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I. ESSAY

Observations From The Program On Chronic Mental Illness

by Miles F. Shore and Martin D. Cohen

The Robert Wood Johnson Foundation (RWJF) Program on Chronic Mental Illness has come to an end. Launched in December 1986, it was the foundation’s first multisite national venture into mental health care. The program sought to establish improved systems of care for persons with serious and long-term mental disorders in nine major cities across the country. Now, almost six years later, the grant period has ended, and it is time to take stock. The nine demonstration programs are still intact, with more than 250 staff in place at the sites. Throughout the program’s lifetime it received $22.5 million in RWJF grant funds, $9 million in foundation loan funds to stimulate housing development, and 1,200 Section 8 housing certificates, issued by the U.S. Department of Housing and Urban Development (HUD).

One view of the impact of this program is offered by Howard Goldman and his colleagues, based on a formal evaluation funded by RWJF and a consortium of federal agencies.’ But there is another view of the program’s impact: the subjective impressions of the national program office staff and the staff at the nine demonstration sites. This perspective has been enriched by RWJF’s style of grant management, which is to fund a partnership between the national program office (typically in a university) and the demonstration sites. Instead of awarding the grant and coming back later to assess the results, RWJF requires that each demonstration site develop its program in collaboration with the national program staff. The national office maintains constant contact with the sites to monitor progress and solve immediate problems and carries out numerous site visits, with special conferences among the sites and other direct contact as needed. This management style affords the national program staff an intimate view of the demonstration sites and an opportunity to compare them as they face common situations.

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The System Of Care

The most unusual feature of the RWJF Program on Chronic Mental Illness was its emphasis on the system of care. Most innovations in mental health services over the past twenty years have involved new treatment approaches or individual components of service systems. This program requested grant proposals to create a single organization with administrative, fiscal, and clinical authority for citywide mental health services. This focus was chosen to respond to a major flaw in the community mental health legislation of the mid-1960s—namely, the requirement that services be organized and delivered within urban “catchment areas” of 75,000 to 200,000 persons. The National Institute of Mental Health (NIMH) insisted on this approach despite the protests of city mental health planners, who were concerned that these catchment areas would not coincide with natural communities and, further, that some patients would fall through the cracks.

Critics of the NIMH approach were right: The community mental health model did not fit large cities. As a result, urban mental health centers had great difficulty in realizing their full potential, and the whole model was unfairly impugned on that basis. In fact, it was the failure of city systems to take care of the homeless mentally ill that persuaded RWJF’s staff to recommend that the foundation launch this initiative.

The other impetus for the program was the failure of public agencies to provide incentives for innovation and sound management. A recurring lament of the leadership in public mental health systems is the encrustation of administrative and fiscal procedures that inhibit creativity, make it difficult to respond to changing service needs, and reward poor performance. The Program on Chronic Mental Illness sought to preserve the public accountability that is essential when using public funds, while creating systems that would be free to operate flexibly within the private sector. These new systems would combine funding streams to create alternatives to inpatient care, experiment with capitation and other funding innovations, break out of restrictive civil service categories to hire essential staff and pay competitive wages, and develop housing in the private market. Most significantly for clinical care, the various elements of the service system would be organized under one clinical authority to minimize boundaries between service elements and thus reduce turf battles over patients.

We are frequently asked which of the nine systems succeeded. The answer is that all of them succeeded in developing components that could be usefully replicated in other cities; no one project attained perfection in all details, however. In general, clinicians and consumers
of services in the nine sites agreed that having an integrated system with multiple linked services was highly satisfactory. Asked to comment on the accomplishments of the program, most consumers mentioned that having a personal case manager was most important to them, with housing a close second. Clinicians were enthusiastic about the advantages of practicing in a system that made a variety of services easily available so that they could follow clients through a course of treatment without a break in care. This was especially true of seasoned clinicians who had previously struggled with discontinuous services and fragmented systems of care.

