

Lessons from the National Mental Health Integration Program

Kathy Eagar, Jane E Pirkis, Alan Owen, Philip M Burgess,
Natasha Posner and David A Perkins

Abstract

Three projects were funded under the national Mental Health Integration Program (MHIP) in 1999, each of which employed a different model aimed at improving linkages between disparate parts of the mental health system. A national evaluation framework guided local evaluations of these projects, and this paper presents a synthesis of the findings. For providers, the projects improved working relationships, created learning opportunities and increased referral and shared care opportunities. For consumers and carers, the projects resulted in a greater range of options and increased continuity of care. For the wider system, the projects achieved significant structural and cultural change. Cost-wise, there were no increases in expenditure, and even some reductions. Many of the lessons from the projects (and their evaluations) may be generalised to other mental health settings and beyond.

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Kathy Eagar, PhD, Director

Alan Owen, Senior Research Fellow

Natasha Posner, PhD, Senior Research Fellow

Centre for Health Service Development, Faculty of Commerce, University of Wollongong, Wollongong, NSW.

Jane E Pirkis, PhD, Principal Research Fellow

Program Evaluation Unit, School of Population Health, University of Melbourne, Carlton, VIC.

Philip M Burgess, PhD, FAPS, Professor, Mental Health Services Research

School of Population Health, University of Queensland, Richlands, QLD.

David A Perkins, PhD, Director

Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven, School of Public Health and Community Medicine, University of New South Wales, Sydney, NSW.

Correspondence: Professor Kathy Eagar, Centre for Health Service Development, Faculty of Commerce, University of Wollongong, Northfields Ave, Wollongong, NSW 2522.
keagar@uow.edu.au

What is known about the topic?

Integrated service delivery among public and private and specialist and primary care providers within the mental health system has been difficult.

What does this study add?

This study has shown that without additional funding it is possible to encourage greater collaboration among the various mental health service providers.

What are the implications for practice?

Service integration requires detailed planning at the local level that is most effective with leadership that encourages the necessary structural and cultural changes.

IN AUSTRALIA, MENTAL HEALTH CARE delivery involves a range of providers. These include public sector mental health services, funded by state or territory health departments, and private psychiatrists and general practitioners (GPs), funded federally. In addition, there are non-government organisations (NGOs) which may be funded from either source, depending on their remit.¹ As with other areas of health, the differing sources of funding create duplication and gaps, opportunities for cost-shifting, and tensions between public and private sector services and providers.

In addition to differing in terms of funding sources, the public and private sectors differ in their approaches to treatment and support, and their service cultures. There are often difficulties in engaging private practitioners to provide services for consumers who are treated predominantly in the public sector, and, conversely, public sector services do not tend to give priority to consumers who are being seen in the private sector. Together, these factors result in a system that is fragmented and often difficult for consumers and carers to

negotiate. Poor integration between services is not a new issue; solutions have been sought in other sectors and other countries.² To date, however, none has been successfully applied to the Australian mental health sector. This paper describes an initiative known as the Mental Health Integration Program (MHIP), which explored approaches to improving linkages between disparate parts of the mental health system.

The policy context

In the last decade, major policy reforms in Australia's mental health sector have occurred under the National Mental Health Strategy. The Strategy has been operationalised in three National Mental Health Plans to date.³⁻⁵ The first plan, which covered the period from 1992 to 1997, was largely focused on reforms to the specialist public mental health sector (eg, increases in community-based care, decreases in stand-alone psychiatric hospitals, "mainstreaming" of acute beds into general hospitals). Under the second plan, which took the strategy forward from 1998 until 2003, far greater emphasis was given to the private mental health sector, and the complementary role it plays to the public sector. Fostering partnerships between the two sectors was a priority of the second plan and remains so in the new plan (2003–2008).

The Mental Health Integration Program

Among a range of initiatives aimed at improving the linkages between the public and private mental health sectors under the second plan, the (then) Commonwealth Department of Health and Aged Care (DHAC) provided MHIP funding for demonstration projects in 1999. The aim of these projects was to establish and document approaches to improving formal linkages between private psychiatrist services and public sector mental health services. Their overall purpose was to create a more flexible integrated framework within which mental health services can be delivered, to improve outcomes within available resources for the consumers of those services.

