National Health and Hospital Networks, COAG and Mental Health Reform

Priorities outside the NHHN reforms

Position Paper

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Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

In April 2010 at the Council of Australian Governments (COAG) meeting, the Federal Government won the support of all states/territories (with the exception of WA) for the National Health and Hospitals Network (NHHN) Agreement.

This Agreement has three primary objectives:

- Reforming the fundamentals of our health and hospital system, including funding and governance, to provide a sustainable foundation for providing better services now and in the future.
- Changing the way health services are delivered, through better access to high quality integrated care designed around the needs of patients, and a greater focus on prevention, early intervention and the provision of care outside of hospitals.
- Providing better care and better access to services for patients right now, through increased investments to provide better hospitals, better infrastructure, and more doctors and nurses.

Of the $7.4 billion announced in the COAG Agreement and the 2010 Federal Budget for health reform, only $181.3 million over the four years was specifically directed to mental health. Of this, a mere $115 million was identified by the Government as new funding – the remainder either being redirected or restorative funding. This represented less than 1.6% of all new healthcare funding.

In February 2011, concerns from a number of state governments relating to the proposed Commonwealth take over of funding resulted in a new Agreement between all state and territory governments. Despite this new Agreement, the situation for mental health remains unchanged. Moreover, changes in government at the state and territory level continue to threaten commitments enshrined in these two Agreements and further perpetuates a state of unease and uncertainty within the Australian health and mental health sectors.

This paper highlights the priority areas for strategic investment and funding support from the Commonwealth Government in the 2011-12 Budget outside of the proposed NHHN reforms. The paper is one of a series of papers published by the MHCA to be considered by members as part of a sector-wide response in the lead up to the 2011 Federal Budget and COAG meetings.

Mental Health – The Second Term Priority

The MHCA calls on the Commonwealth Government to honour its commitment to undertake significant investment and reform in the area of mental health this year in the 2011-12 Budget.

Extensive consultation and documentation of the issues facing mental health consumers, carers and the broader sector has been undertaken a number of times, including the report of the Senate Community Affairs Committee Inquiry into Mental Health Services in Australia

which noted the high level of urgency for extensive overhaul of Australia's mental health system.[1] More recently the MHCA facilitated 14 national forums across Australia for the Minister for Mental Health, the Hon Mark Butler MP. The Minister heard from mental health consumers and carers directly what their concerns were and what needed to be done to improve the lives and outcomes of people living with mental illness, their carers and their families.

Amongst the many issues raised, including both what is working now and what is not, there were consistent points of agreement amongst attendees that were raised at session after session, regardless of location. These included (in no particular order):

- Stigma and discrimination against people with mental illness and their carers
- Minority group issues, including indigenous, culturally and linguistically diverse (CaLD) and others
- Dual diagnosis, co morbidity, physical and mental illness
- Integrated services, including housing, employment, disability services, and others
- Mental health workforce needs
- The need for a mental health consumer peak body, and a carer counterpart
- Enhancing community capacity,

The MHCA strongly recommends that the Federal Government take note of these priorities when it comes time to fulfil its promise of investment in and reform of the mental health system.

Mental Illness and the Social Determinants of Health

In recent times there has been a fundamental shift in the way we understand health and illness and how best to improve outcomes for people living with mental illness. Instead of the predominant bio-medical model of healthcare where individuals are diagnosed with an illness that is most likely caused by biomedical, biological or behavioural factors and is treated with clinical healthcare services and/or medication, an individual's experience of health and wellness can now be viewed through the prism of social determinants.[2,3] Social, economic and environmental circumstances are now recognised as fundamental to understanding health, wellness and illness, and improving the health outcomes of individuals or groups can only effectively be achieved by improving the social, economic and environmental circumstances in which they live.

In practical terms what this means is that to improve health outcomes we need to use not just traditional bio-medical interventions like medication and talk therapies, but, also, we need to strategically address the social, economic and environmental disadvantage experienced by individuals or the target group, i.e. unemployment or underemployment,

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[1] Senate Standing Committee on Community Affairs (2008). Towards recovery: mental health services in Australia, Commwealth of Australia, Parliament House, Canberra.

