

beyond the revolving door  
**Beyond the Revolving Door:**

A Model for Improving  
Support and Accommodation  
for Young People  
with Mental Health Issues

2001

The logo for the Youth Affairs Council of South Australia (YACSA) is a purple, textured oval shape with the acronym 'YACSA' written in white, bold, uppercase letters in the center.

YOUTH AFFAIRS COUNCIL OF SOUTH AUSTRALIA

# Youth Affairs: A Statement of Policy Principles

YACSA believes that the interests of young people in South Australia must be taken into account in public policy decision-making. The objectives of public policy must be the elimination of poverty, exploitation, alienation and all forms of discrimination, including racism and sexism.

The Council believes that economics and political processes must address the basic needs and social harmony of all young South Australians. The first priority of social justice is to guarantee the right of all to the common wealth. This means more than special programs for those young people classified as 'disadvantaged'. Social justice requires action which tackles the structural causes of discrimination, poverty and powerlessness, and which leads to a more inclusive and tolerant society.

Our concern is not only about the rights of young people, but also about any circumstances which deprive the community of the resource that it has in its young people.

YACSA works for fair policies and programs for young South Australians, guided by the principles outlined in its Youth Policy Platform.

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# Part 1: Executive Summary

Because of concerns that homeless young people with high and complex needs including mental health issues are not being well served by accommodation, support and health services, YACSA has conducted consultations with providers and consumers. The key findings of those consultations are also supported by various recent reviews and research into this area, and a new approach and specific proposal are presented.

## **1.1 THE ISSUES**

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In summary the findings are that services are characterised by:

- High and increasing demand associated with the combination of mental health problems and homelessness leading to higher rates of hospitalisation, arrest, misuse of alcohol and drugs etc
- Increasing numbers of young people presenting to agencies with an increasingly severe range of problems in relation to:
  - Sexuality related issues
  - Behavioural problems
  - Substance abuse
  - Depression/anxiety
  - Violence/anger
  - Grief/loss
  - Homelessness
  - Physical and/or sexual abuse
- Fragmentation of services, especially given that clients usually present with multiple needs that may require the involvement of multiple agencies across several sectors
- A tendency for 'difficult' clients to be 'handballed' to other services – that is, referred without any communication between agencies
- A particular shortfall in supported residential services with access to mental health outreach and support
- A concentration on highly focused, short term, acute crisis management casework at the cost of continuity of care and a community development capacity
- A pressure to meet the funding body numbers – output not outcomes
- Restrictive eligibility criteria (age, geographic, diagnostic and behavioural) especially for high need/severe cases, leading to

exclusion and consequent exacerbation of mental health issues, homelessness, and associated problems

- Poor communication across sectors, characterised by confusion about respective roles and expectations
- A lack of flexibility of response from many agencies, failing to address the widely varied immediate needs of young people, and therefore failing to engage with them

One major consequence of this situation is that a relatively small number of young people with high and complex needs, whose extreme and repeated behaviours have effectively excluded them from SAAP accommodation and other supports, are relying on hospital admissions for accommodation and support and creating a significant demand on police and the criminal justice system. The costs to government incurred by this small group are substantial. This proposal argues that a comparatively small investment in a new capacity-building service could significantly reduce these costs.

## **1.2 APPROACH AND PROPOSAL**

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There is a consensus across human service agencies working with homeless young people with high and complex needs that the capacity of agencies to retain and work constructively with these clients needs to be developed. There is also a consensus that there is a need for a residential service that can manage and support these young people in extreme circumstances, as an alternative to hospitalisation or worse.

This proposal is for a Transitional Support Unit (TSU) whose predominant role will be to support existing workers in agencies such as SAAP accommodation projects to continue to provide shelter for young people with high and complex needs, but also to ensure continuity of purposeful case management, access to specialised services such as mental health care and a backup residential facility in the case of behavioural problems that accommodation projects cannot be expected to manage.

The TSU would aim to integrate existing services through facilitating transition across services and supporting services to cope with clients they might otherwise consider referring on before the case had stabilised. The combination of outreach support and residential streams is also ideal for building training and evaluation and research streams. Training of staff in other agencies through coaching and preceptor models is implicit to the approach. Evaluation should be a major component in testing a new approach to service integration.

The key features of the TSU are:

- A highly skilled multi-disciplinary team of up to ten staff, with a primary focus on providing outreach support to services for young homeless people with complex needs
- A small residential unit with capacity for up to eight residents
- Acceptance of residential referrals conditional on establishment of agreed case management arrangements involving the referring agency. Expectation that residential stays will be short term and that in most circumstances, clients will return to referring agency, with continuing outreach support from TSU
- Clients will not be referred on from TSU unless stabilised and with an ongoing case management plan in place
- TSU staff will provide support and training to staff of referring agencies in relation to referred clients
- TSU budget less than \$800,000
- Funded jointly by SAAP and the Department of Human Services
- Expectation to prevent further hospitalisations and self-harm of referred clients within three months of referral

## Part 2: Background and Purpose

The purpose of this paper is to report on the problems, and opportunities for improvement of services providing support, accommodation and treatment for homeless young people with mental health issues. This paper was commissioned by the Youth Affairs Council of South Australia to explore these issues and to provide the basis for a negotiating proposal to the South Australian Department of Human Services. The Youth Affairs Council of South Australia (YACSA) held a workshop for workers in the field (see Appendices 1 and 3) and several consultations with young people who use or could use services (see Appendix 2). Reports of the consultations with workers and young people appear as appendices to this proposal. The consultants (Dr. Kathy Alexander and Mr. Paul Laris) also met with workers and managers and worked with the YACSA Health Policy and Advocacy Group in the development of this document.

This process was initiated by YACSA because of concerns that a group of homeless young people with acute mental health and behavioural problems were being further marginalised by the way in which services were operating. Their behaviour meant that they may be excluded from many accommodation and support options at a time when their needs were greatest.

Systemic problems of fragmentation of services and barriers to access impact most severely on this group and YACSA believes that better models of care can be developed which can help build the capacity of these young people, at the same time as reducing costly and inappropriate dependency on crisis medical and criminal justice system services. The aim is to address both the immediate gaps in service, and, because these problems have been reported nationally, to develop a model with the potential for wider application.

The YACSA Health Policy and Advocacy Group is comprised of:

- Claire Ralfs, Centre of Personal Education (COPE) – Chairperson
- Dorian Marsland, Shopfront Youth Health and Information Service
- Pip Messent, Second Story Youth Health Service
- Adrian Miller, Child and Adolescent Mental Health Service (Marion Team)
- Wendy Fraser, St Johns Youth Service
- Kym Davey, Youth Affairs Council of South Australia (YACSA)
- Michael Colin, Adelaide Central Mission

## Part 3: The Problem

### **3.1 ADOLESCENCE – A PERIOD OF TRANSITION FOR ALL, AND CRISIS FOR SOME**

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Young people in transition are maturing from adolescence into young adulthood. This process involves acquiring a number of developmental capacities, including a sense of personal identity, emotional self-control, an ability to think in terms of relationships and consequences, moral development, a capacity for empathy and a shift from the independence of the young adolescent, to the interdependence of the social adult able to form and maintain close relationships<sup>i</sup>.

This is not an easy task for any young person. Mental health problems are more prevalent in young people than in adults. The Second Story Youth Health Service sees over 700 young people per year, or 10.74% of all attendances, for mental health reasons<sup>ii</sup>. However, as well as mental health issues, some must also cope with homelessness and a constellation of other challenges which can include drug and alcohol dependence, unemployment, lack of stable income, racism, social isolation and loneliness, the effects of physical and/or sexual abuse, involvement with the criminal justice system, and even the task of raising small children of their own. For the sake of brevity, this report refers to this group as young homeless people with high and complex needs.

For some of these young people, these challenges lead to behavioural problems that are difficult for basic accommodation and support services to address. Participants in the youth consultations described a cycle of anger leading to violence, drug/alcohol use and crisis, and stated more counselling and mental health services were needed to talk about feelings and explore helpful strategies to deal with problems (see Appendix 2). Obviously such people are very likely to require significant levels of highly skilled support. However, the response of South Australian human services to the needs of young homeless people with high and complex needs appears seriously flawed and is characterised by inadequate resources, fragmentation, barriers to access, lack of coordination and significant gaps in service. Furthermore, a number of features of the way in which services are organised and the way in which they respond, tend to contribute to some of the difficulties such young people face.

### **3.2 MENTAL HEALTH AND HOMELESSNESS**

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The prevalence of mental health issues in the homeless population is high, with rates of 70% to 75% of people in emergency accommodation having at least one mental disorder being cited in the literature<sup>iii</sup>. A survey of SAAP crisis/emergency accommodation projects in 1997 found 42% of people interviewed were positive for psychosis<sup>iv</sup>. Craze has observed that:

*Those people with mental illness at most risk of becoming homeless have higher rates of hospitalisation and arrest, are more likely to abuse alcohol and drugs than other patients, have higher psychiatric symptom levels, and are less likely to comply with medication<sup>v</sup>.*

Given this pattern of service use, it is apparent that increased demand on high cost crisis management services, such as hospital emergency departments, police, and criminal justice systems, is a likely consequence of the lack of effective 'upstream' support based in accommodation projects designed to cater for this population.

### **3.3 PRESENTING ISSUES**

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Youth workers and youth mental health workers who attended an Adelaide workshop (see Appendix 3) as part of the research for this paper noted that their agencies, especially those dealing with severe problems such as self harm and violence are facing increased demand and applying selective eligibility criteria in order to protect themselves. Their impression is supported by SAAP data that shows a 9% national increase in support periods provided and an increase from four to six days in the median length of support periods from 1996–1997 to 1999–2000. In South Australia the number of support periods rose by 5.3% in the twelve months to June 2000<sup>vi</sup>. Workers at the Adelaide workshop reported that young homeless people with mental health problems are presenting with a range of problems including:

- Sexuality related issues
- Behavioural problems
- Substance abuse
- Depression/anxiety
- Violence/anger
- Grief/loss
- Homelessness
- Physical and/or sexual abuse

In addition, the consultation identified sub-groups within the population of young people with high and complex needs who face particular obstacles. These were Aboriginal young people, people from regional, rural and remote settings and young people (usually women) caring for young children.

