LES TWENTYMAN
FOUNDATION

Submission to Royal Commission into Victoria's Mental Health System

Les Twentyman Foundation
ABN 38 753 312 146

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INTRODUCTION

About the Les Twentyman Foundation

The Les Twentyman Foundation (formerly the 20th Man Fund), established in 1989, provides crucial positive support programs and services for at-risk young people and their families. Our programs and services cover education support, sports and recreation, counselling, personal development, arts and drama, and life experiences. We aim to reconnect socially disconnected youths with their families and communities, enabling them to reach their full potential and be contributing members of their communities. Several of the Foundation's programs mentioned in this submission are the EMBRACE Youth Leadership program, the Youth Support Service diversionary program (funded by the Victorian Government), and the Reconnect - EMBRACE: Positive Futures In Schools program that embeds youth workers in secondary colleges (funded by the Australian Government). It is through these and other programs that the Foundation has gained extensively experience of how young Victorians interact with the Victorian mental health system.

Overview of Submission

The Les Twentyman Foundation welcomes the opportunity to provide a written submission to the Royal Commission on the basis of its more than four decades of experience working with at risk young people, most of whom have mental health issues and interactions with Victoria's mental health system. Our submission takes the form of 11 case studies that illustrate the main challenges faced by the young people we help as directly observed by our youth workers and program managers. The key insights for Victoria's mental health system illustrated by these case studies are as follows:

- **Overly long wait times**

  It is our experience that young people in metropolitan Melbourne are waiting for psychological intervention for between 2 and 12 months.

- **Barriers to access**

  There are several steps which act as barriers for young people to access psychological intervention. For example, they must see a youth worker, see a GP, see an intake worker, then see a psychologist. If in crisis, repeat these steps, then go to Emergency, see a nurse, see a doctor, see a specialist, get admitted, see a team, be exited to see another external service's intake, then see an allocated youth worker.

- **Intimidating clinical environment**

  Young Victorians are expected to 'be themselves' and share their deepest and darkest secrets in a hard chair, in a small room with blank walls under fluorescent lights, in dead silence. Furthermore, clinicians often do not display warmth or authenticity. They seem 'fake', 'forced', often wearing corporate clothing that young people find intimidating. This clinical approach is trained, and useful as a protective factor for the clinician, and may be 'best practiced' according to the literature. But it is our experience that this environment is not conducive to making young people feel comfortable enough to receive the support they need. There needs to be some flexibility to display their human side in order that young people can feel comfortable in sharing and engaging.

- **Inadequate public funding of psychological care**

  The current length of service – 10 sessions subsidised by Medicare – is based on research into mild, first early presentation of depression. But most of our young people have a trauma background that started prenatally. It is our experience, as illustrated in several of the case studies below, that many at risk young people need more than 10 sessions and that Headspace may not be appropriate because there is no Headspace centre nearby or because the waiting time is too long. In these scenarios we have seen many young people go without the support they need because they cannot afford private psychologist fees.

- **Focus on pharmacotherapy**

  Inpatient treatment is often pharmacotherapy, with no other therapeutic interventions. Patients are often released with referrals they are required to follow up independently, with a waitlist. These patients have been hospitalised due to serious mental ill health, suicidal behaviour etc, then are often not provided support in following up on these referrals.

CASE STUDIES

Case study 1: Siblings failed by the system

Two young people – siblings – attended the Foundation's basketball program. They told our program manager they would have difficulty attending basketball training and games regularly because they lived in a household of numerous younger siblings with a single parent, their stepfather, who did not drive. The program manager referred the siblings to one of the Foundation's youth workers for general support. The youth worker's initial conversation with the siblings revealed a lot: Their biological father died by suicide while both siblings were quite young. Their mother found a new partner and had four more children. The mother had been in and out of foster care as a child and now suffered mental ill health and drug addiction. The family had an intervention order against the mother, who at that time was incarcerated, to prevent family violence. The Foundation's youth worker supported the young people in obtaining a mental health care plan and attending [redacted], to deal with anxiety and coping strategies. However, the young people were allocated to a [redacted] in an inconvenient location, making it difficult to transport to after school, with limited after school appointments available.

