To Subscribe:  https://fulfillment.healthaffairs.org
LESSONS FROM THE PROGRAM ON CHRONIC MENTAL ILLNESS


Prologue: In 1986 The Robert Wood Johnson Foundation awarded the first grants under its Program on Chronic Mental Illness, which funded service demonstrations in nine cities to combine scattered services for the mentally ill into a central authority. Since then, the program’s multidisciplinary national evaluation team, led by Howard Goldman, has been collecting data and anecdotal evidence on the program’s impact in the nine cities. Although the final data will not be available until the end of 1992, Goldman and his colleagues offer this “evaluation without the numbers.” They are convinced, Goldman states, that the program’s greatest significance has already been realized: “that the problem of caring for individuals with severe and persistent mental illness has remained part of the public consciousness and has been placed before the mainstream of health and social policymakers.” Goldman, who is principal investigator for the program evaluation, is professor of psychiatry and director of the Mental Health Policy Studies Program at the University of Maryland School of Medicine in Baltimore. Joseph Morrissey is professor of social medicine at the University of North Carolina at Chapel Hill. Susan Ridgely is a research associate and associate director of the Mental Health Policy Studies Program at the University of Maryland. Richard Frank is professor of health economics in the Department of Health Policy and Management, School of Hygiene and Public Health, The Johns Hopkins University, in Baltimore. Sandra Newman is a research professor and associate director for research at the Johns Hopkins Institute for Policy Studies. Cille Kennedy is a research psychologist at the National Institute of Mental Health.
In late 1985 The Robert Wood Johnson Foundation (RWJF) announced the Program on Chronic Mental Illness, a service demonstration designed to “help the chronically mentally ill function more effectively in their everyday lives.” In November 1986 the foundation provided $29 million in competitive grants over five years to nine cities (Austin, Texas; Baltimore; Charlotte, North Carolina; Cincinnati, Columbus, and Toledo, Ohio; Denver; Honolulu; and Philadelphia) to transform their mental health systems. Grantees were expected to centralize administrative, fiscal, and clinical responsibility in a single mental health authority that would, in turn, expand the availability of services and resources, including housing opportunities. The foundation provided a low-interest loan of $1 million to each site to facilitate the development of housing, and the U.S. Department of Housing and Urban Development (HUD) provided each participating city with Section 8 rent subsidies (valued at $75–$80 million) to help individual clients of the mental health system to live in their own homes.

The foundation established a program office in Boston at the Massachusetts Mental Health Center at Harvard Medical School, directed by Miles Shore and his deputy, Martin Cohen. The foundation and the National Institute of Mental Health (NIMH) also provided six-year grants to a group of collaborating investigators from several universities, coordinated by the University of Maryland Center for Mental Health Services Research, to design and conduct an independent evaluation of the program. Several papers published in 1990 presented preliminary observations by the directors of the program and by the evaluators, including a detailed description of the evaluation research design. The evaluation relies on a wealth of data collected longitudinally and cross-sectionally throughout the period of the demonstration. Data are being collected from key informants in every site and from clients and family members in selected sites to assess the impact of the demonstration. Although those data will not be available until late 1992, there are ample qualitative observations to share with planners and policymakers. The observations that form the basis of this policy analysis were made on three waves of site visits (in 1987, 1989, and 1991), during numerous interviews with participants, and from a review of documents.

This paper locates the RWJF Program on Chronic Mental Illness in the context of other efforts to develop systems of care for individuals with severe and persistent mental illness and examines the program's impact on mental health care system reform. Our analysis examines federal, state, and local aspects of the demonstration, assessing the relative contribution and role of each level of government and the private sector. It also looks at the feasibility of implementing systems...
changes in other communities. Finally, it hints at some early lessons for health care financing and housing policy. More detailed findings on these matters, as well as on the impact of the demonstration on individuals with severe mental disability, will be the subject of future reports.

---

**Impact On System Reform**

The RWJF Program on Chronic Mental Illness began about a decade into the “fourth cycle of reform” in mental health policy, a period of recognition of the breadth of the social problems associated with severe and persistent mental illness. Three prior periods of reform had focused on the prevention of chronic illness through early treatment of acute cases. Beginning in the mid-1970s, the new reform movement focused on the welfare and rehabilitation of individuals who were already disabled by severe mental illness. Reformers had developed the concept of a “community support system,” a “network of caring” designed to bring together various health, mental health, and social welfare resources on behalf of individuals with chronic mental illness. The movement was spearheaded by NIMH and its Community Support Program (CSP), which sponsored the development of state and local demonstration projects beginning in 1977. The concept proliferated with increasing financial support from state mental health agencies. The program provided leadership for the reform movement and developed community support systems, especially in towns, suburbs, and small cities. The concept and its categoric financing were central to the Mental Health Systems Act of 1980, but its almost immediate repeal by the Omnibus Budget Reconciliation Act (OBRA) of 1981 dramatically slowed the development of community support systems.