As well as listing the issues facing young people with high and complex needs, the participants in the consultation also agreed that demand for services from this group was increasing at a greater rate than services were able to keep pace with, and that there was also a qualitative change in the nature of that demand, with new referrals likely to exhibit more angry and violent behaviour than in the recent past.

### **3.4 LIMITATIONS OF THE LOCAL SERVICE RESPONSE**

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The capacity of services to respond to these increasing needs is limited by the degree to which they can:

- Provide appropriate access points
- Successfully engage with young people
- Provide a broad and flexible range of services
- Make effective interventions and
- Build the capacity of the young person over the longer term

South Australian human service workers<sup>vii</sup> working with young people in the health, mental health and supported accommodation fields, and the young people themselves, show a high level of consensus in their views on the key limitations of current services:

1. Lack of time/resources/places to meet increased demand for services – especially for supported residential services with access to mental health outreach and support. Young consumers commented that funding cuts to services mean that preventative services are less likely to be available, thus creating more crisis situations
2. A concentration on highly focused, short term, acute crisis management casework at the cost of continuity of care and a community development capacity. For young people with high and complex needs, this can mean not being able to access a service until the situation has reached crisis point. As one of the participant consumers in the young people's consultation said: "You've got to go down to get your needs met, go up when they're met, then go down again to get them met again" (Appendix 2)

3. A pressure to meet the funding body numbers – output not outcomes
4. 'Handballing', which occurs when a young person with multiple needs gets referred to another service without the workers talking to each other. According to the young people consulted as part of the preparation of this proposal, 'handballing' is a frequent occurrence (Appendix 2)
5. The lack of sustainable funding. Services dominated by short-term projects funded on a contract basis. The resulting lack of continuity discourages the development of well-coordinated and integrated services and long-term social capital development
6. Fragmentation of services, especially given that clients usually present with multiple needs often including accommodation, mental and physical health care, relationships issues, income support, substance abuse, effects of physical/sexual abuse, etc, that may require the involvement of multiple agencies across several sectors
7. Restrictive eligibility criteria (age, geographic, diagnostic and behavioural) especially for high need/severe cases, leading to exclusion and consequent exacerbation of mental health issues, homelessness, and associated problems – as well as lack of access
8. Poor communication across sectors, characterised by confusion about respective roles and expectations, and excessive use of jargon, contributing to a lack of continuity of care and greater barriers to access
9. A reluctance from some workers to step beyond professionally/organisationally-defined turf, narrow over-specialised roles and a lack of 'risk-taking'
10. A perceived lack of trust between agencies and across the human services sector
11. A lack of flexibility of response from many agencies, failing to address the widely varied immediate needs of young people, and therefore failing to engage with them
12. Competitive tendering, both workers and consumers agreed, has worked against inter-agency collaboration and discouraged providers from publicly acknowledging problem areas

13. Inappropriate values and attitudes towards young people from some of those who work with them, including youth workers, police and teachers, have acted as a barrier to access
14. Services need to be culturally appropriate and non-judgmental. There was strong agreement from young consumers that those services who provide appropriate and accessible services (cost-free, culturally appropriate, etc) attract more demand
15. A lack of awareness or understanding of the structure of the Department of Human Services which is perceived as an impediment to more effective coordination of services particularly between hospital and community based services

### **3.5 THE SYSTEMIC PROBLEM OF CONNECTING WITH SAAP**

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One of the key barriers to addressing these issues is the lack of a capacity to 'wrap services around' the person in the person's own setting. Many of these young people spend considerable periods in SAAP accommodation projects and in many cases this would be the logical foundation for linking with other services and resources. However, the 1999 national evaluation of SAAP III found an alarming and continuing incapacity in SAAP programs to link adequately with other services<sup>viii</sup>. The authors noted that SAAP projects dealt with homeless clients who had needs across a number of sectors. Furthermore, addressing these needs was crucial to enable clients to establish a successful transition to their own accommodation and independent community living. However, SAAP projects generally had not been successful in making the links to facilitate access to those services. The evaluators go as far as to note that this failure "is one of the main barriers to the timely and appropriate delivery of support to the homeless or those at imminent risk of becoming homeless".

They note also that a recent report on people with 'high needs' within the SAAP system estimated that approximately one in five clients will require the provision of at least seven different types of support in response to intensive needs. However the development of links with crucial services including public and crisis housing, income support, mental health, employment, education and training has been lacking. Even where protocols have been developed, full implementation often has not followed.

Yet, the potential centrality of SAAP accommodation projects in addressing mental health issues for marginalised young people is widely acknowledged. *Monograph 2000* is described by the Federal

Department of Health and Aged Care as providing the theoretical and conceptual framework for Action Plan 2000, setting out the key mental health promotion activities for Australia's National Mental Health Strategy<sup>x</sup>. *Monograph 2000* specifically identifies SAAP accommodation projects as settings for partnerships with mental health services and calls for policies across sectors to facilitate such partnerships. The Action Plan specifies homeless youth programs as linked initiatives expected to influence the achievement of mental health outcomes.<sup>x</sup> However, this potential remains largely unfulfilled.

### **3.6 MENTAL HEALTH SERVICES FOR HOMELESS YOUNG PEOPLE**

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A recent national consultation on young people's views on mental health and mental health services<sup>xi</sup> found that the young people interviewed felt it was most important that a service should have expert and knowledgeable staff, that it should have workers who are "useful and helpful", and that it should provide assistance in a confidential or anonymous fashion. The homeless young people interviewed in the consultation reported that practical survival needs such as housing, money, clothing, food and furniture were closely interrelated to their mental health. Sometimes providing such support to an appropriate extended family member could avoid the need for external accommodation, but this was rarely offered.

Frequent experiences of abuse, mental illness in the family, personal drug use and attempted suicide were not uncommon. Some self-medicated using street drugs and alcohol. The report noted that some young people said it was often hard to distinguish the effects of everyday struggles from mental health issues and vice versa: 'It's everything all in together, you can't get on top of things'.

These young people made a clear distinction between the relationship they might develop with a non-therapeutic youth worker (such as a worker at youth drop-in centres) and those with social workers, case managers, etc. The youth worker who was non-judgmental, helped address basic needs, would trust and was trustworthy, and would 'be on your side' was seen as someone you could open up to, in your own time, if you so chose. They knew about street life and would not suggest what was perceived as silly or unworkable solutions.

On the other hand, psychiatrists, especially in the public system, were seen as "naive, judgmental, ignorant of youth culture, easy to fool, ignorant around drug taking, unaware of child abuse issues, ill-informed about issues of sexuality, not to be trusted and likely to breach confidentiality." The Report cites anecdotes of young people being

admitted to psychiatric hospitals having attempted suicide after leaving an abusive home situation, and then being counselled to return to the abusive situation. There were also reports of young people being kept in hospital for long periods, because appropriate alternative accommodation could not be found.

These concerns echo those of Sawyer, Meldrum et al<sup>xii</sup>, who conducted a national consultation on youth mental health services in 1992. Staff in health, welfare, youth, and education services, members of professional organisations, members of self-help groups, young people living in the community, and young people attending mental health services were interviewed as part of the consultation. Over 90% of the participants reported that there were gaps in the mental health services offered to 15 to 20 year olds:

*The most frequently mentioned gap in mental health services was an absence of residential facilities for young people. This included a lack of inpatient facilities for young people with acute psychiatric disorders, a lack of secure facilities for young people who are considered a danger to themselves or to others, a lack of non-medical residential programs providing both long-term accommodation and short-term respite care, and a lack of supported independent accommodation. Particular groups of young people were felt to lack adequate access to mental health services, including young people living in rural areas, disadvantaged young people such as street kids, Aboriginal young people, young people who belong to minority ethnic groups, and young people with conduct disorders.*

### **3.7 THE SITUATION IN SOUTH AUSTRALIA – SOCIAL AND ECONOMIC COSTS**

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The consultants attended a number of consultation meetings, conducted interviews with key service providers and consumer advocates and reviewed available literature. They note that:

- SAAP/CAP programs in South Australia provide accommodation for approximately 4,200 young people per year, at average cost of approximately \$2,500 per client<sup>xiii</sup>. At any given time there would be approximately 300 young people using SAAP accommodation
- Of these, a small minority (anecdotally estimated to be ten to thirty at any given time) suffer acute psychiatric or behavioural disorders frequently associated with substance abuse, are a danger to themselves and others, and are making frequent use of acute

- hospital services and/or become involved in criminal behaviour and the police and justice systems
- In addition to this small group it is estimated by the YACSA Health Policy and Advocacy Group that there may be up to 150 young people outside the SAAP system. This group of individuals incurs considerable individual and aggregate cost to the various government and non-government agencies involved in dealing with their care and the consequences of their behaviour. One such case that came to depend on admissions to hospital for emotional support and comfort is described below. Another group of three was estimated to have cost around \$750,000 in six months, with up to thirty workers attending one case conference<sup>xiv</sup>
  - While it should be emphasised that extrapolation from these figures is at the best, only indicative, a conservative estimate for the total cost to government for this group would be a minimum of \$3m per annum in South Australia

### **CASE STUDY: MS X**

Aged 18, user of SAAP sector services since age 14. Has accessed six SAAP accommodation services and three non-accommodation services. Agencies involved have included:

- Carlow Place (SAAP)
- St John's Youth Services (SAAP)
- Port Youth Accommodation Service (SAAP)
- Ruby's (SAAP)
- Adolescent Services, Enfield Campus (Health)
- Youth and Parent Services Counselling (SAAP)
- Hospital Links (Adelaide Central Mission and Health)
- Women's and Children's Hospital (Boylan and Adolescent Wards)

Presenting problems have included:

- Depression
- Suicide attempts
- Self-harming
- Anger
- Temper tantrums
- Destruction of property
- Threatening behaviour
- Noncompliance with service rules
- Refusal to attend appointments
- Refusal to interact with staff

Long-term accommodation services could not deal with Ms X's behaviour, and she used 126 nights in emergency SAAP accommodation over twelve months. She used a total of 240 nights of SAAP. She also spent 83 nights in hospital, had 28 counselling sessions with Youth and Parent Services and numerous contacts with other agencies. She is estimated to have incurred costs of \$67,000 for SAAP and hospital services alone in the twelve-month period.

