Mental Health Resource Service
195 Abbott Street Cairns Q 4870
PO Box 201 Cairns Q 4870
Phone: 4051 9622
Fax: 4031 2839
E-mail: mhrs@centacarecairns.org
21st April 2005

Ian Holland
Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600

Dear Mr Holland,

I am writing to convey two major concerns to the Senate Select Committee on Mental Health. The first is the lack of funding made available to mental health organisations from all levels of government. The second concern is the over-representation of people with mental illness in the criminal justice system.

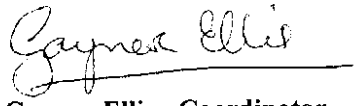
The *SANE Mental Health Report 2004: 'Dare to Care'* states that Australia spends less than 8% of its national Health Budget on mental health. The same report asserts that comparable OECD countries spend upward of 12% of their health budgets on mental health. This is of particular concern for Queenslanders because according to the *National Mental Health Report 2004*, Queensland spends the less per capita on mental health than any other Australian state or territory.

Both the level or funding and the frameworks in which funding is made available to mental health organisations are inadequate. A significantly increased investment is required, particularly in housing and supported accommodation for people with mental illness. Additionally, more needs to be done to progress the aims of the National Mental Health Strategy with regard to moving toward a community-based system of care (including increased outreach services, psycho-social rehabilitation, residential support and services provided by non-government organisations).

The unavailability of community-based and non-government health and human services has resulted in many people remaining untreated, homeless and at great risk of offending or coming to the attention of police. As a result, Australian prisons seem to have become catchment areas for people with mental illness. This is unacceptable – mental illness is not against the law. Attached please find a case history (details changed to protect anonymity) which illustrates these points.

With appropriate support in community settings, rehabilitation and recovery is often possible for people with mental illness. However, the expansion of community-based and non-government mental health services will be required to achieve this goal.

Yours faithfully,



Gaynor Ellis - Coordinator

SUBMISSION TO SENATE INQUIRY MENTAL HEALTH
FROM: MENTAL HEALTH RESOURCE SERVICE, CENTACARE CAIRNS.

An increasingly evident problem for people who are discharged from prison is the issue of dual diagnosis and homelessness. The following story illustrates a situation that is becoming all to common – people who "fall through the net" or end up being supported by services in the non-government sector, when their treatment needs are quite complex. Names and some details have been changed to preserve confidentiality.

Brad was discharged from (the local prison). He has a diagnosis of a long-term psychotic illness and is a substance abuser of (mostly) prescription drugs. He first contacted this service (MHRS) for social support, and was linked-in to some available supports, however he also frequently contacted the service with issues related to difficulties paying bills, which were resolved through advocacy on his behalf, and some assistance from Emergency Relief. He was housed adequately in a private flat.

He was under a GP, or at least several GP's, whom he contacted to obtain prescriptions for drugs, which he would then trade on the black market, or misuse. He had also been in contact with a worker at the Drug and Alcohol Service. This contact seemed to be infrequent and unrelated to any programs or treatment plans. He had visited the local IMHP, (CAT Team), who had assessed him, but not allocated him a continuing care case manager as he was "under a GP". Given his history – more than half his adult life has been spent in jail – it seemed a rather lame approach for the IMHP to be taking. Brad himself felt that he had not been allocated a case manager because of his history of incarceration.

At one stage, I did not hear from him for several weeks. Apparently during this time, he had raked up a sizable debt on his rent, had been in frequent phone contact with the CAT Team due to growing unwellness, and was facing eviction. I advocated with the CAT team that he needed to be followed-up by the IMHP. This was not done. Finally one day he presented at this service unwell, and complaining of hallucinations. He had been evicted and was now homeless. He admitted he had assaulted 2 people in the street the previous night because he "didn't like the way they were looking at him". I took him to the CAT team who gave him some medication, with no follow-up planned.

Less than a week later he presented again, with considerable deterioration, and I again took him to the CAT team. This time he was admitted to hospital. He was discharged about a week later, and presented at this service within two days of discharge from hospital, with both alcohol and drug intoxication, severe paranoia and aggression. He threatened several people in this agency before being quietly talked down out of his upset state. The CAT team was phoned, and I was told that he had not been discharged to follow-up by the IMHP after his hospitalisation. They also told me that he was considered at high risk of violence and I should be careful! Fortunately the situation was handled and resolved without calling security or the police. Had we done this, he may have severed ties with one of the few supports he had. On the contrary, it is now two years since this incident and he has maintained contact with this agency, has his life on track, and is continuing to experience the longest period in his entire adult life that he has lived outside the prison system.

Had the two people whom he assaulted laid charges, I have no doubts that this person would be again in prison. It was left to this non-government service (with a staff of 1) to deal with this person, who has high needs, and multiple issues, when we have two major government services that didn't seem to want to know, or care. This person has had subsequent serious issues due to homelessness, but is now housed, thanks to another non-government service.

This scenario seems to occur frequently, and no doubt those organisations that are involved in service provision to homeless people and ex-prison inmates have many more similar stories to relate. Whilst stories such as these do not directly reflect on the provision of services within the prison system, they indicate that proper discharge planning, follow-up, and mental health prevention strategies should be in place before the person exists the prison system. Otherwise the potential for constant "revolving door" syndrome between the prisons and the community (or the streets) will always be with us.