It was initially anticipated that three or more projects would be established, covering a mix of urban, regional and rural areas. The basic model for the proposed projects was one in which public sector mental health services, private psychiatrists and private psychiatric hospitals developed collaborative approaches to cater for the mental health needs of a defined population in a given area (possibly, but not necessarily, involving pooling of public sector mental health funding with Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) expenditure associated with private psychiatrists). As the projects went through their phases from planning to "wind-down", they were expected to consider the sustainability of their reforms, not just the efficacy of their interventions. As time went on, it became apparent that there should also be capacity to expand the model to include local GPs and non-government organisations.

Projects proceeding beyond the submission of an expression of interest were implemented in three phases. Initially, projects were given funding for a 6-month planning phase, after which they were required to submit a detailed implementation plan. This required settling on a specific model and securing the commitment of a wide group of stakeholders (including the signing of tripartite agreements between the Commonwealth, the given state, and the organisation responsible for the project). If satisfactory progress was made during the design phase, funding was provided for a "live", 2-year implementation phase. The wind-down phase involved consideration of how to sustain gains made during implementation.

In total, 29 projects were proposed. Six were selected to progress to the planning phase, three of which went on to the implementation phase: Inner Urban East Melbourne (Partnership Project), Illawarra (Mental Health Integration Project) and Far West NSW (Mental Health Integration Project).

During the implementation phase, projects received up to three streams of funding. "Cashed out" project funds were derived from the area public mental health sector budget and the previ-

ous 2 years of MBS fees paid for services provided by participating psychiatrists. “Cashed up” project funds were provided in the event that service utilisation (of public sector services and/or private psychiatrists’ services) by residents living in the area was below the national average, in order to bring the total project funding up to the national average. The rationale for this approach was that there were two sources of inequities inherent in the system, which reflected differently in different settings: the MBS contribution to an area is determined by where providers work; and not all state monies for mental health are distributed equitably. It was not realistic to expect an area to be a national demonstration site with below-average funds. “Project management” funds were additional, time-limited monies provided for conducting the project (including funding for project management and evaluation). All projects received cashed out project funds and project management funds; the Illawarra and Far West NSW projects received cashed up project funds as well.

A National Reference Group was established to advise and support all MHIP projects. The Centre for Health Service Development at the University of Wollongong was engaged as a National Design Team, to provide technical assistance regarding the implementation of the projects, and to develop a national evaluation framework to provide some guidance for local evaluations.

The three projects

Inner Urban East Melbourne

The Inner Urban East Melbourne project was implemented between September 2000 and August 2002 in Yarra/Boroondara, where the number of private psychiatrists per capita is high by national standards, and a range of public sector mental health services is available.⁶ It was originally a joint initiative of St Vincent’s Mental Health Service (SVMHS) and The Melbourne Clinic that targeted adults aged 16–64 years. St George’s Aged Psychiatry Service became a collaborator when it became apparent that the model could potentially benefit older consumers. It aimed to improve the linkages between public

sector mental health services and private psychiatrists and GPs, and produce better outcomes for consumers.

The project had two major components:

- a Linkage Unit that was responsible for fostering collaboration between the public and private sectors (eg, facilitating shared care arrangements) and promoting cultural and systems-level change; and
- a series of trial item numbers which, like those in the MBS, were based on duration and location of service, and which allowed private psychiatrists to be remunerated for participating in expanded roles (specifically, supervision and training, case conferencing and secondary consultations).

Illawarra

The live phase of the Illawarra project ran from July 2001 to June 2003 and served a region that has consistently been under-resourced, and has experienced particular difficulties in meeting the needs of certain consumer groups (eg, those with long-term psychiatric disability, children and adolescents, older people).⁷ The project was an initiative of the Illawarra Area Health Service and aimed to provide a more comprehensive, coordinated system of mental health care for a broad range of consumers. It involved enhancing existing integration between different streams of the system, as well as developing a number of innovative, collaborative partnerships between private psychiatrists, GPs, NGOs (eg, consumer and carer support and advocacy organisations) and the public mental health system.

The project involved a series of 21 subprojects, 14 from the original proposal and seven developed during the course of the project. These subprojects contributed in different ways to integration at the service and system levels. The project modelled integration in bits rather than as a whole process, set of processes or structure. It demonstrated ways of doing things (such as supporting GPs), rather than modelling an integrated system as such, and developed into a model of “local commissioning”. This approach was easily adaptable in a situation where the project budget was underspent and the

region historically underfunded. Its drawback was that the bits of scaffolding that were erected (the various subprojects designed to fill obvious service gaps) were more vulnerable to disintegration through lack of financial or other support and connection.

In parallel, the Illawarra Mental Health Service underwent its own strategic planning process. The project and the strategic plan influenced each other and reinforced the direction of developments, such as the greater involvement of consumers, and collaborations with NGOs.