### **3.8 PERSISTENT THEMES OF SERVICE INADEQUACY**

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When Sawyer, Meldrum et al conducted their 1992 consultations<sup>xii</sup> they concluded that there were some specific problems in relation to residential service facilities for young people. The list below has been adapted from their recommendations. It is apparent from the more recent reports and workshops conducted as part of developing this paper that little has changed in the intervening years.

- A lack of non-medical residential programs which can provide both accommodation for young people over longer periods of time, and respite care for short periods. It was suggested that these residential programs benefit from support provided by staff working in mental health services
- A lack of supported independent accommodation for young people. This was considered to be a particularly important issue for young people who have recently been released from institutions and for young people recovering from major psychiatric problems
- A need for staff in mental health units to offer services away from their units. Staff working in mental health units should be willing to "go to where the young people are", rather than expecting them to attend a centrally located unit
- Many participants noted that staff working with young people who suffer from mental health problems are often inadequately trained. It was felt that such staff need specific knowledge and skills in order to provide optimum care for young people. A lack of training for staff about the aetiology, nature, and management of mental health problems disadvantages young people with mental health problems

### **3.9 HOUSING AFFORDABILITY AND INCOME SECURITY**

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These problems of gaps in service, fragmentation and barriers to access should be considered in the context of the wider and interrelated questions of housing affordability and income security. According to a recent submission from Melbourne's Citymission<sup>xv</sup>, the funded homelessness sector is "flooded by the failures in other elements of the housing, justice, child protection and social support systems". This is a view that has been echoed by several Adelaide managers of NGOs. The authors argue that a retreat by governments from the provision of low cost public housing has reduced supply, and contracting welfare services to private providers has led to fragmentation, despite a rhetoric of collaboration. They also cite Centrelink breach policies as having reduced the capacity of young people to obtain and maintain

independent rental accommodation. Young people with a mental health problem may try to avoid the stigmatisation of formal diagnosis, but still suffer from the effects of their condition which may lead to an inadvertent breaching of Centrelink rules. Citymission comments:

*It is also disturbing to see increasing numbers of people approaching our youth homelessness services and crisis support settings who are experiencing a crisis due to being 'breached' by Centrelink. This agency [Citymission] believes that the current policies and practices are actually reinforcing the existing disadvantages experienced by these groups rather than the intended effect of stimulating increased participation in the labour market.*

### **3.10 THE VICIOUS SPIRAL OF EXCLUSION**

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Sadly, some those who are breached by Centrelink – partly because of their mental condition – and made homeless because they no longer have the money for rent may face growing disadvantage when they seek emergency accommodation, especially if their mental state worsens and they behave in violent or unpredictable ways. Such behaviour is likely to lead to further exclusion. SAAP accommodation services frequently ban such young people because the services do not have the skills or resources to manage and support them, partly as a consequence of the poor links from the SAAP sector to mental health and other services.

The young people who participated in the consultation (Appendix 2) considered the waiting period on obtaining income support and housing a significant barrier that seemed to apply to young people with mental illnesses particularly, because of their situation often being more complex to deal with. These waiting periods contribute to the onset of crises because problems can worsen over time, with little or no support being present from immediate networks in the interim.

A recurrent theme also emerging from the focus groups with young consumers and their peers was the cyclic chain of events induced by the combination of housing and mental health needs – needing income to get a house, needing an address to get an income, mental illness restricting chances of getting a house. This situation can bring on the crisis point more rapidly. The process of fragmentation, barriers to access, exclusion, disadvantage, exacerbated mental health problems, further exclusion, and further disadvantage can easily become a vicious downward spiral for which both the individual and society pay dearly.

## Part 4: Key Principles and Approach

### **4.1 OVERVIEW OF THE MODEL**

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The nature of the problem as outlined above and examples of successful responses suggest that these young people with high and complex needs would benefit from an independent outreach and worker support program that incorporated a non-medically based residential program with strong links to mental health services. Such a service would also divert demand from acute care and criminal justice services. In this model, the outreach and residential functions support and inform each other, and staff roles encompass both.

Examples of services using elements of this approach include Sandridge in Melbourne and Ruby's in Adelaide. The experience of the Richmond Fellowship's Sandridge program has been that:

*This particular client group is most effectively worked with in the community rather than in a hospital or mental health setting. The less pathologised or medicalised their situation is, the more effective early intervention strategies are. Program staff, therefore, see themselves as utilising a social development model. To this point in time, the standard response to self-harm, suicidality, borderline personality disorder, etc, is a mental health one. Program staff feel that this approach is misguided and does not match the results of the Sandridge approach<sup>xvi</sup>.*

The Sandridge program reports that it has been able to successfully contain self-harm and hospitalisations within a three-month period of residence. Ruby's in Adelaide follows a similar approach, but requires that the young person's family be involved in the planning and implementation of their care plan. A further South Australian service is needed for those young people where this is not possible or appropriate. The key principles of this approach are described below.

### **4.2 SUPPORTING TRANSITION**

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Because young homeless people with high and complex needs must be able to access a wide variety of services, there is an inherent risk of fragmentation, as discussed above. Currently, as one of the young people noted in a focus group (Appendix 2) the occurrence of a service or worker "referring you on and forgetting about you" was considered to

be common. This practice of 'handballing', or referring without communicating, often results in a young person having to tell their story a number of times to a number of different people which can be tiresome and even traumatic. Stories can get distorted, making it more difficult for actual needs to be met. 'Handballing' threatens a young person's sense of confidentiality and confidence in those supposedly helping them, both of which are essential to good outcomes.

The process of transition, both from one service to another and from a state of crisis and high need, to one of stability and appropriate and adequate services, and eventually, to long term competence, good health and independence is crucial to address the risk of fragmentation. A model addressing this issue must ensure that the young person has at all times, an identified case manager with the responsibility, and the capacity, to ensure that the transition process is well-coordinated and purposeful.

#### **4.3 CO-ORDINATION AND 'STICKABILITY' RATHER THAN COMPETITION AND THROUGHPUT**

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Currently services spend resources on assessment against individual agency eligibility criteria and aim to disengage with clients as quickly as possible. However, the fragmentation of services and costs of 'revolving door' clients who remain a cost to the system despite the repeated involvement of a wide range of agencies suggest a longer term, and bigger picture view are called for. Ensuring one agency, employing the young person's case manager, has the on-going responsibility for ensuring that the appropriate combination of services and resources sticks by the young person to enable issues to be resolved, rather than merely defused, is a key principle. The focus is on the whole person and their life progress rather than on an episode and the provision of particular services. Flexibility in the application of eligibility criteria such as age is crucial. The young consumers noted in one of the focus groups that age criteria don't take into the individual's context into account. One commented: "it's good when services dodge the age thing to your benefit". Dogged adherence to strict criteria can severely compromise the capacity of services to provide 'stickability'.

#### **4.4 A COMPREHENSIVE APPROACH THROUGH STRONG LINKS TO OTHER SERVICES**

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In order to address the wide range of needs and issues of young homeless people with mental health problems, there must be a

commitment to strong links with other services, including sharing of resources and a preparedness to jointly accept responsibilities for outcomes for clients, rather than just for output of a particular service. Links to other services should be based on mutual advantage, for example, providing expertise and support for SAAP projects dealing with difficult residents, which in turn reduces demand on the specialised service for those with identified mental health problems.

#### **4.5 A DEVELOPMENTAL ROLE**

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The implementation of the service should identify and address barriers to more effective, responsive and better-integrated services and, in consultation with other agencies, develop strategies to address them. By jointly planning and sharing costs and risks, a demonstration model can be developed to attract additional resources. Protocol development will be an important aspect of this process, as will on going evaluation and dissemination of findings.

#### **4.6 REFERRAL AND ACCESS**

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There should be a broad range of entry and access points, including hospital adolescent units, courts and police, Child and Adolescent Mental Health Services, emergency services of major hospitals, private adolescent units, the youth housing sector, including youth refuges and Family and Youth Services. However, real access requires that the young person actually chooses to engage with the service. Mitchell<sup>xvii</sup> has identified five key principles or characteristics of services and programs that engage effectively with young people:

1. Communication with young people – the service should have workers who understand and can take the time to listen and allow the young person the opportunity to build a level of trust needed for opening up
2. Knowledge of adolescent development and culture, and non-judgmental attitude
3. Environment – a relaxed, informal, youth-friendly 'space'
4. A holistic approach with the capacity and flexibility to address a range of practical needs – including income, food, clothing, etc
5. Assertive follow-up. Too often the fact that a young person does not turn up for an appointment or drops out of a program is taken as a sign the service is no longer needed and there is no follow

up. In fact it may be a sign that they are not coping and in need of help

#### **4.7 WRAPPING SERVICES AROUND THE CLIENT AND MEETING PRACTICAL NEEDS**

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There should be a capacity for great flexibility in providing a combination of services and resources to suit the particular circumstances and needs of the young person. This should enable the service to address the practical and immediate needs of the young person and so engage them with the service in a positive way.

For example, one worker noted that there are many young people on the streets of Adelaide who might not be prepared to use an accommodation service, but would use the service of a secure locker for their belongings and a safe, free place they could have a shower. This serves as a point of engagement with the agency that can be built on, possibly leading to involvement in more substantial programs. However, agencies don't provide this service, perhaps because they are funded to provide a particular core business in a competitive market.