The most glaring failure of all nine sites was the inability to integrate community services fully with the inpatient service of last resort—in most cases, the state hospital. Some partially successful efforts are still continuing and may ultimately succeed. Still, the gap between the local authority operating the community system and the state mental health authority in charge of the state hospital was too wide to be bridged during the five-year grant period. The failure was surrounded by a bodyguard of rationalizations: lack of trust in the level of clinical expertise in the community system; the reluctance of community clinicians to care for the most seriously ill patients; accusations on the one hand that the state hospital was too paternalistic to let go of patients, and on the other that community programs failed to become involved in discharge planning early enough and were insufficiently aggressive in stabilizing discharged patients. Although there may have been some truth in all of these assertions, the basic problem was one of system organization. In none of the sites was it possible to achieve a single point of clinical responsibility and authority to cover both the community and the state hospital. In all nine sites, however, the movement is clearly in this direction, with the three programs in Ohio leading the way.

**Leadership**

Structural elements were important in contributing to success or failure, but there were other factors as well. Among the most prominent was leadership. Although the sites eventually ended up with outstanding project directors, finding them was not an easy task. At the beginning, there were nine project directorships available, which were advertised nationally as well as locally. The jobs had many attractive features: the opportunity to influence important national policy questions, interaction with the foundation and the other sites, negotiable salary, and desirable working conditions. Yet there were very few applicants, and fewer still who were highly qualified.
This difficulty highlights a national problem in the mental health field. Only rarely are administrative skills and experience combined with clinical expertise—that is, “knowing the business.” To function well as a mental health clinician requires the capacity to listen and to assume a relatively passive stance; to be a successful leader requires the capacity to take charge and to be constructively aggressive. The difficulty in finding strong leadership in the mental health field may be related to this lack of fit between modal personality type in clinical work and the requirements of leadership. Moreover, opportunities to prepare for leadership roles in mental health are few in either professional training or continuing education. Fostering such leadership should be a continuing responsibility of foundations, government agencies, and educational institutions.

The Politics Of Change

Throughout this demonstration, we have observed that creating systems of care for people with serious mental illness is as much a matter of applied political science as it is a matter of mental health. As in electoral politics, various constituency groups in the mental health community look for their “piece of the pie” as change is discussed. While clinical concerns have their place, they are often outweighed by questions of organizational survival, agency budget size, and such personal concerns as jobs, salaries and benefits, and professional status. For the communities participating in the Program on Chronic Mental Illness, these varied interests reinforced the need to ensure that all participants in the mental health system—families, consumers, providers, unions, bureaucrats, and clinicians—work together to plan and implement change. In Denver, for example, the merging of four mental health centers into a single operating authority required commitments and concessions from each group. Intense negotiations on such issues as job security, benefits, and service location occupied a great deal of the project staffs time.

Introducing change in public mental health systems also requires political support from state and local leaders. Cosponsorship of the Program on Chronic Mental Illness by the National Association of Governors, the National Association of Counties, the U.S. Conference of Mayors, and the Conference of State Legislators helped to mobilize these forces when needed. In addition, approval of each site’s initial proposal by key elected officials—the mayor, county manager, and governor—ensured local political investment in the project, which could be called on at a later time if necessary. In many of the sites, plans would have been stalled without a clear demonstration of political interest and, in a few cases, direct intervention by key leaders.
Transplanting The Findings

Two early findings during the application process were (1) that public mental health systems tend to arise *sui generis*, unrooted in research or professional experience, and (2) that mental health staff tend to regard their own programs as unique. Of course, some mental health service innovations have been adopted widely—for example, the NIMH Community Support Program, the Program of Assertive Community Treatment (PACT) model, and the “Fountain House” social club model. But generally, even a single program innovation is difficult to transplant. System innovations that require large-scale change involving many agencies in both the public and private sectors are even more difficult to disseminate.

Communications became an important component of the Program on Chronic Mental Illness. The Robert Wood Johnson Foundation, challenged by the opportunity to have an impact beyond the nine demonstration sites, supported the hiring of a communications director and the development of several communications tools, including a bimonthly newsletter, a national survey of attitudes toward people with mental illness, and site reports circulated to a national audience of policymakers, administrators, clinicians, and consumers and their families.

