

# Submission to the Productivity Commission Inquiry into Mental Health

The Social and Economic Benefits of Improving Mental Health

Georgia Gardner  
Harry Iles-Mann  
Ash Polzin  
Carolyn Thompson

The Youth Health Forum (2019)

*Submission to the Productivity Commission  
Inquiry into Mental Health: The Social and  
Economic Benefits of Improving Mental Health,  
Canberra, Australia*

**P:** 02 6273 5444

**E:** [info@chf.org.au](mailto:info@chf.org.au)

[twitter.com/CHFofAustralia](https://twitter.com/CHFofAustralia)

[facebook.com/CHFofAustralia](https://facebook.com/CHFofAustralia)

**Office Address**

7B/17 Napier Close  
Deakin ACT 2600

**Postal Address**

PO Box 73  
Deakin West ACT 2600

*The Youth Health Forum is supported by the  
Consumers Health Forum of Australia who are  
funded by the Australian Government as the  
peak healthcare consumer organisation under  
the Health Peak and Advisory Bodies  
Programme*

# Contents

# Page

|                                             |                 |
|---------------------------------------------|-----------------|
| <b>Acknowledgements</b>                     | <b>4</b>        |
| <b>What is the Youth Health Forum?</b>      | <b>5</b>        |
| <b>Guiding Principles</b>                   | <b>7</b>        |
| <b>Recommendations</b>                      | <b>9</b>        |
| <b>Barriers to Access</b>                   | <b>11</b>       |
| <b>Social Participation &amp; Inclusion</b> | <b>17</b>       |
| <b>Support Services</b>                     | <b>21</b>       |
| References (in text)                        | 28              |
| References (general)                        | 29              |
| Call to Action                              | Appendix 1 - 31 |
| Case Study - Henry                          | Appendix 2 - 33 |
| Case Study - Oliver                         | Appendix 3 - 36 |
| Case Study - Amiri                          | Appendix 4 - 38 |
| Case Study - Alex                           | Appendix 5 - 45 |
| Case Study - Sally                          | Appendix 6 - 47 |

## Acknowledgements

The Youth Health Forum would like to extend it's sincere thanks to the Consumers Health Forum of Australia, and its sponsors for supporting the Forum and it's 50 attendees.

The YHF would also like to extend thanks to those young Australians who attended the Inaugural Youth Health Forum, to the attendees of the Forum who volunteered their time to author, enable, and compose this response on behalf of those who attended, and to the Youth Health Forum Steering Committee members for their support and guidance.

The YHF would lastly like to thank the Productivity Commission for undertaking this inquiry, and to commend the scope it has applied to such an important subject.

## What is the Youth Health Forum?

The Youth Health Forum (YHF) was launched by the Consumers Health Forum of Australia (CHF) in 2018. Fifty young people came to Canberra to discuss the biggest issues affecting their health and wellbeing, and solutions that they believe will make the system better for young people in the future. Their vision for a better health system and their recommendations can be found in their [Call to Action](#).

The YHF members are young people aged 16 - 30 from across Australia with diverse backgrounds, identities, and lived experience. Their collective knowledge spans physical and mental health services, involvement with the NGO and community sector, and engagement with local issues.

Discussions at the YHF event in 2018 highlighted that young people face many challenges accessing the health and social services. Young Australians are experiencing unprecedented health issues including rising rates of obesity, depression and anxiety. If not addressed, these health issues can plague young people in other serious ways, disrupting their learning and pathways into careers, and their overall ability to participate in their communities.

At a time when young people, governments and health services should be working together, institutional trust is low and young voters feel excluded and unrepresented in discussions that affect them. Without the formal representation that other consumers such as children and older Australians have, engaging with young people about health and social care on a national scale is an onerous task. Effective consultation has fallen to the wayside and a remedy is long overdue.

The outcomes of this Productivity Commission Inquiry will have long-term, far reaching effects on the lives of young Australians. It is essential that recommendations consider the evidence as well as the stories and lived experiences of those who will be most affected by the recommendations of this Commission. For this reason, the Youth Health Forum is pleased to provide a standalone submission that focusses on young Australians in addition to the response of the Consumers Health Forum.

## Guiding Principles

Throughout this submission, you will read the stories of members of the Youth Health Forum sharing their personal experiences with mental ill-health. Though their names have been changed for privacy, these are the real stories of real Australians whose lives are profoundly impacted by these lived experiences. This includes the struggles they have faced with the health sector and the failing safety net of social support. The YHF believes in the importance of lived experience, in partnership with evidence based research, to inform and provide context for how mental health and mental health policy and governance impacts the lives of real Australians.

The Youth Health Forum would like to commend the Productivity Commission for taking a broad and whole-of-person approach to mental health in the scope of this inquiry. The Youth Health Forum believes that health outcomes, especially those related to mental health, are fundamentally linked to the social determinants of health, including financial security, employment, education, housing and justice. The case studies throughout this submission clearly demonstrate the impact of these determinants.

How can someone experiencing domestic violence and abuse seek help for their complex PTSD if they do not know how to access support safely? How can someone manage an anxiety disorder (Australia's most common mental health problem) when they face eviction and homelessness?

How can someone continue a medical treatment plan for their mental health problems when they cannot afford to have food on the table? We cannot separate mental health from the rest of our lives, from the social determinants of health.

A whole-of-person approach to health is vital to improving mental health outcomes. As such, it is absolutely vital to take a whole-of-government approach when seeking to improve mental illness support and prevention, and seek reform which addresses the social determinants of health.

Strategic thinking and system disruption are needed to improve the effective patient-centred integration of services, support of currently under-utilised and digitally enabled care practices, and spur innovation of the qualitative and quantitative measures used by primary care providers to assess the delivery of their services. To bring about this change requires that our policy-makers and strategic thinkers operating within various levels of government make a genuine attempt to re-engage and empower Young Australians with significant lived experience of mental ill health so that they may share in the power of decision making. Ultimately this drives change which, at its core, is built on meaningful engagement and participation.

Based on the feedback and identification of priority areas by the YHF, this submission will discuss, and make recommendations regarding Barriers to Access, Social Participation and Inclusion, and Service Reform within the context of the scope of the inquiry.



## Recommendations

In order to address the challenges faced by Young Australians suffering from, or at risk of developing mental health issues within the context of Improving Social and Economic Participation, the Youth Health Forum asks the Productivity Commission's Inquiry into Mental Health to consider the following recommendations:

**Recommendation 1)** The Youth Health Forum calls for prioritising a whole-of-government approach in all policy, strategy and service delivery around health and mental health. This would be guided by ministerial leadership and demonstration of cross-portfolio collaboration and commitment. Developing meaningful, integrated and adaptive healthcare reform will rely on strengthening inter-departmental collaboration and action.

**Recommendation 2)** Re-establish, and innovate new state and federal parliamentary youth engagement and advisory initiatives.

**Recommendation 3)** Require an expansion of existing public primary health service providers Key Performance Indicators to include, and incentivise measures of cultural responsiveness and competency in service delivery and community engagement.

**Recommendation 4)** Strengthen measures and processes available for young people in crisis, who are unable to engage with traditional and overt support services. This allows people to covertly seek help when there is risk to themselves or others involved in following conventional pathways.

**Recommendation 5)** Expand and further incentivise the creation of accredited tele-Health services to ensure the sustainability of remote/regional practices and equity of access to consistent health services.

**Recommendation 6)** Prioritise the creation and endorsement of effective integrated care models for primary health service providers for children and young people which addresses the intersection of chronic physical and mental health issues as significant risk factors to reducing social and economic participation and engagement.

