



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

April 2019



Jesuit
Social Services
Building a Just Society

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Jesuit Social Services: Who we are and what we do

Jesuit Social Services has been working for more than 40 years delivering support services and advocating for improved policies, legislation and resources to achieve strong, cohesive and vibrant communities where every individual can play their role and flourish.

We are a social change organisation working with some of the most marginalised individuals and communities, often experiencing multiple and complex challenges. Jesuit Social Services works where the need is greatest and where we have the capacity, experience and skills to make the most difference.

Our services span Victoria, New South Wales and the Northern Territory where we support more than 57,000 individuals and families annually.

Our service delivery and advocacy focuses on the following key areas:

- **Justice and crime prevention** – people involved with the justice system
- **Mental health and wellbeing** – people with multiple and complex needs including mental illness, trauma, homelessness and complex bereavement
- **Settlement and community building** – recently arrived immigrants and refugees, and disadvantaged communities
- **Education, training and employment** – people with barriers to sustainable employment
- **Gender Justice** – providing leadership on the reduction of violence and other harmful behaviours prevalent among boys and men, and building new approaches to improve their wellbeing and keep families and communities safe.
- **Ecological justice.**

Research, advocacy and policy are coordinated across all program and major interest areas of Jesuit Social Services. Our advocacy is grounded in the knowledge, expertise and experiences of program staff and participants, as well as academic research and evidence. We seek to influence policies, practices, legislation and budget investment to positively influence people's lives and improve approaches to address long term social challenges. We do this by working collaboratively with governments, business and the community sector to build coalitions and alliances around key issues, and building strong relationships with key decision-makers and the community.

Our Learning and Practice Development Unit builds the capacity of our services through staff development, training and evaluation, as well as articulating and disseminating information on best practice approaches to working with participants and communities across our programs.

We acknowledge the Traditional Custodians of all the lands on which Jesuit Social Services operates and pay respect to their Elders past and present. We express our gratitude for their love and care of people, community, land and all life.

Recommendations

Prevention and early intervention

- *Use place-based approaches to promote early intervention across a broad range of services.*
- *Increase resources for early intervention and prevention to assist children to remain in school who otherwise may go on to develop more serious problems.*

Gender and culture

- *Explicitly recognise the influence that gendered norms and practices have on mental health outcomes*
- *Introduce policies in the areas of mental health and wellbeing, crime prevention, alcohol harm reduction and road safety which:*
 - *explicitly recognise the influence that men's attitudes and behaviour can have on poor outcomes, including poor mental health and suicidality*
 - *make addressing and changing these behaviours and attitudes a priority*
 - *include investments in preventative interventions to deliver on this priority.*
- *That governments, philanthropy, business and community groups partner in developing, testing and evaluating new interventions focused on:*
 - *building awareness, understanding and skills of family and peers (role models) to support young men to understand, critique and negotiate the rules of the Man Box.*
 - *engaging young men in settings where they are (education, work, sport, community) and provide activities/interventions that support them to live positive alternatives to the Man Box norms.*
- *That government, academia and organisations working with boys and men partner on further detailed research into the attitudes and behaviours of Australian men.*
- *That organisations working with boys and men come together to share knowledge and build capability in undertaking work that promotes positive alternatives to the Man Box. This could include practitioner networks and forums, as well as new tools for working with boys and men.*

Social Isolation, depression, anxiety and trauma

- *Increase resources for programs which provide a 'soft entry point' into the system to engage people with mental illness who are not ready for formal participation with other health care workers.*
- *Ongoing funding for activity-based programs such as Jesuit Social Services' Connexions and the Artful Dodgers Studios as a complementary stream to provide holistic specialist care and creative activities for the most marginalised young people with complex problems, including mental health issues.*

Accessibility and navigating the mental health system: Addressing the impact of NDIS

- *Include specialist entry points to the 'mental health service system' to effectively engage people, address complex needs and complement the NDIS service system.*
- *Provide specialised, flexible mental health services for marginalised people, delivered by a skilled workforce and provided where they live (rather than a reliance on telephone engagement).*

- *Ensure the NDIS finds ways to successfully link with other mainstream services such as housing, mental health, drug and alcohol and employment, as well as to other government departments.*

Aboriginal and Torres Strait Islander communities

- *Increase investment in place-based, community-led social and emotional wellbeing, mental health and suicide prevention and postvention responses for Aboriginal and Torres Strait Islander communities as a matter of priority, ensuring this extends to support in remote communities.*
- *Recognise that Aboriginal and Torres Strait Islander community-controlled organisations are best placed to provide culturally appropriate services, developed by and for local communities, and support them to do so.*

Facilitating social participation and inclusion

- *End the immigration detention of children seeking asylum*
- *End the offshore detention of people seeking asylum*
- *Reverse cuts to Status Resolution Support Services (SRSS)*

System Integration

- *Increase funding for specialist dual diagnosis programs which provide integrated care to the significant number of clients who experience alcohol and drug and mental health co-morbidity.*
- *Implement successful components of the Victorian Multiple and Complex Needs Initiative across Australia, including the provision of an independent care coordination function that is underpinned by a legislative framework and skilled workforce, with a focus on people with complex needs who are not eligible for the NDIS.*
- *Reduce red tape by establishing consistent reporting and evaluation requirements across Primary Health Networks.*

Criminal Justice and mental health

- *In recognition of the particular vulnerabilities and higher risk of suicide for people involved in the criminal justice system, increase prison based mental health supports (including additional staff both in the prison and embedded in transitional support teams).*
- *Strengthen links between prison based health and mental health services and community based health and mental health services to ensure planning occurs for those exiting prison prior to their release.*
- *Pursue strategies to divert people with mental illnesses from prison by strengthening pathways to early community treatment and support, including additional court based mental health support services and staff.*
- *Raise the age of criminal responsibility to 14 years and fund programs that take a restorative and therapeutic approach to anti-social behaviour in children under the age of 14 years.*
- *The youth justice workforce, including detention officers and other staff in youth detention centres, must be grounded in principles that place the interests, developmental needs and rehabilitation of children and young people at the forefront, with a minimum qualification introduced across Australia.*
- *Provide additional resourcing for mental health support services, including community health nurses embedded in transitional support programs.*

- *Legislate for a presumption against the use of isolation, with isolation only permissible in rare cases where immediate safety to persons is a concern, and then only for the briefest possible period. In no case should isolation exceed 14 consecutive days, and a period of such length could only be justified in the most extreme circumstances.*
- *Ban the use of isolation for children and young people in Youth Justice Centres.*
- *That youth detention facilities be prioritised as requiring immediate attention as part of Optional Protocol to the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (OPCAT) implementation.*

Suicide Prevention

- *Develop secure, long-term funding for postvention, early intervention services for suicide bereavement and increase access to suicide bereavement services for regional and rural areas.*
- *Provide funding for a dedicated research stream to develop an evidence base on the impact of suicide and the effectiveness of postvention services in reducing risk.*
- *Develop models and invest in short term residential care for people who have attempted suicide or are suicidal.*

Employment, education and training

- *Expand the JobsBank initiative to allow for greater numbers to participate in the program.*
- *Expand eligibility for the Skills First Reconnect program in acknowledgment that people who have completed year 12 or have a qualification can end up in long-term unemployment and need additional support to successfully re-engage in employment.*
- *Expand access to initiatives which provide mental health support and increase awareness of mental health issues in workplaces.*
- *Reinstate funding for mental health supports within the TAFE sector in view of cuts in recent years which have seen a reduction in counselling and support services available to students.*
- *Funding for initiatives which improve and expand mental health support services available for international students.*

Housing and homelessness

- *Investment in new public housing stock and increased access to social housing.*
- *Investment in a diversity of housing options for people with multiple and complex needs.*
- *Specific housing initiatives for single people, young people, women, and people with experience of trauma.*
- *Incentives for social housing providers to offer housing to complex and high support participants.*

Background and context

Jesuit Social Services welcomes the opportunity to provide feedback on the Productivity Commission's Inquiry into 'The Social and Economic Benefits of Improving Mental Health' (the Inquiry). Mental health services are critical to safe and cohesive communities, and allow people and communities to address the complex and entrenched disadvantage they may face.