[2] CSDH (2008). *Closing the Gap in a Generation: Health equity through action on the social determinants of health, Final report of the Commission on Social Determinants of Health,* Geneva, World Health Organisation (WHO)

[3] For example, sex, age, socio-economic status, employment status, housing status, locality, sexuality, cultural or indigenous background, caring responsibilities, co-occurring disability, illness or alcohol and other drug issue, experiences of violence, abuse or neglect, stigma etc.

housing insecurity, social isolation, financial insecurity, relationship breakdowns, legal issues, family violence and sexual assault etc.

Key Areas for Investment and Attention

While the MHCA and its members are keenly following the proposed national health and hospital reform initiatives and assessing how these initiatives will impact on the mental health sector, these are by no means the only areas in which MHCA members support further investment and reform.

Given the clear relationship between social determinants and health, MHCA members are keen to see urgent attention and investment given to the following six areas which remain missing from the Government's overall reform agenda:

1. Consumer/Carer Participation
2. Housing
3. Employment
4. A National Mental Health Promotion and Anti-Stigma Campaign
5. A Life-Course Approach to Early Intervention
6. Mental Health Workforce

The MHCA and its member organisations have already expressed their strong support for new action in these areas and this paper reaffirms our mental health sector-wide position.

Consumer/Carer Participation

Australia continues to have inadequate structures and supports to enable the genuine participation of consumers and carers in their own mental health. Participation is the active engagement of consumers and carers in the design, delivery and monitoring of all facets of the care they receive in managing mental illness. This, of course, is much broader than health, incorporating housing, community, disability and other services.

Meaningful engagement, participation and representation of consumers and carers will require the recruitment of consumers and carers from a wide variety of backgrounds, including young and aged consumers and carers, consumers and carers from CaLD and indigenous backgrounds, rural and remote versus urban and regional consumers and carers etc. Some of these groups are particularly difficult to access and recruit, however, without diversity in representation the views of minority and disadvantaged groups will remain marginalised within the mental health service system and inequity in mental health outcomes will likely persist.

A summary of the principles for consumer and carer participation are outlined in Table 1.

A full articulation of the principles behind this commitment can be found in the *2004 Consumer and Carer Participation Policy*, published by the National Mental Health Consumer and Carer Forum.[4]

Realisation of the goal of a recovery-oriented mental health care system articulated in the National Mental Health Policy and Fourth National Mental Health Plan will not be possible

[4] See http://nmhccf.org.au/documents/ConsumerandCarerParticipationPolicy.pdf

without the resources to support the genuine participation of consumers and carers in all aspects of their mental health care.

Table 1 – Principles for Consumer and Carer Participation[5]

1. Core Principles
Consumers and carers provide unique expertise due to their lived experience of mental illness
Consumer and carer participation will be promoted at all levels of mental health care
Consumers and carers have distinct and separate needs
Mental health organisations will seek formal and informal links with peak bodies for jurisdictional representation
Mental health organisations are encouraged to adopt or adapt this participation policy to local needs
Mental health organisations will need to adapt to the particular communication and participation needs of representatives
2. Principles for defining the role of consumer and carer representatives
The role of consumer and carer representatives is to be clearly defined
Consumer and carer representatives have responsibilities to fulfil
Mental health organisations will be prepared for ill health affecting consumers and carers
Mental health organisations will have conflict resolution processes in place
3. Principles for selection of consumer and carer representatives
Mental health organisations will select appropriately supported consumer and carer representatives
Mental health organisations will select appropriately skilled consumer and carer representatives
Mental health organisations will have transparent processes for the selection of consumer and carer representatives
Mental health organisations will provide information to assist with the recruitment of consumer and carer representatives
4. Principles for employment of consumer and carer representatives
Consumers and carers will be remunerated for representative duties
Consumer and carer representatives will receive relevant and necessary ongoing support, education, training and resourcing
Mental health organisations will utilise consumers and carers as educators
Mental health organisations will ensure adequate information flows and feedback mechanisms
Review and evaluation of consumer and carer participation will occur annually

[5] Ibid.

