

A new model for delivering selected Mental Health Services in Australia

A paper prepared for the
National Health and Hospitals Reform Commission

Contact for correspondence:
Professor Ian Hickie
Executive Director
Brain and Mind Research Institute
The University of Sydney
Ph: 02 9351 0810
Email: ianh@med.usyd.edu.au

1. Synopsis

This paper describes a more co-ordinated and intensive management program specifically designed to meet the needs of two key cohorts of Australians with a mental illness, namely:

- a) those who access public acute and-related psychiatric hospital services for a psychotic disorder (approximately 200,000 persons); and,
- b) those who present to a designated centre for the management of a first episode of psychosis (approximately 10,000 persons).

There are three key elements to this approach:

- a new model of health and related social services funding
- a new model of mental health care partnerships; and
- a new system of accountability for health and social outcomes.

The majority of expenditure in the mental health sector continues to occur in the most expensive acute hospital settings. Given our failure to build a viable community-based alternative, all aspects of these services are faced with increasing demand. Over the last five years the Australian community has expressed its lack of confidence in the ability of mental health services to provide the most basic elements of acute or ongoing care. Most new state-based investments have been made in old and largely failed models of care. By contrast, investment in early intervention services has not been sufficient or sustained. This is a critical failure as 75% of all mental illnesses have their onset before the age of 25 years. Without appropriate health care, social support and recovery services, these illnesses are likely to have a lifelong affect on a person's ability to complete study, find work or participate socially.

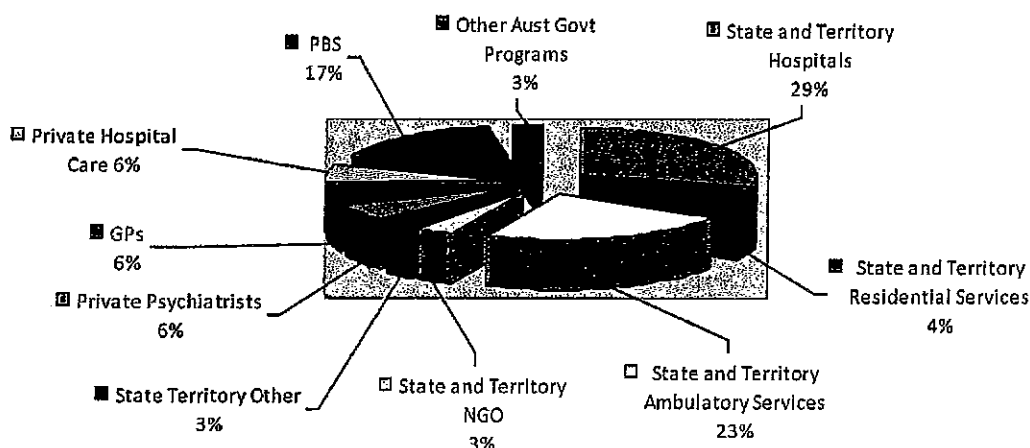
Previous attempts at national mental health reform have not delivered an effective health care system. They have been too conservative, focusing largely on the location of care (hospital versus community-based) rather than providing practical support for real reform, innovative planning or strategic investments. Disparate arrangements within and between levels of government, a lack of partnership developments with other community services and a total absence of agreed measures of meaningful outcomes have further compromised earlier efforts. Here, we set out a new agenda for those most neglected by these past failures.

2. Background

Successive reports have indicated the depth and breadth of the crisis in mental health services in Australia (1,2). Following deinstitutionalisation, mental health has experienced the worst aspects of service mainstreaming, with a failure to invest in community services leading to an expensive and inappropriate dependence on acute hospitals as the predominant setting for mental health care. Community ratings of the most important priorities for mental health reform included national implementation of systems for early intervention, comanagement of alcohol and other substance use and a broader range of acute and sub-acute service systems (3). Those communities are acutely aware of the lack of development of such innovative service structures within our current health care environment (3).