Given the need for systemic and culture change in mental health, Jesuit Social Services is heartened by the Inquiry's focus on how reforms outside of healthcare – such as in workplaces, education, justice systems, housing and social services – can improve mental health and hence social and economic participation. The broad scope of the Inquiry is consistent with evidence that there are many factors in addition to healthcare which must be targeted in order to improve mental health, and in doing so achieving improvements not possible by focusing solely on mental health services.

Ultimately mental health must be seen through a social and public health lens, and in this context integration across all service systems is critical – including alcohol and other drugs, family violence, youth and adult justice, child protection, employment, housing and homelessness, and the NDIS. A holistic investigation of the social determinants of mental health is required.

Overall, we believe the following themes and issues deserve consideration or require greater emphasis as part of the Productivity Commission's deliberations:

- Social determinants of health (with a focus on housing, education and employment)
- Integration across all service systems including AOD, family violence, youth and adult justice, child protection, employment, housing and homelessness, and NDIS
- Co-design and the incorporation of the voice of people with lived experience of mental health in program design and delivery
- Development and support for a peer workforce
- Impact of trauma and the need for therapeutic responses specifically to support vulnerable individuals in this area
- Mental health and the justice system – links between custody and mental health services (including those delivered via the NDIS)
- Use of isolation, seclusion and restraint in mental health facilities, prisons and youth detention
- Addressing the needs of vulnerable cohorts including Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds, those in contact with the criminal justice system, people with a history of homelessness, those with multiple and complex needs, young people exiting out of home care or youth justice, people with an Acquired Brain Injury, LGBTIQ community, international students, people seeking asylum, and refugees
- Impact on families and siblings – moving beyond a focus on the individual to a holistic understanding of a person's relationships and environment
- Commonwealth/State funding arrangements and whole of system oversight (i.e. funding, system governance, accountability, monitoring, and provision of NDIS)
- Place-based responses to social disadvantage that account for mental health needs
- Ensuring that the mental health system is underpinned by quality research and evaluation of programs and services
- Better understanding of how gendered norms and practices impact on mental health outcomes

- Better understanding of the gendered ways in which men and women's (and people who identify as neither) mental health presents and how they access and participate in mental health services.

The following submission picks up on the headings identified in the Productivity Commission's Issues Paper and makes a series of recommendations based on our experience of providing support to the most vulnerable and marginalised in the community.

Specific health concerns: Prevention and early intervention

Jesuit Social Services has consistently argued that public policy must pay greater attention to the role of structural factors and social inequality as key determinants of health and wellbeing. We support a holistic approach to mental health and wellbeing that takes account of key drivers like poverty, discrimination, family dysfunction and histories of trauma. We also recognise that mental illness (as well as alcohol and drug issues) is often a contributing factor to involvement in the criminal justice system. We support the approach in the Productivity Commission's issues paper which takes a broad view of the factors that contribute to mental health outcomes.

There is a need for more early intervention services in the mental health system. Services need to be provided early to those who are likely to go on and develop more serious problems. Currently there are long waiting lists for access to services such as mental health assertive youth outreach services. Often only those in severe crisis are able to be seen in a timely manner. Jesuit Social Services believes there is a lack of programs for young people to access support, particularly those who are aged under 12 and may go on to develop more serious problems without adequate early intervention.

Place-based approaches

In 2015, Jesuit Social Services along with Catholic Social Services Australia released the findings of its fourth Dropping off the Edge Report (DOTE), which found that complex and entrenched disadvantage continues to be experienced by a small but persistent number of locations in each state and territory across Australia. These communities experience a web-like structure of disadvantage, with significant issues including mental health problems alongside unemployment, a lack of affordable and safe housing, low educational attainment, and poor quality infrastructure and services.

There is growing recognition that place-based approaches are an appropriate response to addressing entrenched locational disadvantage. Place-based approaches aim to empower communities to develop and deliver local solutions over the long term by bringing together members of the community, community organisations, businesses, government and public services like schools and health centres. Place-based approaches focus on the causes rather than the consequences of entrenched disadvantage, embracing prevention and early intervention in an effort to resolve issues before they escalate. Individuals and groups work together to design and implement innovative solutions to complex social issues specific to their community, drawing on local strengths, opportunities and goals.

Without a sustained, collaborative, long-term commitment across the government, community and business sectors, there is a significant risk that some of Australia's most severely disadvantaged communities will continue to 'drop off the edge'. The web of disadvantage can be broken effectively by a multi-layered, cooperative and coordinated strategy that is owned and driven by the community.

This strategy should be:

- **Targeted** – Concentrated to specific areas of the most severe disadvantage (selected by use of a nationally agreed, transparent and shared evidence base).
- **Tailored** – Meet needs as identified by residents within these communities and respond to the unique mix of issues they face.
- **Integrated** – Recognising that the web of multiple and interconnected causes of disadvantage cannot be addressed with compartmentalised solutions.

- **Cooperative** – Responses are founded on new systemic, coordinated ways of working that draw together different levels of government and departmental portfolios, integrated community initiatives and social impact investment.
- **A long-term horizon** – A long-term commitment of 20 years to address complex, entrenched disadvantage in identified communities.
- **Community owned and driven** – Community leaders drive the agenda, recognising the strength within communities and work with them to build capacity, generate action, attract external resources, and maintain direction and energy.
- **Engaged at the individual, community and national levels** – Recognising the complex interplay of the individual, their family circumstances, their community, and the broader social, economic and ecological environment in causing and addressing disadvantage.

Critically, place-based approaches must encompass interventions from birth across the life span, such as early childhood, school, mental health, justice and crime prevention, and building the capacities and resources of local communities. In particular, there are not enough schools based programs to support those ‘at risk’ who are beginning to disengage from education and may go on to develop more serious problems.

Recommendations

- **Use place-based approaches to promote early intervention across a broad range of services.**
- **Increase resources for early intervention and prevention to assist children to remain in school who otherwise may go on to develop more serious problems.**

Gender and culture

Boys and men are in trouble – and they are causing trouble. We see it in high levels of substance abuse, mental health issues, radicalisation and violence. Around 95 per cent of victims of violence experience violence from a male perpetrator,¹ and 93 per cent of all prisoners in Victoria are male.² The impact on women, children, families, communities and society as a whole is profound. As a society we have recently begun to acknowledge one significant aspect of the problem – violence against women and children.

The focus has been, as it should be, on supporting the victims of this violence. But we must also address the root causes of the problem by supporting boys and men to live respectful, accountable and fulfilling lives, where they are able to develop loving relationships free from violence and contribute to safe and equal communities. We need to promote positive change around gender norms and stereotypes and what it means to be a healthy and respectful man. We need to focus on the contributing factors to male violence like mental health problems, substance abuse and social isolation.

To this end, Jesuit Social Services recently established The Men’s Project. The Men’s Project is working with boys and men to understand their attitudes and behaviours, as well as to support them to establish meaningful relationships, to build hopes and aspirations, and to fully realise their potential.

The Man Box

Evidence from research into men's behaviours and attitudes conducted overseas has found that adherence to social pressures to behave like a 'real man' can result in perpetrating acts of violence, and in poorer outcomes for men in a range of areas including mental health and wellbeing, drinking, and risk-taking behaviours.

The Men's Project undertook a similar study, *The Man Box*, released in October 2018 – the first comprehensive study that focuses on the attitudes to manhood and the behaviours of young Australian men aged 18 to 30. The 'Man Box' is a set of beliefs within and across society that place pressure on men to be a certain way – to be tough; not to show any emotions; to be the breadwinner; to always be in control; use violence to solve problems; and to have many sexual partners. Findings show that the Man Box is alive and well in Australia today. The majority of young men agree there are social pressures on them to behave or act a certain way because of their gender. Living up to the pressures of being a 'real man' causes harm to young men and those around them.

Young men who most strongly agree with these rules report poorer levels of mental health, engage in risky drinking, are more likely to be in car accidents and to report committing acts of violence, online bullying and sexual harassment. Of these young men, 44 per cent had thoughts of suicide in the last two weeks (twice as likely as those outside The Man Box); 56 per cent perpetrated verbal bullying in the past month; 46 per cent made sexual comments to women they didn't know in a public place in the past month; and 83 per cent reported having little interest or pleasure in doing things in the last two weeks.