This effort has highlighted the need for targeted dissemination—social marketing—to reach groups that have an essential role in the formation of mental health policy: national agencies, such as NIMH, the Health Care Financing Administration, and the Social Security Administration; state mental health program directors; state legislative staff; and advocacy and consumer groups, such as the National Alliance for the Mentally Ill (NAMI) and its state chapters. How focused, sustained, and elaborate such a dissemination effort should be remains unclear. What is clear is the necessity to develop a new approach to dissemination, recognizing that good works, ingenuity, and even publication in peer-reviewed journals will not necessarily be enough to promote change in other quarters.

Was This Demonstration Worth It?

A vital question for The Robert Wood Johnson Foundation and for the other funders is, Was this demonstration worth it? It is also important to the many individuals who devoted years of effort to the enterprise. The feedback that we have received from staff at each site indicates that the answer is yes. All sites reported marked change for the better in their systems of care—change that has been of tangible benefit
to consumers.

Timing and history necessarily play a role in the outcome. Because the Program on Chronic Mental Illness came into being at a time when a host of health and public services were being rethought, some of its findings may be adopted. In any case, this initiative, like all mental health demonstrations, underscores the need to review, renew, and in many cases reinvent the complex systems that serve persons with such demanding and disabling disorders as chronic mental illness.

The initiative also shows that much can happen, even with a relatively small investment of funds. RWJF funds were leveraged roughly three to one by HUD’s commitment of 125 Section 8 vouchers per site. Compared with the total amount of money from all sources devoted to mental health services in any one of the sites, the foundation’s commitment was very small—on the order of 2 percent, including the allocated cost of grant management and technical assistance by the national program office.

Several factors made this relatively small investment work. First, the program had the “Good Housekeeping Seal of Approval,”—the sites had the prestige of succeeding in a national competition for a grant from a highly regarded foundation. Second, the projects attracted considerable ongoing public attention, not simply momentary fame. Third, the grants were two-stage awards—each site was revisited after two years to make sure that its amount of progress justified continued funding. Fourth, the sites enjoyed considerable flexibility in using the foundation grants, in sharp contrast to the rigidity of public funding. Finally, technical assistance played an important part. There was close interaction between the national program office and the sites. There is little question that the projects evolved in very different directions—and most would say in more successful directions—than they would have if the sites had not had this level of assistance.

At the same time, there are potential yields on RWJF’s investment that may go unharvested. First, in the later stages of the demonstration, the national program office identified a number of areas that could be developed with continued, centrally organized technical assistance, to capitalize on the relationships already developed with and among the sites. Examples are clinical care (case conferences with case managers identified the need for greater sophistication in diagnosis and management) and fiscal reform and innovation.

A second potential yield is the systematic gathering of information that can be disseminated to other city and state programs across the country as the systems evolve further. There is a danger, however, that without continued cross-pollination from the nine sites, the impact of
the demonstration will dissipate. While no foundation wishes to tie up its funds in a few projects for long periods of time, projects of this magnitude and complexity may need more than five years to deliver their full impact.

Impact On The Foundation

From the perspective of the national program office, this venture into mental illness treatment appears to have influenced The Robert Wood Johnson Foundation in several respects. First, the foundation has enumerated a new set of priorities that offer ample room for projects related to mental illness. Chronic care, access to services, substance abuse, and costs of care are all central issues in the mental health field that deserve to be addressed in services research and future demonstration projects. The foundation’s interest and sophistication in these issues and in the field of mental health are substantially greater than they were six years ago. Second, the foundation’s commitment to system organization, particularly to the integration of services and funding, is now central to a number of health care issues being addressed by its programs. Third, the foundation’s success in developing joint ventures with HUD and other federal agencies in this demonstration program has already led to other partnerships with government entities. These collaborations may hold the key to new directions and consequent contributions to policy change in various areas of health care, including mental health care.

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