Australia spends \$3.9bn on mental health (4) yet the Australian Bureau of Statistics suggests that up to two-thirds of people with a mental illness get no care in a year (5). The AIHW estimate the burden of disease represented by mental illness to be 13% (6) yet mental health attracts only around 8% of the health budget. In 2004-05, the mental health budget was spent as per Figure 1 (3).

Figure 1 How Mental Health Spending was distributed in 2004-05



Recent changes under COAG have increased the spending on services provided by GPs and psychologists in particular, under the Better Access Program. However, the situation remains that the overwhelming majority of mental health funds in Australia are spent in the acute care sector by the states and territories. With these services in crisis, the level of acuity a person must reach in order to gain access to any care is increasing dangerously.

As indicated in Figure 1, there has also been very minimal investment in the type of psycho-social rehabilitation and support services often provided by NGOs. With few alternatives or early intervention services, Australians generally must wait until they are extremely unwell before they can access clinical care in a hospital setting.

This paper proposes a new and better way to manage those people who seek care in Australia's hospital-based psychiatric services. This new arrangement will deliver better care for the clients and free up state and territory resources to focus more on those services best delivered in acute hospital settings.

3. The Client Groups

The data available regarding mental health services is poor. The recent COAG Action Plan Progress report was only able to report against 5 of its 12 outcome measures (7). However, we do know some key characteristics of the people currently using hospital psychiatric facilities:

- While mental health related hospitalisations (2005-06) account for only 4.4% of all hospitalisations, they account for 12.2% of total patient days (average stay of 9.2 days) (7)
- In total, mental disorders accounted for 322,110 hospitalisations, including 204,186 admitted patient episodes and 2,960,201 patient days (7).
- The data does not tell us how many individual patients required hospitalisation as several states do not have unique patient identifiers, nor can we assess re-admission rates nationally. Local area based health data indicate that the number of persons managed per year is about 50% of the number of recorded hospitalisations (i.e. about 100,000 persons admitted to public psychiatry services. Those states that do collect readmission rates indicate that the average 28-day readmission rate is 14% (8).
- On this basis, it would be reasonable to assume an existing target population with psychotic illnesses likely to require admission of about 100,000 per year, with a total population group of about 200,000 (assuming that about 50% of the key group are likely to be hospitalised in any one year.
- Well-developed first-onset psychosis services in the public sector (e.g. Orygen Youth Health) are likely to see 250 young persons/1,000,000 Australians in the target age range per year. Therefore,

there is a national need for services for approximately 5,000 young persons per year. About 50% of these patients will progress to long-term care, while the remainder need intensive care (to achieve optimal social and health outcomes) for up to five years (references). Therefore specific services need to be established nationally to serve 10,000 young persons with recent-onset psychosis per year.

- Private hospitals provide 79.3% of ambulatory equivalent (day-only) separations (9)
- Public acute hospitals report the highest number of involuntary separations (79%). The highest proportion of involuntary separations is for those aged 25-34 years. Males aged 15-44 account for the majority of involuntary separations (8).
- The 25-34 age group has the highest rate of mental health related hospitalisations (9.3/1000). Hospitalisations are also higher in those who are Australian-born and resident in metropolitan areas (8).
- Approximately half of those admitted have never been married (9), and are highly likely to be dependent on family of origin or other social and housing services for their basic accommodation and welfare needs.
- Depressive disorders account for the highest percentage of hospitalisations (25.8%), with schizophrenia the next highest (18.4%). Schizophrenia accounts for the largest proportion of patient days (22.2%) (8).
- After exclusion of ambulatory equivalent (day-only) admissions, there were 204,186 mental health separations for admitted patients. Most (80.9%) were from public hospitals with an overall length of stay of 13.9 days (8).
- Between 2001-02 and 2005-06 mental health related separations increased by 2.2% per annum and the majority of separations (58.1%) involved specialist psychiatric care (8).
- The diagnosis of schizophrenia accounted for 18.4% of separations involving specialist psychiatric care and was the most commonly reported diagnosis for public acute and psychiatric hospitals (8).
- By contrast, a depressive episode was the second most common diagnosis overall but the most commonly reported diagnosis for those admitted to private psychiatric hospitals (8).
- Over the period 2001-02 and 2005-06, there was an average annual increase of 4% in specialised psychiatric care in private hospitals (8).
- The National Mental Health Report 2007 indicates that in 2005, hospital spending on psychiatric services totalled over \$1.1bn with a further \$1.2bn spent on ambulatory/community services (4).
- According to the 2006-07 casemix national average cost weights (for public hospitals only) an episode of schizophrenia (U61A) costs \$15,237 and acute depressive disorders \$11,220 (U62A) (10). Using the public hospital separations data above, this would equate to 17,402 episodes of schizophrenia costing around \$265m and 15,658 episodes of severe depression costing just under \$176m.
- Conservative estimates of Australian Government spending alone suggest that, for every dollar allocated to specialised mental health care, an additional \$3.10 is spent providing other support services to assist people with mental illness. This is equivalent to \$4.3 billion in 2005 prices (4).