**Recommendation 7)** Invest in social psychoeducation - including programs for the friends and family of people with a diagnosed mental illness.

**Recommendation 8)** Develop and maintain a funded program to allow people with long term and/or complex mental health diagnoses to have continuous and equitable access to effective care.

**Recommendation 9)** Innovate social programs which acknowledge people as more than “just a patient” by encouraging organisations to develop non-clinical, and organic social relationships with their communities.

**Recommendation 10)** The Youth Health Forum joins organisations such as ACOSS, CHF, The Human Rights Law Centre, and many others in calling for an increase in Newstart, Youth Allowance and related payments of \$75 a week. The Youth Health Forum believes this increase is necessary to move people on these support payments out of poverty, improve mental health outcomes, and support their ability to meaningfully participate in social and economic life.

**Recommendation 11)** The Youth Health Forum supports the timely implementation of all recommendations from the ‘Jobactive: failing those it is intended to serve’ report from the Senate’s Education and Employment References Committee. The Youth Health Forum also recommends undertaking further review and restructuring of the Targeted Compliance Framework, which is punitive and lacks appropriate measures for individuals to challenge incorrectly applied penalties.

**Recommendation 12)** The Youth Health Forum recommends all current and future development of the Department of Human Services and particularly Centrelink is based on the value of being human-focused, and calls for a review or inquiry into program design and delivery of the Department of Human Services and Centrelink.

## Barriers to Access

- *Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?*
  - *What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?*
- 

The Mental Health Sector, and within it specifically Youth focused services and support, face a challenge shared by the broader health system, with the addition of a number of unique complexities that make the quality of the services delivered in itself not enough to effectively remedy the explosive growth of diagnosed and undiagnosed mental health issues<sup>[1]</sup>. Barriers to accessing support and care services render the quality of those services obsolete if they cannot be equitably accessed in a manner that is culturally empathetic, geographically convenient, and empowers help-seeking behaviour that is indifferent to socioeconomic determinants.<sup>[2]</sup>

### Case Study

*Henry was a victim of domestic abuse as a child, and teenager. Due to a lack of awareness of support, both formal and informal, he was unable to disclose, or document his abuse to any support or law enforcement. Instead he was left to get by "on the false hope that I could access justice when I was old enough to leave, and safe enough to seek justice without potentially deadly retaliation."*

*It wasn't until confiding in his university counselling support that he "disclosed harrowing experiences from being made to eat (his) own vomit, having sharp knives thrown at (him), being threatened with cruel graphic tortures weekly, (and) frequent beatings."*

The effectiveness of available support mechanisms are ultimately irrelevant if young people are unable to reach out or engage with those mechanisms in the first place.

*"I didn't seek mental health treatment till I entered university. I didn't know till then that I could access GP's and even psychologists for free under our welfare system (Centrelink support) and Medicare. It's not taught at school." - Henry*

The capacity to develop meaningful responses to the crisis of mental health issues amongst our youth, and therefore a reduction in the ability of young people to engage and participate in social and economic activities around them, is driven in a large part by the Australian Government's policy and strategy direction; a direction which currently lacks any meaningful input through engagement with Young Australians with lived experience of mental ill health. It stands to reason that the lack of a youth voice at the table where decisions are made impacts greatly on our ability to develop a coherent and effective national strategy. Youth engagement and participation must not only be considered in terms of their capacity to access services and support around them, but also within the context of how the mechanisms of change attempt to engage them in contributing to that change. Youth involvement in policy making is internationally evidenced as an effective way of driving the development of more appropriate and effective policy.<sup>[3]</sup>

Yet in spite of this, most key mechanisms for youth involvement in driving policy change in the mental health sector (or any sector) have to date been defunded or discontinued.<sup>[4]</sup>

In order to address the challenge of improving Young Australians' capacity to participate and engage through effective ways of addressing the challenges of mental ill health, we must first support their meaningful engagement and participation with the mechanisms that drive policy and service based decision making.

In addition to the co-design of Youth Mental Health services, the challenge of appropriate and effective service delivery arises. The value of lived experience informing service provision in the mental health sector is widely evidenced, and in health broadly.<sup>[5]</sup> No less important is the impact that the experience of engaging with support and services can have on an individual or community's desire or hesitancy to seek help. An effective service in itself, with ineffective or culturally insensitive methods of delivery or engagement, is ultimately ineffective as the barriers for access are insurmountable for the communities attempting to access care. Cultural responsiveness measures for many Primary Health Networks (PHN's) centre on the provision of training and staff education. However, the mere delivery of a training program tells an organisation nothing more than that the training was given. This focus on process based measurements for people who have interacted with a care provider does little to account for, or act as a catalyst for improving and understanding the barriers that communities of varying backgrounds and cultures face when accessing care, as those barriers prevent access in the first place.

In this context, and within the context of the uniquely sensitive challenge that mental ill health presents, it is necessary to support the meaningful quantitative, and qualitative measurement of the outcomes of effective cultural responsiveness and competency within PHN's in order to ensure that care providers are:

- providing mental health services which effectively support people from diverse cultures and backgrounds including, but not limited to, Indigenous and Torres Strait Islanders, Culturally and Linguistically Diverse communities, and the Lesbian, Gay, Bisexual, Transgender, and Queer communities; and
- developing meaningful platforms of engagement with their care seeking communities, and maintaining an agile awareness of the current and evolving barriers that exist for young people in need of, or attempting to access support.

The development of these measures, and the ongoing effort to address challenges must also involve and engage patients, and health consumers to ensure effective and appropriate action.

Models of care provision are an additional, and fundamental consideration. The intersection of chronic physical health and mental health create significant challenges for Young people trying to participate socially and economically. On average, 1 in 5 Australians will suffer from one of the five highest prevalence disorders. Of those, 43% have an existing physical illness. The existence of a physical health issue is one of the strongest contributing risk factors for depression.<sup>[6]</sup> It is therefore necessary that models of care for young people experiencing chronic physical illnesses are holistic in their approach to, and attempts to intervene early in the prevention or treatment of associated mental health issues. The relationship between mental and physical health can be volatile, and significantly impair an individual's capacity to engage socially and economically.<sup>[7]</sup> To use an example:

## Case Study

*Oliver, a 24 year old male with multiple serious chronic physical and mental health issues experiences a flare-up of his Ulcerative Colitis. His capacity to maintain an active and healthy lifestyle are restricted due to his physical health, and as a result he suffers an exacerbation of his diagnosed Severe Depression. As a result of the substantial loss of motivation and willingness to engage in healthy self care activities, his adherence to taking medication for both physical and mental health issues diminishes. This further compounds the severity of his flare-up.*

*Due to these factors, he quickly becomes anaemic, dehydrated, withdraws socially, is unable to work, and ends up requiring medical attention to stabilise his health. Including recovery, he is absent from work and doesn't participate socially for the two weeks following the initial event, which itself took place over a 16 day period.*

For other young people like Oliver, care models which support a whole-of-person approach to both health and wellbeing management presents a powerful opportunity to intervene early, or mitigate the impact of mental ill health as a contributing factor to barriers in accessing care, and in participating socially and economically in the broader community.

In addition to the importance of integrated care models, the provision and availability of mental health focussed tele-health services and supporting models of care is a fundamental pillar of providing equitably accessible support for those experiencing similar challenges in rural and remote settings. Indeed, the capacity for those living in metropolitan areas to maintain continuity of care and access mental health support services is restricted by limitations of physical health. Traditionally, chronic physical health issues are thought of as primarily relevant to older generations of Australians.