After a few weeks, both young people disengaged from [redacted], stating they didn't feel they were getting anything out of it. The youth worker continued to engage with both young people and continued to encourage mental health support, however due to past experiences with Headspace they declined. Instead, they accepted an invitation to the Foundation's EMBRACE Youth Leadership program and engaged well. During this time, both young people were excelling at school, with one already having a Western Chances Scholarship, and the second being awarded one at the end of the school year. Both had obtained part-time employment and were engaging in both basketball and martial arts.

About six months into their involvement in the EMBRACE program (18 months since initial meeting), one of the young people began to express suicidal ideation. Around the same time, the young people's mother was released from prison and started making contact with the children. The youth worker went through the same process: GP for mental health care plan, intake phone call, intake appointment. Prior to ongoing engagement with [redacted] the young person phoned the youth worker in crisis, resulting in the youth working taking the young person to Footscray hospital and subsequent admission to the [redacted] ward for suicidal behaviour. The young person was discharged several days later with a referral to Orygen youth health. However, as they had had the previous negative experiences, they did not want to engage.

After an additional admission three weeks later to the Banksia ward, the youth worker was

able to convince the young person to attend Orygen, with the youth worker's support. The Orygen worker was in constant contact with the Foundation's youth worker, asking for support in engaging the young person. At this point, the youth worker was not able to provide intensive support as the program they worked under (the Foundation's Youth Support Service) had a maximum length of service which had expired. The youth worker did continue to support the engagement of the young person with Orygen, and there was a third admission to the [redacted] ward. The young people both ended up disengaging from the Foundation's programs entirely for 12 months.

There were multiple additional referrals to external agencies but none were able to engage with the siblings. Both disengaged from schooling and their part time jobs, and both were homeless for a period of time with their mother, refusing to return to the stable home with their stepfather. In that time there were requests from child protection for support that the Foundation's Youth Support Service program could not progress, as at that time a child protection order made a young person ineligible for the Victorian Government-funded program. Both young people were invited back to the EMBRACE Youth Leadership program after the 12-month break and accepted this invite. They have both been attending, but both are significantly affected by the impact of their mother's return. The younger sibling has remained at alternative school but the older has not returned, and neither have employment.

Case study 2: [redacted] year-old male 'off the rails'

A [redacted]-year-old male was referred to the Foundation's Youth Support Service three times in one week – twice by Victoria Police and once through [redacted]. The young person had been engaging in minor offending behaviour, and had been reported as a missing person several times. After multiple failed attempts to make contact, the Foundation's youth worker was finally able to meet with the young person after another client of the Foundation spoke with the young man to reassure him that youth workers 'are not as scary as you might think'.

Upon meeting the young person, the Foundation's youth worker soon realised this was a very complex case: the young person had been put in the care of his biological mother's foster parents at birth, as she was unable to take care of him, and his biological father had a significant violent history. The young person's foster parents were quite well educated, with one qualified in and working in mental health in the local area. At the time though, the foster parents were separating which is thought to be the catalyst for the escalation in behaviour. The young person engaged well with the youth worker, disclosing self-harm behaviour and suicidal ideation. They talked about the young person's anger towards his biological father, the stress of being forced to move schools nine times, and the fact he had not attended school since Year [redacted] The young person also had diagnosed learning difficulties, but they were not 'severe enough' to warrant funding for the school to provide additional support.

The youth worker was able to engage the young person in alternative education, but a court case regarding the offending behaviour scared the young man and threw off his focus, resulting in him disengaging yet again. He disclosed a recent suicide attempt but refused to attend local mental health services or hospital due to his parent's connections. He also refused to continue attending an AOD service the youth worker linked him with, as he felt he didn't need help controlling his substance use. At this point, his substance use was alcohol, prescription medication and marijuana. One month later, this expanded to methamphetamine.

