card (at time or at all). Many unemployed young people simply cannot afford the costs of travel, particularly when they are ineligible for concession rates that are offered to full time students. In addition, some monthly and weekly travel cards do not offer concession rates for young people receiving allowances or student concessions. Youth health workers have noticed increased targeting of young people by transit police. Fines can be incurred when young people are using public transport to make positive changes to their lives (e.g. travelling to job interviews, accessing non-local health services, etc). Many clients have received

numerous fines and accumulated large amounts of debt with little capacity to repay, creating a cycle of further financial disadvantage (interest charges are applied to the debt), greater obstacles to employment (e.g. not eligible for a driver's licence) and further disconnection and marginalisation from mainstream society.

### **Child protection issues and reporting young people at risk**

Many youth health services are consistently reporting concerns about the reduced or in some cases lack of response to reports made by youth health services to the NSW Department of Community Services (DoCS) regarding the safety and well-being of young people.

Whilst there is a marginally better response by child protection authorities to reports regarding alleged sexual abuse, services claim that reports to the child protection authorities of young people experiencing neglect, physical or emotional abuse go without investigation and intervention.

Youth health services are especially concerned about reports by young people living with domestic violence where the non-offending parent and other family members are not able to acknowledge the violence. Youth health services often find they are supporting young people in various ways whilst the young person often continues to live within an abusive or hostile situation. This issue raises ethical dilemmas for staff about working with and supporting young people living with domestic violence where the health intervention can be misconstrued to be about helping the young person live with the violence. This is not an aim of youth health services and is not supported by the current NSW Health Policy on Domestic Violence.

In discussions with various local DoCS offices, youth health services have come to understand the limited resources DoCS have to respond to child protection matters. In particular, youth health services are aware that young people are identified by the Department as being "at less risk" than younger children, primarily because they have identified young people as being able to "remove" themselves from these abusive situations. NAAH and youth health services are concerned that young people are just as much at risk of experiencing the trauma, restrictions and impact of neglect, physical and emotional violence as other family members may be and that to "remove oneself" is not a likely option in most cases. It is noted that where young people are able to "remove" themselves from the family situation, this usually means "running away" which places the young person at further serious risk of harm and exploitation as a result of homelessness.

Lastly, it appears that the widening of mandatory reporting appears to have defined many more family difficulties as child at-risk situations and the volume of reports has made it difficult for DoCS to respond to matters other than children at risk of harm. Unless additional funding and resources are delivered to meet the increased number of reports, there seems little reason to include 'requests for assistance', even if it is supposed to encourage children, young people and families to ask for help earlier than later.

### **Pregnancy termination**

Clinics which 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.

## **Juvenile Justice**

Young people in custody and on community orders have an increased incidence of health problems including mental illness and drug and alcohol misuse compared with the general community. Youth health services play an important role in improving links between health care services in custodial settings and those in the community when young people are released from custody. These links need to be maintained to provide support, information and practical assistance for these young people. Youth health services are encouraged to see a greater focus on community alternatives to detention but strongly advocate for further investment into post-release services such as supported accommodation/ housing and employment.

### ***The need for vision and a state-wide youth health policy***

The NSW government policy related specifically to young people's health and wellbeing is in need of review. The last policy document released by NSW Health *Young people's health: our future* was published in 1999. Currently, implementation of the principles contained in the document is uneven across the state, and depends very much on support for youth health within each Area Health Service management structure. As a result, there is a lack of transparency and consultation in decision-making about the management of individual services and an ongoing issue about how to measure quality, as there are no commonly agreed benchmarks informed by evidence. The NSW Association for Adolescent Health (NAAH) has been working with youth health services to develop a comprehensive quality tool and it is hoped that this tool will be compatible with different data collection systems used by the various Area Health Services and resourced accordingly.

The youth health sector looks forward to participating in the development of a new NSW Youth Health policy. Despite the various challenges currently facing youth health services in NSW, their work continues to demonstrate alternate models of health service delivery in a system that is slowly starting to shift from a tertiary care focus to an early intervention and primary and community health care focus. The introduction of the NSW State Plan, the NSW State Health Plan and NSW Health Integrated Primary and Community Health Policy indicate a shift in values and priorities for the NSW Government, from a focus on tertiary care to a focus on primary health care. However, despite this being an exciting time for youth health, until Chief Executives of Area Health Services endorse and fulfil the requirement of mandatory implementation plans, placing the health needs of young people, particularly homeless and marginalised young people on the agenda, it will continue to be a slow but steady process.