Whilst it is true that Australia's aged population experience chronic illness at a higher rate than those under the age of 44<sup>[8]</sup>, it is important to remember that chronic illness in youth has a far more profound impact on educational and employment outcomes on an individual basis - especially in the context of the risk factors, and intersection of physical and mental health outcomes.

In order to address the challenges faced by marginalised, remote, and complex communities in accessing support and services, the Productivity Commission's Mental Health Inquiry is asked to consider the following recommendations:

**Recommendation 2)** Re-establish, and innovate new state and federal parliamentary youth engagement and advisory initiatives.

**Recommendation 3)** Require an expansion of existing public primary health service providers Key Performance Indicators to include, and incentivise measures of cultural responsiveness and competency in service delivery and community engagement.

**Recommendation 4)** Strengthen measures and processes available for young people in crisis, who are unable to engage with traditional and overt support services, to covertly seek help when there is risk to themselves or others involved in following conventional pathways.

**Recommendation 5)** Expand and further incentivise the creation of accredited tele-Health services to ensure the sustainability of remote/regional practices and equity of access to consistent health services.

**Recommendation 6)** Prioritise the creation and endorsement of effective integrated care models for primary health service providers for children and young people which addresses the intersection of chronic physical and mental health issues as significant risk factors to reducing social and economic participation and engagement.



## Social Participation & Inclusion

- Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?
- 

There are multiple groups in Australian society that are at higher risk of social exclusion or reduced capacity for social participation. In particular, people with diagnoses such as psychosis, personality disorders, or alcohol and other drug (AOD) issues face higher stigma from the wider community and employers. Additionally, people from CALD/ATSI backgrounds and those who identify as LGBTQ+ are predisposed to rejection and social exclusion which is compounded by mental ill-health.

There are two approaches to increasing social participation and inclusion for these groups:

- education for friends and family of people with mental illness, as well as the broader community; and
- targeted social interventions which give people from these at-risk groups the chance to be individuals with fulfilling lives beyond being 'just a patient'.

*"Imagine what it's like when your family puts your wellbeing last and you're already in a bad headspace... The moment you get the family or the parents to understand and get behind the young person, everything else falls into place." - Amiri, 25*

The first approach involves a large scale commitment to reducing stigma and improving understanding of mental illness. Studies have shown that employers are less likely to employ someone with mental health issues<sup>[9]</sup>, and that Australians have a variety of misconceptions and stigmatising attitudes towards symptoms of mental illness, especially towards schizophrenia and social phobia<sup>[10]</sup>. By implementing large scale psychoeducation on the reality of mental illness - especially that people with mental health issues are not inherently lazy, dangerous, or weak - people are more likely to be able to maintain social participation including friendships and meaningful employment.

The second relies on a whole-of-government commitment to practical, financial, and emotional support for people with diagnosed mental health issues. Although prevention is the best treatment, some form of mental illness will always exist in our society, and acknowledging this is vital to improving outcomes and reducing rates of issues such as homelessness, social exclusion, underemployment, and others that disproportionately affect people in the groups mentioned above. Significant, and poorly managed funding boosts for particular areas of care is in itself not a sufficient, or reasonable demonstration of problem solving.

The Mental Health Coordinating Council (MHCC) states that *"There is little prospect of accessing work or community activities by people whose housing is unstable, who have problems with money, who are unable to access affordable transport, and who feel isolated by stigma and discrimination (actual and/or feared)"*<sup>[11]</sup>.

When a person faces unstable employment or other financial strain, compounded by the stigma of mental illness and belonging to a marginalised group, motivation and ability to "pull oneself up by the bootstraps" is limited. To use an example:

## Case Study

*Alex is a 19 year old nonbinary person, with diagnosed mental health conditions including Complex Post-Traumatic Stress Disorder and Bipolar Disorder type II. The fluctuating nature and unpredictability of their conditions mean that they have been unable to maintain stable employment for more than a few months at a time. They incur high costs of living - multiple medications, up to four different specialist appointments in a month, and pre-prepared food are all vital to continued stability.*

*However, due to strict Centrelink requirements, they are unable to access financial support and have frequent periods of financial strain which exacerbate episodes of depression, anxiety, and suicidality. Applying for jobs is already difficult, and the process is demoralising and anxiety-inducing. Even when they do get an interview, they are forced to decide which is less detrimental to their mental health - disclosing their transgender status and risking discrimination, or pretending to be someone they are not and carrying that weight to work every day.*

*Since Alex has no stable income, they feel uncomfortable making plans with friends, as most social activities incur some kind of cost - so they gradually stop having any social interaction, or even leaving the house.*

For people such as Alex, where the 'revolving door' of time-limited emergency supports followed by periods of little-no support can discourage help-seeking, contributing to further isolation and withdrawal from social participation. Having a mental illness is already an isolating experience, and when a person has complex needs but is not classified as disabled - thus unable to receive support from disability job service providers - it can be easy to become overwhelmed by isolation and loneliness. Withdrawing from society is, in many cases, an easier 'solution' than continuing to navigate the stress of day to day life.

In order to address the challenges faced by those more at risk of mental ill-health due to inadequate social participation and inclusion, the Productivity Commission's Mental Health Inquiry is asked to consider the following recommendations:

**Recommendation 7)** Invest in social psychoeducation - including programs for the friends and family of people with a diagnosed mental illness.

**Recommendation 8)** Develop and maintain a funded program to allow people with long term and/or complex mental health diagnoses to have continuous and equitable access to effective care.

**Recommendation 9)** Innovate social programs which acknowledge people as more than "just a patient", and encourage organisations to develop non-clinical, and organic social relationships with their communities.

## Support Services

- *How could non-clinical mental health support services be better coordinated with clinical mental health services?*
  - *Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?*
  - *How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?*
- 

*“Getting through a degree requires a really high level of privilege in terms of being neurotypical, financially stable, and having housing and food security”. - Sally, aged 25, Newcastle*

Sally has chronic fatigue, anxiety and depression. She didn't qualify for Youth Allowance so, like many students, she worked while studying for a few years. This became too much for her and she needed to take a break from studying for a while. Sally tried to return the following year but ended up needing to stay in a hospital mental health ward for a month.

Sally was old enough to be classed as 'independent' and after this incident she became eligible for income support through the Sickness Allowance, which provided essential support for four to six months. She had been taking antidepressants and felt like she could manage her chronic fatigue with the extra support being offered.

Given her plan to return to study, Sally thought that Youth Allowance would be the appropriate channel of support, so she put in a claim to make this change.

*"I thought there would be a process for coming off Sickness Allowance and I was happy to be back at uni after a really challenging year – it was cool to be doing what I wanted again".*

She enrolled in her subjects and started studying but didn't hear anything for three weeks. Her medical certificate expired and her Sickness Allowance payments ceased. Sally was told it was busy and her claim was being processed so she borrowed money from her parents to pay the week's rent.

After a couple of weeks, Sally needed to pick up casual work and borrow money from friends for rent. Her pantry was empty and she had to get meals from the university's student association.

After six weeks, Sally followed up with Centrelink again. Her application had been sent to a 'virtual office' by mistake and so had not been processed yet. The financial pressure began to take a toll on her health and ability to study, but the census date to withdraw from the semester had passed.

*"I couldn't afford to replenish my meds and people were already helping me with money for food and rent so asking for extra money was too much... I stopped taking the antidepressants that I had spent a year working out the right dosage for... Everything starts falling apart, I'm flunking my classes but I need to stay enrolled to be eligible when the payments come through, which feels horrible."*

*"I'm definitely not in the position to do the assignments or absorb information. The landlord started calling everyday about our overdue rent. I think I spent about thirty hours on the phone to Centrelink and spent the time I wasn't studying or working at in the Centrelink Office trying to sort the issue out. It was so hard when the landlord was calling every day and all I could do was hope that they trusted me."*

Sally and her partner were evicted, she was excluded from university due to poor academic performance, and she was forced to move back into her parents' house in Newcastle to look for a job. Her mental health, interpersonal relationships and confidence have been badly impacted. She is still unable to reapply to that university, and her eviction remains on record.