This paper posits that there is well-defined cohort of very frequent users of our hospital-based mental health facilities that are extremely resource intensive and stuck in a cycle of readmission and ongoing social exclusion.

We suggest that a fundamentally new approach is required to assist these clients and, in doing so, free up acute hospital resources. Additional benefits may include decreased reliance on emergency

department assessments, reduced acute hospitalisations and decreased reliance on emergency housing supports.

4. Providing coordinated systems of care

The evidence is now clear that the best quality mental health services are delivered through collaborative care (11, 12). Available evidence and past history indicate that the existing mental health system, with its reliance on acute care and individualised fee-for-service medicine, together with Australia's federated polity cannot engender this collaboration.

For the client group described above, we propose a needs-based system of funding support, case-coordination and information technology support to improve the quality of life of clients described.

There is a precedent for this approach. The Department of Veterans' Affairs has a clearly identified client cohort and is legislatively empowered to coordinate and manage their needs holistically. The DVA approach to client identification and case management to some extent informs this paper.

4.1 The Department of Veterans' Affairs

The DVA have a budget of \$4.8bn, to holistically manage the needs of a client group numbering just under 300,000 veterans and their families (12). Of this total, some 143,000 people within the DVA treatment population have had some experience with mental illness, including people with an accepted mental health disability and others who have either received mental health care or drug treatments for mental illnesses. The most common mental illnesses affecting the DVA client group are anxiety, depression, alcohol dependence and posttraumatic stress disorder.

DVA purchase a range of services for their client group, including:

- Contracts with 443 public state, territory and private hospitals and clinics to provide services including mental health.
- Primary care services, including general practitioners and others
- Counselling services
- Chronic disease management
- Case coordination
- Rehabilitation
- Dental
- Pharmacy
- Respite Care
- Allied health
- Home Care and Community Support
- Carer and Volunteer Support
- Peer Support and Education

The fundamental principle of DVA's approach to mental health service provision is to tailor packages of care designed to meet the individual needs of each client.

In strengthening community-based mental health services, the department acknowledges that there is a need to move beyond a focus solely on treatment and to recognise the importance of services that look at the health and wellbeing of the individual. Improving awareness of mental health issues is critical to support early intervention.

DVA Annual Report 2005-06

DVA's approach and role allows them to transcend the traditional organisational and funding barriers which preclude collaborative care. They are able to purchase services from any provider able to demonstrate they can meet the client's needs. Typically, the client will have a choice between services.

There are models of this kind of holistic care already in the mental health sector, albeit standing as islands of excellence. Some examples are provided below.

4.2 The Housing and Supported Accommodation Initiative (HASI) – NSW

HASI is a program which began in 2002-03 and by 2007 was delivering differing levels of stable housing and accommodation support allied to a suite of clinical and psycho-social services to over 1000 people with mental illness. Some of the key findings from the Program evaluation are (13):

- Reduced hospitalisation, frequency and duration for 84% of participants
- Time spent in hospital and emergency departments decreased by 81%
- 85% of all participants remained with same housing provider
- An increase in community participation – 94% of participants had established friendships and 73% were participating in social and community activities
- 43% of HASI clients were working or studying, a 34% increase in these types of participation
- A 77.6% decrease in imprisonment
- Increased connection to community mental health services with 92% of HASI clients in regular contact with their case managers and 89% still in contact with their psychiatrists
- An improvement in psychological wellness with 68% of participants reporting improvement in symptoms, social and living skills as well as improved diet
- 50% of participants reported improved physical health
- Better family connectedness for clients

Each HASI place costs around \$57,000. Data limitations preclude cost comparison with a control group of similar clients outside the HASI program.