After much trust was built, the young person agreed for the youth worker to make a referral to [redacted] The youth worker persisted in making attempts to contact the service, however no calls were ever returned to continue the referral, and it was recommended to not cold call with the young person to the clinic location. The young person continued to spiral, resulting in further offences and increased substance use. Unfortunately, at this point, the Foundation's Youth Support Service was forced to close the case due to geographic limitations imposed by the Victorian Government on the program. The young person's mother moved to be closer to family and though it was only a few suburbs away it was outside the Foundation's service area. Referrals were made but engagement was nonexistent, with calls from those agencies back to the youth worker requesting support to engage. The young person did not engage any further. A former friend told the Foundation that the young person's behaviour has escalated and that he is "completely off the rails". The friend asked the Foundation to support, but the tyranny of distance prevents this.

Case study 3: A turning point

The young person was known to their school for significant previous violent behaviour. The young person got into a fight at school which caused her parents to drop her off at the Department of Health and Human Services (DHHS) where she was left with two garbage bags of belongings. The young person's parents had become so frustrated with her that they had relinquished care without a plan or consideration for wellbeing. The school wellbeing system could not provide any support as this was at the end of Term 4, with four days until school holidays. The young person's friend agreed to take her in.

The Foundation's youth worker met the young person where she was staying and with the support of the Foundation gave her a Christmas hamper, along with some essentials she did not have. Her new carer had not yet received any money from DHHS for support and money did not come in for a long time. The young person was struggling to settle into the new home, she wasn't eating much, crying most nights and it was rare she would sleep at all. The young person was confused about the entire situation and the justice system. She missed her brothers with whom she was very close. She was only having cold showers as she had promised her carer she would not use hot water, and was eating very small amounts of food,

to keep down expenses.

Over the Christmas period, the Foundation gave her extensive support with a significant number of outreach support sessions and strategies to increase her wellbeing. She was willing to access mental health services but the waiting list was so long that she wouldn't even meet her support worker until school returned. The Foundation's youth worker also sat with her through all her DHHS meetings and explained everything in terms she could understand. By the end of the holidays, the young person was functioning in a far better capacity in the home. But upon returning to school, she struggled. She believed the DHHS system and mental health system had failed her. Our youth worker attempted to engage the young person in the school wellbeing system, but she did not connect with this style of support. She was given as much wellbeing support as she was willing to take from the Foundation's youth worker, which proved a detrimental step in her wellbeing as her Headspace worker was not able to engage her.

The young person returned home against court orders and began to slip back into old habits and the Foundation's youth worker was frequently putting out spot fires to keep her engaged and out of trouble at school. After Term 2, she was on the brink of being expelled after she punched another student in the mouth. However, the school decided against this decision based on advocation from our youth worker. This was a turning point. She began concentrating in school, setting smaller goals, and achieving what she could based on techniques used by our youth worker in previous sessions. At time of writing, no further complaints have been made about the young person. She is now doing well in school, passing all her subjects, with no violent or angry episodes.

Case study 4: Female, [redacted], frightened by system

A [redacted] year-old female client of the Foundation had been on a waiting list for [redacted] for 8 weeks. She had her intake appointment and was deemed not at risk enough to get an appointment with a counsellor straight away. She decided weekly appointments with the Foundation's youth worker were enough to keep her stable until she received psychotherapy treatment. During the wait for the [redacted] appointment, she had a crisis with her family and self-harmed and had suicidal thoughts. She revealed this to the Foundation's youth worker, who had a duty of care to disclose the self-harm and suicidal behaviours. The young person was too afraid to seek help through [redacted] because they require an appointment for a mental health appointment with the [redacted] The last time the young person was exposed to a mental health assessment in the [redacted] she was required to be an inpatient in the unit and the fear of that happening again was strong enough that she will now not engage with any mental health services at all.