Housing

> *One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live it is virtually impossible.*
>
> *HREOC, 1993*

The steps to fix Australia's housing crisis as it relates to people with a mental illness were clearly articulated in the 2009 MHCA publication, *Home Truths: Mental Health, Housing and Homelessness in Australia*.[6] The most important findings of this report were:

- Mental health consumers who are not adequately supported in appropriate and stable accommodation have a significantly increased risk of becoming acutely unwell and requiring acute mental health services, usually hospital based.[7] [8,9]
- Periods of acute mental ill health make it more likely that consumers will lose stable accommodation options and be at risk of homelessness.[10] [11,12]
- Mental health consumers who manage to obtain, and are appropriately supported in, accommodation of their choice are more likely to feel in control, more settled in their home and less stressed.[13]

Despite the clear recommendations of *Home Truths* and others (i.e. the Senate Community Affairs Committee report, *Towards Recovery: Mental Health Services in Australia*[14]), there has been little focus on a strategic approach to addressing the housing needs of one of the most vulnerable population groups in our community: mental health consumers. For example, the Fourth National Mental Health Plan may have committed to:

> *Develop[ing] integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.*[15]

However, strategies such as this do not address the acute shortage of appropriate and affordable accommodation options for mental health consumers and will provide only

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[6] See http://www.mhca.org.au/publications

[7] Parker et al. (2002). *Homelessness and mental illness: mapping the way home,* Mental Health Coordinating Council, Sydney.

[8] Centre for Mental Health Services, *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders,* Department of Health and Human Services (Substance Abuse and Mental Health Services Administration), Rockville 2003.

[9] Australian Institute for Health and Welfare (2007). *Australia's welfare 2007* (AIHW Cat. No. AUS93), AIHW, Canberra.

[10] SANE Australia (2008). *Housing and Mental Illness* (Research Bulletin 7), SANE Australia, Melbourne, 2007.

[11] Harris, G. (2006). *The right home in the right location with the right support': submission in response to the Discussion Paper 'Accommodation and Personal Support for People with Disabilities in South Australia,* Mental Health Coalition of South Australia, Adelaide.

[12] Robson, B. (1995). *Can I Call this Home? An evaluation of the Victorian Housing and Support Program for people with psychiatric disabilities,* Psychiatric Disability Services of Victoria, Melbourne.

[13] Robinson, E. and Adams, R. (2008). *Housing stress and the mental health and wellbeing of families,* Australian Family Relationships Clearinghouse Briefing No 12), Australian Institute of Family Studies, Melbourne.

[14] Senate Community Affairs Committee. (2008), *Towards Recovery: Mental Health Services in Autralia,* Commonwealth of Australia, Canberra, 2008

[15] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

minimal relief to the workload of overburdened and understaffed public mental health and housing services.

A whole-of-government approach is required to establish safe, affordable and secure accommodation and integration of complementary services for Australians living with mental illness[16] and we strongly urge the Commonwealth to implement such an approach.

Employment

> *Work is one of the most important defining aspects of who we are, our sense of meaning, value and belonging. The therapeutic value of work cannot be understated.*
>
> *Mental Health Council of Australia, 2007*

In November 2007, the MHCA released *Let's Get to Work: A National Mental Health Employment Strategy for Australia.*[17] *Let's Get to Work* was developed following almost 12 months of background research, consultation and extensive input. It describes social, personal, economic and productivity implications of Australia's low rate of workforce participation amongst people with a mental illness and highlights a range of strategies to improve the way the sector supports mental health consumers including:

- measures to determine the success of services
- investing in skills
- policy changes
- support services for employment providers and the work place
- leadership within the field and by government.

The overall aim of the strategies in *Let's Get to Work* was to increase the level of workforce participation for people with mental illness by focussing on the needs of the consumer.

The report highlights that a person with mental illness must be at the centre of decision making about their lives. If the process of seeking or remaining in employment or participating in training or vocational support is disempowering for the individual then it is unlikely to be successful. The disadvantages created by the Welfare to Work policies of the Australian Government at the time were also covered by *Let's Get to Work* which outlined a range of strategies to assist agencies improve their services and achieve a more person centred approach.