#### **4.8 CASE MANAGEMENT ASSURED**

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While there should be maximal flexibility about the range and nature of services provided, there should be strict adherence to the principle of having a clearly identified and on-going case manager who is responsible for negotiating the package of services for the young person. The case manager advocates with service providers and gate-keepers. It is their role to encourage links between their clients and other service providers – for example, by encouraging and facilitating case conferencing. In many cases the case manager would be a residential care worker at the service, however, in all cases the case manager should be operating at the local level and in close contact with the client in the residential setting so that services are coordinated around that setting.

#### **4.9 A SIGNIFICANT TRUSTED ADULT**

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A prime objective of involvement with the young person should be to ensure that they have developed a strong and trusting relationship with an adult mentor. This could be a resident youth worker or case manager, though preferably it would be a separate person, but it should be reasonably long term and not be with a therapist. In functional families this role is filled by family members who take an active part in guiding and supporting the young person through the process of

transition. However where there are no functional links to the family, as is often the case with young homeless people with mental health problems, then someone else should fill this role. While the absence of such a person should not be a barrier to access, it should be a priority for the case manager to address in developing the package of care.

#### **4.10 OUTREACHED MENTAL HEALTH CARE**

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Because these clients have significant mental health problems, professional mental health services should be available, but outreached to the residential setting, rather than requiring the young person to go to a mental health care setting. In addition, it is anticipated that significant professional support would be provided to the residential care workers by the mental health outreach service. It would be essential that 24-hour emergency mental health support would be available, with a capacity to deal with anger management and violent behaviour.

#### **4.11 REACHING THE MOST MARGINALISED**

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The literature and our consultations with workers and consumers consistently identified four sub groups with the wider population of young people with high and complex needs who faced particular additional challenges that should be acknowledged and addressed by services. These were Aboriginal young people, young people from other ethnically and culturally diverse backgrounds, those from rural and remote areas, and those (usually young women) caring for young babies and young children.

##### **A B O R I G I N A L   Y O U N G   P E O P L E**

Young homeless Aboriginal people are often dealing with issues of lost identity, culture and community and a history of families torn apart by forced removals. This is deeply distressing for young Aboriginal people, but not seen usually as an issue for counselling. Aboriginal young people may suffer because their needs may go unrecognised by mainstream services, as they are essentially a minority within a minority. Services need to develop appropriate responses. Young Aboriginal people may respond positively to having Aboriginal case managers or mentors for example.

##### **E T H N I C   A N D   C U L T U R A L   S U B - G R O U P S**

Cultural issues such as arranged marriages, parent-child relationships, gender roles and values, may be the primary problem that young people seek help with. These, combined with mental health issues require a culturally sensitive and appropriate approach that many agencies cannot

provide. One Asian participant in the youth consultations said that in four years of contact with the mental health/accommodation system they had met only two other Asian people – "you wonder if you're the only one". Such isolation can compound distress. Workers need to understand this especially when placing young people in accommodation.

#### YOUNG PEOPLE FROM RURAL AND REMOTE AREAS

Young people who are coming from rural and remote areas who require hospitalisation for mental health issues are admitted to Glenside. Young people consulted in preparing this document believed that hospital workers not aware of the shame associated with mental illness in country areas and believe that referring workers from the country should discuss this with hospital workers in the city (Appendix 2).

#### YOUNG PEOPLE CARING FOR CHILDREN

A significant number of young women with high and complex needs are caring for young babies and children. However many youth accommodation services are not responsive to the special needs this involves. Any service for this group should ensure appropriate child-care supports are in place.

### **4.12 TRAINING AND RESEARCH**

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There is a broad consensus that the standards of knowledge and skills amongst those who work with young homeless people with mental health problems is inadequate. Responses of youth workers, police, teachers, health workers and others are sometimes inappropriate and even destructive. For any new program to achieve sustainable improvements in the way the sectors respond to young homeless people with mental health problems, it must include a strong training and awareness raising capacity. This should include formal links to training institutions and the development of on-site teaching capacity in residential settings.

### **4.13 QUALITY ASSURANCE**

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A quality assurance (QA) strategy should accompany the development of the service including the development and documentation of policy and procedures. However it is also important that QA tools do not impede the capacity of the service to provide a flexible, rapid and client focused response.

## **Part 5: The Proposal**

The following proposal is based on applying the principles of approach, as described above, to support young people with high and complex needs. Essentially, it recommends two inter-linked strategies, provision of highly skilled outreach support and training, and a small residential unit with the capacity to successfully work with young people with high and complex needs.

### **5.1: THE TRANSITIONAL SUPPORT UNIT**

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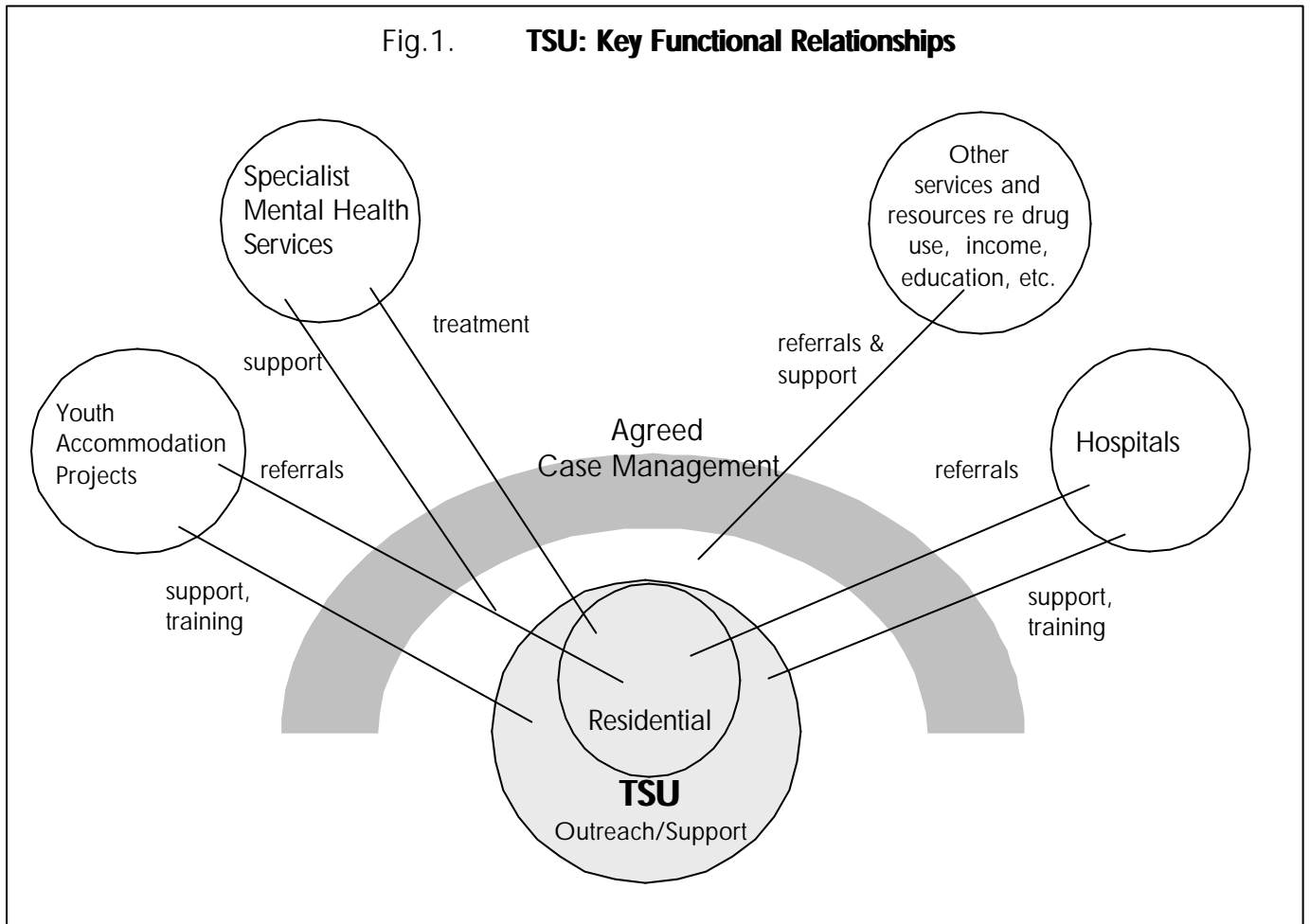
The Transitional Support Unit (TSU) will be a specialised residential, non-medical youth accommodation unit designed to address the transition needs of homeless young people with mental health problems. The TSU would be a new service in a physical facility built or modified specifically for this purpose. Central to the TSU approach would be a commitment to establishing strong case management, an appropriate package of services and resources and providing continuity of case management and support.

### **5.2 OUTREACH SUPPORT AND TRAINING**

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The Transitional Support Unit (TSU) would operate in and with the network of existing agencies supporting this client group, through mutual skills transfer and outreach support strategies. The TSU would have close links with mental health services which would outreach to the TSU. The wide range of services available will enable the diverse needs of individual clients to be appropriately addressed. TSU staff will be specially trained to work with young people with a history of self-destructive behaviour and poor anger management and would provide outreach support to other agencies to ensure clients get continuity of quality support.

Fig.1. **TSU: Key Functional Relationships**



### 5.3 MAKING A DIFFERENCE TO THE SYSTEM, NOT JUST ADDING CRISIS BEDS

While the TSU will have a small residential capacity (able to accommodate young people with high and complex needs whose behaviour may mean other accommodation services have difficulty with them), it will not be a residential 'too hard basket' or dumping ground. Referrals will only be accepted on the proviso that the referring agency continues to take an active role. Normally, when a young person is accepted as a residential referral to the TSU, the young person's place ('bed') in their current accommodation would be retained pending a case conference decision to determine ongoing case management arrangements. Restoring the young person to the most normalised accommodation would be a key TSU priority. It should be noted that even holding two beds for a young person is cheaper than a hospital admission. The major focus of the TSU, as reflected in staffing plan and resource allocation, will be to the provision of outreach support and training, rather than residential services. In general terms, approximately

60% of resources will be spent in outreach and 40% on residential services.