Case study 5: Male, [redacted] pulls away

A [redacted]-year-old male was referred to the Foundation for support after he was bullied at school. As a result of the bullying and the lack of a strong and caring male role model in his life, he would only build rapport with a female worker. It took three months for the young person to build enough trust in his allocate youth worker to enter the worker's car alone and talk about his troubles in life. The young person started talking about suicide and self-harm to his mother, but would not open up to the youth worker about this.

The Foundation's youth worker made a referral to [redacted] From intake to the first appointment he had to wait four weeks – a relatively short time, as most referrals in the area had a 10-week waiting list. The young person met with an intake worker and felt comfortable with her and opened up well, even trusting her with information from the first appointment which was attended by the youth worker. The Foundation's youth worker reassured the young person that this was a safe space for him to talk about issues.

However, the young person was then made to wait four weeks and was allocated a different intake worker. This resulted in the young person losing trust in the process and not wanting to tell his story a third time. He disengaged completely with [redacted] and stopped communicating with the Foundation's youth worker. Two weeks later the young person punched a hole through a wall at school in angry outburst. He remains disengaged from the Foundation at this point.

Case study 6: Female, [redacted] refuses to talk to anyone else

A [redacted]-year-old female with undiagnosed mental health, drug and alcohol issues and extreme family violence in the home – including a recent drug overdose by father – was referred to the Foundation. Over five months, the youth worker has weekly appointments with the young person, sharing information and building rapport. A mental health referral is completed for the young person with a doctor, who refers her to a male psychologist as there is a 10-week waiting list at [redacted]. She refuses to see the psychologist, saying she would prefer that the Foundation's youth worker help her with her mental health. Our youth worker agreed on the basis that the young person is honest and consistently risk assesses young person's mental health issues.

One day, our youth worker receives a phone call from the young person at 10AM. She says if youth worker cannot see her today she will kill herself. Youth worker drives to young person and immediately transports her to the [redacted]. The young person is assessed by nurses, doctors and the mental health team. Child protection is called and the young person is assessed as having environmental stress and sent home with a child protection

worker.

After this, the young person disengages from the Foundation's youth worker and risk-taking behaviour increases. The young person is now case managed by child protection and reports to our youth worker that they "do nothing" and she would only continue to see our youth worker. The Foundation's youth worker becomes burnt out by young person as she will not speak to anyone else after nine months of support. The young person is exited from the program and referred back to child protection and alcohol and drug services.

Case study 7: Female, [redacted], cannot afford help

A young woman encountered by the Foundation had recently given birth. She was distressed as she had found out her partner had been cheating on her while she was pregnant. She had used up all 10 sessions of her Medicare-covered psychology treatment. She could not afford to continue private treatment as she was of a low socioeconomic status. The young woman had a breakdown in front of her friends and begged them for advice on what to do. No answers could be offered. The suggestion was to lean on Lifeline in times of crisis and lean on her friends who had no counselling backgrounds.

Case study 8: Male, [redacted], attempts suicide

A [redacted]-year-old male encountered by the Foundation was diagnosed with Borderline Personality Disorder and Bipolar. He was referred to the mental health team at the hospital and was given case management support. But he was discharged from the mental health team soon after as he was deemed low risk and recovering. He was referred out to a private psychiatrist and psychologist. Once his 10 Medicare-covered sessions finished, he could not afford to continue counselling privately. Without the support of the mental health team and the psychiatrist he could not cope with the demands on his life and felt hopeless. He lived alone and felt there were no resources left for him to look for support. He called [redacted] but was assessed as being 'safe' as he sounded in control of his emotions and did not express great hopelessness. He was advised to call a friend if he felt worse. A week later the young man attempted suicide.