We acknowledge that the Government has already enacted some of the recommendations of *Let's Get to Work,* but there is still more work to be done.

With the onset of the Global Financial Crisis (GFC), the Organisation for Economic Cooperation and Development (OECD) has urged governments to do more to improve workforce participation rates for young people and those with disabilities, most particularly people with mental illness.

The OECD warned that Australia's rate of employment for people with disability was low (and falling) in comparison with other developed economies despite a low rate of unemployment across the adult population. The OECD also pointed to the high rates of

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[16] NMHCCF (2010). NMHCCF Advocacy Brief, Supported Housing and Homelessness. See http://www.nmhccf.org.au/documents/Housing%20&%20Homelessness%20Brief%202010.pdf

[17] See http://www.mhca.org.au/publications

poverty for people with disability – almost one in every two people with a disability lived in poverty. These figures were just prior to the onset of the GFC.[18]

The OECD also pointed to innovations in the Netherlands and Sweden. In the Netherlands employers are working together to form employer networks that facilitate the redeployment of workers no longer able to continue in their current role because of illness or injury. In Sweden, the medical community is working to apply new and world-leading guidelines that help GPs award sick leave in a way that maximises health and labour market outcomes.

There are numerous best practice examples for increasing workforce participation of people with disabilities, including mental illness, and it is time for the Commonwealth to commit to addressing the shortfalls in our National Disability Strategy, and the National Mental Health and Disability Employment Strategy.

A Life-Course Approach to Early Intervention

Early intervention programs that target wellbeing across the life-span are essential in order to improve the mental health outcomes of all Australians. Moreover, early intervention programs should not just be limited to clinical mental health interventions, but should rather address the full range of social determinants that are likely to negatively impact upon the mental health of Australians, including family and domestic violence, substance misuse, poverty and homelessness (to name a few).

Early intervention programs that specifically target infants, children and youth must be sufficiently funded by the Government as a matter of priority, including the full implementation of a national youth primary care service (*headspace* or similar), a national network of EPPIC programs and other evidence based prevention and early intervention mental health services. The MHCA would also support other evidence based models like Kids Life Centres (as recommended by the RANZCP) – which provide early intervention mental health services for children aged 0 – 12 that co-locate family supports, parenting interventions and mental health assessment and treatment for children and infants experiencing mental health problems.

Integration and coordination of early intervention programs and mental health services cross-sectorally and across the life span is fundamental to supporting the smooth transition of mental health consumers and carers through early intervention and treatment programs that cater to their specific needs.

A National Mental Health Promotion and Anti-Stigma Campaign

There is currently no national mental health promotion and anti-stigma campaign in Australia. Mental illnesses, particularly lower-prevalence disorders such as schizophrenia or bipolar disorder, are still the subject of powerful negative community stigma and media portrayal. Discrimination is still a major barrier to community reintegration of people who have experienced a mental illness. Moreover, there is an urgent need to inform people about what they can do to manage risk factors for mental illness, the benefits of seeking early intervention and how to avoid or minimise a relapse.

The Australian Government's Preventative Health Taskforce's discussion paper *Australia: The Healthiest Country by 2020* is highly supportive of preventative campaigns that are

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[18] OECD (2010). *Sickness, disability and work: Breaking the Barriers*. Organisation for Economic Development, Paris.

strategically developed and linked with community action. It cites past successful prevention programs including those targeting tobacco control, road trauma, drink driving, skin cancers, immunization, Sudden Infant Death Syndrome and HIV/AIDS. The Preventative Health Taskforce has initially focused on alcohol, tobacco and obesity. They have also acknowledged that mental health should be the next preventative health priority.

To be effective, a mental health promotion and anti-stigma campaign must not be limited to glossy advertising campaigns; it must be vertically integrated to reach communities, workplaces, the mental health and community sector workforces, schools and universities. The campaign should have clear goals, and its impact must be evaluated against these goals.

New Zealand's *Like Minds Like Mine* campaign provides an example of what an effective anti stigma campaign can achieve. Australia lags behind New Zealand and many other countries in this critical area of effective promotion and anti stigma strategies.