By the mid-1980s the problems associated with the care of individuals with severe and persistent mental illness had deepened, especially in large urban centers, where the CSP approach had not taken root and where homelessness was an additional problem associated with chronic illness. To make matters worse, few new resources were being pumped into the system. Furthermore, CSP deemphasized inpatient services and tended to ignore the public mental hospital system, which accounted for the lion’s share of public mental health resources and represented the most likely source of dollars to be reallocated to community programs.

The repeal of the Mental Health Systems Act, the rise of the “New Federalism,” and the retreat of NIMH from its role as a national leader in services dampened efforts for reform in the care of individuals with severe and persistent mental illness. Almost from the beginning, The Robert Wood Johnson Foundation’s interest in these issues meant that
they would not be neglected. RWJF involvement renewed hope that the gains of the new reform movement could be expanded, consolidated, and returned to the policy spotlight. From the outset, the RWJF Program on Chronic Mental Illness was guaranteed at least this level of successful impact—that the health policy community would not be able to continue its retreat from the problem of chronic mental illness.

Origins And Motivation

The basic logic of the demonstration rested on the assumptions that changes in the organization and financing of the system of care, in particular through the creation or strengthening of a local mental health authority, would lead to the development of a comprehensive system of mental health and social welfare services, which, in turn, would improve the quality of life of individuals with severe and persistent mental illness. Although clinical studies had suggested that coordination of services at the individual level could improve outcomes, there was no previous evidence that coordination at the systems level would have a similar positive effect. This was the challenge of the demonstration.

During the era of deinstitutionalization and community care, cities and counties rarely stepped forward with authority to assume responsibility for the care of individuals with severe mental illness. Typically, responsibility was fragmented among multiple providers and levels of government, including federally funded community mental health centers, private practitioners, Veterans’ Affairs (VA) facilities, state and county mental hospitals, and clinics and inpatient units in nonprofit and city-operated hospitals. In most jurisdictions the state mental health authority had primary responsibility, while city and county health or social service departments assumed a secondary role. In a few communities, however, local mental health agencies had primary responsibility. For example, in California the mental health system had been community based since the 1950s funded with a mix of state and county resources. In response to the federal community mental health center program of the 1960s and 1970s) several other local communities designated centers as responsible agencies. In Wisconsin, Michigan, and Ohio, independent mental health boards were invested with the public trust to contract for mental health services and to administer state and federal funds, as well as to raise local revenues through a millage. These local entities were thought to be more creative than a single state agency and more responsive to the needs of citizens in their communities. None of these early forms of local authority, however, fully centralized responsibility for the care of individuals with mental illness. None had
control over use of state mental hospitals; few had access to substantial inpatient resources; and few focused on individuals with severe and persistent mental illness as a priority population.

At the local level, fragmentation in services reflected the division and diffusion of responsibility. Patients were discharged from hospitals without any aftercare services, and community mental health center clients were not followed when admitted to inpatient services. Individuals with severe and persistent mental illness had difficulty obtaining housing and other social welfare resources needed to survive in noninstitutional, community settings. Although demonstrated as cost-effective, few alternatives to traditional mental health services, such as assertive community treatment teams, were available.

Compounding the problem of fragmentation, larger cities had been divided into “catchment areas” in the 1960s, each to be served by a federally funded community mental health center. Only half of the planned centers were ever funded; their federal grants declined throughout their lifetimes; and OBRA 1981 eliminated their direct funding in favor of limited block grants. Cities and counties, however, were left with a divided system. Clients of one catchment area often were unable to use services in another area. Catchment areas had become dysfunctional, impermeable boundaries, and there were few citywide services, especially in the absence of responsible local mental health authorities.

The RWJF Program on Chronic Mental Illness began with the assumption that creating an effective local mental health authority was key to solving the problems of delivering mental health services in large U.S. cities. The basic strategy was the familiar “integration of services” approach of several earlier demonstrations in mental health services, including both the community mental health centers and community support programs. Integration of services was to be enhanced by forming a public/private partnership, combining the efforts of private providers and public authorities. In some cases the mental health authority was to become a private, nonprofit entity. The demonstration focused on creating or strengthening a local mental health authority by operationalizing and centralizing its administrative, fiscal, and clinical functions. Although there were antecedents to the local mental health authority concept, there were no models that had effectively centralized these functions and had control over a comprehensive system of inpatient, residential, ambulatory, and housing services.