He was placed in an inpatient facility after being in the emergency department for 48 hours waiting for a bed. He was kept in the inpatient facility for a week with only medication support and a bed – without any psychological support. During this time he reported feeling unsafe and out of control as others on the ward were aggressive and violent. He was given the option of being sent to another facility in the community however there was a three-week wait and he had to be discharged home first. He chose to be discharged home alone.

After being discharged, the young man was given outpatient treatment but his case was closed again soon after due to low risk and he was diagnosed with Borderline Personality Disorder and environmental instability. He was referred to Dialectical behaviour therapy in the city but there was a wait of a year due to insufficient Medicare rebate sessions.

Case study 9: South Africa the 'only option'

Two years ago, [redacted] experienced a significant change in her family. Her older sister by two years ended her own life. Since this, [redacted] has been experiencing severe mental health issues that have impacted her engagement in schooling, her relationship with her family and friendships. Her mother requested support from the secondary college, who then requested support from the Les Twentyman Foundation. At that time, the support available was an outreach worker with a youth worker to be based in the school within the next two months.

The manager of the Foundation's schools program contacted the mother who herself was in significant distress. [redacted] mother expressed grave concern for her daughter, who was self harming, suspected of abusing several substances, staying out from home for several days at a time and being abusive towards both parents. Her mother was at breaking point and did not know where to turn, with local services being unable to engage with [redacted]. The Foundation's schools program manager referred the young person to the [redacted] worker, with the intent of [redacted] being referred back to the school program once a staff member was positioned. The outreach worker worked with [redacted] to set short term goals to settle her living arrangements. Home wasn't a negative environment, however it was filled with the memories and hurt caused by her sister's passing.

[redacted] is currently living with a family friend due to her severity of her mental health, behaviours and relationship with her family. She has moved to three different schools over a two-year period. Over a three-month period [redacted] has been admitted more than three times to [redacted] and [redacted] for her mental health. She has most recently been diagnosed with Borderline Personality Disorder. This has affected her attendance and engagement at school immensely, recording on average at least 30 days absent each term. Since working with the Foundation's youth worker through the In Schools program for the last two months, [redacted] has been trying to attend school as much as she can, which has increased and she has been able to have a main support service while at school. But at times she struggles with the pressures and procedures of school, ultimately affecting her mental health and engagement.

[redacted] grandfather has phoned the Foundation stating his granddaughter and daughter are in crisis, his daughter (the young person's mother) and he are at their wits ends. The grandfather said he did not believe the mental health services were providing adequate care,

as they were constantly being told to call 000, which results in the young person being transported to an emergency department to wait for a specialist. While waiting, she absconds and is dragged back by the family. The family now are looking to fly her to South Africa to a service which provides a nine-month long program, at the family's expense, as they've had no success with services within Australia. [redacted] in-school youth worker will continue to support Hayley, but [redacted] has been let down within the mental health sector to find a more permanent and support care.

Case study 10: [redacted] team fails drug-addicted young man

A [redacted]-year-old male from a non-English speaking background assaulted his father with a baseball bat due to addictive behaviour. His family is unable to communicate with services or understand support available due to the language barrier. Police attended after the assault and a [redacted] team assessed the young person. He was released without admission due to being drug induced. He continued down a criminal path to support his addiction. He was apprehended, attended court and completed assessment. He was referred to a mental health team and was given a 'depot' injection of an antipsychotic to slow his speeding mind. Despite this, he continued to take drugs.

[redacted] were involved to provide support for his offending behaviour. Our youth worker received a phone call from his mother, after the mother heard an interview on the radio by the Foundation's youth worker who described working with drug addictions in a culturally specific way. The mother requested support from our youth worker as her son was becoming more violent at home. The youth worker attended the home, as [redacted] had advised there was no risk. But as he entered the young person became violent as he was under the influence, and the youth worker was forced to exist via a window. Our youth worker phoned [redacted] and stated disappointment that he was not advised of the young person's violent tendencies.