Three years later, Sally has just secured part-time work and she is planning to move out of her family home. With chronic fatigue and no university qualification, it has been hard to find a suitable job. She was receiving a NewStart Allowance and continues reporting her income and meeting with a case manager each fortnight even though her income now makes her ineligible for payments.

*"Even though I have a contract and regular work, the idea of having to start with Centrelink again is so traumatic that it's easier to deal with jobseeker programs... The whole system is designed to intimidate people".*

Sally's story is a demonstration of the negative domino effect that occurs when support is removed from a vulnerable person at a critical time.

*"If I had just stayed on Sickness Allowance and not tried to do the right thing I would probably have a degree right now. Early intervention fixes so many issues - finishing my degree would have meant that I wouldn't have needed NewStart for three years and I could have been working much earlier".*

When approaching mental health from a whole-of-person perspective, we can see that the social service sector is posed to have a huge impact on mental health outcomes.

Unfortunately, the research is clear: Social services, particularly government human services, are not providing appropriate and necessary supports for Australian consumers. To quote directly from the Productivity Commission report on Human Services Reform, *"The social housing sector is broken.... Family and community services are not effective at meeting the needs of people experiencing hardship....Current approaches to commissioning human services in remote Indigenous communities are not working."*<sup>[12]</sup>

As stated in the recent 'Jobactive: failing those it is intended to serve report', published by the Senate's Education and Employment References Committee, it is *"clear that the jobactive program is not fit for purpose. It is not delivering on its stated objectives."*<sup>[13]</sup>



Youth Development Australia's recent National Report Card on Youth Homelessness has showed that 10 years of promises about leadership on youth homelessness have been large empty, stating that *"...there have been some positive initiatives and advances but whole areas of neglect and under-achievement... the early promises made have only been partially delivered... As a nation, we cannot be satisfied with a less than average response to youth homelessness."*<sup>[14]</sup>

When social services fail, the health and mental health of Australians suffer and our families and communities bear the costs. Australians facing financial insecurity or living in poverty or homelessness experience higher rates of stress, and poorer engagement in positive health and self-care behaviours. This can exacerbate existing mental health problems and increase the likelihood of developing new mental health problems.

Australians experiencing financial insecurity or living in poverty are also less likely to seek mental health interventions early, which can increase the severity of mental illness and the subsequent costs of their mental health treatment in the future. As demonstrated by Sally's story, when poor mental health impacts on housing, education, and employment, - the negative impact can last for years, and force people to remain 'in the system' where they are dependent on social services for significantly longer than they would otherwise have been if appropriate support had been provided earlier.

This concern is of particular importance to the YHF, and to young people more broadly. Like Sally, young people who do not receive adequate support for housing, education and employment can suffer from consequences to their careers and economic futures for decades. As life-expectancy continues to grow, it is even more important that support services are able to provide the best start to life and career, in order to strengthen individual economic participation, and to improve the lives of future families.

In addition to these costs and losses to individuals and families affected by preventable mental health conditions and poor social support, we should also examine the community costs. In some cases, community services and NGO's may be available to assist those who are not provided a safety net through social support.

These organisations provide an important and valued lifeline. However, the cost of these services and organisations to support preventable mental ill-health should be considered in the context of the overall impact on our community and economy when we fail to provide adequate social support.

The implications of failing to address this challenge are clear, with the Medical Journal of Australia stating that the community costs of homelessness are *"estimated as exceeding \$25 000 per person [per year], while the cost of youth homelessness in Australia... has been calculated to be \$626 million per year.<sup>[15]</sup>"*

Mental health prevention is fundamentally tied to adequate social services. Social service reform and expenditure is therefore an investment in the health of individuals and communities - with demonstrated potential for realising significant long-term economic benefits.

The YHF believes social service reform is a key factor in preventing mental illness, and supporting individuals with mental illnesses to have the resources and opportunities to meaningfully participate in social and economic life.

In order to address the challenges faced by those currently receiving, or unable to access Support Services, the Productivity Commission's Mental Health Inquiry is asked to consider the following recommendations:

**Recommendation 10)** The YHF joins organisations such as ACOSS, CHF, The Human Rights Law Centre, and many others in calling for an increase in Newstart, Youth Allowance and related payments of \$75 a week. The YHF believes this increase is necessary to move people on these support payments out of poverty, improve mental health outcomes, and support their ability to meaningfully participate in social and economic life.

**Recommendation 11)** The YHF supports the timely implementation of all recommendations from the 'Jobactive: failing those it is intended to serve' report from the Senate's Education and Employment References Committee. The YHF also recommends undertaking further review and restructuring of the Targeted Compliance Framework, which is punitive and lacks appropriate measures for individuals to challenge incorrectly applied penalties.

**Recommendation 12)** The YHF recommends all current and future development of the Department of Human Services and particularly Centrelink is based on the value of being human-focused, and calls for a review or inquiry into program design and delivery of the Department of Human Services and Centrelink.

## References (in text)

1. Australian Government Department of Health, 2007 *National Survey of Mental Health and Wellbeing*, accessed March 30 2019, last revised May 2009, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhaust2-toc~mental-pubs-m-mhaust2-hig~mental-pubs-m-mhaust2-hig-pre>>
2. Bessant, Judith (2003) 'Youth participation: a new mode of government' *Policy Studies*, 24(2): 87-100, and Bessant, Judith (2004) 'mixed messages: Youth Participation and Democratic Process' *Australian Journal of Political Science*, July 2004 39(2): 387-405, and Carson, lyn & katharine Gelber (2001) *Ideas for Community Consultation: A Discussion on Principles and Procedures for Making Consultation Work*, Sydney: NSW Department of urban Affairs and Planning.
3. Bell, J, Vromen, A, Collin P, et al, National Youth Affairs Research Scheme, *Rewriting the Rules for Youth Participation: Inclusion and diversity in government and community decision making*, published by the Commonwealth of Australia.
4. Australian Youth Affairs Coalition, *Press Release: AYAC Funding Not Extended*, accessed March 30 2019, last revised 2018, <<https://ayac.org.au/news/269/67/ayac-funding-not-extended-help-us-sustain-our-future.html>>
5. Dr Louise Byrne, *Promoting Lived Experience Perspective Discussion paper*, Queensland Mental Health Commission, and World Health Organization, *User empowerment in mental health: A statement by the WHO regional office for Europe*. 2010, World Health Organization: Copenhagen: Denmark, and Repper, J. and T. Carter, *A review of the literature on peer support in mental health services*, *Journal of Mental Health*, 2011. 20(4): p. 392-411.
6. Australian Institute of Health and Welfare, *Chronic Disease: Overview*, accessed March 28 2019, revised March 27 2019, <<https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>>
7. David M Clarke, Kay C Currie, *Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence*, *Medical Journal of Australia* 2009, 190 (7), s54-s60.
8. Australian Institute of Health and Welfare, *Chronic Disease: Overview*, accessed March 28 2019, revised March 27 2019, <<https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>>
9. Biggs, D., Hovey, N., Tyson, P., & MacDonald, S. (2010). Employer and employment agency attitudes towards employing individuals with mental health needs. *Journal Of Mental Health*, 19(6), 505-516.
10. Hocking, B. (2013). *A life without stigma: a SANE report* (p. 5). South Melbourne: SANE Australia.