The fact that those in The Man Box had thoughts of suicide at double the rate of those who were most free of the box is particularly alarming, suggesting more concentrated experiences of poor mental health among this group.

Given these findings, there must be a renewed focus on addressing these attitudes and behaviours in relevant policy areas including mental health and wellbeing, crime prevention, alcohol harm reduction and road safety. This work would complement the *National Plan to Reduce Violence against Women and their Children (2010 – 2022)*.³

Recommendations

- **Explicitly recognise the influence that gendered norms and practices has on mental health outcomes**
- **Introduce policies in the areas of mental health and wellbeing, crime prevention, alcohol harm reduction and road safety which:**
 - **explicitly recognise the influence that men's attitudes and behaviour can have on poor outcomes, including poor mental health and suicidality**
 - **make addressing and changing these behaviours and attitudes a priority**
 - **include investments in preventative interventions to deliver on this priority.**
- **This focus and investment should be informed by, and complement, work already underway in the prevention of family violence field.**
- **That governments, philanthropy, business and community groups partner in developing, testing and evaluating new interventions focused on:**

- **building awareness, understanding and skills of family and peers (role models) to support young men to understand, critique and negotiate the rules of the Man Box.**
- **engaging young men in settings where they are (education, work, sport, community) and provide activities/interventions that support them to live positive alternatives to the Man Box norms.**

- **That government, academia and organisations working with boys and men partner on further detailed research into the attitudes and behaviours of Australian men.**

- **That organisations working with boys and men come together to share knowledge and build capability in undertaking work that promotes positive alternatives to the Man Box. This could include practitioner networks and forums, as well as new tools for working with boys and men.**

Specific Health Concerns: Social isolation, depression, anxiety and trauma

Recognising and responding to the experience of trauma

Jesuit Social Services strongly endorses a focus on the experience of trauma and believes we need to enhance the capacity of mainstream mental health services to respond to trauma, particularly for families and children. Trauma, loss, abuse and neglect are common underlying issues of mental health and substance misuse.

Jesuit Social Services has significant experience working with young people in contact with the justice system who have complex needs, including histories of trauma. Many of these young people have been excluded from mainstream mental health or community services because they fail to meet service expectations around attending appointments, or have challenging behaviours. Young people with trauma related behaviours are also often indirectly excluded from services where they are not made to feel welcome, or perceive that the service is 'not for them'.

While mainstream services can and should adjust service delivery to be more inclusive and responsive to people with histories of trauma, the gap between where they are now and where they need to be to offer a service equivalent to a specialist response is substantial.

Soft entry points into the system

Specialist services for disadvantaged people with mental illness have been developed out of a recognition that this cohort is difficult to engage in mental health care, particularly in formal treatment, and that many programs are not appropriate for their needs.

We know from our extensive hands-on work with marginalised young people that many of them won't engage with particular service models and that they lack the supportive peer relationships which are often crucial to seeking further help. Jesuit Social Services' Artful Dodgers Studios and Connexions program are initiatives that provide 'soft entry points' into the system. At intake, it is common that participants do not identify any mental health concerns. However, over time, a level of trust is developed between the case worker and the person, at which time mental health issues may surface. Feedback from our participants is that it is a positive and empowering experience to be treated as a creative individual and not defined by their 'problem'.

The Artful Dodgers Studios opened in 1996 as a response to the demonstrated need to offer a 'soft entry' to engage vulnerable young people with mental illness who aren't ready for formal participation with social workers or health workers. Creative projects are both a 'hook' for engagement and a mental health intervention in their own right. This approach of 'mental health care without the white coats' provides seamless access to the specialist 'dual diagnosis' counsellors and social workers at Connexions.

The Artful Dodgers Studios working model was developed in response to the specific needs of our 'at-risk' participants. Many of this vulnerable cohort live with concurrent and complex difficulties which contribute to chaotic lives and subsequent difficulty in engaging in appointment-based activities. Many have also experienced serious breaches of trust from adults and are understandably wary of them. The Artful Dodgers Studios' sustained engagement model is relationship based, flexible and centred on

the needs of the participant. It is premised on the understanding that building trust takes time and is achieved through a consistent response, respect and the provision of a safe environment.

Soft entry points are critical to engage people who may otherwise choose not to seek support from the mainstream mental health system. These programs excel in engaging vulnerable young people, using art and music to build relationships of trust, and to support them in addressing the various issues they face. Over the past six months, nearly 200 young people have engaged with the Artful Dodgers and staff have provided over 785 episodes of support. Our young participants are extremely diverse with links to many different cultures. We recommend the establishment of these kinds of programs in other geographical locations to address the needs of vulnerable young people living in those areas.



Mental health and wellbeing profile: Casper

I first came to Artful Dodgers Studios in 2014. It was a very welcoming, colourful space.

When I first walked in I thought, 'Okay, I have to be here to make art, I have to be really driven'. But it's not about that. It's a place you can go to be yourself.

It seemed like there was always something bubbling in the background – somewhere anything was possible.

It's about the arts, but if there's anything else going on, you're open to talk about it and try to work through it. It's really free-form. When I've been in a rough patch, I've been able to just go in and they're there to talk to.

I feel a bit reserved going out to places by myself. Staff go to a lot of art events – like theatre, the Gertrude Street Projection Festival, and art gallery hops – and I would have been intimidated to go by myself. It's really nice to have people to go with.

I've moved house a lot and changed TAFE courses and friend groups a lot and Artful Dodgers has been a constant through all of that. It's been great to know I have something to rely on. It's definitely a backbone.

Recommendations

- **Increase resources for programs which provide a 'soft entry point' into the system to engage people with mental illness who are not ready for formal participation with other health care workers.**
- **Ensure ongoing funding for activity-based programs like Connexions and the Artful Dodgers Studios as a complementary stream to provide holistic specialist care and creative activities for the most marginalised young people with mental health issues.**

Accessibility and navigating the mental health system

Addressing the impact of NDIS for people with complex needs

Effective implementation of the National Disability Insurance Scheme (NDIS) has the potential to benefit many people with a disability, including people with a psychosocial disability. However, the introduction of the scheme has also resulted in a shift to more generalist services and the limiting or de-funding of specialised mental health services that work with the most marginalised people with mental illness, including vulnerable young people, homeless people, women and those experiencing alcohol and drug co-morbidity.

People with multiple and complex needs require a specialist response to effectively address their multifaceted needs as there are often additional vulnerabilities and extra barriers that they face when accessing mainstream services. The NDIS, in its current form, does not lend itself to the type of intense case management required for people with multiple and complex needs, which requires the support of experienced and skilled practitioners. In this context, it is concerning that, as noted in the National Disability Services' *State of the Disability Sector Report 2018*, there continue to be significant challenges in recruiting disability support workers with a mental health speciality.⁴

A coordinated approach is required to ensure that care for people with multiple and complex needs is effective and impactful and that co-occurring issues are not compartmentalised and dealt with in isolation by numerous service providers. The vulnerable cohorts we work with include young people with an intellectual disability who also have psychosocial health issues and do not necessarily have the capacity to navigate the complexities of the NDIS and successfully engage with appropriate services. They would benefit from better integration between the NDIS and the wider health and social services system to ensure all their needs are met, including action to address complex issues of abuse, trauma and delayed cognitive development. The NDIS must find ways to successfully link with other mainstream services such as housing, mental health, drug and alcohol and employment services, as well as to other government departments, to ensure that no person with disability goes without support, and that people requiring a multi-agency response have their needs met.

The NDIS cannot become a substitute for mental health services, particularly considering the high rates of undiagnosed mental health problems. According to Community Mental Health Australia, it is estimated that as many as 10,000 Victorians living with serious mental illness will be ineligible for the NDIS and are at risk of not receiving appropriate psychosocial rehabilitation services.⁵ People with undiagnosed mental health problems will go unsupported as current mental health services lose their funding to NDIS funded services. Often participants are pushed to access other services wherever possible. However, the existence of the NDIS has created a number of service funding gaps meaning there are fewer services available outside of the NDIS to those who are not eligible, or who need a more nuanced response than the scheme can provide.

