Submission to
The NSW Liberals and Nationals
Social Policy Framework
'Smarter, Stronger, Healthier, Safer'

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Submission to the NSW Liberals & Nationals Social Policy Framework
'Smarter, Stronger, Healthier, Safer'

The Mental Health Coordinating Council (MHCC)

MHCC is the state peak body for community managed organisations (CMOs) representing the views and interests of over 200 CMOs throughout NSW. Member organisations specialise in the provision of services and support for people with a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community.

Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development. The organisation consults widely in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector, and is a registered training organisation, delivering accredited mental health training and professional development to the workforce.

MHCC thank the NSW Coalition for providing the opportunity to respond to the Social Policy Framework paper ***'Smarter, Stronger, Healthier, Safer'***, and appreciate the deadline extension that was agreed to.

Objectives

In order to provide comment on the Coalition's social policy framework ***'Smarter, Stronger, Healthier, Safer'*** (SSHS) our purpose in this submission is to present our feedback under the following headings:

1. **An approach to developing a social policy framework**
2. **A picture of Community Managed Organisations (CMOs)**
3. **Recommendations regarding infrastructure; capacity building and service delivery planning**
4. **Recommended models for service delivery**

Summary of Recommendations

MHCC recommend that a Social Policy Framework:

- Adopts a Population Health approach which takes into account the Social Determinants of Health.
- Actively promotes socially inclusive strategies that remove barriers to housing, employment, securing and sustaining jobs; education and training.
- Targets increased funding to Community Managed Organisations to reduce the burden on overstretched under-resourced public health services.
- Increases the number of AHSs, creates Community Health Boards in each location, and manages funding by centralised coordination, monitored for quality and outcomes by a Community and Clinical Program Council reporting to the Minister.
- Sets benchmark targets for minimum levels of service access in each region.
- Makes a strong statement acknowledging the principles of recovery oriented practice in mental health care.
- Promotes prevention and early intervention and minimises risk by recognising the safety issues for people with mental illness in terms of suicide and vulnerability to interactions with the criminal justice system.
- Promotes continuity of care, especially after discharge from Emergency Departments and inpatient psychiatric units to minimise risk of suicide-related morbidity and mortality.
- Targets vulnerable groups with co-existing mental illness and drug and alcohol abuse at risk of interacting with the criminal justice system.
- Targets vulnerable groups with complex needs as a consequence of childhood abuse, domestic violence and other severe trauma.
- Outlines models of service delivery that appropriately meet the goals as identified under the NSW Coalition Goal headings *Smarter* and *Stronger*:

1. An approach to developing a social policy framework

1.1. This submission proposes that a social policy framework should adopt a Population Health approach which takes into account the Social Determinants of Health described by the World Health Organisation as:

> *…the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries*.[i]

MHCC's initial response to the Coalition's social policy framework is that it is narrower than the 'population health approach' we favour. This approach is described by John Macdonald, Professor of Primary Health Care, University of Western Sydney (2001), as generally including:*'…a concern for an integrated approach to the health of various subgroups of given populations*.'

MHCC endorse the characteristics of this approach highlighted as:

- *'a social view of health, which acknowledges biological influences but also encompasses consideration of the social determinants of health'* [ii]
- *'a conceptualisation of health and health services that represents a balance between prevention and treatment, with an emphasis on appropriate care according to need, but with an equal emphasis on the generally neglected areas of prevention and promotion of wellbeing'* [iii]
- *'the incorporation of the elements of the World Health Organization's Health for All Declaration*, [iv] *notably a concern for equity; an acknowledgment of the role that other sectors play in creating sustainable environments for health; and the participation of the population'*
- *'a concern for evidence-based policies and programs.'* (Starfield, 2001). [v]

The Public Health Agency of Canada provide a good example of how a population health approach can be embraced and positioned as a unifying force for the entire spectrum of health system interventions - from prevention and promotion to health protection, diagnosis, treatment and care - and integrates and balances action between them.