#### **5.4 FUNDING**

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The TSU would be funded partially through SAAP and partially through the Department of Human Services, but would be managed and auspiced by an NGO. The referring agencies would continue to be funded by a range of government and non-government bodies, but those funded under Department of Human Services service agreements would have TSU involvement specifically tied to their funding.

#### **5.5: REFERRAL PROCESSES**

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The TSU would be a resource for all agencies working in the sector with homeless people aged 12 to 25 with high and complex needs. The Unit would support young people and their carers in the process of transition in both directions, that is from intensive treatment settings such as hospital, to less intensive accommodation and social support settings, and vice versa. Referrals would be accepted on the basis that:

- The referring agency would continue to be involved, and referring workers accept education and field support from the service
- Clients would not be referred on, unless stabilised and with appropriate and on-going support in place. As one of the young consumers in the youth consultation focus groups said: "If you get stable while staying at a shelter – you're less likely to come back". The youth consultations also recommended that no one be discharged without a comprehensive discharge plan (Appendix 2)
- The key principles for facilitating coordination between agencies will be support for skills transfer and outreach support

Protocols would be developed in consultation with referring and referee agencies to ensure referral processes were consistent, well understood and in line with TSU principles, aims and objectives.

#### **5.6 TARGET GROUP/ ELIGIBILITY CRITERIA**

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Homeless young people from 12 to 25 years with high and complex needs. The TSU will be based in metropolitan Adelaide, but will accept referrals and provide support to clients and their workers from all over South Australia. Residents may have experienced disrupted family lives, a high level of transience, abusive relationships, disrupted schooling, institutional care, and rejection by parents or family, sexual, physical, emotional abuse, death of family member or friend leading to self-

harm/suicidal gestures, anger management issues, issues of grief/loss, anxiety states, depression, offending behaviours, social withdrawal, struggles with substance abuse, repeated hospitalisation.

## **5.7 AIMS AND OBJECTIVES**

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### **AIM**

To effect preferably early and short-term intervention with homeless, traumatised young people in order to prevent the development of chronic psychological or psychiatric problems and to increase their life choices as they move on to independent living.

### **OBJECTIVES**

- Provide safe stable living environments which residents can experience as home
- Foster the development of supportive relationships within the program
- Practice alternative strategies to self-harm and parasuicidal behaviours
- Address counselling and mental health needs
- Encouraging a range of educational, vocational and recreational pursuits
- Involve residents in the decision-making processes which effect their progress through the program
- Prepare residents for eventual transfer to independent community living

## **5.8 RISK/PROTECTIVE FACTORS ADDRESSED**

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Sexual abuse within the family is a major risk factor for the development of mental disorder. Diagnoses include depression, post traumatic stress disorder, borderline personality disorder, obsessive compulsive disorder, anorexia and bulimia. Many residents will have no diagnosis on leaving the TSU and will require no medication.

## **5.9 BASIS OF PROGRAM**

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Youth work context, principles of acceptance, choice, personal responsibility, belonging and participation in decision-making processes should be central to the TSU's work.

## **5.10 STRATEGIES**

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- Provide a safe, stable communal living environment
- Facilitate the development of relationships with peers and adults

- Explore alternatives to self-harming behaviour
- Encourage educational/vocational/recreational activities
- Address practical living skills
- Address mental health issues with outreach services
- Involve the young people in the decision-making processes of the program

### **5.11 CAPACITY**

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- Eight residents (four to six beds)
- Duplex arrangement with male and female sections
- Limited capacity for child care, either on site or adjacent/nearby

### **5.12 PROFESSIONAL STAFF EMPLOYED**

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Up to ten full-time equivalents (indicative only). The quality and range of skills and experience among the TSU staff would be crucial to the success of the Unit. The Manager would require excellent project management skills with the credibility to negotiate with senior clinicians, bureaucrats and NGO executives. The staff would be multi-disciplinary and would need to include an Aboriginal person. The staff mix and their preparedness to be flexible in their roles would be important factors in making the Unit accessible and acceptable to young people.

### **5.13 MANAGEMENT SUPPORT**

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The Manager would be accountable to a Management Committee that would include representation from across the scope of agencies and consumer groups relevant to the Unit's role. The Management Committee would report to the auspicing NGO and would include at least two young people (preferably former clients) in its membership.

### **5.14 DURATION OF THE INTERVENTION PROGRAM**

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Four to eight weeks, but highly flexible and including residential and outreach components.

### **5.15 AVERAGE FREQUENCY OF CONTACT WITH CLIENTS**

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Contact constant for residential service. Casework sessions as per case management agreement.

### **5.16 REFERRAL PROCESSES**

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Referrals will be direct to the Unit. Referring agencies will include hospitals, Adult Crisis Intervention Service, SAAP accommodation projects, Crisis Care, the Child and Adolescent Mental Health Service, Family and Youth Services, self-referrals, etc. Referrals accepted would be conditional on the involvement of referring agency in ongoing case management. Clients would be referred on only when stabilised and according to continuing case management plans.

### **5.17 EVALUATION AND REVIEW PROCEDURES**

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- Evaluation plan built in to program plan
- Action research focus
- Annual evaluation reports and a comprehensive review after five years of operation

### **5.18 TRAINING/TEACHING ROLE**

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The TSU will also have a training role with staff of other services. This will primarily be via a coaching/preceptor role with workers in SAAP projects and other referring agencies in relation to particular (former and potential) TSU residents. The possibilities for formal training agencies such as TAFE and universities providing accredited courses which would include placements or practicum associated with the Unit, should also be explored.

### **5.19 STRENGTHS OF PROGRAM**

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- Able to contain self-harm/hospitalisation within a three-month period
- Enables continuity of purposeful managed support over time and across agencies and sectors
- Supports workers in a range of settings and builds system capacity
- Strong emphasis on providing a safe, stable environment with staff present 24 hours
- Clear boundary setting and residents are *actively* involved in this process
- Development of strong, lasting personal relationships
- Program works with the young person, not the family. There is no ambivalence about whom staff are there for

## **5.20 COMMUNICATIONS STRATEGY**

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- To reach other services, create positive links, encourage appropriate referrals
- Will include web site, newsletter, and workshops, seminars, etc, to the broader sector

## **5.21 POSSIBLE FUNDING SOURCES**

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SAAP, the Department of Human Services, resource sharing/links with existing programs.

## **5.22 INDICATIVE BUDGET**

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An indicative preliminary estimate suggests a recurrent budget of approximately \$800,000. This would comprise around \$500,000 for site-based services and \$300,000 for outreach services. It should be noted that there is potential for linking up some existing government and non-government programs to reduce additional costs for outreach services.

## **Part 6: Further Development Tasks**

YACSA believes this proposal has:

- The potential to deliver better, more effective care for young homeless people with high and complex needs leading to more positive outcomes and reduced dependency
- The potential to enable a reduction in costs and in inappropriate and expensive use of crisis services, hospitals, and police by young people with high and complex needs, and to reduce the costs to wider society of some criminal and socially destructive behaviour
- Wide support from across the sectors dealing with young people with high and complex needs

YACSA suggests that the proposal could be further developed by the establishment of a joint Department of Human Services and NGO Steering Committee to conduct a more detailed feasibility study. The report of this study could be used to initiate a consultation and development process as outlined below:

1. Consultation on the detailed proposal as developed by the feasibility study
2. Proposal redrafted in the light of the consultation, under the guidance of the Steering Committee
3. Final Proposal endorsed by the Department of Human Services and sent to Cabinet by May 2002
4. Cabinet approval and funding allows TSU establishment by January 2003

# Appendix 1

## **EXECUTIVE SUMMARY**

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YACSA Support and Accommodation for Young People with Mental Health Issues Consultation Day, Thursday, 21 September 2000.

## **PROCESS**

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The consultation was attended by thirty-seven workers from the youth mental health sector. A list of their employing agencies appears at the end of this Executive Summary report. The program began with initial input from Professor Graham Martin (Southern Child and Adolescent Mental Health Service) Ms Julie Gunn (Department of Human Services) and Mr Paul Willy (Department of Human Services). Kathy Alexander then facilitated the consultation process. Mixed small groups followed by plenary sessions were used to explore service issues, to identify criteria for choosing priorities for service development and then to identify strengths, obstacles, and recommended strategies.

The initial task of the small groups was to identify: *the types of clients seen, the problems they present with, the degree of severity of these problems, approximate numbers of clients in each group, and the services that were currently in place to address their needs.* Key findings from this session were:

## **PRINCIPLES OF SUPPORT**

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- The mildness–severity continuum was seen as having limited value because young people can move rapidly across it
- Workers are guided in allocating their time approach to clients by an assessment of the risk of harm to the client and/or to others
- A specific individual client focus is needed for each person – there is often a complex array of problems and context. No two cases are the same
- There should be a health promotion focus for all services because of the protective value that increased mental health capacity has in limiting the harm caused by mental illness
- The special needs of Aboriginal people need to be appropriately addressed by workers
- Provider partnerships are essential for efficient use of scarce resources (to avoid 'resource exhaustion')

- 'Stick-ability' needs to be a key feature of the focus on approach of services. Currently the system tends to respond to crisis episodes, rather than following through and supporting clients in dealing with their ongoing issues over time

## **SERVICE ISSUES**

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- 'Disconnection' is a key theme of mental health problems with young people. At the individual level it is manifest as lack of confidence, low self-esteem and lack of support from family or other significant others. At the Service level it appears as fragmentation of services, gaps in barriers to access. At the social level it is apparent in isolation and diminishing levels of social capital. Participants believed that both disconnection and the need for mental health support and treatment services are increasing
- Agencies, particularly those dealing with severe problems such as self-harm and violence, are facing increased demand, and applying selective eligibility criteria in order to protect themselves. This is leaving growing gaps in access
- There is also an inadequate capacity to respond flexibly to the needs of young people with mental health problems. Problems may manifest across the spectrum of grief, loss, anxiety, depression, substance abuse, violence and anger, and self harm. Appropriate treatment and support also varies widely both in terms of resource intensity and the nature of service, including accommodation, counselling, support, specialist medical services, information provision and so on. Agency focus on 'core business' can contribute to fragmentation of services and consequent barriers to access and poor service response

At the plenary sessions these issues were discussed and a consensus positioned reached. The four key points of this consensus were:

### **1. PRINCIPLES TO UNDERPIN SERVICE PLANNING**

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- Young people must have a say in decisions about their care at both broad service and personal levels
- Assessment of risk and harm is continuous rather than static. Service planning should be driven by client capacity rather than provider menus or medically defined eligibility
- Services should have a health promotion/protective focus approach
- Services should incorporate partnerships between agencies/professionals and young people

- Services/support to be available beyond episodes, and not be subject to repeated application of provider driven eligibility criteria
- Services should stick with and follow the young person. The young person should not have to further disrupt their lives in order to access services

## **2. CONTINUUM OF DELIVERY**

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It is easier to achieve successful outcomes for some clients than for others. The key feature of easier cases is that sustainable community or family supports are in place. It is much harder when multiple agencies are involved (when poorly coordinated), there are multiple severe and chronic problems and the young person is disconnected socially.