Thank you for providing NAAH with the opportunity to provide comment during the National Youth Homelessness Inquiry process. We welcome the opportunity to discuss these matters further and to participate in future forums to address or further elaborate on these concerns.

Yours sincerely



**Vanessa D'Souza**  
**Executive Officer**  
**NSW Association for Adolescent Health Inc**  
**On behalf of the youth health sector**

## **APPENDIX: Case studies of typical clients**

*(Note – basic facts are taken from real cases. Some details such as initials, age, area of study, occupation, geographic locations etc have been slightly altered to protect the privacy of clients.)*

### **Case Study 1: LP**

1. **“LP”**: LP is an 18-year-old Aboriginal female. She has several older and younger siblings and step-siblings, several of whom have at different times have been taken into the care of the Department of Community Services (DoCS). LP’s parents are separated and she has had intermittent contact with her father from a young age. She has a history of depression and suicide attempts, for which she has previously received psychiatric treatment. Both her parents have a history of mental illness including schizophrenia, depression and bipolar disorder. At the age of 13 a DoCS notification was made in respect of LP for neglect and physical abuse. LP was then removed from her mother’s care and placed in a refuge for young people where she stayed for 12 months. She then moved in with family friends but shortly after was forced to leave due to conflict. Since then she has moved between refuges and short periods staying with friends and extended family. LP has been unhappy with care arrangements made on her behalf by DoCS, and wants no further involvement with DoCS. As a result of behaviour management issues LP was expelled from 2 schools and asked to leave some of the refuges. Her behavioural issues have improved markedly in the last two years, and she has been able to set and achieve both short and long-term goals. Her living skills are good and sufficient for her live independently with minimal or no support. Although her living circumstances have been highly unstable, LP has completed her schooling and enrolled in a TAFE diploma in community services management.

LP presented to the youth health service at the age of 18 when 30 weeks pregnant seeking assistance to obtain appropriate accommodation after her child is born. The child’s father is in gaol and will not be eligible for release for another 3 years. Having recently presented to the service, LP is receiving Centrelink youth allowance and rent assistance (\$452 per fortnight). She is currently staying with friends, but has been told she will only be able to remain until her child is born. She is not registered with the Department of Housing, and as she has always made informal accommodation arrangements, she has no rental history. She is studying in a location close to the city, and needs to be close by and located near pram-accessible public transport in order to manage her parenting responsibilities and study arrangements after the birth of her child. She has a network of family and friends in the area who will be able to support her, and also receives services in the area.

The youth health service has assisted her to register with the Department of Housing, and advocated for her to be given priority housing. She was placed on the waiting list but was refused priority housing on the basis that there is no reason she is unable to rent on the private market. Having spent many years in and out of refuges, LP did not want to enter a refuge as she felt it would be a step backwards from the positive changes she had made in her life. However, with no options she was forced to accept crisis accommodation, where she remained after the birth of her child, awaiting a vacancy in a longer-term accommodation option.

### **Case Study 2: SD**

2. **“SD”**: SD is a 19 year old, transgender young man who has accessed a youth health service on and off and has done for a number of years. SD identifies as male, but was born female. He has received hormone treatment in the past, although instability of treatment and contact with services makes this very difficult. He reports living in a number of different

squats located close to the service. It is unclear how long he has been homeless, but it is suspected to have been from an early age. SD provides very little information about himself or his history, though presents as very isolated, reporting no contact with family, and no friends, though he has had partners at times. He accesses multiple services within the youth health setting – basic needs (showers, food, laundry), medical and arts programs, and drop-in. He engages in sex work and IV heroin use, for which he obtains safe sex and clean injecting equipment from the service.

After the break down of a relationship, SD presented more often, and more often in distress. He began to use amphetamines, and his use quickly escalated to daily use.

SD regularly presented with cuts and sores, which are believed to have been self-inflicted. He has also expressed thoughts of self-harm and suicide. However, when questioned directly around his safety, and given the option of calling the Mental Health Team, SD has never described feeling unsafe. When the mental health team was called due to concerns for his safety, SD would leave the service to avoid seeing them.