As the Foundation's youth worker became more involved, the [redacted] worker realised there was a better rapport due to cultural similarity and the flexibility of our youth worker (i.e. working after hours) so [redacted] withdrew support. Our youth worker attended a variety of care team meetings, which he observed did not meet the needs of the young person or his parents. The specialists were under the impression the young person was doing well, despite the fact he was continuing to take drugs. Soon after the young person continued to spiral out of control and the [redacted] team was called again but the young person was released due to being drug affected. That night, the young person journeyed to [redacted] and injured himself with a steel pole, smashing windows of cars along the street, finally hitting a car with a woman and baby inside. Police arrested the young person and he was finally assessed after being admitted to [redacted] The youth worker was provided updates by the specialists, with one saying: "We do have one sick boy." The young person was kept in the

clinic for six months. He can now can manage his symptoms independently. The young person was able to be treated eventually, with his symptoms appropriately controlled through various interventions. It is the youth worker's view that had the [redacted] team and associated services intervened at the first instance, the young person's family and himself, the community and court system would have experienced significantly less trauma.

Case study 11: Girl, [redacted] of Somalian background

A [redacted]-year-old female of Somalian background met one of the Foundation's youth workers while working in [redacted] during school hours. When approached the young person said she had issues at home and was under the guidance of a school welfare worker who was unable to get to the core of the issues. She disclosed she was chroming with other friends and would not return home for days on end. Our youth worker contacted her mother, who said her daughter was missing. The youth worker located the young person at a house tenanted by two people funded by the [redacted] Neither of the two tenants were at the house, but in excess of 15 other young people were at the house. Our youth worker was concerned by the number of young people and the age and gender disparity of the occupants. Our worker informed the girl to contact her mother, which she did.

After a fortnight, the young person again went missing and her mother approached a Centrelink multicultural worker and said the Foundation's youth worker would know where to find her daughter. The Centrelink worker and police rang our youth worker, who said the young person was safe but would escape quickly if police approached. Our youth worker worked with police to develop trust so they could approach and return the young person home, in the belief she would not be abused when returning home. She went missing again and this time our youth worker was on leave. When the worker returned from leave, he found the young person had suicidal ideations. Concerned for her safety, our youth worker rang the [redacted] and informed them of the situation. The youth worker transported the young person to [redacted] awaiting the [redacted] team. The [redacted] team requested that our youth worker leave the room and he obliged. As the youth worker left, they informed the [redacted] team there had been significant trust built, for them to be sensitive, and to not inform the mother of the young person's location due to abuse at home by uncle.

As our youth worker was leaving the hospital, they observed the mother and uncle approaching the hospital entrance and as he glanced behind, the three [redacted] workers were approaching. The young person abused the youth worker and ran off. Our youth worker turned to the [redacted] team staff and said: "I will hold you responsible should this young person hurt themselves, as I had clearly stated you must not inform mother of location due to uncle's abuse." The youth worker left, went home and was unable to sleep and so he went looking for the young person. The youth worker found where the young person was, spoke at length that she needed some support and requested she attend [redacted]. Sometime after midnight, the

young person agreed and the youth worker transported her to [redacted] Our youth worker met with clinicians and reiterated they should not advise the mother of the young person's location, to prevent her running away. But when the youth worker returned to [redacted] the next morning, he was informed the young person had run away. When questioned, [redacted] staff said they had informed the mother and uncle, and when the young person had seen them on [redacted] grounds she ran away.

Our worker, again concerned for the young person's wellbeing and safety, sought out the young person for a third time and offered support to her cohort of friends, trying to rebuild the trust. The worker eventually worked with the family, gaining assurances she would be safe within the family home. The young person transitioned to school and her mental health conditions were dealt with in a care team setting involving the family. We believe the young person should have been case managed by a specialist at the beginning to prevent the escalation of events.