11. Merton, R., & Bateman, J. (2007). Social Inclusion: Its Importance to Mental Health. Rozelle: Mental Health Coordinating Council.
12. Productivity Commission. (2017). Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Canberra: Australian Government Productivity Commission.
13. Education and Employment References Committee. (2019). *Jobactive: failing those it is intended to serve*. Canberra: Australian Senate.
14. Youth Development Australia. (2019). A National Report Card on Youth Homelessness. Youth Development Australia.
15. Steen, A. (2018). The many costs of homelessness. *Medical Journal Of Australia*, 208(4), 167-168. doi: 10.5694/mja17.01197

## References (general)

Australian Institute of Health and Welfare. (2016). *Australia's health 2016* (pp. 127-175). Canberra: Australian Institute of Health and Welfare.

AYAC Funding Not Extended – Help us sustain our future. (2018). Retrieved from <<https://ayac.org.au/news/269/67/ayac-funding-not-extended-help-us-sustain-our-future.html>>

Baumann, A. (2010). User empowerment in mental health – a statement by the WHO Regional Office for Europe. Copenhagen: World Health Organisation.

Bell, J., Vromen, A., & Collin, P. (2008). Rewriting the Rules for Youth Participation: Inclusion and diversity in government and community decision making. Commonwealth of Australia.

Byrne, L. (2017). Promoting Lived Experience Perspective: Discussion paper prepared for the Queensland Mental Health Commission. Queensland Mental Health Commission.

Bennetts, W., Cross, W., & Bloomer, M. (2011). Understanding consumer participation in mental health: Issues of power and change. *International Journal Of Mental Health Nursing*, 20(3), 155-164, 20(3): p. 155-164.

Catalano, R., Berglund, M., Ryan, J., Lonczak, H., & Hawkins, J. (2004). Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs. *The ANNALS Of The American Academy Of Political And Social Science*, 591(1), 98-124.

Chronic disease Overview - Australian Institute of Health and Welfare. (2019). Retrieved from <<https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview>>

Corscadden, L., Levesque, J., Lewis, V., Breton, M., Sutherland, K., & Weenink, J. et al. (2017). Barriers to accessing primary health care: comparing Australian experiences internationally. *Australian Journal Of Primary Health*, 23(3), 223.

Currie, K., & Clarke, D. (2009). Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence. *Medical Journal Of Australia*, 190(7), 54-60.

Department of Health. (2009). 2007 National Survey of Mental Health and Wellbeing. Canberra: Department of Health.

Trachtenberg, M., Parsonage, M., Shepherd, G., & Boardman, J. (2013). *Peer support in mental health care: is it good value for money?*, London: Centre for Mental Health.

Wilhelm, K., Mitchell, P., Slade, T., Brownhill, S., & Andrews, G. (2003). Prevalence and correlates of DSM-IV major depression in an Australian national survey. *Journal Of Affective Disorders*, 75(2), 155-162.

# Appendix 1 - Call to Action



*The Youth Health Forum is a network of over fifty young leaders from across the country who came together in September 2018 to discuss our perspectives on the current health system. We are not health policy experts, but experience matters. Our views highlight key areas that will help shape the health of Australians in the future.*

## Our vision for the future

The Youth Health Forum, believe young people need more say in the health system. Good health begins early in life yet young people have little say about what works best for them.

We believe that long-term changes to the health system must begin with policies, laws, funding models, and research priorities that are determined by young people. Our health system is not keeping up with the needs of an increasingly sick and aging population. Rates of preventable disease are rising. Young people are increasingly time poor and face unprecedented living pressures. This is something that we, as future leaders and healthcare users, worry about.

We need the government to invest in keeping Australians healthy and to focus on making the health system more supportive and easier to navigate.

Consumers should be included in decision-making and at all levels of the health system to ensure that the support provided is what people want and need. At a minimum, consumer involvement should include leadership, system design, peer support worker, and educator roles. Young people have views on the health system and want to be included and equipped to participate in the decisions affecting us.

## Empowering and equipping young people to help themselves

We believe that health is a life-long investment. Good habits start early. Providing young people with knowledge, tools and resources to manage their health and well-being should be at the heart of any health strategy. Investment in education and preventative health is cost-effective and reduces the burden of ill health on society.

Providing young people with reliable health information, teaching an effective and engaging national health curriculum, and implementing technology and research initiatives would make a difference to the way we experience the health system now and into the future.

## Designing services for people, not providers

We believe that health services should be supportive and accessible for everyone regardless of financial need and personal circumstances. The focus should be on what the person needs, not what they can afford. People should receive respectful and effective healthcare regardless of their culture.

The need is greater than ever for safe, appropriate and accessible mental health services which meet the unique needs of people aged 12 to 25. More youth specific services with greater investment are needed and the transition for those moving between the paediatric and adult systems warrants greater attention.



## Strategies for Action

*Genuine change based on deep consultation with healthcare users could take years: Australians cannot afford to delay change. The Youth Health Forum called for immediate steps to strengthen the voice of youth in health care, including school surveys to ascertain students' health needs, support for more peer-supported youth-friendly mental health services, transition measures to bridge the gap between paediatric and adult health services, and focused mental health training for emergency staff.*

### Work with young people and their communities to refine health education

Parents, communities, cultural leaders and educators need to understand what young people are interested in and their current perceptions of health before they can build healthy behaviours that will continue from childhood to adulthood. A good place to start is to involve young people in designing the national health education curriculum.

**Action:** Conduct a longitudinal study surveying what Year 7 students want from health education and repeat the research at various points during their high school years.

**Support:** Funding for the Youth Health Forum to design and conduct this study in collaboration with a research organisation such as the Centre of Research Excellence in Adolescent Health.

### Ease the transition to adult services

For frequent users of the health system, the transition between a very supportive paediatric system and an adult system can be difficult to navigate and result in poor experiences of care. The movement can see young people disengaging from the system during an important time and it is essential that health professionals are given more power and resources to make this a gradual, collaborative and flexible process if needed.

**Action:** A national review of current local transition initiatives to identify areas that need support and funding to provide better transition services. A national consultation with consumers, Local Hospital Networks, community health services, General Practitioners, and Primary Health Networks.

**Support:** Funding to conduct the review and consultation, and a commitment to implement the recommendations around transition support services. Consumers must be involved at all stages.

### Embrace lived experience and peer-support in youth mental health services

Peer support services have potential to meet high levels of demand for alternative, approachable, and youth friendly mental health services. These services can offer a platform where safe and culturally appropriate sharing can happen, and trained peer support workers are recognised and employed as part of a comprehensive mental health team.

**Action:** Youth Health Forum to partner with headspace to develop mental health peer support guidelines.

**Support:** Funding for the implementation and expansion of online and face to face mental health peer support services through a national service provider such as headspace.

### Emergency services for mental health crises

People experiencing a mental health crisis can interact with police or paramedics in their transport to the emergency department. Mental health training is part of basic training for all first responders, including emergency department workers, however, there is variation in their practical experience and the depth of their mental health training. Young emergency service workers at the Youth Health Forum expressed concern that their basic training had been inadequate in providing a sensitive response to the growing number of people experiencing a mental health crisis. This recommendation aims to raise the base level of mental health training that first responders receive.

**Action:** A commitment to fund mental health first aid training for first responders (police, paramedics and emergency department workers) in providing a sensitive response and keeping people safe while connecting them to appropriately trained mental health professionals e.g. psychologist, mental health nurse.

**Support:** Funding for training and resources to improve the first response, support and transfer of people experiencing a mental health crisis.