## **3. TYPES OF PROBLEMS**

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Problems range broadly and can include all those listed below. All these problems can range across the continuum from easy to hard to deal with.

- Sexuality related issues
- Behavioural problems
- Substance abuse
- Depression/anxiety
- Violence/anger
- Grief/loss
- Homelessness
- Physical and/or sexual abuse

## **4. SOCIAL CAPITAL AND HEALTH PROMOTION**

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Mental healthcare, accommodation and support agencies have an important role to play in mental health promotion. Policy and resource allocation should support this. However, while building social capital and enhancing its protective role against mental illness is primarily the province of social policy, agencies concerned with young people and their mental health have an advocacy role in supporting the development of such policy.

After a break for lunch, the participants moved into the second round of small groups with the tasks of identifying:

- What works well about current service arrangements and should be built on

- What are the major obstacles to improving services for young people with mental health problems
- What are the key strategies that should be pursued

The table below collates the responses from the small groups:

## **STRENGTHS**

- Rural/regional models of collaboration
- Programs that link chronic and community care, using formal shared case management (e.g. Hospital Links Program)
- Programs which provide access and a broad and flexible response to complex multiple needs (e.g. Streetlink Youth Health)
- Formal inter-agency partnerships which cut through access barriers and shared skills and information (e.g. Kumangka Aboriginal Youth Service and SAPOL)
- Training, information and knowledge base
- Mentoring at the base level – acknowledging that mental health services to young people are a job, not a hobby
- Appropriate community volunteerism

## **OBSTACLES**

- Lack of funding sustainability
- Short-term project funding, rather than program funding works against long-term social capital development
- Competitive tendering works against inter-agency collaboration and acknowledgment of problem areas
- Inappropriate attitudes to young people from some workers
- Concentration on highly focused short-term acute crisis management casework to the exclusion of continuity of care and a community development approach. Pressure to meet the funding body numbers – output not outcomes
- Values and attitudes of some police and teachers
- Aging demography of teachers
- Jargon and poor communication across sectors
- Confusion re roles and expectations across agencies
- Restrictive eligibility criteria for high need/severe cases, leading to access barrier issues
- Lack of time/resources/places to meet increased demand for services
- A reluctance by some workers to step beyond professionally/organisationally defined turf
- Lack of trust
- Department of Human Services structure – not well understood/lack of information

- Lack of 'risk taking' by services
- Workers being too narrow in their role

## **STRATEGIES**

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- Therapeutic residential services
- Training for bureaucrats/policy makers and community sector workers re characteristics of clients, attitudes and issues
- Communication strategy
- Specific programs set up to create links (e.g. resourced regional case management conferences, network development, conferences)
- Recurrent funding model to support longevity/principles
- Policy and endorsement for experimentation at all levels
- Cross medical/social network to build working relationships
- Review policy, identify obstacles to implement the principles
- Need more 'bricks and mortar' to bring that facility up to a basic level
- Models which bring services to young people rather than young people to services – more flexibility
- Broad banding/multi-skilling of workers

In the final plenary session, consensus was reached on the essential strategy areas the group felt should be pursued by the Department for Human Services in partnership with the sector. Key strategies included:

### **1. TRAINING**

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Contents should include characteristics of client group, attitudes of workers and their impact on clients, and cultural awareness.

Recipients should include bureaucrats and policy makers, community sector agencies, and those working with young people with mental health problems. A formal program of mentoring for workers through teaching organisations based in the sector and incorporating practical field experience was strongly recommended. Worker training programs should build multi-skilling.

### **2. COMMUNICATIONS STRATEGY**

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Fragmentation of services, institutional and professional barriers, and the tendency to retreat to 'core business', mean improving communications both within and across sectors is a vital priority. The communications strategy should include measures to enhance networking, support conferences, and encourage joint learning.

### **3. REVIEW POLICY AND FUNDING MODELS**

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Identify obstacles across the range of relevant policies and funding models. Recommend changes to support the principles outlined above, and to support greater experimentation, diversity, and devolution of services.

### **4. SPECIFIC PROGRAM/SERVICE DELIVERY**

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Linkage projects including resourced case management/conferencing models and building on some rural and other existing models. Increased mobility of services to go to where clients are at (culturally as well as geographically). Increased flexibility of services to provide what the client needs, rather than what the service is used to providing. Increased involvement of clients in decisions that involve their treatment, care and support.

### **5. INFRASTRUCTURE DEVELOPMENT**

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'Bricks and mortar' – ensure the acquisition of a greater range and volume of supported accommodation options.

In discussion, it was noted that Strategies 1 to 3 could be implemented without significant additional funding support from the Department of Human Services, and some re-allocation of existing resources. Strategies 4 and 5 are priority areas for new funding.

# Appendix 2: Support and Accommodation for Young People with Mental Health Issues – Findings from Youth Consultations

## INTRODUCTION

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In order to develop a Negotiating Proposal to be discussed with the Department of Human Services, a one-day workshop was held to consult workers in the mental health and accommodation sectors who work with young people.

## METHOD

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Four focus groups and three interviews were held with young people who are consumers of mental health and accommodation services and their peers. Overall, twenty-four young people between the ages of 16 and 25 were consulted – nine females and fifteen males. The focus group process was designed and facilitated by Roxanne Adams, Tanya Rigney, Karen Darling and Ann Deslandes.

Where possible, records of the focus group responses have been divided according to participants' relationship with the mental health and accommodation sectors, as follows:

- Group 1:** Consumers of mental health and accommodation services
- Group 2:** Young people with a peer perspective on support and accommodation for young people with mental health issues

Participants were asked to reflect on the following issues established by the sector workshop in order to obtain their feedback:

1. You need to be 'in crisis' before you can get a service, services need to have 'stickability'
2. Services for young people with mental health issues, and services for young people with accommodation issues don't always work together very well

3. There is an increasing amount of young people trying to get into services. The workers said that services should get money and do their planning based on how many young people are actually asking for/needing a service
4. Young Aboriginal people have special needs that not all workers are aware of. The workers have said that the special needs of Aboriginal young people need to be addressed by workers through training
5. Anything else that participants thought the Government should be aware of in relation to support and accommodation for young people with mental health needs

## **1. YOU NEED TO BE 'IN CRISIS' BEFORE YOU GET A SERVICE**

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### **GROUP ONE: CONSUMERS OF MENTAL HEALTH AND ACCOMMODATION SERVICES**

#### **What does this mean to you?**

"You've got to go down to get your needs met, go up when they're met, then go down again to get them met again," – Focus group participant.

"No-one seems to want to offer the service first," – Focus group participant.

Participants believed services should be available at any time, especially when people are seeking help at times when feeling depressed. All services should be provided to stop things getting worse. Some participants noted that people look for their own solutions while waiting for a service such as drug abuse.

Many participants provided strong feedback on the experience of being turned away from a service due to their situation not being perceived as severe enough to warrant attention. Being turned away means that you won't go back. It is easy then give up on the issue, "and then it comes back later", setting you up for a crisis to occur. It often means you feel worse about yourself because you're told 'you're not bad enough to need a service, yet you've been through this for three years and know when you're at a bad stage'.

The experience can also induce dangerous behaviour. You might feel you have to overdose in order to get help. You put yourself and others

at risk through behaviour such as self-harm and dangerous driving. The incidence of sex for favours can occur after being turned away from a service if needing a sense of being loved or even just a place to stay.

It was strongly agreed that there is an attention-seeking notion about the general youth population which clouds what's really happening with mental health e.g. anxiety.

**Has this sort of thing happened to you or to anyone that you know?**

The following examples were given:

"I rang ACIS five times before a violent situation occurred", and

"You get asked to do unrealistic things before you get the service – such as take a person to the doctor in Noarlunga when they live in Underdale".

**What do you think needs to happen to make this better/make a difference to the situation?**

The following suggestions were provided, aimed at workers and policy-makers alike:

- All rooms at an accommodation service should have ensuites because of mental health issues – or four beds could share two bathrooms
- Workers need to be very patient and not give up on a young person – "seeing them not give up on me gave me the trust to work/talk through things because they were still there. This came from the idea that they were just working with me because it's their job but because they're still there later, I knew they were genuine and they took my stuff on"
- Lots of young people, particularly those with mental health issues want a mother figure. Perhaps under 18s in units could have such a figure stay with them
- When a new person/group moves in, there should be a meeting to accommodate their needs i.e. a different eating time
- Keep to appointments – "if I've been on the waiting list for six weeks, don't let me rock up and then make me wait another six weeks!"
- More early intervention work to be done by mental health and accommodation services
- It is important to keep in mind that you can be 'in crisis' when you're suicidal or when you're just sitting in a room

- Accommodation services for young people with mental health issues need a range of shared spaces
- Mental health services need to teach negotiation skills to deal with the potential stresses of mental illness in the home – for example, conflict occurs when Mum might say "be home for tea" when you've got an appointment at the Second Story
- Young people need assistance with their housing after leaving a mental health service.