Far West NSW

The Far West NSW project was conducted from January 2002 onwards by the Far West Area Health Service, which serves a large, remote geographical area with a scattered population, few public and private sector mental health services, and a high turnover of providers.⁸ The area is divided into four sectors, each of which comprises a number of towns and communities. All of these have health services that provide generalist care. Four towns (one in each sector) are designated “hubs” and have specialist services, providing support and advice to the generalist workers in the area.

The project adopted a population health approach to planning, and a primary health care model of service delivery. Specifically, visiting psychiatrists incorporated into their schedules direct clinical care of consumers, secondary consultation and supervision/training (for GPs, mental health and counselling workers, and Royal Flying Doctor Service staff), and health promotion/liaison. The services offered by visiting psychiatrists were tailored to the given community, based on its size and service profile. The project provided access to multidisciplinary mental health services to residents in locations where only generalist care was available and for whom travel to specialist services was not feasible.

Evaluation method

From the outset, DHAC had a commitment to evaluation, and each project appointed a local evaluation team. The Centre for Health Program

Evaluation (University of Melbourne), the Social Policy Research Centre (University of New South Wales), and the Centre for Equity and Primary Health Research in the Illawarra and Shoalhaven (University of New South Wales) evaluated the Inner Urban East Melbourne, Illawarra and Far West NSW projects, respectively.

The national evaluation framework provided a structure within which the local evaluations could be conducted, but recognised that a uniform local approach was neither desirable nor achievable, given the variability of project models. The framework also recognised that the projects’ complexity required that the framework itself and the local evaluations be responsive to changing demands.

The key elements of the framework were the separation of three levels of integration activities and impacts (provider, consumer and carer, and system) and the characteristics of the settings and stakeholders. At the highest level, the framework was designed so that the findings from the local evaluations could be synthesised to answer the following key questions:

- What were the impacts (for providers, consumers and carers, and the wider system) of the projects funded under MHIP? What elements of the projects facilitated or impeded these impacts?
- Did the projects represent value for money?
- Were the projects sustainable?
- Were the models adopted by the projects generalisable?
- Are lessons from the evaluation model useful elsewhere?⁹

All three local evaluations used a variety of methods to collect evidence to inform these questions, drawing on a range of quantitative data (eg, routinely collected utilisation statistics) and qualitative information (eg, survey and interview data). These methods and data sources, and the specific findings from the local evaluations have been described in detail elsewhere.^{1,6,8,10,11}

This paper draws together the findings from the local evaluations, synthesising quantitative data wherever possible, and classifying qualitative data into themes. Comparisons are made across

projects, in order to examine similarities and differences between the projects and the lessons learned from each. A full report of the evaluation synthesis is available elsewhere.¹²

Synthesis of evaluation findings: results and discussion

What were the impacts of the projects funded under MHIP? What elements of the projects facilitated or impeded these impacts?

All three projects involved careful negotiation and planning, and had strong local leadership by consortia representing different interests (including key local psychiatrists) and committed, dynamic project staff. As a result, the projects had considerable provider, consumer/carer and system impacts, highlighted below.

Impacts for providers

Box 1 shows the level of involvement of private psychiatrists in the three MHIP projects. In total, 46 psychiatrists participated. In terms of absolute numbers, the Inner Urban East Melbourne project accounted for the greatest number of psychiatrists, and the Far West NSW project the least. However, the percentage of local psychiatrists who took part in MHIP activities was an inverse function of the number of psychiatrists practising within the catchment area of the given project, with all available psychiatrists in Far West NSW participating and only 30% of those in Melbourne's Inner Urban East doing so. In both absolute and percentage terms, the Illawarra project sat between the other two.^{6,8,10,11}

In all three projects, participating private psychiatrists experienced greater levels of integration with the public mental health sector, GPs and NGOs. They were positive about improved working relationships with other providers, the chance to learn and share information, and opportunities for using different skills in the context of a new role.^{6,8,10,11}

Other providers also observed enhanced levels of integration with private psychiatrists. Many commented on their increased ability to refer consumers to private psychiatrists, to jointly share the care of consumers with private psychiatrists, and to have

I Psychiatrists' involvement in Mental Health Integration Program (MHIP) activities

| | Estimated no. of FTE psychiatrists | |
|----------------------------|------------------------------------|--------------------------------------|
| | Total no. in catchment area | No. involved in MHIP activities n(%) |
| Inner Urban East Melbourne | 105 | 32 (30) |
| Illawarra | 16 | 12 (75) |
| Far West NSW* | 2 | 2 (100) |