## Case Study - Henry (appendix 1)

### Health and social service education -

*I didn't seek mental health treatment till I entered university. I didn't know till then that I could access GP's and even psychologists for free under our welfare system (Centrelink support) and Medicare. It's not taught at school. But my university had a counselling service which was free, which paved the way for me. I disclosed the family violence I'd experience since my earliest memories for the first time in that setting. Slowly I disclosed harrowing experiences from being made to eat my own vomit, having sharp knives thrown at me, being threatened with cruel graphic tortures weekly, frequent beatings, put downs and much more. Had I access to a GP before then, I may have disclosed earlier, and been spared the latter years of abuse. Had I known about standards for evidence in court rooms, I would have documented my bruises or scars rather than getting by on the false hope that I could access justice when I was old enough to leave, and safe enough to seek justice without potentially deadly retaliation.*

### Parental gatekeeping and gendered narratives -

*I didn't report in other contexts. Because parents are gatekeepers to many children's world views, I did not realise it was abnormal. For example, I believed my mum who said she'd accuse all three of my dad, my brother and myself - then a prepubescent boy, of raping her. She said both the law and society would take her side. I believed her because school and media told me mothers are caring, women are victims not perpetrators and men are dangerous. I never saw my brother, father or myself ever shout at let alone hit back at her.*

*My high school once sent a slip home to all the students for permission to participate in a student wellbeing survey. Some students were referred to the school's counsellor based on their results. Obviously, my parents did not give their permission.*

## **Centrelink -**

*I depended on Centrelink income support to leave that childhood home. I am grateful for the assistance. However, I was unable to access it to leave earlier in life because it is means tested against my parent's income...*

## **Service coordination failures -**

*I was shuffled from one specialist services and clinician to another, having to retell my story, redo assessments and get to know a new treatment team, due to different opinions re: my diagnoses making it confusing, hard to make informed decisions, trust my service providers or prioritise treatments. There were further complications in transitioning from a 'child and youth' to adult service setting.*

## **Diagnostic difficulties -**

*Over time I racked up diagnoses ranging from PTSD, OCD, generalised anxiety, schizoaffective disorder, schizophrenia, personality disorders not otherwise specified, schizotypal personality disorder, depression and autism spectrum disorder to a nonverbal learning disability. In some instances, I found the organisations and found diagnoses different than I had been informed in person, without explanation.*

## **Perverse incentives around medical malpractice for complex cases -**

*Today, I face different challenges. For example, clinicians refusing to specify a specific diagnosis for me on forms important for disability management at work, gain access to government services or to support my involvement in patient advocacy bodies. Clinicians risk medical malpractice claims for incorrect diagnoses and know that mental disorders need not fit into neat clusters of symptoms. I have FOI-d health services before and discovered diagnosed different than they'd told me in person. Mental health services should admit patients on that basis of how applicable the treatment they offer is, not on the basis of the diagnoses, since evidence-based treatments don't neatly match diagnoses. In addition, the less than typical presentation of my illness can make it hard to meet the eligibility criteria for appropriate services. For instance, my OCD affects my eating patterns and I'm underweight, but I am ineligible for any kind of diet related support from various eating disorder services or organisations, or a nutritionist through the NDIS, even though my two written NDIS goals are diet related.*

## **NDIS usability -**

*I wrote in for a review of these matters and they said my circumstances hadn't changed enough, but literally every detail about me on the NDIS had changed. I moved interstate because I finally found a job, I completely lost the 'informal supports' listed on my document, my disability diagnoses changed, and I found out how to actually use the NDIS - since I hadn't before that out of ignorance (and still don't).*

## Case Study - Oliver (appendix 2)

Oliver is a 24 year old male from Sydney. He was diagnosed with Ulcerative Colitis and Liver Disease at the age of 3, and has since developed Osteoporosis, Severe Depression and an Anxiety Disorder. The combined stresses of his physical health issues, schooling, and two rounds of major abdominal surgery to remove his large bowel at the age of 15 have contributed significantly to his diagnosed mental health issues.

Because of the unpredictable and unavoidable nature of his Colitis, he is prone to experiencing flare-ups which compound the symptoms of both his physical and mental health. During a flare-up, his capacity to maintain an active and healthy lifestyle are restricted due to his physical health, and as a result he suffers an exacerbation of his diagnosed Severe Depression. As a result of the substantial loss of motivation and willingness to engage in healthy self care activities, his adherence to taking medication for both physical and mental health issues diminishes. This further compounds the severity of his flare-up.

Due to these factors, he quickly becomes anaemic, dehydrated, withdraws socially, is unable to work, and ends up requiring medical attention to stabilise his health. Including recovery, he is absent from work and doesn't participate socially for the two weeks following the initial event, which itself took place over a 16 day period.

This same cycle, and the challenges that come with it, were a frequent occurrence throughout his schooling - even more so before having surgery. Even though he completed his Higher School Certificate and now attends university, he admits that *"without the immense support from my family, friends, peers, and school community... I likely would not have graduated, and wouldn't be attending university"*. He notes that there was a *"lack of broader community support available that was supportive of the additional complexity that my physical health issues added to my mental wellbeing."*

Despite performing well academically, he is not conventionally employable due to the nature of his illnesses. In addition to this, he has often been unable to make it to appointments with his clinical psychologist because of his physical health - meaning that the burden of ensuring he is appropriately looked after has fallen to both himself and his parents, who act as his carers during periods of severe ill-health.

The lack of early intervention, or even awareness of the higher risk of mental health issues resulting from his chronic physical conditions by himself and his parents has posed a daunting challenge. It has often meant that avoidable aggravations of his mental ill-health have followed flare-ups because of a lack of knowledge on effective ways to manage how both physical and mental health intersect.

## Case Study - Amiri (appendix 3)

***Amiri is a 25-year-old New Zealand citizen who currently works with different youth programs in local councils across Sydney.***

### **Social and Cultural Barriers to accessing mental health services -**

Amiri was previously in a relationship with someone who faced extreme difficulties in trying to live a normal life. She was a Muslim, half Pakistani and half Indonesian, and faced significant cultural barriers in accessing mental health care and support.

Her parents refused to recognise or prioritise her mental health as they believed it would reflect negatively on the family name.

*"After she was discharged from hospital, her mother was grilling her and asking, 'What do you think your Aunty and Uncle will think of this?' and 'Don't you ever think of the family?' Imagine what it's like when your family puts your wellbeing last and you're already in a bad headspace."*

She also didn't receive support from health professionals, which meant she was more likely to stay at home and avoid going to the hospital when she really needed to.

*"When she went critical and I had to take her to the hospital, the nurses treated her as if she wasn't a real patient and she didn't have real issues. They were extremely unprofessional in the way they spoke to her: in their eyes she was a young person in a hospital, taking up a bed that belonged to someone else who had real problems or real injuries... one nurse even told her she had moved up from an 'underage cutter' to an 'adult overdoser'..."*

*"The cultural barriers for young people are huge, I know many who don't go to hospital anymore because of the way they've been treated in the past. They would rather stay at home and hurt themselves than go to these places that are meant to help them."*

*"Some cultures place more value on males than females, I wasn't sure the girl I was seeing would stay alive if she continued living with her family... She had really toxic relationship with her father and a younger brother who was favoured and treated much better than her because he was a boy... all of these cultural factors play a big part for a young person trying to recover from mental health issues, trying to get support or trying to lead a normal life... she attempted suicide multiple times. I tried to convince her to move in with me or go to a youth refuge..."*

*"I got her involved with a few youth organisations to get her outside of her bubble... all of her friends when I met her were connected to her family and cultural circles, but she really came out of her shell by meeting new people... She can speak her mind now and you can see a massive positive difference which goes to show that if you have someone who is able to support you, especially if they're family, you're already a million steps ahead... even though at the end of the day it comes down to the individual person"*

## **Impact of social and cultural stereotypes -**

*"In Bankstown in Western Sydney, it's just not fun for us, especially after the shooting in Christchurch this week. We're all on edge, New Zealand is closer to Western Sydney than Western Australia and we feel like this has happened on our doorstep. I did a resilience workshop at a boy's school today and only two out of fifteen were not Muslim... the headlines, the social media, the reputation of Western Sydney is playing with their heads... you can see how scared, frightened and sceptical they feel about a positive future after what's happened and the way they see themselves in the media and social media."*

*They see how their whole community is labelled by political leaders in contrast to this [shooting in Christchurch] being seen as a single, individual white person on the side that had nothing to do with everyone else... the kids are scared because there is a lot of momentum around solidarity, community, and rebuilding those relationships and they're afraid of the minute minority in the group of Muslims that wish to attack or harm others because this ruins it for everyone"*

The workshops are really beneficial for the kids and provide them with a platform to discuss mental health.