Our understanding of what makes and keeps people healthy continues to evolve and be refined. A population health approach reflects the evidence that factors outside the health care system or sector significantly affect health. It considers the entire range of individual and collective factors and conditions - and their interactions - that have been shown to be correlated with health status, commonly referred to as the: *'social determinants of health,'* these factors are complex and interrelated and may include these key elements:

Income and Social Status
Social Support Networks
Education
Employment/Working Conditions
Social Environments
Physical Environments
Personal Health Practices and Coping Skills

Healthy Child Development
Biology and Genetic Endowment
Health Services
Gender
Culture

A Vision for Change policy is another example of a comprehensive model of mental health service provision for Ireland. The *Vision for Change* model describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

The model proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person-centred treatment approach which addresses each of these elements through an integrated care plan, reflecting best practice, and evolved and agreed with service users and their carers.

Special emphasis is given to the need to involve service users and their families and carers at every level of service provision. Interventions are aimed at maximising recovery from mental illness, and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life.

MHCC strongly recommend that the Coalition adopt a population health approach which focuses on improving the health status of the population, which requires the reduction in inequalities in health status between population groups. The underlying assumption of a population health approach is that reductions in health inequities require reductions in material and social inequities.

The outcomes or benefits of a population health approach, therefore, extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement.[vi]

2. The character of the mental health sector in NSW

Community Managed Organisations (CMOs) also known as Non Government Organisations (NGOs) support people in the community to stay well out of hospital and avoid crisis, and support them to be participating citizens and meet their personal goals for recovery. CMOs provide mental health supports for people affected by mental health problems, their families and carers in NSW. CMO services include a range of accessible; effective; coordinated; client-centred; recovery-oriented programs which can be broadly broken down into seven core types of service:

1. Helpline & Counselling Services
2. Self-Help & Peer Support
3. Accommodation, In-home Support & Outreach
4. Employment, Education & Community Integration
5. Family & Carers
6. Information, Advocacy & Promotion
7. Leisure, Recreation & Community Access

These services are an integral component of the mental health service system. Currently in NSW their potential is not fully realised for people with mental illness, due to the NSW Mental Health System's focus on the delivery of acute bed-based services.

3. Recommendations regarding infrastructure; capacity building and service delivery planning

Whilst supporting the objectives that underlie the Coalition's stated six policy principles [vii] MHCC propose that in order to develop a Social Policy Vision for the future of NSW, the principles need strengthening to underpin the population health approach mentioned earlier in this submission (p. 4). As a consequence the four goal areas identified in the *Smarter, Stronger, Healthier, Safer* (SSHS) framework document need to reflect the strengthened principles.

Smarter

The NSW Coalition has identified a number of goals under this heading, which MHCC support. However, an aspect that is missing concerns people disadvantaged as a consequence of mental illness.

3.1. Many people with a mental health disability have ambitions to participate in the workplace in a meaningful way. This should not be interpreted as merely a desire to fill their time, but as an indicator of their aspirations to achieve career and income objectives. Consumers regularly report that employment promotes recovery, improving the prospect of maintaining ongoing improved mental and physical health.

Consumers experience many barriers to social inclusion that impact on their ability to overcome obstacles to employment objectives, including securing and sustaining jobs, education and training. It is in the area of employment that there is the most compelling evidence linking social inclusiveness with improved mental health and recovery from mental illness.[viii]

3.2. MHCC suggest that another consideration is absent from the document - the importance role community services play in reducing the burden of disease and cost to the community both on an individual and fiscal level, and therefore the need to increase funding to CMOs to reduce the burden on overstretched under-resourced public health services. This surely is a strong contender under ***Smarter*** policy goals?

MHCC provide the following to support our argument:

The Australian Institute for Health and Welfare reported mental disorders to be the third leading cause of overall disease burden, accounting for 13 per cent of total burden and 27 per cent of total years lost to disability. Mental disorders rank third after heart disease and cancer as the largest causes of illness related burden in Australia. However, they represent the largest cause of disability, accounting for nearly 30 per cent of the burden of non-fatal disease. Depression and anxiety account for nearly half of this burden. Depression was the leading single cause of disability. (AIHW, 1999)

Mental disorders are estimated to account for substantial lost productivity in the workplace. In Australia it is estimated that absenteeism due to depression accounts for around six million working days lost each year, at a cost to employers of approximately $1.2 billion. In addition, depression is estimated to reduce workers performance by at least 40 per cent. For the Australian workforce as a whole, this equates to around 30 million working days per year with reduced productivity, at a cost to employers of approximately $2.3 billion. (Work Outcomes Research and Costs-benefit [WORC] Project 2000, University of Queensland).