* Far West NSW numbers have been rounded.

the back-up of private psychiatrists for specialist advice and support. Depending on the model of integration, some providers also noted that many of these advantages were not restricted to private psychiatrists. For example, from the perspective of public sector mental health care providers, greater referral options and increased sharing of care also applied to GPs and NGOs.^{6,8,10,11}

Impacts for consumers and carers

Consumers and carers across the three projects commented on the benefits of their involvement in steering committees and advisory groups, noting that their input was respected and helped to shape the projects in positive ways. They were more cautious about describing the impact for consumers and carers at a grass roots level. There was an acknowledgement that the MHIP projects provided a greater range of options for consumers and carers and increased continuity of care. For example, the employment of consumers as rehabilitation assistants in the Illawarra was viewed positively by consumers (and providers). However, these advantages were not experienced across the board.^{6,8,10,11}

In addition to the qualitative evaluation of the impact for consumers and carers, public sector providers in two of the projects collected consumer outcome measures, data from which are reported in their individual evaluation reports. It was not possible to synthesise these results here, as differ-

ent measures were used by different projects and subprojects. However, it is fair to say that the data pointed to positive outcomes for consumers. So, for example, in the Illawarra project, consumers experienced reductions in symptomatology and improvements in levels of functioning during episodes of care rendered during the life of the project.¹¹

Impacts for the wider system

The MHIP projects successfully promoted collaborations between private psychiatrists, the public mental health sector, GPs and NGOs. In doing so, they improved integration between key elements of the mental health sector and, to a greater or lesser extent, forged links with the wider community support sector.

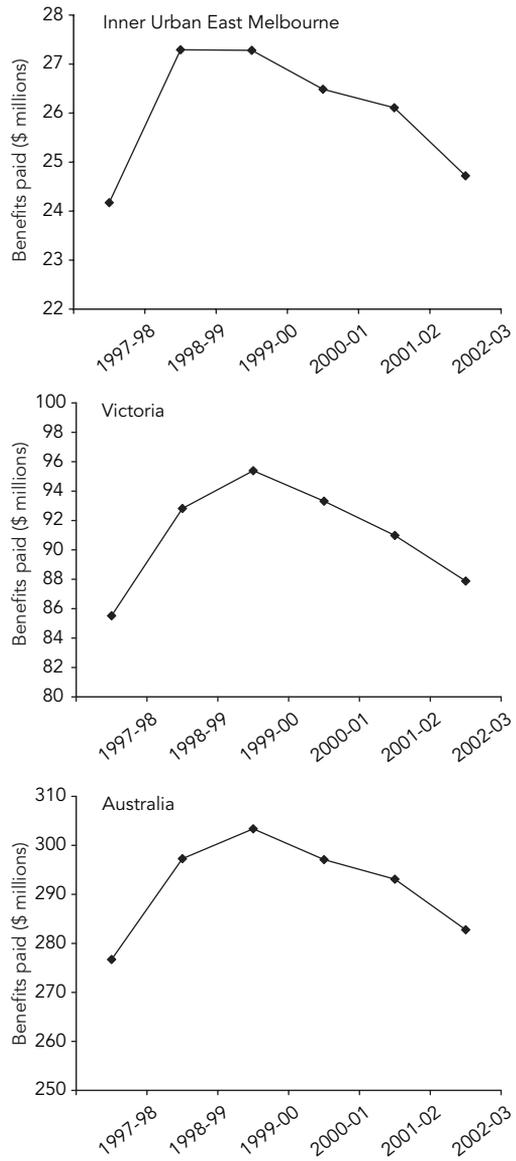
In promoting integration and coordination within and across sectors the projects achieved significant systemic changes, often within a broader change process (eg, a strategic planning process that was occurring simultaneously in Illawarra). The projects established structures and processes to facilitate integration, such as new and/or improved referral/booking systems, communication channels, and payment mechanisms for psychiatrists and others. These systems required thoughtful design, as they needed to operate smoothly to engage and maintain providers' commitment.^{6,8,10,11}

Perhaps more importantly, the projects also achieved major cultural changes. In the Inner Urban East Melbourne project, for example, cultural changes were seen to be the most significant of the gains made. These changes had sizeable impacts in terms of how private psychiatrists viewed the public mental health sector, GPs and NGOs, increasing their comfort with and understanding of these other providers. Likewise, they made a difference to how many public sector mental health clinicians, GPs and NGOs approached their work, offering them the chance to think about collaboration with and referral to private psychiatrists and other providers.^{6,8,10,11}

Did the projects represent value for money?