Queensland's Project 300 initiative is a similar model of holistic care (14).

4.3 Prevention and recovery care services

Victoria's Psychiatric Disability Rehabilitation and Support Services (PDRSS) (15) sector is the most developed in Australia, with around 10% of the mental health budget in that state directed towards this type of NGO-driven community support. Most other states spend around 3-5% (ref).

The prevention and recovery care (PARC) (16) services attempt to blend the clinical and non-clinical needs of people with a mental illness, offering step-up and step-down care, with links to ongoing community support, employment, housing and other services. The newest PARC model operates as a conjoint service between the Alfred Hospital in Melbourne and the Mental Illness Fellowship of Victoria. An onsite mental health nurse assists a range of allied health professionals and case managers tailor individualised programs of care for clients, either to prevent escalation of symptoms to the point where hospitalisation is required (step-up) or as part of a planned transition from acute care to community living (step-down). The key feature of this care is careful balance and respect between both the clinical and non-clinical aspects of the service provided.

Another PARC at Linwood is run jointly by the Association for Relatives and Friends of People with a Mental Illness (AREFEMI) and the Central East Area Mental Health Service. This service has been running for two years and has demonstrated (ref):

- 80% occupancy rate in the overnight program
- Successful collaboration between clinical and psychosocial aspects of the program
- Reduced hospital admissions into acute clinical care
- Particular emphasis on first episode psychosis clients
- Improved self-management for clients
- Improved engagement for families and carers, including respite care, expert advice etc

Another PARC is the Specialist Residential Rehabilitation Program (SRRP) in Shepparton in which the Goulburn Valley Area Mental Health Service (GVAMHS) and the Mental Illness Fellowship (MIF) work in partnership to deliver services. Through their partnership commencing in 2001, MIF has been able to provide residential and rehabilitation support and GVAMHS provides treatment and clinical rehabilitation. It focuses on people who have higher needs that have not been able to be fully met in the absence of a 24-hour longer term unit.

The SRRP enables people with a mental illness to learn or relearn living skills in a supportive and safe 'live in' environment. It assists people who require more support than can be provided by visiting workers. Residents build social and living skills through shared learning with others, while accepting responsibility

for themselves within a supportive environment. The program also fosters vocational and educational connectedness in the community.

The Program helps individuals achieve their maximum potential in gaining skills with daily living through meal preparation, budgeting, personal care, sharing a house and domestic care. Wherever possible the program involves all stake holders in the development of the rehabilitation plan.

4.4 Headspace: the national youth mental health foundation

Headspace has been established recently in Australia (17,18) to develop a novel set of locally coordinated services for young persons aged 12-25 years with significant mental disorders (and comorbid alcohol or substance misuse). It is supported by the Australian Government to develop 30 Communities of Youth Service nationally, as well as a national community awareness, training and evidence centres. Each centre relies on a locally-developed service consortium. Headspace centres access service funds from a variety of national, state, research and other funding mechanisms. Each centre responds to local population needs and is not constrained by state-defined or federally defined area health service or divisional boundaries. Clinical governance and IT frameworks are being developed to promote team-based care between a range of professionals who are self-employed or employed by different government, educational or non-government agencies. Early service data indicate the capacity to deliver multi-disciplinary and collaborative care, driven by local innovation and direct response to community needs.