SD's presentation became marked with frequent mood swings, impulsive behaviour which was violent and abusive in nature. SD has been arrested on numerous occasions for theft and violent behaviour. SD presented frequently intoxicated, and often during these times his thoughts were delusional in content. When not intoxicated SD would not present with delusional thoughts or with interrupted thought patterns. SD was encouraged by staff to address the issue around his drug use and mental health, however SD stated that he did not wish to address his substance use, and was frequently intoxicated in counselling sessions, making intervention difficult in the area of mental health. Police have reported that they transported SD to a psychiatric institution on numerous occasions requesting that he be admitted. Police report that this request has not been met due to SD's drug use.

The following interventions were undertaken:

- SD regularly accessed the Basic Needs Program for food, showers, and laundry services. He also regularly engaged with the intake worker for emotional support. During these visits he was supported to access other services both within and external.
- Assistance provided to SD to register with Centrelink to obtain financial assistance.
- SD accessed medical services to address cuts, infections etc, as well as to access hormone and anti-depressant medications.
- SD made a referral for counselling and attended approximately 3 sessions.
- SD engaged with an Arts Worker and started attending an arts program
- SD was encouraged to access The Gender Centre, but lack of consistency in attending appointments and staff shortages made it difficult to coordinate a visit from the Gender Centre Worker.
- SD was supported to access drug and alcohol services and mental health services, though these offers were not taken up.
- SD was regularly offered support accessing accommodation services. SD stated that he wouldn't go to a refuge as he didn't feel safe in them.
- Numerous attempts were made by staff to obtain assistance from both Mental health Services and Drug and Alcohol Services, though these requests were limited by SD not wanting to access any other services.
- Requests made to Mental Health Services that he be considered for admission. In addition, that liaison with Drug and Alcohol services, jointly with mental health, address his presenting drug and alcohol and mental health concerns.

SD was eventually gaoled for assault, and maintains contact with the service while in prison. Key issues pertaining to SD's case include

- Lack of safety in accommodation services, particularly transgender young people.
- Lack of responsive mental health care that is able and willing to respond to client distress regardless of substance use issues.
- Lack of a coordinated response between mental health and drug and alcohol services which would allow 'dual diagnosis' to be less of a 'hot potato'.
- Lack of internal psychiatric support
- Youth health providing the only link to the healthcare system and responding in a way that allows ongoing engagement with the client.

### **Case Study 3: LA**

3. "LA": LA is a 22 year old female with a long history of depression, self-harming behaviour and repeated suicide attempts, resulting in several hospital admissions. She left home at the age of 16, having been subjected to physical and sexual abuse by her father, and moved between various refuges and short-term supported accommodation before finding long-term supported accommodation 2 years ago. Initially LA received Centrelink Youth Allowance, supplemented by short-term and intermittent casual work at times when her mental health permitted. LA's mental state, together with alcohol and other drug problems, have resulted in her becoming disorganised and creating complex difficulties resulting in chaotic and often isolated life circumstances. She has found it difficult to maintain routines and therefore comply with administrative tasks of Centrelink. At one point, she was engaged in steady work and failed to report her income, resulting in her accumulating a debt. When she did report, the accumulated debt was deducted from her weekly payments. Not long after, LA was forced to move suddenly and found herself in an uncertain housing situation. She did not have a contact address to report to Centrelink and with her circumstances changing rapidly, found it difficult to keep them updated. During this time, Centrelink sent her a letter updating her of her mutual obligation requirements, which she did not receive. When she again made contact several weeks later, she had accumulated an additional debt, further reducing her weekly payments to a level insufficient to meet her needs. The financial pressure this created led to LA engaging in sex work rather than face and deal with the administrative requirements to resolve her debt issues with Centrelink.

### **Case Study 4: NG**

4. "NG". NG is approximately 20 years old – his exact age is not known as he was born in a rural area of Sudan where records were not always kept, or were lost during the war. At the age of nine, his village was caught up in the war, and several members of his family were attacked. He and his older brother were separated from the rest of their family during the attack, and subsequently forcibly drafted into the army. As part of his induction process, he was forced to watch and commit a variety of violent acts which haunt him to this day. He served in the army until the age of 12, when he and his brother escaped. Initially they survived on the streets in the towns and cities of Sudan, before fleeing to Kenya, where they lived in a refugee camp. During their time on the streets and in the camp, they relied on the support and protection of petty crime gangs. With their gang "brothers" they developed their own rules and moral codes, and became involved in drug use to help them cope with the trauma they had experienced through the war and separation from their families. Often stealing food was their only option to avoid going hungry.