Recommendations

- **Include specialist entry points to the ‘mental health service system’ to effectively engage people, address complex needs and complement the NDIS service system.**
- **Specialised, flexible mental health services for marginalised people, delivered by a skilled workforce and provided where they live.**
- **The NDIS must find ways to successfully link with other mainstream services such as housing, mental health, drug and alcohol and employment, as well as to other government departments, to ensure that co-occurring issues experienced by people with multiple and complex needs are not compartmentalised and dealt with in isolation by numerous service providers.**

Facilitating social participation and inclusion

Victoria’s mental health architecture must consider the needs of vulnerable cohorts, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) or refugee backgrounds, people in contact with the criminal justice system and those experiencing, or with a history of, homelessness. Jesuit Social Services calls for a focus on addressing the needs of people who are most vulnerable and disadvantaged in the community, as well as integrated care approaches.

It is also important to consider the ongoing issues presented by people who are seeking asylum, international students and those on partner or temporary visas who may experience mental health issues and often face systemic barriers accessing family violence or mental health services. Exploration of the complex interaction between family violence, mental health and immigration law for vulnerable cohorts is warranted, recognising that these and other sectors largely operate in silos, are fragmented and under-resourced. A person’s immigration status can affect their ability to access a range of services such as post-crisis, education, employment, housing, healthcare and accommodation.

Aboriginal and Torres Strait Islander communities

Addressing the mental health needs of Aboriginal and Torres Strait Islander communities, including in rural and remote areas, demands a specific response. The dispossession of ancestral lands has had devastating intergenerational social consequences for Aboriginal and Torres Strait Islander people, resulting in disadvantage and marginalisation that is reflected in disproportionately high incarceration rates, deaths in custody and low health indicators, including impacts on mental health outcomes.

The Northern Territory recorded the highest rate of suicide per capita in 2017, at 20.3 deaths per 100,000 persons, according to the Australian Bureau of Statistics (ABS).⁶ In 2017, 165 Aboriginal and Torres Strait Islander persons died as a result of suicide, with a standardised death rate of 25.5 deaths per 100,000 persons — a slight increase from 2016. Indigenous children and young people are particularly affected, with Aboriginal and Torres Strait Islander children and young people accounting for more than a quarter of all suicide deaths in this age group over the 5 years from 2013 to 2017 (93 of 358 deaths, or 26 per cent).

It is critical to base any services, supports, and responses on the unique conceptions of mental health within Aboriginal communities and cultures, and the understanding of mental health as part of a continuum that applies to individual people, extended families and entire communities, interconnected with physical health and spirituality. The most effective mechanism for improving the responsiveness of services and effectiveness of outcomes is to increase the involvement of, and control by, communities and locally-based organisations in the planning, coordination and provision of services.

Of particular importance is the need to extend support to people in remote communities. As highlighted in a recent Centre for Rural and Remote Mental Health report⁷:

In 2016, the number of suicides per 100,000 people in rural and remote Australia was 50 per cent higher than in the cities. This rate gets higher as areas become more remote and has been growing more rapidly than in the cities. The rate for Aboriginal and Torres Strait Islander people is twice that for non-Indigenous people.

The social fabric of communities can play an influential role in buffering the worst effects of disadvantage⁸, with community factors being shown to influence mental health levels in children,⁹ education, and levels of safety and crime.¹⁰ Jesuit Social Services' community capacity building approach provides a framework whereby cultural and cross-sector partnerships are fostered. Through these partnerships, the strengths of Aboriginal and Torres Strait Islander people can be harnessed to increase protective factors and prevent the impacts of disadvantage – in turn improving the mental health, and social and emotional wellbeing, of these communities.

Recommendations

- **Increase investment in place-based, community-led social and emotional wellbeing, mental health and suicide prevention and postvention responses for Aboriginal and Torres Strait Islander communities as a matter of priority, ensuring this extends to support in remote communities.**
- **Recognise that Aboriginal and Torres Strait Islander community-controlled organisations are best placed to provide culturally appropriate services, developed by and for local communities, and support them to do so.**

Refugees and people seeking asylum

The damaging physical and mental health impacts on people detained for long periods on Nauru and Manus Island, including children, have been widely documented.¹¹ Several deaths, reports of self-harm, sexual abuse and other incidents¹² clearly underline that people's basic safety and security in offshore processing centres cannot be guaranteed and, indeed, has been severely and consistently undermined.

There is clear and confronting evidence of the harm that immigration detention has had on children and their families under Australia's care. The Australian Human Rights Commission's 2014 *The Forgotten Children* report found that "prolonged, mandatory detention of asylum seeker children causes them significant mental and physical illness and developmental delays".¹³ The report detailed that almost 300 children committed or threatened self-harm in a 15-month period in Australian

immigration detention.¹⁴ On Nauru, harrowing details have been reported of children swallowing razor blades, repeatedly expressing a wish to die and the emergence of ‘Traumatic Withdrawal Syndrome’, or ‘resignation syndrome’, a rare psychiatric condition characterised by dramatic social withdrawal.¹⁵

While we acknowledge the significant decrease of children in offshore detention following sustained community pressure, for many, the damage that prolonged detention has caused will be lasting. Protections must be enshrined in legislation to ensure the harmful treatment of children does not continue. We support the End Child Detention Coalition recommendation for the Australian Government to pass legislation which ensures the well-established practice on the Australian mainland of placing children in alternative to detention programs in the community.

The Status Resolution Support Services (SRSS) is a vital safety net for people seeking asylum in Australia, providing basic income support, casework services, and access to torture and trauma counselling services to many women, men, and children. However, government changes to the eligibility criteria for the program threaten to leave many people in destitution, without this vital basic support.

A survey led by the Refugee Council of Australia¹⁶ found that four in five (79 per cent) of people seeking asylum across the caseload of 24 organisations were at risk of homelessness or destitution if this support was cut. Community services are already overstretched and are meeting this demand through private donations and volunteer assistance and are struggling to continue this work.

As outlined in a joint statement between CAPSA, Jesuit Social Services and Jesuit Refugee Service in April 2018, people seeking asylum should be:

- Issued bridging visas with study and work rights, Medicare, and access to SRSS, including where cases are being reviewed by the court system.
- Supported to find sustainable employment through culturally appropriate, specialist employment support services.
- Provided with income support while looking for work or studying.
- Exempt from employment tests, if assessed by independent healthcare professionals as unfit to work, as is standard practice across the welfare system.¹⁷

Recommendations

- **End the immigration detention of children seeking asylum**
- **End the offshore detention of people seeking asylum**
- **Reverse cuts to Status Resolution Support Services (SRSS)**

System Integration

Assessment

We support a ‘no wrong door’ approach that builds capacity for initial intake and assessment into the services that people are already accessing and integrates rather than separates the two functions. Intake and assessment functions should be built into frontline services, including homelessness, community mental health, youth services and the justice system. This should be complemented by the capacity for people to walk into provider agencies to go through the process of intake and assessment face to face.

Dual diagnosis services

The specialist expertise in these services is important in order to provide integrated care (often through multi-disciplinary teams) which concurrently addresses both mental health and alcohol and drug use, and acknowledges the way in which co-morbidity impacts upon a person's experience of health.

Jesuit Social Services' Connexions program started in 1996 as Victoria's first dual diagnosis service working exclusively with young people dealing with concurrent issues of mental illness and substance abuse. Connexions offers a relationship-based approach to intake and assessment, and uses assertive outreach where workers follow up with a disadvantaged and hard to engage person who has been identified as needing support. Specialist assertive outreach focuses initially on developing a relationship of trust to create a foundation that enables discussion of mental health issues. The program links with and refers to clinical mental health service providers as required (for example, Jesuit Social Services has a partnership with headspace, and a strong relationship with St Vincent's inpatient unit).

"Making an appointment at the same time and place each week doesn't always work for the group of young people we work with. The Connexions model is flexible and allows us to work with people even if they're not feeling up to coming on-site to visit. A participant I work with, Katie, has been able to develop positive relationships with the different services she's working with. I've seen huge improvement in her managing other areas of her life like education, housing and social interactions with family and friends."