The costs of the projects were calculated using Health Insurance Commission (HIC) data on benefits paid for services provided by psychiatrists to

2 HIC benefits paid for services provided by psychiatrists to any consumer, and by GPs to consumers who had seen a psychiatrist in the same year, 1997–98 to 2002–03 (Inner Urban East Melbourne, Victoria and Australia)



any consumer and by GPs to consumers who had seen a psychiatrist between 1997–98 and 2002–

03. Psychiatrists and GPs were restricted to those practising within the given project's catchment; consumers could potentially come from outside the catchment. For comparison purposes, equivalent data were provided for Victoria, New South Wales and Australia. All costs were expressed as constant 2003 prices, using deflators from the Australian Bureau of Statistics (Implicit Price Deflators – Gross Non-Farm Product).¹²

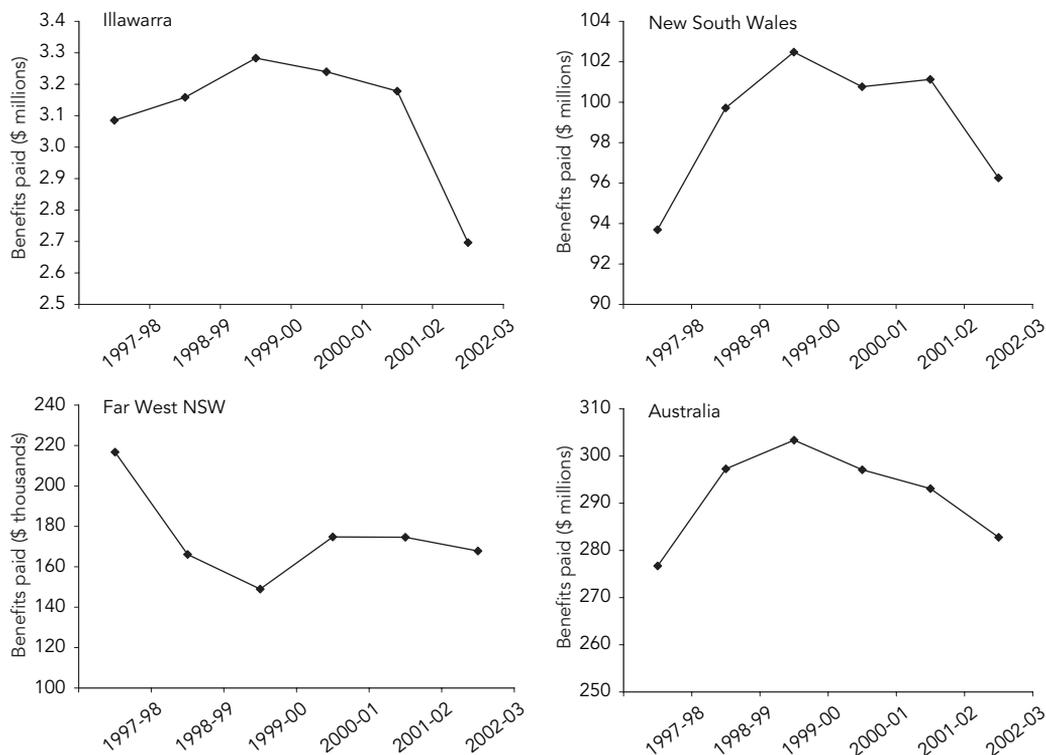
Box 2 and Box 3 show the raw results for the Victorian project and the two NSW projects, respectively. In each case, comparison data from the relevant state and the whole of Australia are provided. Because of differences in size, different scales are used in each of the graphs.

Box 4 presents the same results in terms of the annual percentage change in HIC benefits paid for the above services, relative to the base year of