*"Some of the schools have implemented mental health and wellbeing into their curriculum but implementation varies from school to school and principal to principal and this can make a big difference to how the kids digest it."*

*"I believe what would make a difference is including family... bring grandparents and parents in to educate them about the importance of mental health. We need to break down the intergenerational, cross cultural issues that a lot of the first-generation Australian kids have with their migrant parents. There's massive power dynamics when kids become translators for their parents... and a lack of understanding that parents have about their kids' mental health... what does a dad do when he can see his son is not being himself but can't find the words to start that conversation? What does a daughter do when every word she says to her mum seems to hit a brick wall? That's a really big problem here in Western Sydney."*

*"Kids are taking on big roles for their families and have a lot of responsibility, but they don't always know how important this role is. Sometimes they're responsible for things they shouldn't be involved in, I'll hear about a ten-year-old child translating information for Centrelink about their family's financial situation that they probably don't need to know for Centrelink... it's an unnecessary burden for them".*



## **Ideas for the future -**

*"The moment you get the family or the parents to understand and get behind that young person, everything else falls into place"*

*"Interactive educational workshops in languages like Arabic or Chinese would be great... particularly around mental health vocabulary. In Vietnamese, they don't have a word for depression so how does someone of Vietnamese background explain how they're feeling to their parents without this context? Creating language so people from different backgrounds can understand mental health would save so much time"*

*"Any fun programs will get young people and the community involved... food has to be one of the most underestimated, underutilised tools available... free food and free Wi-Fi"*

## **Being a New Zealand Citizen living in Australia -**

Amiri is on a temporary visa that allows him to live and work in Australia for as long as he likes. The fact that it is temporary means the government can change their minds about him living here at any time, which is a scary thought and he feels constantly on edge about his security.

Amiri's family became homeless and he found it really difficult to access support through the normal channels when he was living in crisis housing with Mission Australia. Luckily, he had been in Australia for 10 years and was able to access Centrelink payments for a fixed 6-month period, but things would have turned out differently if he hadn't been eligible for this support.

*"I went to school in Australia, I've worked in Australia and I pay taxes in Australia... but at a time when I needed help, the government shut the door in my face"*

*"Access to this funding was just enough to keep a roof over my head"*

*"It's disheartening and dehumanising when you go to a Centrelink office and they tell you they don't want to talk to you, you need to go to Immigration. When I go to Immigration, they don't want to have a meeting because I don't have a visa application in process... but the process is incredibly confusing and none of the visa options available are relevant to me. The option that I am most likely to be successful with is a child's visa for people under 27 but I would need to move back home with my parents for 12 months, which I can't do, and I would need to be fully dependent on them so I would have to quit my job, which I also can't do."*

His other options are to be sponsored by his work or to marry an Australian.

There is a streamlined process, which Amiri ticks most boxes for: living, working, and paying taxes in Australia for the last five years and passing a police and health check. The only issue is that he has not earned enough (\$53,000 per annum for the last 5 years). As someone who has been through and is still part of the specialist homelessness services, he would struggle to meet this requirement and feels there should be some consideration around this requirement.

*"I'm someone who's worked for the last five years, but I've never had a full-time job. It gives me limited time to juggle other things I need to do, like sorting out these immigration issues and pursuing my own goals and aspirations"*

Amiri's visa status also limits his ability to access health care and NDIS funding. His prosthetic leg has broken twice in the last few years. There were times when he had pressure sores that became open wounds because his leg wasn't fitting properly. Walking is his main mode of transport and as a casual worker he is not able to work unless he can walk and with no income or government support, he is at risk of becoming homeless again.

*"I had no choice and I had no time to rest because I was a casual worker... so a wound that would normally take 3 – 4 days to heal with rest took 4 – 5 months because I worked on it"*

He was finally supported to fly back to New Zealand to get a new prosthetic leg by a small community employment agency in his local area that he had done a program through. One of the workers spoke to their Board and they were able to help fund his flights and organise a meeting with the doctor in New Zealand.

## **Ideas for the future -**

*"Pathways for young people like me who have faced homelessness and immigration issues to access visa support... it's really hard given the thinking that people from New Zealand probably don't need help"*

## **Homelessness -**

This is a significant issue for young people and the reasons for homelessness vary hugely.

His ex-girlfriend didn't feel comfortable staying at home because it was a toxic environment.

*"Some are homeless because their parents can't afford rent, some have been disowned by their family because they brought someone home that they shouldn't have, and others are homeless because of domestic violence."*

There are services and processes in place, but Amiri says you only get to know about them once you become homeless.

*"The three-month turnover rate for crisis housing is too short... expecting a fifteen or sixteen-year-old who has been living at home to grow up and have the skills of an adult who might have work experience or finished university is just unrealistic. They need to keep people moving through crisis level housing but putting young people in medium or long-term accommodation too soon doesn't help the issue"*

## **Ideas for the future -**

*"There are so many reasons for youth homelessness that it would be impossible to have a blanket policy that would address everything, what would be helpful is more beds and more refuges. Although that's still treating the symptoms and not the reasons for homelessness... but how do you stop a Muslim family from disowning their gay son? How do you prevent that from happening?"*

## **Other programs he sees working well in communities -**

Mission Australia uniting funding for community organisations (in light of increased competition in the human services sector)

The Green Light Movement helps young people who wouldn't otherwise have access to a car or driving lessons normally learn to drive in order to get a licence -

<https://www.stfrancis.org.au/greenlight-movement>.

OzHarvest's FEAST program - <https://www.ozharvest.org/what-we-do/feast-food-education-sustainability-training/>

## Case Study - Alex (appendix 4)

Alex is a 20 year old nonbinary person with diagnoses of Complex Post Traumatic Stress Disorder, Bipolar Disorder type II, and Anxiety, stemming from childhood emotional abuse. They left home at 18, but could not access Centrelink payments until two years and four Youth Allowance applications elapsed. Only by chance did their application go through when a Centrelink social worker asked if anyone had actually explained why the previous applications were rejected - they had not been told about a workaround for one of the forms for claiming unreasonable to live at home.

Because of the fluctuating nature of their conditions, and the impacts on their physical health, Alex struggled to hold down a job for more than a few months while studying at the same time. After a year at university, they were forced to change degrees to stay enrolled, after finding out they would be unable to get a job in the field with a mental illness.

Alex is prescribed multiple medications and needs to buy pre-prepared food most days to ration their limited energy, resulting in higher costs of living. Additionally, they need to see their GP, psychiatrist, psychologist, and endocrinologist regularly to manage their mental health and transition care - all of which incur an out of pocket cost.