It is also important to emphasise the direct contribution CMOs make to the economy. In the Productivity Commission Report on the Contribution of the Not-for-Profit Sector [ix] the commission writes that:

> *The sector makes a significant contribution to the Australian economy. In 2006-07, it accounted for 4.1 per cent of GDP (which does not include the contribution of volunteers), employed close to 890 000 people and utilised the services of some 4.6 million volunteers. Three-quarters of volunteers across all NFPs contribute to culture and recreation activities or to social services. The value of volunteer time rose from $8.9 billion in 1999-2000 to $14.6 billion in 2006-07, with 2.2 per cent annual growth in total hours.*
>
> *Contribution to GDP grew at an annual average rate of 7.7 per cent in real terms, to $42.9 billion. NFP employment grew from 6.8 per cent of total employment in 1999-2000 to 8.5 per cent in 2006-07; all activity areas (except culture and recreation) reported positive growth in the number of employees. The sector makes valuable contributions in promoting social cohesion, providing cultural, environmental and other community benefits, and delivering human and other services.*
>
> *Survey results also suggest that NFPs are more trusted providers than government or corporate organisations.*[x]

According to the ABS (2009) the NFP contribution to measured national income (value added) in 2006-07:

> *…….the sector generated $41 billion gross value added (GVA) — equivalent to 4.3 per cent of total GVA . Put into context, this is comparable to the measured contribution to national income of the wholesale trade sector ($48 billion), transport and storage ($48 billion) and government administration and defence ($40 billion). It is larger than the gross value added of the communications sector ($25 billion), but smaller than that of finance and insurance ($77 billion) (ABS 2009b).*

Stronger

3.3. In its SSHS policy document the NSW Coalition refers to a number of **Potential Policy Directions**, one of which is management of the NSW Health System. Under this Direction is a proposal: *Abolishing Area Health Services and replacing them with smaller, community-focussed Health Districts oversighted by boards to improve management of the State's health system.*

We now know that good health is about access to community based services in conjunction with hospital care where needed. The important point being that the community rather than hospital is the centre for the health care system.

MHCC is concerned that the model identified in: *A Healthier Future for All Australians: Discussion Paper and The Final Report of the National Health and Hospitals Reform Commission* – June 2009, [xi] will be a reversion to an entirely medical model of service delivery of earlier decades. Whilst we support a reduction in size of, and an increase in number of Area Health Services; and the greater localization of planning, we strongly disagree with power being in the hands of hospital clinicians 'as the only experts' which is likely to lead to prioritising clinical services, as stated in the Commonwealth Government's response to the Garling Report.

Such an initiative will negatively impact on the direction of funds which will inevitably be focused towards acute services and medical equipment rather than prevention and early

intervention provided in the community. What is critical is to improve the balance of service delivery. MHCC strongly recommend that whilst local boards are a good idea, the central focus must be that they are Community Health Boards, with funding coordinated centrally, monitored by a Community and Clinical Program Council reporting to the Minister; ensuring independent monitoring and auditing.

Community Boards must establish good relationships with hospitals that lead to improvements to coordinated care between hospital and community services resulting in better outcomes for people engaging with the system. The community board model would be represented by its chair in the representative Program Council, and the Program Council would divert funding from NSW Health to the Community Boards.
The Community Boards would receive funding in relation to local need with the proviso that a minimum set of obligations are met, e.g. a minimum benchmark for core services in each location to be met.

3.4. Under Goal – ***Stronger***, item 1,

1. Improve government decision making by increasing community involvement.

   MHCC recommend that the initiative suggested later in the SSHS document under ***Potential Policy Directions - Healthier*** (dot point 4 : *The creation of partnership arrangements……to specialist care in acute hospitals* [xii] should also appear under ***Stronger*** item 1 heading.

3.5. Under Goal – ***Stronger***, item 2,

2. Better protect the most vulnerable members of our community and break the cycle of disadvantage.

The Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014 [xiii] sets out a number of actions that break the cycle of disadvantage amongst which most importantly in our view is that:

- There needs to be recognition that the focus of care may differ across the life span and according to need. In mental health services there is no such thing as a 'one size fits all'. Service delivery must meet a diversity of need from social support, living skills and employment to step down from acute services, age and culturally appropriate, flexible and individually focused. Mental health should be provided at a standard at least equal to that provided in other areas of health. Services should be informed by the available evidence and look to innovative models as examples of service improvement.