- Rebecca. Connexions staff member

The SUMITT (Substance Use and Mental Illness Treatment Team) program, funded through the Victorian Dual Diagnosis Initiative, is another example of a dual diagnosis specialist response, however, this program is only available to registered consumers with Northwestern Mental Health.¹⁸

Recommendation

- **Increase funding for specialist dual diagnosis programs which provide integrated care to the significant number of clients who experience alcohol and drug and mental health co-morbidity.**

Coordination between clinical and non-clinical services

Clinical mental health services must deliver holistic responses for people who have multiple and complex needs, with a particular focus on:

- the centrality of relationships as the cornerstone of engagement
- use of a strengths-based approach for therapeutic support
- a whole of person approach that addresses holistic needs

- a “no wrong door” model of access to health and social services that enables people to access multiple supports irrespective of where they first seek support
- a flexible approach to service delivery that can be tailored to an individual.

Greater integration and coordination between clinical and non-clinical services is needed. In order to facilitate this, Jesuit Social Services calls for the following:

- proactive follow-up support after hospitalization
- involvement of families and carers in care
- information sharing across networks
- recognition of the impact of trauma on people with mental health and co-morbidity issues, and how that impacts on people’s development and their capacity to engage in support and service provision (particularly clinical services)
- better integration of clinical mental health services with the broader social support system.

A significant issue noted by Jesuit Social Services is that those with Borderline Personality Disorder or complex trauma are sometimes not attended to in clinical services as their issues do not always strictly fit within a medical model. These people often fall through the gaps of service delivery and due to the demand pressures outlined in the Victorian Auditor General’s Report (2019) do not receive adequate service responses. The Auditor General’s report also raises a number of concerns with the current clinical mental health service catchment areas that were established in the 1990s.¹⁹ Jesuit Social Services has observed that, at times, those with significant mental health issues who are homeless are often discharged from hospital emergency departments without any follow up support. This effectively amounts to discrimination against those who are homeless.

Service coordination for those with multiple and complex needs

Service coordination is an issue not only between clinical and non-clinical services but also across the broader system. Jesuit Social Services notes that there may be a number of caseworkers from several organisations supporting a person with multiple and complex needs. Care coordination can be unclear and the sharing of information inconsistent, even when regular meetings are scheduled between caseworkers supporting the person. The Multiple and Complex Needs Initiative (MACNI) provides a robust model for working with people with co-morbid needs.

MACNI provides targeted, flexible interventions to a small number of people aged 16-years and over with combinations of mental illness, substance dependency, intellectual impairment, acquired brain injury, and who pose risk to themselves and/or others.

MACNI provides for an individually tailored response based on a comprehensive assessment of need, service system capacity and case-by-case considerations.

Focusing on a more effective and coordinated approach to support, MACNI aims to:

- stabilise housing, health, social connection and safety issues
- pursue planned and consistent goals for each individual
- provide a platform for long-term engagement in the service system.

MACNI is funded by the Victorian Department of Health and Human Services, the Victorian Department of Justice and Community Safety, and the Director of Housing and is underpinned by the *Human Services (Complex Needs) Act 2009* which establishes the authority for a coordinated approach to planning service delivery for people with multiple and complex needs.²⁰

Recommendation

- **Implement successful components of the Victorian Multiple and Complex Needs Initiative across Australia, including the provision of an independent care coordination function that is underpinned by a legislative framework and skilled workforce, with a focus on people with complex needs who are not eligible for the NDIS.**

Primary Health Networks

Jesuit Social Services has built strong relationships with the various Primary Health Networks (PHNs) that fund our Support After Suicide program to deliver services in Victoria. The PHN model, first established in 2015, has been working well in terms of enabling local organisations to deliver key services to meet local needs. However, each PHN has different reporting and evaluation requirements, which places a sizable administrative burden on specialist programs such as Support After Suicide. Establishing consistent reporting requirements across different PHNs would help ensure greater efficiency, particularly for service providers with limited resources.

Recommendation

- **Reduce red tape by establishing consistent reporting and evaluation requirements across Primary Health Networks.**

Criminal justice and mental health

For over 40 years, Jesuit Social Services has worked with people involved in the justice system. Our experience is that too many people end up in the prison system because primary support systems like health, mental health, education and housing have failed them. Data on the health of Australian prisoners indicates that almost half of prison entrants (49 per cent) reported having been told by a health professional that they have a mental health disorder, and more than 1 in 4 (27 per cent) reported currently being on medication for a mental health disorder.²¹ Recent research has identified that women released from prison were 14.2 times and men 4.8 times more likely to die from suicide than would be expected in the general population.²²

People released from prison also have elevated mortality rates connected to drug overdose, and are highly vulnerable to homelessness (85% of the women we work with are released from prison into unsafe or unstable accommodation), mental illness, and unemployment. Imprisonment also places strains on families and the effects on the mental wellbeing of children can be long lasting.

Despite the known prevalence of mental health needs amongst prisoners, mental health services across the justice system are under-resourced and fragmented. Moreover, the prison environment, including practices of isolation and restraint, often exacerbate existing mental health issues.

The mental health needs of people involved in the justice system must be recognised and met from initial contact through to eventual release. Early identification of mental health needs from the outset enables appropriate and integrated support. This may include identification of potential cognitive

impairment and intellectual disability. We know that a high proportion of individuals in the justice system have acquired brain injury – in 2011, Corrections Victoria reported that 42 per cent of men and 33 per cent of women, in a sample of the Victorian prison population, had been diagnosed with ABI; this compares with just two per cent across the general population.²³

The conditions of imprisonment can have dire impacts on individuals' mental health, even when pre-existing conditions or illnesses are not present. Jesuit Social Services' report – *All alone: Young adults in the Victorian justice system* – raises a number of serious concerns regarding the welfare and treatment of young adults in Victorian prisons.²⁴ The report can be found at <https://jss.org.au/>, including a full list of our recommendations.

Solitary confinement negatively affects an individual's overall level of physical and mental health in custody. Many people describe experiencing physical health impacts such as deterioration in eyesight, poor appetite and joint pain. Mental health impacts are more profound and include increased difficulty in regulating emotions, constant hypervigilance and paranoia, distortions in time, increased suicide or self-harm risk and increased symptoms of anxiety or depression. Solitary confinement also creates significant barriers to achieving successful rehabilitation and reintegration.

For individuals exiting prison, mental health is critical to reintegration. There is a poor intersect between effective mental health care in a custodial setting and in the community. Issues in relation to privacy and confidentiality and lack of shared information between agencies represent particular challenges. For example, dependence on medication during time in prison also presents challenges for people who may not be aware of exactly what medication they were taking while in prison. Although a discharge summary of medication is meant to be provided to the person upon release, this is often lost in transit. For these reasons, strengthening the relationship between health services in prisons and community health and mental health services is particularly important.

Once in the community, individuals with mental health needs face multiple changes and gaps in support. There are limited stepped care options for prisoners being released, including a lack of appropriate housing. For prisoners released into homelessness or precarious housing situations, aside from the obvious mental health ramifications of homelessness, additional problems arise around clarity of catchment areas for support.

CASE STUDY: James

James* is an Aboriginal man who was transferred to an adult prison in Victoria from a youth justice centre at the age of 16. James was released from an intermediate regime placement (22 hours in cell, two hours out of cell with a small group of prisoners) at the age of 19. Following this transfer, he struggled to manage his transition back into the community. While James secured a transitional property, he found this too challenging to live in, and made his bathroom into a cell. He slept in the bath and prepared his food in the bathroom. James brought a number of items, including a radio, a kettle and a toaster, into his bathroom to replicate the cell he had in prison. James returned to custody shortly following his release and his struggles in the community were the source of much concern to his family, who were not immediately aware of his transfer to an adult prison at the age of 16.