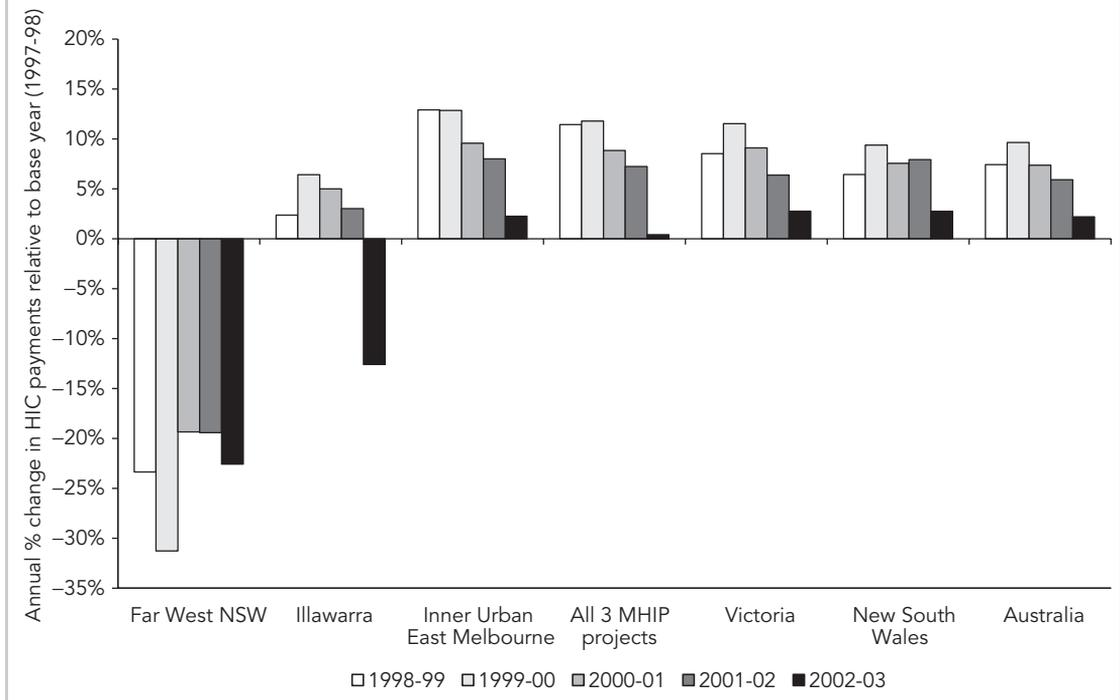
1997–98. Melbourne's Inner Urban East experienced an increase in HIC benefits paid in the early part of the period under study, which then levelled out and declined. The decline corresponded with the start of the Inner Urban East Melbourne project, and continued for its duration and beyond. After a period of considerable stability, Illawarra experienced a significant decline in HIC benefits paid towards the end of the period examined. This decline was most apparent during the latter part of the Illawarra project. Far West NSW experienced a sharp decline in HIC benefits paid, followed by an increase. A plateauing occurred during the Far West NSW project, with expenditure being relatively constant and never reaching the earlier high.¹²

These findings are positive, as they suggest that at worst there were no increases in HIC expenditure

3 HIC benefits paid for services provided by psychiatrists to any consumer, and by GPs to consumers who had seen a psychiatrist in the same year, 1997–98 to 2002–03 (Illawarra, Far West NSW, NSW and Australia)



4 Annual percentage change in HIC benefits paid for services provided by psychiatrists to any consumer, and by GPs to consumers who had seen a psychiatrist in the same year, relative to base year (1997-98)



that occurred alongside the MHIP initiative, and at best there were reductions. Some caution should be exercised in interpreting these findings, since without more complex trend analyses it is not possible to causally attribute the declines in HIC expenditure to the projects. Having said this, it is worth noting that the local profiles of HIC expenditure occurred within a secular trend of considerable stability, as is evidenced by the flat expenditure curves for Victoria, New South Wales and Australia.

In interpreting these results, it is useful to compare them with other similar national initiatives, the most relevant being the first round National Coordinated Care Trials (CCTs) for people with chronic health conditions and/or complex care needs. These involved enrolling specific individuals and pooling both national and state funds.¹³ The CCTs achieved good consumer outcomes, but not within existing resources. By contrast, the MHIP projects demonstrated good system-level

outcomes (and, in many cases, consumer-level and provider-level outcomes) that were largely achieved within existing resources. MHIP and the CCTs had different emphases, with the former focusing on the integration of services for population groups and the latter on planning for the care needs of individuals, so comparisons should be treated cautiously. Arguably, however, MHIP represented better value for money than the CCTs.

Having said this, it is important to note that it was beyond the scope of the local evaluations to conduct cost-effectiveness analyses. This would have required systematic data to be collected on consumer outcomes as well as costs, and a base case for comparison. The costs were relatively easy to calculate, but, as noted above, the data on outcomes were complex and could not be easily aggregated across projects. In general terms, the costs were contained and the outcomes for consumers appeared to be positive, but it is not

possible to quantify the relationship between costs and outcomes more definitively.

Were the projects sustainable?