In addition to structural change, the foundation recognized a need for specific additional resources, in particular, housing rental subsidies (HUD provided each site with 125 Section 8 certificates), loans for leveraging housing development (provided by the foundation), facili-
tated access to Social Security Administration (SSA) disability benefits, and increasingly flexible use of Medicaid mental health services benefits. Furthermore, it was expected that the local mental health authority would assume financial responsibility for inpatient care, gain control of state mental hospital budgets, and reduce use of costly hospital care. Reallocating state mental hospital dollars was viewed as the most important mechanism for adding resources for community services.\(^8\)

Many of the major policy lessons of this demonstration are to be found in the analysis of implementation efforts in each of the sites. Each city explored various forms for its mental health authority, adapting to the special circumstances of each community. Also instructive is an examination of the relative roles of federal, state, and local governments; the relative importance of integration of services; and the allocation, reallocation, and development of resources.

**Implementation Analysis**

Within its five-year period the RWJF program demonstrated the feasibility of implementing a local mental health authority in large urban centers. Completely new organizations were established in three cities (Baltimore, Denver, and Philadelphia); four sites strengthened an existing authority (three in Ohio and Charlotte, which created and then abandoned a new public/private partnership); and two sites made only a few internal administrative changes (Honolulu actually focused on state rather than local government) (Exhibit 1). The most dramatic changes occurred in Denver, where there was no previously existing authority and where four community mental health centers and two other agencies were consolidated into a new centralized authority.\(^9\)

This experience suggests that nearly any community probably can develop a local authority, but the form that the authority takes will vary, depending on local conditions. For example, the county mental health authority in Charlotte transferred responsibility for the care of individuals with severe and persistent mental illness to a local (general) hospital authority that previously had begun to operate the only community mental health center in the area under contract to the county. After a year’s experience, county officials took back responsibility for the RWJF grant, concluding that affiliation with the hospital authority had enhanced political clout and brought added medical/psychiatric expertise to the service system, but that the professionals associated with the hospital authority had very little experience with the target population and its need for rehabilitative and social welfare services. County government resumed responsibility for these services, leaving inpatient and
### Exhibit 1
Features Of Public Services For Chronically Mentally Ill Patients Before And During Participation In The Program On Chronic Mental Illness, September 1989

<table>
<thead>
<tr>
<th>City</th>
<th>Number of catchment areas</th>
<th>Before program</th>
<th>During program</th>
<th>Additional features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin, Texas</td>
<td>1</td>
<td>Quasi-public/community mental health center (CMHC) (501(c)(3) corporation); provided most services directly</td>
<td>No change</td>
<td>Fiscal incentives to reduce state hospital USC</td>
</tr>
<tr>
<td>Baltimore</td>
<td>7</td>
<td>City health department; purchased services</td>
<td>Publicly appointed 501(c)(3) corporation; purchases most services</td>
<td>Specialized case management</td>
</tr>
<tr>
<td>Charlotte, North Carolina</td>
<td>1</td>
<td>Board of County Commissioners; provided most services directly</td>
<td>Authority returned to Board of County Commissioners after transfer to county hospital authority; provides most services directly</td>
<td>Continuing care division; case management</td>
</tr>
<tr>
<td>Cincinnati, Ohio</td>
<td>5</td>
<td>County mental health board; purchased services</td>
<td>No change</td>
<td>Countywide case management; managed care plan; Ohio Plan</td>
</tr>
<tr>
<td>Columbus, Ohio</td>
<td>5</td>
<td>County mental health board; purchased services</td>
<td>County mental health board with new unit for needs of chronic patients; purchases services</td>
<td>Systemwide treatment teams; CMHC specialization; Ohio Plan</td>
</tr>
<tr>
<td>Denver</td>
<td>1</td>
<td>No city-based authority; state mental health authority only; purchased services</td>
<td>Publicly appointed 501(c)(3) corporation; provides most services directly</td>
<td>Citywide case management; ceiling on inpatient bed days</td>
</tr>
<tr>
<td>Honolulu</td>
<td>6</td>
<td>No city-based authority; state mental health authority only; provided most services</td>
<td>Subcabinet committee and the State Mental Health Division; provides most services</td>
<td>Ceiling on inpatient bed days</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>13</td>
<td>City Office of Mental Health and Mental Retardation; purchased services</td>
<td>City Office of Mental Health and Mental Retardation with new publicly appointed 501(c)(3) corporation; purchases most services</td>
<td>Plan for capitated financing for Medicaid beneficiaries; closure of state hospital and reallocation of resources</td>
</tr>
<tr>
<td>Toledo, Ohio</td>
<td>4</td>
<td>County mental health board; purchased services</td>
<td>County mental health board with new unit for needs of chronic patients; purchases services</td>
<td>Ohio Plan</td>
</tr>
</tbody>
</table>