*Name has been changed

Jesuit Social Services notes the significant gaps in access to the NDIS post release. Individuals with psychosocial disability arising from mental health issues are eligible for NDIS support, but the NDIS is not available for individuals in prison. Individuals are expected to navigate a complex system, and strong self-advocacy is needed to secure an appropriate package. Limited planning occurs prior to release from imprisonment to link up individuals returning to the community with the NDIS, resulting in significant wait times for access to services upon release.

Finally, increased stigma when accessing mainstream services is an issue for those who have had contact with the criminal justice system. Funding for more outreach services is required for this particular cohort who often have unstable accommodation in the community and may not attend office-based appointments easily. People exiting prison should be included as a target group for assertive outreach suicide prevention initiatives. This would include those who have previously self-harmed or attempted suicide while in custody. Issues in relation to privacy and confidentiality and lack of shared information between agencies present particular challenges for those people exiting prison.

CASE STUDY: Jack

Jack* is currently living with his girlfriend, however, he has been experiencing difficulty in adjusting to the community after being held in isolation. He often spends most of his time cleaning the house, as this is something he would do in his cell during his time in isolation. Jack often walks laps of his backyard and his hallway, as this was something he would do in his cell. He finds these activities comforting. He also often paces in public places and experiences anxiety around other people. Jack recently celebrated his 25th birthday in the community, but locked himself in his friend's bedroom for the day as he found this experience overwhelming.

*Name has been changed

Recommendations

- **Governments should recognise the particular vulnerabilities and higher risk of suicide for people involved in the criminal justice system and increase prison based mental health supports (including additional staff both in the prison and embedded in transitional support teams).**
- **Strengthen links between prison based health and mental health services and community based health and mental health services to ensure planning occurs for those exiting prison prior to their release. Clearly articulated pathways on exit plans are required that link individuals with support providers.**
- **Pursue strategies to divert people with mental illnesses from prison by strengthening pathways to early community treatment and support, including additional court based mental health support services and staff.**
- **Legislate for a presumption against the use of isolation, with isolation only permissible in rare cases where immediate safety to persons is a concern, and then only for the briefest possible period. In no case should isolation exceed 14 consecutive days, and a period of such length could only be justified in the most extreme circumstances.**

Youth Justice: support in custody and community

In the Victorian Youth Parole Board annual survey of 226 young people involved with youth justice in 2017, 53 per cent presented with mental health issues and 22 per cent had a history of self-harm or suicidal ideation.²⁵ Children involved in the criminal justice system are already likely to have significant mental health issues, compounded by experiences of trauma; between 1 July 2013 and 30 June 2017, 48 per cent of those under youth justice supervision in Australia had also been in child protection.²⁶

Young people who come into contact with the justice system must be diverted from further involvement at every possible opportunity. Alternative responses, including restorative approaches, can be used to hold young people to account while in the community, maintaining access to supports like school and family that protect against reoffending. Restorative justice group conferencing has been shown to reduce reoffending and promote victim satisfaction.²⁷ Children and young people with mental health needs must be held to account with responses to offending that address the underlying causes of their behaviour.

Detention must be used only as a last resort. When young people are detained, from day one, programs and interventions for young people in prison should be geared toward their transition back into the community. Youth justice custodial environments need to provide cultural safety, health and mental health services, alcohol and drug services, disability support, and responses to young people's experience of trauma. They must have links to the natural environment, provide freedom of movement, access to physical activities and support that is individually tailored and responsive to gender, age and culture. Services must engage with family, and the system should provide 'step-down' access to educational, vocational and employment opportunities in community. On a practical level, access to food for growing boys is important – often food is unavailable from 9pm in custody.

We need a holistic and therapeutic approach that is integrated into a wider through-care model. This must be underpinned by ongoing, coordinated and youth-focused practice, which we know can produce better outcomes.

The Victorian *Youth Justice Community Support Service (YJCSS)*, delivered by Jesuit Social Services, provides a positive example of this approach. YJCSS helps prevent re-offending by focusing on a young person's development, preparing them for adulthood and re-connecting them with the community.

Our case work focuses on broad aspects of a young person's life, such as social connection, economic participation, wellbeing and resilience, gender and identity, health, and self-determination. Through our case work, young people in the justice system develop:

- independence, resilience and pro-social connection to family and community
- skills and knowledge to make informed choices about their future
- the means to participate more fully in their community
- connections to family, education, training, employment and community

A 2013 evaluation of the program found that it delivered an effective form of support and had improved outcomes for young people in the system²⁸, and internal analysis of relevant cases¹ in Jesuit Social Services YJCSS Closure Reports shows the following:

¹ (Figures for 133 closed files for the period 1/7/2013- 30/6/2016 for North West and East and 2014 and 2015 for the South); based on worker report at exit ('not known' and 'not applicable' excluded)

- 70 per cent involved the young person completing statutory orders
- 97 per cent resulted in improved engagement with family
- 93 per cent resulted in improved mental health
- 80 per cent resulted in improved participation in education
- 76 per cent resulted in improved engagement with employment
- 66 per cent resulted in improved engagement in training
- 96 per cent resulted in improved stable accommodation
- 88 per cent resulted in reduction in substance use.

Programs like YJCSS need to be further resourced so that support is provided to **every** young person exiting youth detention. Jesuit Social Services believes that being able to work holistically with a young person, their family, their community, and Youth Justice is critical to ensure that the young person is held in a net of support.

Specialised mental health services for young people are another important part of this approach. To ensure appropriate services are delivered, specific funding, workforce capacity building and appropriate programs are required. Victoria needs ongoing, sustainable and comprehensive forensic mental health services for young people, both in the community and custody. We need a state-wide service network providing:

- secondary consultation and support for community mental health outreach services that manage young people with offending behaviours (predominantly referred via the Youth Justice Mental Health Clinician initiative). These services should be embedded/integrated into support services working with the young person and their family.
- comprehensive training and supervision to community services to assess and manage mental illness related violence and offending (including family violence).

Underpinning of all this is a skilled and resourced workforce that can address the needs of a vulnerable and complex group of children and young people. We can turn to international jurisdictions to see examples of best-practice in youth justice workforce capability. In the Netherlands, staff require a minimum three-year bachelor degree to work in youth prisons,²⁹ and in Spain's youth detention 'Re-education Centres' run by non-profit organisation Diagrama, front-line staff (named 'educators') are expected to have a professional qualification.³⁰

During the #Justicesolutions tour, Jesuit Social Services witnessed a particularly promising model of staff training and capacity building. In Norway, the training undertaken by correctional staff is currently a minimum of two years, and plans are in place to extend this to a three year Bachelor degree in the very near future. The course involves both academic and on the job (i.e. within prison) components. Prison officer training included equipping new staff with capacity to focus on engagement and building relationships with people. Entrants are screened for life experience and positive, humanistic attitudes. Course participants are paid to undertake the training – they are the only paid students in the Norway system. This provides an incentive for people to embark on this career path, which is sought after, and entry is competitive. The status of this profession is respected in the community.

We envision a youth justice workforce in Australia that is highly qualified and grounded in principles that place the interests, developmental needs and rehabilitation of children and young people at the forefront.

Recommendations

- **The youth justice workforce, including detention officers and other staff in youth detention centres, must be grounded in principles that place the interests, developmental needs and rehabilitation of children and young people at the forefront, with a minimum qualification introduced across Australia.**
- **Provide additional resourcing for mental health support services, including community health nurses embedded in transitional support programs**

Raising the age of criminal responsibility from 10 to 14 years

Primary school aged children should be in school, not in prison. A small number of vulnerable children enter the system at a very young age. We know this group is among the most vulnerable in our community and that children first detained between the ages of 10 and 14 are more likely to have sustained and frequent contact with the criminal justice system throughout their life. We believe the age of criminal responsibility needs to be raised to at least 14 years of age.

Raising the age of criminal responsibility and keeping children out of prison and engaged with community based services is likely to prevent trajectories into the justice system given the evidence that children's brains are still developing and that the permanent harm of early contact with the justice system is well documented.³¹

We have been consistently advocating at both State and Federal levels of government for the age of criminal responsibility to be raised and acknowledge the recent commitment from the Council of Australian Governments to establish a working group to develop a discussion paper on the issue.