- There needs to be consideration of the spectrum of mental health. Mental health promotion, prevention and interventions need to include consideration of the spectrum from wellbeing to mental health problems to mental illness. The range of service options needs to include those illnesses that are most often managed within the primary care sector, as well as those that may require greater specialist involvement. Services should be provided on the basis of need, not diagnosis or whether an illness or disorder is common or uncommon.

- Services must be provided that support continuity and coordination of care in a way that lessens the risk of people falling through gaps, unnecessary duplication and promotes

information sharing. The level of service provision and the outcomes of care should be transparent to consumers and carers.

There is real value in getting behind a model that quarantines funding for the CMOs to ensure equal access to services in the community. Benchmark targets for minimum levels of access in each region must be set. The Housing and Accommodation Support Initiative (HASI) in NSW is an exemplar of an innovative partnership program between NSW Health, Housing NSW and non-government organisations that provides housing linked to clinical, psychosocial rehabilitation and support services for people with a range of levels of psychiatric disability.

In July 2006, the Council of Australian Governments endorsed the *National Action Plan on Mental Health* (2006-2011), in this Plan COAG stated its commitment to ensuring coordinated care for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system. The Plan established a basis for a Care Coordination initiative to be implemented in each State and Territory. This involved collaboration in each jurisdiction between Commonwealth agencies and the relevant State/Territory government agencies, and non-government and private sector organizations linking care for people with a mental illness in need of extensive support in the community.

NSW has commenced implementation of a range of care-coordination programs for people with severe mental illness, for example: the Housing and Accommodation Support Initiative (HASI), designed to assist people with mental health problems and disorders requiring accommodation (disability1) support to participate in the community, Resource and Recovery Services and other programs under the NGO Grant Program. However, these are few and far between.

Healthier

3.6. Promoting Recovery Orientated Practice

MHCC recommend that under the Healthier Goals heading that a stronger statement is made in terms of acknowledging the principles of recovery oriented practice in mental health care. Recovery Orientated Practice is: individualised and person-centred; enables self direction; promotes and protects people's legal and citizenship rights; promotes dignity and respect; acknowledges partnership and communication as part of the process; evaluates the process.

Safer

3.7. Risk of suicide post discharge

The Goals of Safety identified in the NSW Coalition social policy framework fail to recognise safety issues for people with mental health issues and the risk this presents in terms of suicide/ self-harm and vulnerability in their interactions with the criminal justice system. The focus of the Safer Goal appears to be law & order, rather than prevention; early intervention and minimising risk.

ABS (2007) data tells us that suicide deaths in Australia represented 1.3% of all deaths and that for Aboriginal people this figure climbs to 3.7%. [xiv] These figures may be substantially higher for both Aboriginal and non aboriginal peoples if unexplained vehicle and other accidents were to be included.

Trends show that men aged 30 to 34 years and 40 to 44 years are now at highest risk of suicide, compared with a decade earlier when men aged 20 to 24 years, 25 to 29 years and 75 years and over were at highest risk.[xv]

Over the past 20 years the chronic problem of post-discharge suicide remains of significant concern worldwide. Reported suicide mortality rates are 213 fold higher than the general

population in the first twelve months after discharge from inpatient care.[xvi] These figures need not be so high if adequate levels of ongoing community support services were put in place.

Lapses in continuity of care, especially after discharge from Emergency Departments and inpatient psychiatric units, contribute significantly to suicide-related morbidity and mortality.

3.8. Divert Women from the Corrections System

Over the last two decades, both in Australia and internationally, numbers of women in the criminal justice system have increased by 260 percent. Increasingly women are going to jail for longer periods for minor crimes, most frequently related to drug and alcohol crimes or theft. The statistics for Indigenous women is even more alarming.