Mental Health Workforce

A sufficiently resourced and appropriately trained mental health workforce is an essential component to improving the mental health outcomes of all Australians, and there is an urgent need for committed investment by all Governments to enhance the capacity of the mental health workforce and ensure that the community's mental health needs are adequately met.

Attracting and retaining appropriated skilled and experienced staff in the mental health workforce remains an issue for the sector. There are significant shortages in mental health professionals (including, psychiatrists, general practitioners and mental health nurses) across the country, most acutely affecting rural and regional Australian. Reports also suggest that the stigma associated with mental health can often act as a disincentive for new health professionals from specialising in mental health. Consumers and carers also report limited mental health literacy amongst medical practitioners who are not mental health specialists.

The completion of the NGO Mental Health Workforce Study this year by Health Workforce Australia[19] will also shed further light on the composition and skill level of the 1,000 non-government organisations around Australia providing mental health and co-morbid treatment and community services. As a result of this study, there will likely be additional NGO-specific workforce issues to be considered and addressed.

The Australian mental health sector remains united in its support for the development and implementation of a National Mental Health Workforce Strategy that addresses these endemic workforce issues. Such a strategy would also seek to define the roles of both clinical and non-clinical service providers[20] and acknowledge the important contributions of all parties as part of an integrated multi-disciplinary team.

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[19] See http://www.hwa.gov.au/programs/research-and-data/mental-health-ngo-workforce-study

[20] Non-clinical providers include, consumers and carers, Indigenous and CaLD mental health workers, medical practitioners in non-mental health related fields, works from other sectors (i.e. employment services, housing, disability, education, and corrections)

A Mental Health Sector-wide Position on Priorities outside the NHHN reforms

These issues or principles are proposed to underpin a whole of sector advocacy position in relation to other priorities outside the NHHN reforms.

Position: Consumer and carer engagement, participation and representation must be integrated into the design, implementation and evaluation of all relevant programs and reforms that may impact on them.

- Australia continues to have inadequate structures and supports to enable genuine and meaningful consumer and carer engagement, participation and representation. Resources must be committed to support both a national mental health consumer peak body and a national mental health carer peak body.
- Appropriate benchmarks must be set for both performance and monitoring of consumer and carer participation in mental health from the service level to the national policy development level.
- There must be appropriate funding and effective monitoring of initiatives outlined in the Fourth National Mental Health Plan, including:
  - the establishment of an effective peer workforce and expansion of opportunities for meaningful involvement of consumers and carers[21]
  - increased consumer and carer employment in clinical and community support settings[22]
  - accountability of service delivery including public reporting[23]
  - establishment of a culture of continuous quality improvement within service delivery systems that revolve around benchmarking and consumer and carer involvement.[24]
- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

Position: Cross-sector[25] service systems must be integrated, collaborative and flexible in order to address the unique needs of mental health consumers within a social determinants of health framework.

- Working collaboratively to improve the social, economic and environmental determinants of poor health at both the systemic and individual levels will lead to greater equity in mental health outcomes amongst Australians.
- Data collection standards need to be introduced at all levels of Government and service delivery in order to inform and support targeted and innovative service delivery models that will meet the needs of disadvantaged and marginalised mental health consumers and carers.

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[21] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

[22] Ibid p51.

[23] Ibid p61.

[24] Ibid.

[25] Including, but not limited to, the mental health, aged care, disability, AOD, housing, employment and education sectors.

- More research and monitoring of the nature and scale of mental health inequity and its relationship with social determinants is urgently required at all levels of Government and service delivery.
- Service funding formulas that mix performance based and activity based incentives are likely to support responsiveness to service demand and the development of innovative service models that target hard-to-reach client groups.

Position: Systemic issues relating to housing, including housing affordability, housing insecurity and homelessness must be addressed in conjunction with mental health reforms.