The evaluations considered sustainability at the beginning, middle and end of each project. They noted that at the beginning of all projects considerable effort went into brokering agreements between relevant parties to ensure ongoing commitment and to maximise the likelihood of success. In the two NSW projects, cashing out at the level of the national average of Commonwealth outlays and state resource distribution formula shares resulted in a fairer share of resources and therefore a reasonable test of their respective models. Commonwealth–state negotiations reached a measure of agreement on continued funding where the models showed promise, which augured well for lasting change. Key informants in all evaluations observed that continued economic support would be required for the gains to be continued.

The evaluations explored the significant structural and cultural shifts during the life of the projects, acknowledging these factors as key underpinnings of sustainability.¹⁴ As noted, the projects demonstrated different ways to promote mutual respect and understanding between private psychiatrists and public sector mental health services (and others), and to facilitate clear channels of communication between parties. As a result, integration was viewed as a process of collaboration between complementary parts of a bigger system, rather than, as was initially feared by some, an attempt to merge different sectors. The separate evaluations concluded that these structural and cultural changes were necessary but not sufficient conditions for sustainability and that achieving a better integrated system is an ongoing process.^{1,6,8,10,11} The momentum for change would need to be kept up, and that meant taking the lessons from MHIP further at national and state levels, as well as within local governance structures.

The evaluations were positive about the efforts made by projects to ensure sustainability during wind-down. Specifically, the “exit strategies” of projects were commended for giving careful consideration to how their functions could be contin-

ued. The Inner Urban East Melbourne project, for example, considered how the role of the Linkage Unit could be absorbed under the broader infrastructure of SVMHS and how private psychiatrists and GPs could maintain their input.

However, the proof of the pudding will be in the eating. Anecdotal reports suggest that some elements of the projects have continued beyond their respective lifetimes. To continue with the example of the Inner Urban East Melbourne project, SVMHS has maintained ongoing collaboration with private psychiatrists and GPs through their representation on shared care committees. A systematic revisiting of all three projects to ascertain the extent to which efforts put in place through the projects have actually been sustained in the absence of specific project funding would clearly be desirable.

Were the models adopted by the projects generalisable?

The evaluations of all three projects considered their generalisability, typically inviting key informants to comment on aspects that could work elsewhere. Evidence from the Inner Urban East Melbourne project suggests that both the Linkage Unit model and the expanded activities for private psychiatrists would be suitable for regions with high concentrations of private psychiatrists (and GPs), a well-developed public mental health service, and appropriate payment mechanisms (eg, MBS item numbers). In the Illawarra project, several subprojects showed promise for transferability to other contexts, namely the Clozapine Shared Care Pilot, Consumers Working as Rehabilitation Assistants, Continuity of Care and St Vincent de Paul project, the Visiting Medical Officer (VMO) Linkage Clinic, the GP VMOs in Community Mental Health Teams approach and the Lifeline South Coast partnership. The hub approach implemented in Far West NSW also had potential in terms of generalisability, particularly for remote regions, subject to the negotiation of suitable cashing out arrangements for MBS funding.

More generally, the evaluations commented on features of the MHIP projects that were necessary conditions of generalisability. A common theme

was that the flexibility of funding arrangements in the MHIP projects gave providers (and service planners) opportunities to work outside the conventional funding boundaries. It allowed funding to be freed for reimbursement of activities not currently covered by the MBS and infrastructure changes to provide better services, particularly in underserved areas. Fee-for-service funding tends to fragment and run counter to integration because the organisational and administrative costs of meetings and secondary levels of activity that are crucial to good collaboration cannot be built in easily. The complex nature of the tasks involved and the scale of the infrastructure and skills needed to successfully manage the projects meant that a dominant public sector role was vital.

Several other elements that augured well for the generalisability of the MHIP projects were also highlighted in the evaluations. These included: the attention to communication, consultation and culture change; the active participation, as equal partners, of consumers and carers in planning and implementation; and the leadership of key psychiatrists in driving culture change within the profession.

Are lessons from the evaluation model useful elsewhere?

As noted, the MHIP projects were evaluated by separate local evaluation teams, within the context of a national evaluation framework that then synthesised the findings.¹² This model made sense in the context of an initiative that involved complex systemic and cultural changes, via projects that were not conducive to evaluation by controlled trials but instead required the evaluators to collect different kinds of data from multiple sources. It would not have been possible for one national evaluator to come to terms with the complexities of the various projects. Since other areas in the health sector are also implementing projects aimed at improving linkages between different services (eg, the Coordinated Care Trials), there may be useful lessons in this evaluation model. Experience in the current context suggests that: (a) projects need to be designed with the active participation of evaluators, or by designers who are clear about how their objectives will be measured; (b) it may be neces-

sary to focus on process and intermediate outcomes before understanding final outputs and outcomes; (c) consumers and carers must be a key part of the intervention and of the evaluation; (d) a constructive partnership with project management and staff is vital if the evaluation is to be of any use or credibility; and (e) evaluations like these require long-term partnerships — fly-in evaluation methods do not work.