One study found that 80 - 85% of women in Australian gaols have been victims of incest or other forms of abuse.[xvii] Another study of 27 NSW correctional centres in 1999 found 65% of male and female inmates were victims of child sexual abuse and physical assault. [xviii]

According to the 2008 NSW Inmate Census by Corrective Services NSW, women represent approximately 7.3% of inmates in NSW of which 29% are Aboriginal. [xix] The 2009 NSW Inmate Health Survey found:

- 45% experienced domestic violence or abuse as an adult
- 20% have been admitted to a psychiatric unit or hospital
- 27% have attempted suicide
- 66% have been in a violent relationship

Source: Indig, D et al. (2009).
2009 NSW Inmate Health Survey: Key Findings Report (in press). Justice Health.

MHCC propose that there is need to provide diversionary support programs for vulnerable women in the community so that they can be helped to overcome mental health, and co-existing drug and alcohol problems whilst continuing to care for their children, minimising the risk of generational dysfunction and disadvantage.

4. Recommended models for service delivery

MHCC recommend a number of models of service delivery that would appropriately meet the goals as identified under the NSW Coalition Goal headings *Smarter* and *Stronger*:

Smarter

4.1. Employment

NSW needs to establish support services to achieve employment outcomes for disadvantaged people with specific health and social needs that don't have jobs and to compliment the National Mental Health and Disability Employment Strategy. Supported employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Supported employment programs are staffed by employment specialists who have frequent meetings with treatment providers to integrate supported employment with mental health services.

Evidence-based practice tells us that employment support services must accompany job training and placement opportunities and that for people with mental illness these best occur in separation from clinical treatment services. Whilst it is important to ensure that clinicians in

mental health services understand the important links between job placement and meaningful activity to mental health outcomes, employment specialisation is not a function a health service should be performing. MHCC is concerned that the NSW Health Vocational Education, Training and Employment (VETE) pilot program would be better situated within and expanded upon from existing community organisations working in the specialist employment sector.

Stronger

4.2. Recovery Support Centres

The Recovery Support Centre approach is a new model which provides practical support assistance enabling people with mental illness to remain in the community. This model should be conceived as providing the stepping stones to independent living. Recovery Support Centres provide a place for people who require significant levels of support in an environment where they are accepted, welcomed (not tolerated) and feel safe. Recovery Support Centres are synergistic within the suite of mental health programs in NSW that address a range of complex needs that individually targeted programs such as HASI are not designed to deal with, providing the practical psycho-social supports people need to fit into the local community.

Meeting consumers' psycho-social needs these centres will reduce demand on community mental health teams, easing current workforce pressures. As a central point of service Recovery Support Centres provide an auspice for programs funded through sponsorship, philanthropy or Government Programs including HACC and a range of other services such as: outreach GP, dentistry and optometry provided by local clinicians; psychological and counselling services; employment and vocational training; victims of crime; legal advocacy; DV; adult education; etc.

4.3. Family Options - USA

Family Options (FO) takes a family-centred, strengths-based approach to dealing with mental illness; parenting and family relationships. FO partners with parents to enhance their family lives and build networks of supports and resources. The aim is to strengthen families to improve their long-term mental health status and well-being and the functioning of all family members.

The FO premise is that people dealing with mental illnesses can be successful parents if they have the right supports. The program provides personalized support to each family member. Family members, rather than providers, determine goals. The program has a framework of psychiatric rehabilitation with a focus on skills building and recovery. Family coaches help parents build natural support systems that can fill in during crises, and the program works with all family members--children as well as parents--to draw on each family's unique strengths.

Research evidence is now available from families in a two-year pilot study with a team of researchers from the University of Massachusetts Medical School. The model is has achieved growing acceptance as best practice, and has a program operating in 23 states in the US.[xx]

4.3. Prevention and Recovery Care (PARC)

Discharge planning must provide a seamless transition from acute care to community living. This requires communication between agencies and action should be taken to enhance care coordination. The transition between hospital and home needs to take into account the provision of 'step down' facilities. A consumer may not need hospitalisation but may not be well enough to cope in the community. Early intervention sub-acute services that use existing partnership models with NGOs that have a strong evidence base. An example of this is the Victorian Prevention and Recovery Care (PARC) service model, a partnership between NGO community mental health services with 24-hour community clinical services. This model aims to intervene early, prevent risk of suicide or prevent admission or re-admission to acute mental health inpatient care.

PARC presents a step-up and step-down alternative to hospitalisation that is Step-up' occurs when a person is becoming unwell, minimising risk of suicide or self-harm.