### **What has this meant for people in terms of accommodation?**

- "If you get stable while staying at a shelter – you're less likely to come back"
- Normal rules don't always fit – i.e. if a rule is that you have to be out during the day, you might have anxiety and not be able to get on the bus
- Placing many young people with mental illnesses in together can trigger memories/issues of bad relationships and encouraging each other to self-harm
- "It's hard to concentrate on things that you need to get done when you're trying to keep your mind together"

### **'Stickability' explained**

- All services should have 'discharge plans' in the form of follow-up, the option to call again, etc
- Age criteria doesn't take into account your context – "it's good when services dodge the age thing to your benefit". Criteria can severely compromise the capacity of services to provide stickability
- A co-operative housing arrangement could be a good solution if it had a mental health focus – tenant ownership, flexibility, can break your lease easily and may have a worker/manager living on site that is aware of the issues

## **GROUP TWO: YOUNG PEOPLE WITH A PEER PERSPECTIVE ON SUPPORT AND ACCOMMODATION FOR YOUNG PEOPLE WITH MENTAL HEALTH ISSUES**

### **What does this mean to you?**

It was agreed that you have to be "at rock bottom" before you can get assistance from workers/organisations that could help with mental health issues.

**Has this sort of thing happened to you or to anyone that you know?**

In response to this question, one participant gave the example of when he was "kicked out of home" at the age of eighteen. He was not eligible for income support, yet he needed money to find a place to live independently. Other members of this group agreed with him that mental illness made this harder because "you need to keep a level head" in times like this.

Along the same lines as the "level head" argument, it was agreed that young people with mental health issues are among the least able to communicate their issues and needs when looking for accommodation. They are therefore "more likely to end up on the street" – with the crisis coming pretty quickly then!

A recurrent theme was the cyclic chain of events induced by the combination of housing and mental health needs – needing income to get a house, needing an address to get an income, mental illness restricts your chances of getting a house. This situation can bring on crisis point more quickly.

The waiting period on obtaining income support and housing was considered a significant barrier and one that seemed to apply to young people with mental illnesses particularly because of their situation often being more complex to deal with. These waiting periods contribute to the onset of crisis because problems can worsen over time while waiting for assistance, especially with little or no support being present from immediate networks in the interim.

**What do you think needs to happen to make this better/make a difference to the situation?**

There was strong support for more measures to be put in place to prevent crises from occurring in the first place. Teachers and General Practitioners were identified as people who had key roles in early detection and intervention of mental health problems experienced by young people. This included the provision of practical support such as with housing. A potential role for youth workers in schools was also mentioned by one participant and supported by others. It was also suggested that general practitioners receive more training and a revised set of guidelines regarding dealing with young people, especially those with drug and alcohol as well as mental health issues.

Some participants displayed an understanding of the relationship between service funding criteria and service response to an individual

young person. These young people were of the view that services need to be involved in crisis prevention work instead of being funded only to help those in the direst need – e.g. 'in crisis'. There was a common view that many youth services are currently in this position.

Participants also discussed the need for flexibility of criteria for accessing accommodation services such as emergency accommodation, especially in terms of age. It was felt that there should at least be more functional linkages between services that cater up to a certain age group and services that cater for people beyond that age group. To cite a relevant example, a young woman who turned 18 was no longer able to access a mental health service and had to re-establish herself with an adult service and had no support to do this – this can exacerbate rather than diminish trauma associated with gaining accommodation for a young person with mental health needs.

Participants also identified a need for accommodation and mental health services to ensure that a young person's already-existing support base is not diminished through their mental illness. One participant gave the example of a friend who was staying with the participant's family due to her illness and lack of support. The family were the only ones supporting this young woman and they felt she was abusing their generosity to her – the friendship broke down as a result. Participants agreed that if there had been a service or worker involved in this situation to help her work through the issues, learn about the family's limits and find somewhere else to live the friendship would have been maintained and the young woman's support base would not have been diminished.

A general point was endorsed by one group about the need for more ongoing support provided by services and individual workers – the occurrence of a service or worker "referring you on and forgetting about you" was considered to be common.

### **What has this meant for people in terms of accommodation?**

Participants raised the problem of a lack of co-ordination between services that impact all at once on the lives of individuals: e.g. accommodation, mental health and income support. It was also noted that the supported accommodation service run for victims of domestic violence is a useful model for young people with mental illnesses because it provides peer support and opportunities to develop independent living skills.

### **'Stickability' explained**

Again, the way services are funded was raised by participants in the context of the notion of stickability. Participants felt that services are currently in competition for government funding, which impacts on their 'stickability'. Reductions in funding for some services was also cited as a stickability inhibitor with the example given of one worker having close to thirty clients at a time and "constantly jumping from crisis to crisis rather than managing the situation".

## **2. ABILITY OF SERVICES TO WORK TOGETHER**

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Services for young people with mental health issues and services for young people with accommodation issues don't always work together very well.

### **GROUP ONE: CONSUMERS OF MENTAL HEALTH AND ACCOMMODATION SERVICES**

#### **What does this mean?**

- Someone with a mental health problem e.g. alcoholism/sexual abuse being placed near a pub/paedophile
- "You have to stick up for yourself to get a worker to stick up for you"
- Behaviour issues of young people in shared accommodation – need a few different living areas so you can 'escape'
- Can't manage paying rent, bills, etc, if you're unwell
- When you're admitted to hospital, should ask if need assistance with accommodation e.g. paying rent, feeding pets
- Mental health issues can cause you to leave home

#### **In what ways have you or other people you know experienced services not working well together?**

- The South Australian Housing Trust not understanding mental illness in young people very well. For example, they "lump young people with mental health [issues] all in together". This would be OK if they provided support
- Hard to get private rental if unwell – and when you are well you're unsure about whether or not to mention your mental health issues even though they could have an impact on the lease agreement
- Young people who are coming from rural and remote areas only have Glenside Hospital to go to if they need to be hospitalised for mental illness reasons. Hospital workers obviously not aware of

the shame associated with mental illness in country areas. Referring workers from the country should discuss this with hospital workers in the city

**What do you think needs to happen to make this better/make a difference to this situation?**

If services are going to talk to each other more, this should happen only if workers were given permission, and only to talk about specific things. Notably this was felt most strongly by Aboriginal participants in the Magill Training Centre focus group. All participants strongly agreed that confidentiality, trust and being kept informed are essential.

- A criteria that mental health and accommodation workers have to talk to each other – would reduce the ability for young people to tell different stories
- If you have a full-on counselling session, you should be able to ring accommodation and let them know, or when you're doing better, so that they are able to take more responsibility
- Once you leave a service, should be able to come back for outreach appointments
- Interagency regular meeting: to provide opportunities for workers to talk to each other – i.e. if a young person 'runs away' accommodation workers need to talk with other workers about contributing factors
- Make guidelines and consequences really clear when you move in but also be aware that everyone makes mistakes
- If one young person "freaks the other young people out", then they can't come back while the 'freaked' people are there
- House meetings for residents to discuss issues as well as opportunity to discuss one-to-one
- If a young person is asked what they think their consequence should be it makes you take responsibility – much more effective
- Facilities should be funded by the number of beds they serve
- More support in transition between hospital and home (i.e. through the Hospital to Home Transition Team) – perhaps a hostel type of arrangement where people aren't as sick and they can come and go
- A day centre that you can drop into and decide what to do each day
- Mental health worker should work with accommodation worker to explain things like triggers – young people don't always have the confidence to say

**GROUP TWO: YOUNG PEOPLE WITH A  
PEER PERSPECTIVE ON SUPPORT AND  
ACCOMMODATION FOR YOUNG PEOPLE  
WITH MENTAL HEALTH ISSUES**

**What does this mean?**

Members of this group cited the incidence of a "slightly depressed" young person being placed in a temporary accommodation arrangement with people that have "major psychotic illnesses". This situation can affect a vulnerable young people's perception of what is 'normal' by making them feel as though slight depression is a major psychotic illness. However, there is also a role for accommodation services in being able to recognise a non-viable share-housing arrangement, and for a higher level of communication between the mental health service and the accommodation service.

**In what ways have you or other people you know experienced services not working well together?**

The example of a young person being "shoved into" a group for older people when she turned 18 was re-iterated. It was felt that crisis occurred for this young woman because she couldn't access her former service and there was no carry-over.

Participants discussed what they felt to be a current occurrence – 'handballing'. 'Handballing' occurs when a young person with multiple needs gets referred to another service without the workers talking to each other. Furthermore, it often results in a young person having to tell their story a number of times to a number of different people which as well as being tiresome can be quite traumatic. In this situation, it is also possible for stories to get distorted which makes it more difficult for actual needs to be adequately met. The occurrence of 'handballing' can severely threaten a young person's sense of confidentiality and comfortability, both of which are essential to good service.

**What do you think needs to happen to make this better/make a difference to this situation?**

A number of suggestions were made towards long- and short-term solutions to the problems identified by this group. They included:

- All youth services should be open after 5.00 pm
- If you are going to be referred on to another service, the service that refers you should provide access to communication devices such as a phone to set up appointments, etc

- An internet site could be set up that has a database of youth services, alongside a general campaign to increase awareness about services, so that young people are more aware of what services are out there and what they do and "they're not relying on workers who can't work with each other"
- Services should be promoted more to young people than to youth workers

### **What has this meant for people in terms of accommodation?**

The issue of services competing for funding was raised again in answer to this question. Several more vocal participants were strongly of the view that competitive funding for accommodation services (and any other services!) is not functional and doesn't help services to work together to house young people with mental health issues.

## **3. NUMBERS REQUIRING A SERVICE**

The workers felt that there is an increasing amount of young people trying to get into services.

### **GROUP ONE: CONSUMERS OF MENTAL HEALTH AND ACCOMMODATION SERVICES**

#### **Have you noticed this?**

The example was given of a young boy feeling anxious about his release from detention, which is due during the school holidays. Some participants felt that the timeline of contact with services has been reduced, because more young people need more workers. JPET was cited as an example here.