Key messages

The MHIP initiative has scratched the surface of the integration agenda and provides further evidence of why integration needs to remain a priority issue. Ten key messages emerged from the evaluations of the MHIP projects:

Key message 1: Improving integration is hard but possible

Each of the three projects achieved important and positive outcomes and demonstrated that, given attention to careful planning and support structures, it is possible to improve the integration between public sector mental health services, private psychiatrists, GPs and NGOs. However, these changes did not occur easily. Even with the injection of large amounts of money for planning to galvanise action, and the flexibility created through pooled funding, changes in workforce practices required enormous efforts on the part of the project teams and their allies. Three projects did not proceed beyond the planning phase, providing further evidence of the practical challenges in achieving a better integrated system.

Key message 2: Improved integration can only occur in the context of structural and cultural change

Structural and cultural change is necessary, though not sufficient, for improved integration. Without such change, improvements in collaboration across sectors cannot occur.

Key message 3: Integration needs to be planned at the local area level

Funding an extensive planning phase was a good use of resources, as it meant that the live phase of

the successful projects had the greatest chance of succeeding.

Key message 4: System-level integration is required within the specialist mental health sector and beyond

Initially MHIP focused on improving integration within the specialist mental health sector (ie, between public mental health services and private psychiatrists), but the agenda changed during the course of the initiative to include other key mental health care providers such as GPs and NGOs. The former can be regarded as public/private sector integration and the latter as specialist/primary sector integration. Ongoing efforts are needed at both levels.

Key message 5: The magnitude of change depends on the starting point

Using the metric of proportion of eligible private psychiatrists involved, the Far West NSW project achieved the greatest level of integration, and the Inner Urban East Melbourne the least. By other measures, the projects might be ranked differently, but this does illustrate the “inverse integration law”, which borrows from the work of Tudor Hart.¹⁵ Specifically, it suggests that providers in well resourced areas perceive they have less reason to work collaboratively than those working in areas with fewer resources.

Key message 6: No one model fits all

The three MHIP projects employed very different models, as a result of their being tailored to their local context. The funding initiative actively encouraged this, recognising that the ways to improve integration differ between areas and depend on their size, level and mix of existing resources, availability of local leaders, and existing relationships.

Key message 7: Change requires leadership

Leadership from within the profession of psychiatry is critical to driving cultural change among psychiatrists. Leadership from within the psychiatry profession is less critical (but still important) in driving culture change within mental health

services more broadly. Success was dependent on consumers and carers and non-psychiatrist mental health care providers working with their psychiatrist colleagues to drive the processes of culture change.

Key message 8: Fee-for-service arrangements are limited

Many of the successful MHIP activities would not have been possible under traditional fee-for-service arrangements. For example, fee-for-service funding would have precluded many of the services offered by private psychiatrists in the Far West NSW project.

Key message 9: Money alone does not drive change

As noted, alternatives to fee-for-service funding for direct care created an incentive for private psychiatrists to be involved in the MHIP projects and meant that their involvement did not leave them out-of-pocket. By itself, however, this would not have been enough — the activities had to be of interest to them, communication had to be clear and they had to be shown respect.

Key message 10: Changes occur in a policy context

MHIP did not occur in a vacuum, but rather in parallel with other policy developments. The most significant of these was the increasing recognition of the role of primary care providers and the need for better integration between specialist mental health services and the primary care sector. This recognition gained momentum after MHIP began, and the MHIP projects aligned themselves with this policy change, adjusting their focus to include GPs (and other primary care providers such as NGOs).

Conclusions and future directions

A more integrated health system is striven for but never completely achieved. The MHIP projects demonstrated important gains, but there is an ongoing need for initiatives and incentives to achieve better integration between the public men-

tal health sector, private psychiatrists, GPs, NGOs and others (eg, community health). The next step should not be another round of regional projects, but rather the gathering and dissemination of systematic evidence on what already works in practice and how it can be rolled out to settings where integration is poor. This exercise should glean information from the MHIP regions in their role as national demonstration sites (including evaluation of the extent to which the achievements of the projects have been sustained), but should also be broader, exploring innovations occurring elsewhere and drawing on national and international literature as relevant. The learnings from MHIP form a solid basis for further integration work, but there is still much to be done.

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Competing interests

None identified.

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