After two years in the refugee camp, they were sponsored by a distant relative to receive a special humanitarian visa to migrate to Australia. The conditions of the visa required that

their sponsor provide funding to cover most of their material needs for their first two years in Australia. Their sponsor, herself traumatised by war experiences and with a heavy financial burden to support family still in refugee camps, was unable to continue providing support beyond the first six months, and asked NG to leave. Since his sponsor had been responsible for him in those initial months, NG was unaware of many of the services available in Australia, and in any case was distrustful of authorities and did not understand how service provision worked in this country (in his experiences outside Australia, all services typically required payment). By this time he was 16 and permitted by law to live independently. He was registered for Centrelink youth allowance and enrolled in a number of study programs, but due to his experiences and ongoing drug use behaviour management became an issue and he was suspended. Other study attempts were disrupted due to custodial sentences.

With no experience of living independently and limited literacy and numeracy, he typically spent all his allowance within a couple of days, leaving him unable to pay for food and transport. He increasingly relied on friends with similar backgrounds for support and again became involved in petty crime as a way to survive. He suffered symptoms of post-traumatic stress disorder and increasingly used drugs to alleviate the symptoms, resulting in ongoing mental illness and culminating in drug-induced schizophrenia. While delusional, he committed an armed robbery and was arrested. He was found guilty and sentenced to 6 months detention in a juvenile justice facility. During his time in detention, he was diagnosed with drug-induced schizophrenia and placed on medication. Upon release, he was referred to a mental health service for ongoing follow-up, and compelled to attend appointments as part of his probation conditions. Although the medication stabilised his condition, he was not able to access stable, ongoing case management support to improve his basic living skills such as budgeting and cooking, as well as strategies to deal with his drug use. As a result he continued to rely on his "brotherhood" for support, and engaged in petty crime to support his survival. Shortly after turning 18, while still under a supervision order, NG was arrested for stealing apples. He was remanded in custody before being found guilty and sentenced to a further 6 weeks custody. For reasons unknown, it was a further 3 months before he was released. During this time, he did not receive any mental health care, although his drug use did cease and he has since improved.

NG speaks four languages fluently, including English, which he learned during his time in the refugee camp. However, having received almost no basic schooling, his literacy and numeracy levels are below basic functional benchmarks. He has commenced a number of courses to improve his literacy and move on to other training programs, but has always been asked to leave due to disruptive behaviour. Centrelink have enrolled him in a support program to assist him to overcome barriers to training and employment, however he is only required to attend the office once per month, and there is no requirement for him to receive a proper vocational assessment and be enrolled in appropriate education to improve his basic literacy and receive intensive support to develop the study skills most people develop when they participate in primary school education.

For the first several years that NG was in Australia, he did not know what had become of his parents and several siblings. Eighteen months ago he and his brother received news that his father and a younger brother had been living in a refugee camp in Uganda for several years. Shortly after, he learned that an older sister and younger brother were living in similar circumstances in Kenya. He also learned that his mother had died several years ago. His father and younger brother recently were granted a visa to immigrate to Australia, and for the first time in many years NG has been living with his father and younger brother. Since he does not automatically qualify for the independent Centrelink rate, NG's allowance has been reduced to the dependent rate as a result of him living with his father. The years of separation and the violence and trauma they have been subjected to have taken their toll, and the family experiences a high level of conflict.

With little in the way of social supports, and with his traditional role in the family eroded by the family's experiences and his son's forced premature independence, NG's father appears to be suffering from an untreated mental illness, is occasionally violent towards his sons and often leaves the family home to seek itinerant labouring jobs. The family also feels a responsibility towards NG's siblings still living in Kenya, and regularly send whatever money they have to support them, often leaving nothing for food and other basic essentials. NG regularly travels on trains without a ticket and has accumulated several thousands of dollars in transit fines. Recently he spent part of his allowance without his father's permission, resulting in conflict and his father evicting him from the family home. His older brother has moved away in the search for work and is unable to offer him accommodation. NG sought emergency assistance from the Department of Housing, and was placed on the priority list. After one week in emergency accommodation, he was advised by the Department that he would need to make an attempt to find private accommodation. At the time of writing, he is living in a men's refuge in a dormitory with several men with a long history of homelessness and imprisonment. It is unclear what his future holds.