#### **Has it affected the service that you have received from either mental health or accommodation services?**

It has meant that the Adult Crisis Intervention Service will only do outreach for three months.

#### **What do you think needs to happen to make this better/make a difference to this situation?**

There was general agreement that there is a need for more services, and that services should be provided more often (e.g. after hours and during school holidays). This strengthens the argument for services to be open after 5.00 pm provided by Group Four under Question Two.

It was the general consensus of one group that "government needs to work out the reasons for increased numbers and address them". Support is needed to stay well, because you need to stay well for six months because of the waiting list lengths.

**GROUP TWO: YOUNG PEOPLE WITH A  
PEER PERSPECTIVE ON SUPPORT AND  
ACCOMMODATION FOR YOUNG PEOPLE  
WITH MENTAL HEALTH ISSUES**

**What does this mean to you? Have you noticed this?**

It was the view of this group that accommodation services in particular, for example, the South Australian Housing Trust, was experiencing very high numbers of young people requiring service at present.

Participants felt that a lack of funding to services makes the amount of people needing a service more visible – which may create the impression that there are more people requiring a service. It was also felt that funding cuts to services means that preventative services are less likely to be available, thus creating more 'crisis' situations for young people.

There was strong agreement that there are also lots of young people 'lining up' for certain services that might be free, culturally appropriate, non-Christian, etc. In that sense, it's not just about a high number of young people requiring a service, but a high number requiring an appropriate service.

It was also suggested that the perceived number of young people trying to get into a service is also due to the criteria by which services are funded – many are funded per population of the region in which they are situated, instead of on the basis of need.

With the incidence of supply not meeting demand, many young people with mental health and accommodation needs are resorting to 'sneaky' ways to get into a service.

**Has it affected your ability to get either accommodation or mental health services?**

The waiting time associated with big numbers has contributed to access to, and the level of, services available to young people.

**Has it affected the service that you have received from either?**

- Quality of service is affected because workers act like they need to get through the appointment and refer you on ('handballing')
- Psychologist = expensive yet psychiatrist = Medicare yet young people have different mental health needs

**What do you think needs to happen to make this better/make a difference to this situation?**

- Mental health services need to be part of generic youth services (removes stigma, etc)
- Accommodation (private and public) is strapped
- Boarding houses who are looking after young people with mental health issues need to be connected into the system

**The workers said that services should get money and do their planning based on how many young people are actually asking for/needing a service. What do you think about this?**

- Sounds like it's "based on how many young people you can get through the door" which wouldn't help co-operation
- Young people with an experience of services, etc, should be involved in selecting who gets funding, etc
- Services should focus on client satisfaction – it's about getting an effective service not getting numbers processed
- Train youth workers in mental health issues
- Youth workers time not being taken up with processing forms, writing reports, etc

**4 . NEEDS OF ABORIGINAL YOUNG PEOPLE**

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Young Aboriginal people have special needs that not all workers are aware of. Are there any indigenous young people here? Does anyone here know an indigenous young person who needs/wants/is accessing these services?

**GROUP ONE: CONSUMERS OF MENTAL HEALTH AND ACCOMMODATION SERVICES (INCLUDING TEN YOUNG ABORIGINAL PEOPLE IN MAGILL TRAINING CENTRE ON REMAND OR DETENTION ORDERS)**

**What does this mean to participants?**

- Taken away from family = lost identity/culture. Deeply distressing for young Aboriginal people, but not seen as an issue for counselling
- Loss of community = loss of elders
- Community is a major issue that people don't understand
- Aboriginal young people with mental health issues are "a minority in a minority"
- Cultural issues faced by Aboriginal people may also be faced by people from other cultures – for example, in four years of contact with the mental health/accommodation system, one Asian participant reported meeting only two other Asian people – "you wonder if you're the only one" – this compounds distress

**Have cultural issues affected you or a person you know, when getting mental health and/or accommodation services?**

In general: cultural differences evident in how an agency is structured as opposed to a community. In a community, elders are elders because of their knowledge, etc. In an agency, it is because they are employed. Employees don't deserve the same respect as elders.

**What do you think needs to happen to make this better/make a difference to this situation?**

The ideal qualities of a worker:

- ✓ Being honest
  - ✓ Being real, up front and straight out
  - ✓ Using humour but not laughing at young people
  - ✓ Bringing you up when you feel down
  - ✓ Being a friend
  - ✓ Trusting
  - ✓ Being empathic
- Aboriginal young people found having Aboriginal workers preferable but would work with anyone who had these ideal qualities
  - Should be time to develop a relationship with a worker

- Should be able to choose worker or change if not comfortable
- "Shouldn't be given special treatment" but should have environment set up to cater for them specifically
- Education of parents through a discharge plan – try to keep kids at home
- Government funded transport in the south to get home from support group meetings

**The workers have said that the special needs of Aboriginal people need to be addressed by workers through training. What do you think of this?**

Priority should be given to Aboriginal people.

**GROUP TWO: YOUNG PEOPLE WITH A  
PEER PERSPECTIVE ON SUPPORT AND  
ACCOMMODATION FOR YOUNG PEOPLE  
WITH MENTAL HEALTH ISSUES**

**What does this mean to participants?**

Cultural appropriateness of a service to an individual is important to quality of service received.

**Have cultural issues affected you or a person you know, when getting mental health and/or accommodation services?**

- Yes – sometimes if a worker is from the same culture as a client there is concern about confidentiality and shame on the family
- Sometimes cultural issues (broader than for Aboriginal people) are the problem that young people seek help with, especially young people with mental illnesses: e.g. arranged marriages, parent-child relationships, gender roles and values. Workers need to understand this especially when placing young people in accommodation

**What do you think needs to happen to make this better/make a difference to this situation?**

- Workers dealing with specific mental health issues associated with specific groups with specific experiences – e.g. newly-arrived young people with an experience of war, famine and transitioning to a new country and culture
- Living skills for young Aboriginal people

**The workers have said that the special needs of Aboriginal people need to be addressed by workers through training. What do you think of this?**

Training is helpful for awareness of cultural issues for young people. It would need to be pretty thorough.

## **5. ANYTHING ELSE?**

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In general – what kinds of support is needed for young people with mental health issues, especially in finding accommodation? What issues come up in getting these services?

### **GROUP ONE: CONSUMERS OF MENTAL HEALTH AND ACCOMMODATION SERVICES**

#### **The Family**

The family/extended family was seen as very important to providing support and accommodation to young people in need. Safety was an important issue raised by the participants, and keeping drugs and alcohol out of the home was identified to help provide this. Participants described a cycle of anger leading to violence, drug/alcohol use and crisis, and stated more counselling/mental health services were needed to talk about feelings and explore helpful strategies to deal with problems. Assistance with talking to parents and resolving family conflicts was also raised as a need. Participants also agreed that more practical support was required to help extended families support young people, this includes money, clothing, food and furniture.

- Wardang Island (an adventure-based detention alternative, previously conducted by MAYT)
- Frahn's Farm
- Schools
- Aboriginal cultural studies
- Strong emphasis on counselling for refugee young people

### **GROUP TWO: YOUNG PEOPLE WITH A PEER PERSPECTIVE ON SUPPORT AND ACCOMMODATION FOR YOUNG PEOPLE WITH MENTAL HEALTH ISSUES**

- Something needs to be done with all this research and consultation
- University accommodation service sues one participant over unpaid rent due to a problem with receiving Austudy payments – no negotiation possible when you have no income!

## **Appendix 3: Support and Accommodation for Young People with Mental Health Issues – List of Organisations and Attendees**

**CONSULTATION DAY,  
THURSDAY 21 SEPTEMBER 2001**

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<b>Organisation</b>	<b>Name</b>
Adelaide Central Mission – Adolescent Services	Michael Colin
Adelaide Central Mission – Ruby's Place	Robyn Sutherland
Adelaide Hills Community Health Centre	Dana Shen
Baptist Community Services – Youth Team	Phil Dunkley
Centacare – Suicide Prevention Project	Hannah Ciesielski
Centre of Personal Education (COPE)	Claire Ralfs
Centre of Personal Education (COPE)	Roxanne Adams
Child and Adolescent Mental Health Service – Eastern	Sharon Wright
Child and Adolescent Mental Health Service – Northern	Ian Pearce
Child and Adolescent Mental Health Service – Port Pirie	Jan Reynolds
Child and Adolescent Mental Health Service – Southern	Sam Gibbon
Drug and Alcohol Services Council (DASC)	Toni Hanna
Enfield Campus – Adolescent Services	Ian Dobson
Family and Youth Services – Policy and Planning Unit	Bernie McGinnes
Hallett Cove Youth Project	Vanessa Elvey
Hallett Cove Youth Project	Lesley Hodgson
Hospital Links – Women's and Children's Hospital	Greg Shepherd
Hospital Links – Women's and Children's Hospital	Pat Mead
Hospital to Home Transition Team (HHTT)	Christine Yelland
Kumangka Aboriginal Youth Service	Rangi Timothy
Kumangka Aboriginal Youth Service	Margie Jackson
Marion Youth Centre	Ben Smith
Metropolitan Aboriginal Youth Team (MAYT)	Karen Darling
Shopfront Youth Health and Information Service	Dorian Marsland
Shopfront Youth Health and Information Service	Fiona Mort
South Australian Council of Social Service	Margaret Galdies
St Johns Youth Service – Chisholm Place	Wendy Fraser
Streetlink Youth Health Service	Cathy Vockins
The Second Story Youth Health Service – Central	Pam Sharley
The Second Story Youth Health Service – Central	Pip Messant

The Second Story Youth Health Service – South  
Women's and Children's Hospital – Boylan Ward  
Youth Advisory Forum (DASC)  
Youth Affairs Council of South Australia  
Youth Affairs Council of South Australia  
Youth Consultant  
Youth Consultant  
Youth Consultant  
Youthlink

Liz Higgs  
Tim Crowley  
Kate Gommau  
Ann Deslandes  
Sarah Macdonald  
Cecelia Button  
Jose Parsons  
Cherie Przedworski  
Ann Crago

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