Recommendation

- **Raise the age of criminal responsibility to 14 years and fund programs that take a restorative and therapeutic approach to anti-social behaviour in children under the age of 14 years.**

Children and young people in youth detention

We must ensure that young people's needs are thoroughly assessed so that interventions are targeted and effective. This means from the moment a young person enters youth detention, they receive intensive multidisciplinary assessment by educators, doctors, dentists, psychiatrists and alcohol and drug specialists, as well as individualised plans tailored to their offending behaviour, that ensure they can re-integrate with family and community during detention and post-sentence. Critically, this assessment must incorporate a response to the needs of family and siblings.

In 2017, senior members of Jesuit Social Services conducted a 'Justice Solutions' study tour of Europe, the US and UK, and witnessed models of best practice in youth justice first hand. In Norway, the "principle of normality" is the framework for youth detention. The principle of normality holds that:

- **The punishment is the restriction of liberty** – no other rights have been removed by the sentencing court. Therefore the sentenced offender has all the same rights as all others who live in Norway.
- **No-one shall serve their sentence under stricter circumstances than necessary** for the security of the community. Therefore offenders shall be placed in the lowest possible security regime.
- During the serving of a sentence, **life inside will resemble life outside as much as possible.**

While accepting that the principle of normality may be impacted by security and infrastructure needs, Norwegian Corrections emphasises that "the basic principle is there, and deviation from it will need to be based on argumentation. You need a reason to deny a sentenced offender his rights, not to grant them."

This guiding principle is especially important in the context of meeting mental health needs, minimising the impact of the detention environment itself on young people's mental health.

Use of isolation in youth justice settings

For children, researchers have demonstrated the link between isolation and lasting psychological damage.³² Children and young people are particularly vulnerable due to the fact that they are still developing mentally and physically. The traumatic nature of isolation can have severe consequences on adolescent brain development, making young people all the more vulnerable to sustained contact with the justice system and to suicide.³³

In light of the health and community safety risks associated with solitary confinement as confirmed by both international research and local experience, Jesuit Social Services considers that the use of isolation in youth justice centres should be banned. Practices must ensure that harm to children and young people is minimised and that their rights are protected.

We recognise and support the findings of the World Health Organisation,³⁴ which acknowledge the range of detrimental effects that solitary confinement can have on the mental health and wellbeing of those subjected to it. International human rights law requires that the use of solitary confinement be kept to a minimum and reserved for the few cases where it is absolutely necessary and for as short a time as possible.

In the Northern Territory, excessive use of isolation, lockdowns and restraint in youth detention centres has been identified in a number of reviews:

- *Michael Vita report, 2015*: "The review found that too much reliance was placed on confinement and separating detainees away at Don Dale in particular. This was probably due to the lack of appropriate cellular and other centre infrastructure as well as a lack of training and supervision of staff".³⁵
- *Office of the Children's Commissioner, 2016*: "...prolonged and often repeated episodes of isolation for extended periods of time were identified. This often led to further outbursts with the young person becoming increasingly more agitated and attempting self-harm".³⁶

- *Royal Commission Final Report, 2017*: “Isolation of children and young people was used on some detainees excessively, punitively and in breach of section 153(5) of the Youth Justice Act (NT) ... detainees were placed in physically and mentally unhealthy conditions”.³⁷ The conditions at the centres in question “caused suffering to many children and young people and, very likely, in some cases, lasting psychological damage to those who not only needed their help but whom the state had committed to help by enacting rehabilitative provisions in the *Youth Justice Act (NT)*”.³⁸

In Victoria, *The Same Four Walls* report from the Commission for Children and Young People found that isolation and lockdowns were closely related practices used to manage behaviour in Victorian youth justice centres. The report found the number of lockdowns was “unacceptably high” and “had a detrimental impact on young people”, and that isolation was repeatedly being used on portions of the youth prison cohort, often without relevant authorisation.³⁹

In NSW, the Inspector of Custodial Services found that confinement was the most prevalent form of punishment in places of juvenile detention, used in 71 per cent of cases.⁴⁰ Isolation was disproportionately meted out as punishment to Aboriginal and Torres Strait Islander children and young people in detention — despite making up roughly 47 per cent of the prison population, 63 per cent of children and young people placed in confinement over the two year period of inspection were Aboriginal or Torres Strait Islander.

We believe that custodial environments need to apply and use restorative practice and principles, which should be at the heart of any approach in responding to the needs of vulnerable young people in a custodial setting.

Recommendation

- **Ban the use of isolation for children and young people in Youth Justice Centres**
- **Youth detention facilities are prioritised as requiring immediate attention as part of Optional Protocol to the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (OPCAT) implementation.**

Preventing suicide

Jesuit Social Services supports a systems approach and a coordinated community response to the prevention of suicide. We believe it is critical that suicide prevention starts as far upstream as possible. This understanding is critical to establishing an effective suicide prevention approach and cannot be emphasised enough. Without the fundamentals of education, opportunities in employment, freedom from violence and discrimination, access to healthcare and social support, any prevention approach will be fundamentally flawed.

More generally we believe that any suicide prevention framework should commit to a consistent level of mental health service availability and quality across all regions of Australia. Access to high quality assistance following a mental health episode, such as a suicide attempt, should not be based on a person's geographic location. This pertains both to suicide specific services and mental health services generally.

Postvention support

Jesuit Social Services has delivered Support After Suicide throughout Melbourne and regional Victoria since 2004. In 2017-18, Support After Suicide directly assisted 964 children, young people and adults bereaved by suicide. The program provides counselling, support groups and online resources. We also deliver training to health, welfare and education professionals.

It is critical to recognise the risk of suicide amongst those who are bereaved by suicide. Support After Suicide works to reduce this risk by working closely with people affected by suicide. However, Support After Suicide is significantly underfunded, and there is a lack of certainty regarding ongoing funding, putting Victorians at risk of missing out on timely service, including those referred by the Victoria Police. Additionally, while Support After Suicide operates in regional areas (the Macedon Ranges and Geelong), its ability to provide robust services, in spite of increased demand, is limited due to restricted funding.

Postvention research

There is also a related research gap that needs to be addressed. There is emerging research on how postvention services reduce the risk of suicide, however, dedicated research funding is required to develop a strong evidence base on the impact of suicide on others, and the effectiveness of bereavement support in reducing risk.

Short-term residential care

We welcome the Victorian Government's recent expansion of the HOPE initiative, which provides support and follow up for people leaving hospital after a suicide attempt. Research has established that people are at high risk of suicide after a discharge from hospital following a suicide attempt.⁴¹ The Victorian Suicide Prevention Strategy cites a study in the United Kingdom which found that 43 per cent of deaths by suicide occurred within one month of discharge from hospitalisation or treatment following a previous suicide attempt, with nearly half of those deaths occurring before the first follow-up appointment.

The Victorian Chief Psychiatrist's investigation into inpatient deaths between 2008 and 2010 attributed this increased risk after hospitalisation in part to the emotional isolation and lack of social support individuals often experience after a suicide attempt.⁴²

We commend the HOPE model of assertive outreach, which works with families, friends and carers of people who have attempted suicide. We know that suicide can occur in clusters, making support for the networks around people after suicide all the more critical.⁴³

We call for the establishment of short-term residential care following suicide attempts, beyond a clinical environment. We can look to the UK for examples of this model – the Maytree Respite Centre offers a free stay in a non-medical setting, filling a gap in service provision for individuals experiencing suicidal crisis. However, we note that the Maytree facilitates a stay of up to five days. Jesuit Social Services believes that a longer term program, of up to six weeks, would be more effective in delivering holistic support.

Jesuit Social Services supports a short-term residential care model that is therapeutic and offers relationship-based support and counselling, and connection to peer support. A residential option will help fill a service gap for the most vulnerable who may have limited family and community support.

In addition, programs will include families of individuals who have attempted suicide, providing education on responding to suicide and suicide attempts. Tapping into family and community networks around individuals, and ensuring this network is well-informed, gives individuals at risk of suicide much-needed support. We believe the period immediately after a suicide attempt is a critical time in which to provide support to individuals in crisis.