4.5 Early Intervention in Psychosis (Orygen Youth Health Model)

Recent economic analyses of the Orygen Youth Health Early Intervention in Psychosis Model has demonstrated that over both short and long periods (eight years, Mihalopoulos et al. 2008 submitted) this model delivers better health and social outcomes at approximately 50% of the total costs of conventional services. The greatest savings are initially in terms of reductions in acute hospitalisations and, over time, additional reductions in outpatient care occur. Medication costs are similar in both forms of care. In well-established services (within the state sector) the per patient/per year cost is approximately \$5,000 in standard care and \$2,500 in the enhanced services model.

5. A new system of accountability

Existing accountability measures in mental health have proven inadequate, particularly as they provide almost no information whatsoever on consumer outcomes and social participation. A new model is required.

The following measures have been assessed by the mental health sector as being key to determining the performance of the mental health system:

- a. The rate of suicide and death rates <3 and <12 months post discharge from a mental health facility, including cause of death
- b. The rates of community follow up for people within the first seven days of discharge from hospital
- c. Readmissions to hospital within 1 month and 6 months of discharge
- d. Percentage of persons with psychosis seen by a community-based mental health professional within seven days following discharge from a facility
- e. Waiting time for admission to a supported mental health place in community
- f. Waiting time for admission to a supported drug and alcohol place in community
- g. Waiting time for mental health emergency community support.
- h. Consumer experience of being treated with dignity using agreed criteria
- i. Participation rates by people with mental illness of working age in employment
- j. Percentage of persons using mental health services with access to stable housing

Over time, neither the states and territories nor the Australian Government have been able to provide data against these measures. These measures have been most neglected in relation to persons with psychotic illness. Current hospitalisation data suggest that the quality of life of persons living with these conditions, particularly young men who are socially disconnected, may have declined over the last decade.

The alcohol and drug sector is able to mine a rich vein of information with regard to changing trends in drug use across Australia. A cadre of well-informed researchers has developed to conduct this work, publish articles and provide advice. Services can be and are configured in response to the information developed. This process is not in place in the mental health sector. Investing in independent research across these critical measures will not only contribute to changing this situation but make it more likely these critical measures will be collected effectively and routinely.

6. A new model for mental health services in Australia

A new model for selected mental health services in Australia is proposed. This model is designed to meet the needs of two well-defined cohorts of very frequent users of our public and hospital-based mental health facilities that are extremely resource intensive and stuck in a cycle of frequent admissions and/or long-term social disability.

For the target cohorts, we propose a needs-based system of funding support, case-coordination and information technology support to improve the quality of life of the clients described.

The proposed schemes are likely to include:

- a) at least 200,000 Australians with established psychosis in the first three year; and
- b) at least 10,000 young Australians with first-onset psychosis in the first three years.

The new model requires the development of a national coordinating body, whether state based or federal, that accounts for the financial and purchasing aspects of the model as well as the annual reporting of outcomes.

We propose that this coordinating body be called the “National Health Model for Australians with Psychotic Disorders”

The key features of the model are:

- 1) co-ordinated national and state funding of health and related social, educational, employment and accommodation services;
- 2) national accreditation of organisations recognised to provide services to these people (and hence receive funding from the national pool); and,
- 3) annual reporting of the activities and outcomes achieved under this model.

Consideration of “capped” vs “uncapped” models of funding

Two possible funding models are possible for supporting services provision for these two key and related patient groups.

In an uncapped model, finance would follow the individual across the private and public mental health and general health sectors. This ‘entitlement card’ approach would increase the access of these persons to the wide range of inpatient and ambulatory care services available across the traditional private and public health sectors. However, such a model would still require external care coordinators or advocates to ensure that such persons were offered a wide range of appropriate services. This model also does not prioritise reductions in hospitalisations. In fact, it could simply lead to increased day-hospital and private

hospital organised care. While this may reduce demand on state services it may translate to less cost-efficient forms of care.

In a capped mode, it is more likely that large scale national health and welfare organizations would tender to provide the full range of inpatient and ambulatory care services (in major and smaller population centres). This model has advantages for Government (known costs) and is also more likely to bring additional administrative, infrastructure and IT capacity into the field. Within such a model, realistic funding levels per person per year need to be provided. This model is likely to prioritise reductions in hospitalisations in both the private and public sectors and development of genuine home-based and other residentially-based but lower cost clinical care options.