4.4. HASI is designed to assist people with mental health problems and disorders requiring accommodation support to participate in the community, maintain successful tenancies, improve their quality of life and most importantly to assist in their recovery from mental illness. HASI has been identified as a key program under the *New South Wales Interagency Action Plan for Better Mental Health* that is a collaborative approach to the provision of mental health services, including health, education, housing, police, justice, community and disability services. The Plan sets out a coordinated approach to managing the needs of people with mental health issues, including prevention and early intervention; community support; and coordination of emergency responses.

MHCC thank the NSW Coalition for their interest in our comments on their social policy framework and express our willingness to be consulted further on any details contained in this submission.

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[i] The World Health Organisation (2009). Available: http://www.who.int/social_determinants/en/

[ii] Wilkinson RG & Marmot MG (editors). *The Social Determinants of Health: the solid facts.* Copenhagen: World Health Organization Centre for Urban Health, 1998, 2000. Kawachi I & Kennedy BP. *Health and social cohesion: Why care about income inequality?* BMJ April 1997; 314. Cited in: MacDonald J (2001). NSW Public Health Bulletin, Vol12 No.12, p 313.

[iii] Starfield B. *Basic Concepts in Population and Health Care*. J Epidemiol Community Health July 2001; 55: 452–454. Cited in: MacDonald J (2001). NSW Public Health Bulletin, Vol12 No.12, p 313.

[iv] World Health Organization. *The Alma Ata Declaration.* (1978). New York: World Health Organization. Cited in: MacDonald J (2001). NSW Public Health Bulletin, Vol12 No.12, p 313.

iv MacDonald, J. (2001). NSW Public Health Bulletin, Vol12 No.12, p. 313.

[v] MacDonald, J. (2001). NSW Public Health Bulletin, Vol12 No.12, p. 313.

[vi] Public Health Agency of Canada. (2004).*Toward a Healthy Future: Second Report on the Health of Canadians,* p.315.

[vii] The NSW Coalition has identified their six social policy principles, which are:

1. *The importance of early intervention and prevention.*
2. *The value of local decision making and community partnerships.*
3. *The rights of individuals to make informed choices and the expectation they will accept responsibility.*
4. *The belief that NSW should offer the highest quality and standard of services in Australia.*
5. *A promise to deliver timely and equitable services for all.*
6. *A commitment to openness, transparency and accountability.*

viii Bateman, J & Merton, R. (2007). Social Inclusion: its importance to mental health. Mental Health. Coordinating Council. Sydney, Australia.

[ix] Productivity Commission (2010*).* Contribution of the Not-for-Profit Sector: Research Report, Canberra.
[x] Ibid, p.53-53.

[xi] Australian Government (2009). A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009. Available:
http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report

[xii] Quote SSHS - The creation of partnership arrangements between Government and other health care providers to offer seamless health care, particularly for those at risk of developing chronic illnesses…..hospitals.

[xiii] The Fourth National Mental Health Plan (2009). Commonwealth Government of Australia. Available:
http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/45274/Draft_Fourth_National_Mental_Health_Plan.pdf
[xiv] ABS (2007) 3303.0 - Causes of Death, Australia, 2007. Available:
http://www.abs.gov.au/ausstats/abs@.nsf/0/F7FFC6536E191ADBCA25757C001EF2A5?opendocument

[xv] DOHA (2006). Evaluation of the National Suicide Prevention Strategy – Summary Report.

[xvi] Goldacre, M., Seagroatt, V. & Hawton, K. (1993). Suicide After discharge from psychiatric inpatient care. The Lancet, 342, 283-286.

[xvii] Easteal, P. (1994). "Don't talk, don't trust, don't feel". Alternative Law Journal, 19, 2, 185-89.

[xviii] T.Butler, et al. (1999). Childhood sexual abuse among Australian prisoners. Venereology, 14, 3, 109-15.

[xix] Indig, D., Topp, L., McEntyre, E., Ross, B., Kemp, P., Monkley, D., McNamara, M., Rosina, R., Allnutt, S., Greenberg, D. & D'Espaignet, E. T. (2009). 2009 NSW Inmate Health Survey: Key Findings Report (in press). Justice Health. NSW, Australia.

[xx] Research material available from the Psychiatric Rehabilitation Journal, 2009, Vol 33, No 2, 98-105.