Recommendations

- **Develop secure, long-term funding for postvention, early intervention services for suicide bereavement and increase access to suicide bereavement services for regional and rural areas.**
- **Provide funding for a dedicated research stream to develop an evidence base on the impact of suicide and the effectiveness of postvention services in reducing risk.**
- **Invest in short term residential care for people who have attempted suicide or are suicidal.**

Employment, education and training

Supported employment programs

There are strong links between educational attainment and future work outcomes for young people with mental health issues. We would like to see ongoing funding for programs like Skills First Reconnect, Transition to Work and Jobs Victoria Employment Network (JVEN) First Time Young Offenders, which aims at improving awareness of, access to and engagement with vocational education and training opportunities for a high risk group of young people or people who may be long-term unemployed. Central to breaking the link between entrenched disadvantage and poor educational outcomes is ensuring people stay in education or training initiatives and reach their potential for better life opportunities.

Jesuit Social Services believes that one of the key components to assist people with mental health issues into education, training or employment is additional flexible support and funding provided as part of initiatives to support the individual, as well as prospective employers.

An example of a program that meets this requirement successfully is JobsBank, funded by the Victorian Government. JobsBank was announced in August 2017, with the government asking leading businesses across Victoria to participate in the \$5 million program by each pledging at least five jobs for a minimum period of six months. Pledging businesses receive intensive support to help make this work. A dedicated employment broker matches businesses with the right jobseeker, helps them develop a culturally safe and supportive working environment, and provides post-placement support.

JobsBank also provides people with enhanced, specialist services including intensive case management and a flexible funding pool to support expenses like travel costs, childcare, appropriate clothing and workplace modifications. This initiative targets jobseekers with complex needs. Currently, the number of people who can participate in the program is capped. Jesuit Social Services believes this initiative works well to assist those with multiple and complex needs into employment and would like to see this initiative expanded.

Skills First Reconnect is a Victorian Government program under which TAFEs and Learn Local registered training organisation (RTOs) receive funding:

- to address barriers to enrolling in and completing an accredited training program and a supervised work experience placement; and
- to provide Victorian learners with access to specialist support services such as health, accommodation, and personal and relationship supports.

The Skills First Reconnect program is designed to address disadvantage and promote equity. Jesuit Social Services is one of the providers of this program. Whilst we believe the program works well in principle, eligibility restrictions mean some people who may benefit from the program are missing out. People able to be referred to the program include high-needs learners aged 17 to 19 who have not completed year 12 or equivalent and are not in education, training or full time employment; or individuals aged 20 to 64 who have not completed year 12 or equivalent and who are long-term unemployed.

Jesuit Social Services believes there are many people who have completed year 12 or have a qualification but for a number of reasons (including mental health problems) would benefit from access to a program such as this.

Stigma

Stigma is a significant issue for people with mental health problems in the workplace which often leads to a lack of disclosure. More community education about living with mental health problems is needed. Some employers offer aides such as the Employment Assistance program to assist employees, however, this is predominately up to the individual employer. It would be helpful if interventions such as the Employee Assistance program were made more accessible. Mental health first aid training is another intervention that could be rolled out across organisations to increase awareness and reduce the stigma of mental health.

Recommendations

- **Expand the JobsBank initiative to allow for greater numbers to participate in the program.**
- **Expand eligibility for the Skills First Reconnect program in acknowledgment that people who have completed year 12 or have a qualification can end up in long-term unemployment and need additional support to successfully re-engage in employment.**
- **Expand access to initiatives which provide mental health support and increase awareness of mental health issues in workplaces.**

Mental Health Support for students

Students with identified mental illness have low subject completion outcomes in vocational education and training (VET). VET providers (both public and private) report limited capacity to provide effective support for these students. In some states and territories funding changes to the public VET system have threatened the capacity of even larger TAFE providers to maintain levels of student support services such as counselling. Smaller private providers and Registered Training Organisations (RTOs) often lack the size and infrastructure needed to deliver student supports and therefore rely on strong connections and links with community based and mental health services. Conversely, TAFE staff report that mental health providers promote TAFE as a therapeutic option for their clients but incorrectly assume there are extensive support services on campus available to them.⁴⁴

We call for investment in initiatives to address the prevalence of mental health and adjustment experiences of international students in the tertiary sector. While the Australian economy largely benefits from the international education market, international students experienced significantly higher levels of anxiety and stress than their Australian counterparts and reported higher levels of social isolation.⁴⁵ Evidence shows that adapting to a new environment, significant financial pressure, racism, unemployment, exploitation of labour, navigating a new culture, family pressure to succeed, language barriers, minimal social support networks and adjusting to a new academic system are key drivers that increase risks of poor mental health.⁴⁶ Jesuit Social Services calls for initiatives with a focus on improving mental health support services available for international students.

Recommendations

- **Funding for mental health supports within the TAFE sector in view of cuts in recent years which have seen a reduction in counselling and support services available to students.**
- **Funding for initiatives which improve and expand mental health support services available for international students.**

Housing and homelessness

The availability of safe, secure and stable housing is a major issue for many in our community, but particularly for people with mental illness, alcohol and drug problems, and other complex needs. The majority of social housing tenants are some of the most disadvantaged in the community, and market failure has arisen when other human services have been privatised, leading to people with complex needs falling through the cracks.⁴⁷

In particular, there is an absence of housing options and associated supports for vulnerable young people with multiple and complex needs, including young people who have experienced trauma or who may be transitioning from out-of-home care or the justice system. In Victoria, the number of people exiting prison into homelessness has grown by 188 per cent over five years from 2011-12 to 2016-17.⁴⁸ Access to safe and affordable housing is fundamental to a person's ability to get their life back on track, and has a significant impact on their mental health. It is vital that housing issues are resolved prior to release from prison. Supports must also be in place that address each individual's needs, including assistance to build basic independent living skills such as navigating tenancy obligations, meal preparation, budget management and personal hygiene.

Evidence⁴⁹ confirms that there is a serious undersupply of social housing and affordable housing in Australia – the latest census data shows overall rates of social housing declined from 5.0% in 2006 to 4.2% in 2016 – and the high costs of housing as a proportion of household income is leading to household stress and in many cases homelessness and poverty.

Concern is further heightened in light of the National Rental Affordability Scheme (NRAS) coming to an end in 2018, without a replacement initiative. The NRAS sought to encourage investment in affordable housing by offering financial incentives to persons or entities to build and rent new dwellings to low or moderate income households at 20 per cent or more below market rates.⁵⁰

Housing and mental health services are critical to addressing the complex and entrenched disadvantage that marginalised individuals and communities face. Our work involves people who have experienced homelessness, housing instability and housing stress. Our experience tells us that the provision of public, social, and affordable housing helps build safer and cohesive communities. Long-term housing can help set a firm foundation for improving well-being and enhancing personal agency. Safe, affordable and supported housing is fundamental to supporting people to get their lives back on track, particularly for people with mental illness, alcohol and drug problems, and other complex needs.

Recommendations

- **Investment in new public housing stock and increased access to social housing.**
- **Investment in a diversity of housing options for people with multiple and complex needs.**
- **Specific housing initiatives for single people, young people, women, and people with experience of trauma.**
- **Incentives for social housing providers to offer housing to complex and high support participants.**

Workforce development and retention

We need to invest in, train and support a workforce with the skills, attributes and qualifications to work effectively in a culturally safe and sensitive way with people from diverse backgrounds. We support the identification of learning and development in priority areas – including responding to trauma, family-inclusive practice, forensic issues, dual diagnosis, cultural safety, and gender sensitivity and safety. We believe that priority should be given to the development of positive attitudes and culture, and combatting stigma.

Values, culture and attitudes inform the way that mental health services are delivered and received. Individual practitioners have their own personal beliefs and values. Mental health practitioners, given their training and choice of occupation, have been found to hold less stigmatising attitudes about mental illness than the general public. However, while many practitioners hold non-stigmatising attitudes, it is still the case that some of the mental health workforce hold negative attitudes about certain mental health issues such as suicidal behaviour, or alcohol and drug use or may be reluctant to work with people who have had contact with the criminal justice system. It is critical that our workforce leads the way in non-stigmatising approaches and attitudes and this issue needs to be highlighted and supported in training and skill development.

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