Issues of Accountability

To obtain accountability data, the National Model will require the ability to identify individual patients as they obtain services from all services providers, whether public or private. This could be achieved with the introduction of national unique identifiers and data matching systems. In addition, we would recommend the establishment of the Australian National Mental Health Survey. The preferred approach is to conduct localised surveys, sampling users of the mental health system over, for example, a one month period in different sites across Australia. Rather than relying on inflexible and inconsistent jurisdictional information systems, independent researchers would be engaged to purposively collect data in relation to the measures listed in Table 1. Most of the elements listed in Table 1 are in fact measures called for under the COAG Action Plan, but so far failed to be collected.

Table 1

Australian National Mental Health Survey Data Elements	
Outcome	Progress Measures
Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention	Percentage of people with a mental illness who receive appropriate mental health care
	Mental health outcomes of people who receive treatment from State and Territory services and the private hospital system
	The prevalence of mental illness in the community (<i>National Household Survey every 3 years</i>)
Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery	Rates of use of illicit drugs that contribute to mental illness in young people
	Rates of substance abuse
Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation	Participation rates by people with mental illness of working age in employment
	Participation rates by young people aged 16-30 with mental illness in education and employment
	Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities
	Prevalence of mental illness among homeless populations
Increasing consumer and carer participation in treatment planning and service quality enhancement	Public reporting of consumer and carer satisfaction measures
	Level of engagement of consumers in treatment planning
	Level of engagement of carers in treatment planning and support
Reducing the risk factors for families and children of people with a mental illness	Level of family assessment and support provided to carers
	Level of family assessment and support provided to children of consumers
Active monitoring of outcomes from mental health service providers	Ongoing program of health care audits involving follow-up patient and carer assessments for GP plans and psychological services

Australian National Mental Health Survey Data Elements	
Outcome	Progress Measures
	Ongoing program of health care audits involving follow-up patient and carer assessments for people who receive treatment from State and Territory services and the private hospital system
	Ongoing program of health care audits involving follow-up patient and carer assessments for community mental health service providers
General health and well being of mental health consumers and carers	General health assessment including diet, exercise, dental needs, level of alcohol, tobacco and other drug use by consumers
Employment status	Access to stable full time or part time employment or training
	Access to appropriate vocational assessment and planning services provided
Stigma and Discrimination in the Community	Community surveys of attitudes towards mental illness, including target populations such as employer groups, CALD communities and others.
Housing status	Access to stable housing
	Access to appropriate housing assessment and planning services

7. Conclusion

People with mental illness using acute care hospital services are resource intensive and often stuck in a 'revolving door', in which pressure on services leads to early discharge and frequent re-admission. A key to national mental health reform is to break this cycle.

It is possible to identify this cohort of clients and design and deliver more packages of care that more holistically meet individual needs. DVA is empowered to make the most appropriate purchases of services for its clients, regardless of whether these services are offered by the public, private, not-for-profit or other sector. This new scheme would operate in a DVA-like manner and would facilitate the entry of new providers of care and services.

This new service would be strongly governed by a transparent set of accountability measures, so that client welfare and progress could be regularly monitored.

An appropriate level of start-up funding for the scheme is required, taking into account what we know about the costs of health, housing, employment, community and other services. This funding would be pooled from the relevant federal and state budgets and regular reports would be provided to ensure the cost effectiveness of the new arrangements.

At this stage, it is estimated that this start-up pool of funding for the new ("capped") scheme would require (for health funding only):

- i) \$20,000 per person with enduring psychosis; and

2) \$20,000 per person with first episode psychosis.

Additionally, organizations should only be contracted to provide care to at least:

- 1) 100 persons with persistent psychosis (i.e. minimum \$2m service contracts); and/or
- 2) 50 persons with first-episode psychosis (i.e. \$ minimum \$1m service contracts).

It may be possible that larger service contracts will offer better per person costs and/or that costs per person will decrease after establishment of the new services.

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