- Thirty percent of public housing stock must be set aside for people living with a mental illness.
- Properly resourced and monitored discharge planning must be implemented across Australia, with zero tolerance for discharge from hospitals to homelessness or unstable housing. This goal must be independently monitored and publicly reported.
- Home and community must become the preferred treatment sites with the number and scope of peer, carer, allied health and community options being significantly increased.
- A whole-of-government homelessness strategy that includes appropriate recognition of the relationship between mental health and homelessness should be developed in consultation with stakeholders, and then appropriately resourced.
- More research and monitoring of the nature and scale of homelessness and housing insecurity amongst people living with a mental illness is urgently required.

Position: Systemic issues relating to employment of mental health consumers and carers, including unemployment, underemployment, and inappropriate support services must be addressed in conjunction with mental health reforms.

- The employment rate for people with a mental illness needs to be increased from 29% to 53% — this is the rate for people with other forms of disability (physical and intellectual) and comparable to the rate of employment reported by the OECD in other developed economies for people with mental illness.
- Australian Government employment of people with a disability needs to increase from its current level of 3%[26] to at least the 1986 level of 6.6% of the of the total public service workforce.
- Support for innovative models of employment assistance for people with a mental illness including psychiatric-specialist employment service providers.
- There must be appropriate funding and effective monitoring of initiatives outlined in the Fourth National Mental Health Plan, including:
    - The establishment of an effective peer workforce and expansion of opportunities for meaningful involvement of consumers and carers[27]

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[26] In 2009, the number of employees in the APS was 4,566 or just 3% of total ongoing employees - the lowest recorded. Employment statistics of people with disability in the Australian Public Service can be found at http://www.apsc.gov.au/mac/disability6.htm#f61 and http://www.apsc.gov.au/stateoftheservice/0809/ataglance.html)

[27] Australian Health Ministers (2009). *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014*. Canberra: Commonwealth of Australia. p29.

- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

Position: A life-course approach that recognises and addresses the social determinants of health must be employed across all early intervention mental health programs.

- The Australian mental health system is overwhelmingly skewed towards providing acute and continuing psychiatric care to adult Australians, and is ill-equipped to provide the targeted early intervention and support needed to improve the mental health outcomes of Australians outside the 26 – 64 age bracket, including children, youth and adolescence, and older people.
- Children's mental health outcomes, for example, are fundamentally influenced by their relationships with caregivers, other significant adults and their peers.[28] As a consequence of this, effective early intervention programs targeting children often employ a family and community focus, incorporating broad intersectoral partnerships between mental health, health, AOD, education, child care, child protection and judicial sectors. This model of service delivery is mostly unsupported within Australia's current mental health system.
- Early intervention programs must go beyond solely clinical interventions and address the full gamut of social and environmental factors that may negatively impact on the mental health of Australians.

Position: A national mental health promotion and anti-stigma campaign that addresses issues like stigma and discrimination, mental health illiteracy and help seeking behaviours must be undertaken as a matter of priority.

- State, territory and federal governments commit millions of dollars in highly visible campaigns promoting physical illnesses and injuries associated with smoking, alcohol consumption, obesity and road accidents, but have so far neglected to address mental health in such a comprehensive and systematic way.
- Anxiety and depression are the leading cause of burden of disease and injury in Australian women and the third cause for Australian men. Suicide and self-injury amongst Australian men ranks 8th in the leading cause of burden of disease and injury.[29]

Position: A national mental health workforce strategy must define roles for clinical and non-clinical service providers and enhance opportunities to expand services in areas of need

- A National Mental Health Workforce Strategy will address workforce issues experienced by both clinical and non-clinical service providers working with Australians experiencing mental illness. It will also outline mechanisms for attracting mental health personnel to rural, remote and other areas of geographic and other need.
- A National Mental Health Peer Workforce Development Strategy must be established under the National Mental Health Workforce Strategy.

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[28] Further information in relation to the mental health needs of infants, children and adolescence can be accessed in the Australian Infant, Child, Adolescent and Family Mental Health Association's 2011 Position Paper entitled *Improving the mental health of infants, children and adolescents in Australia.* See http://www.aicafmha.net.au/resources/files/AICAFMHA_pos_paper_final.pdf

[29] Australian Institute of Health and Welfare (2007). *The burden of disease and injury in Australia 2003*, Cat No. PHE 82. AIHW, Canberra.

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