Applying for jobs exacerbates Alex's anxiety, and even when they do get an interview they fear discrimination as a transgender person. They have to decide whether they will try and pretend to be cisgender, risking uncomfortable or even dangerous situations if they are outed, or to be upfront about their identity and potentially miss out on job opportunities because of it. This is a demoralising and frustrating process, as although it is illegal to discriminate on the basis of gender, it is near impossible to prove this as the reason for not being hired.

Without a stable income or any guarantee of functionality on any given day, Alex finds it difficult to make plans with friends. Most social activities cost money, and they cannot predict if an episode of mental ill-health or a bad night's sleep will stop them from leaving the house. As a result, they begin to withdraw socially, and sometimes won't leave the house for several days at a time.

At age 15, Alex was denied access to mental health care after their mother overheard their psychologist referring to them by their preferred name; they were unable to access care until turning 18 for multiple reasons including not having their own medicare card, geographic isolation/transport disadvantage, and consent issues. Once they turned 18 and were able to access care, they were placed on a three month waiting list for the local headspace - by which time they were about to move states and could not establish a strong therapeutic relationship. In the meantime, they accessed eheadspace telehealth services to get through particularly difficult times in their life.

Their mother had limited understanding of mental illness and suicidality, and thought that Alex was trying to gain attention or get time off school, rather than experiencing genuine distress; she used a punitive approach to try and make them stop self harming, which resulted in more distress. She also advised them not to tell people at school where they had been after a short psychiatric admission to hospital, as she believed it would open Alex and their family to bullying and judgement.

Alex was not aware that their mother's behaviour constituted abuse until age 17, when a friend spoke to them about her boyfriend's abusive behaviour and showed them a list of signs of abuse. Education about and recognition of types of abuse beyond physical and sexual, through school or public campaigns, would have helped them recognise the issue earlier and given them the tools to reach out for help - and potentially given their treating psychologists a better insight into why they were experiencing mental health problems, rather than dismissing it as "teenage hormones" or "school stress".

## Case Study - Sally (appendix 5)

*"Getting through a degree requires a really high level of privilege in terms of being neurotypical, financially stable, and having housing and food security"*

### **Physical and mental health -**

Sally, aged 25 from Newcastle, has chronic fatigue, anxiety and depression. She didn't qualify for Youth Allowance so, like many students, she worked while studying for a few years. This became too much for her and she needed to take a break from studying for a while. Sally tried to return the following year but ended up needing to stay in a hospital mental health ward for a month.

Sally was old enough to be classed as 'independent' and after this incident she became eligible for income support through the Sickness Allowance, which provided essential support for four to six months. She had been taking antidepressants and felt like she could manage her chronic fatigue with the extra support being offered. Given her plan to return to study, Sally thought that Youth Allowance would be the appropriate channel of support, so she put in a claim to make this change.

*"I thought there would be a process for coming off Sickness Allowance and I was happy to be back at uni after a really challenging year – it was cool to be doing what I wanted again"*

## Mismanagement of support services and economic anxiety -

She enrolled in her subjects and started studying but didn't hear anything for three weeks. Her medical certificate expired, and her Sickness Allowance payments ceased. Sally was told it was busy and her claim was being processed so she borrowed money from her parents to pay the week's rent.

After a couple of weeks, Sally needed to pick up casual work and borrow money from friends for rent. Her pantry was empty, and she had to get meals from the university's student association.

After six weeks, Sally followed up with Centrelink again. Her application had been sent to a 'virtual office' by mistake and so had not been processed yet. The financial pressure began to take a toll on her health and ability to study, but the census date to withdraw from the semester had passed.

*"I couldn't afford to replenish my meds and people were already helping me with money for food and rent so asking for extra money was too much... I stopped taking the antidepressants that I had spent a year working out the right dosage for... Everything starts falling apart, I'm flunking my classes, but I need to stay enrolled to be eligible when the payments come through, which feels horrible. I'm definitely not in the position to do the assignments or absorb information. The landlord started calling everyday about our overdue rent. I think I spent about thirty hours on the phone to Centrelink and spent the time I wasn't studying or working at in the Centrelink Office trying to sort the issue out"*

After twelve weeks, she finally received an email approving her claim, but the relief is short-lived as the following week Centrelink calls and emails to suspend her payments until she can justify why she has taken so long to complete her degree. She needed to provide evidence for the last four years.



*"It's very complicated, it's not like I have one illness. I have a bunch of different conditions that intersect... and I was really poor and needed to work to support myself and the first few years were very challenging for me. I only had pieces of evidence across the four years for example, I don't have a GP because I had to go to the bulkbilling walk-in clinics where you see someone different each time... I also hadn't quite found the right therapist at that point, so I had seen about five... the amount of admin and labour needed just completely overwhelmed me and led to me having a nervous breakdown. I ended up calling my parents and they came and got me. As we started collecting evidence it just became too much and I had an even worse mental health incident..."*

With no evidence about her situation with Centrelink, Sally had nothing to show the university and landlord.

*"It was so hard when the landlord was calling every day and all I could do was hope that they trusted me."*

## **Long term economic impacts including, eviction and expulsion from university -**

Sally and her partner were evicted, she was excluded from university due to poor academic performance, and she was forced to move back into her parents' house in Newcastle to look for a job. Her mental health, interpersonal relationships and confidence have been badly impacted, she is still unable to reapply to that university, and her eviction remains on record.

Three years later, Sally has just secured part-time work and she is planning to move out of her family home. With chronic fatigue and no university qualification, it has been hard to find a suitable job. She was receiving a NewStart Allowance and continues reporting her income and meeting with a case manager each fortnight even though her income makes her ineligible for payments.

*"Even though I have a contract and regular work, the idea of having to start with Centrelink again is so traumatic that it's easier to deal with jobseeker programs".*

## **Stressful, dehumanising, and punitive support services -**

With each new role, someone from Centrelink has called to check that Sally is reporting correctly and to tell her that she is being audited.

*"When they call, everything is phrased to imply that I have a debt... the first time they called we went through every payslip over the phone until they finally agreed that I had been reporting my income correctly. If I hadn't been assertive or feeling well that day, I would probably be busy paying back \$1,200 that I didn't need to... the whole system is designed to intimidate people"*

Sally's story shows the domino effect that occurs when support is removed from a vulnerable person at a critical time.

*"If I had just stayed on Sickness Allowance and not tried to do the right thing, I would probably have a degree right now. Early intervention fixes so many issues - finishing my degree would have meant that I wouldn't have needed NewStart for three years and I could have been working much earlier"*

## **Ideas for the future -**

1. More transparency with the claiming process to reduce the time and energy spent on chasing this information and to provide evidence for claimants if there is a delay outside of their control.

*"It's really hard to show documentation of the Centrelink process, a letter to show my landlord or the ANU student services would have been really helpful – there was no way to prove what was happening. All I had to show was the date that I submitted my application and my own record of the phone calls."*

2. Making jobseeker activities more productive and giving people a purpose and way to rebuild their confidence through further study:

*“There’s a perception that unemployed equals unskilled, but these days there’s a lot of really qualified, intelligent people without jobs. Expanding programs like Smart&Skilled to include Diplomas and Associate Diplomas would be really beneficial as these count towards university credits more easily than Cert 3 and 4. Completing a course counts as an activity and is much more productive than endless job applications.”*

3. More access to meaningful mental health services

*“Providing people with more access to trained psychologists through an extension to their mental health plan and more qualified staff who can handle complex cases at places like headspace. This extra support would be life-changing during tough times.”*

4. More tangible support provided through community organisations e.g. food, grocery vouchers, crisis housing for young people, and making bond loans more widely available.