1During the program, each catchment area has lead agency.
2Under the Ohio Plan, local mental health boards may elect to receive an allocation of state resources to arrange for the provision of inpatient as well as ambulatory mental health services.
3Four catchment areas before the program began; currently only one.
4Two catchment areas in Honolulu, four in other parts of the island of Oahu.
5Twelve base service units and one citywide service unit.
6During the program, community mental health centers in two of the four catchment areas provide care for all chronically mentally ill clients.
emergency psychiatric services in the partnership.

In Toledo, a community that had an existing local mental health authority, initial attempts to create a new organization ceased when it appeared that the new entity would only duplicate the functions of the existing authority. New functions were added in other communities to further centralize administrative, fiscal, or clinical authority. Several of the Ohio sites, for example, developed a position of medical director to assume more clinical responsibility and respond to new legislation, giving the mental health boards responsibility for resources previously in state hospital budgets.

In an earlier report on the demonstration’s progress as of 1989, we described the slowness of the implementation of the local authorities. These conclusions unfortunately were misperceived as a criticism of the demonstration and as evidence of the failure of the concept of the local mental health authority. This was a distortion of our findings in 1989 and clearly does not reflect our conclusion now. Expectations about the potential for rapid change were exaggerated and unrealistic, as has happened so often before in mental health services reform.

The authorities in most sites continued to change as the demonstration proceeded. In Baltimore and Philadelphia, which had been slowest to change, there was noticeable maturation of the authorities between 1989 and 1991. In sites with preexisting authorities, there was some further centralization and increased coordination. The RWJF program demonstrated that a relatively small amount of grant money could accomplish a considerable degree of organizational change. All of the change over the period of the demonstration was not positive, however. In Denver, for example, severe financial problems threatened the new authority and undermined public confidence in the system of services. The system had been underfunded relative to the volume of services that the mental health authority tried to deliver, and it had difficulty finding replacement dollars for services funded by the foundation. The Denver project attempted to produce extensive and costly change in an environment of relative resource scarcity. The Denver example illustrates both what is possible in terms of dramatic change and what cannot be accomplished without considerable added, ongoing resources.

Local mental health authorities can be established and may even be essential to promoting integrated services in a large city, but an authority alone is not sufficient. As noted in other demonstrations, integration of services without adequate resources does not necessarily lead to the development of a comprehensive system of services. This is particularly true of a local demonstration in mental health care, because so few of the resources available are local resources. In fact, the RWJF Program on
Chronic Mental Illness cannot be viewed as an exclusively local demonstration. It is a state/federal demonstration as well, given the dominance of state and federal resources in mental health services.

**Local Lessons**

Experience with the nine program cities indicates that with a modest infusion of resources and technical assistance, nearly any large city can establish a local mental health authority, and that authority can become a key actor in service design and delivery. (The prestige of The Robert Wood Johnson Foundation conferred a “halo” upon the demonstration, which also seemed to facilitate change—at least initially.) It is striking that there seem to be as many solutions to the problem of creating a local mental health authority as there are sites to create them. In spite of the diversity of arrangements, the goals and objectives associated with centralizing responsibility in local mental health authorities continued to be salient throughout the demonstration. The RWJF Program on Chronic Mental Illness has focused the attention of the mental health field on the sites’ attempts to centralize administrative, fiscal, and clinical responsibilities in a single authority structure. Each local mental health authority is trying to balance its commitments to the public trust as an agent of government with its need for operational flexibility to support innovation. The structure and functions of the mental health authority in each site represent opportunistic solutions to the problem of implementing and operationalizing these goals.

Operationally, centralization of authority means increasing control and responsibility for the care of individuals with severe and persistent mental illness. Administratively, this means either directly providing services, including housing, or contracting for those services with private providers (or arranging for care with other public agencies). Financially, this means taking control of as many of the resources as are available to finance care and treatment, serving as payer and guarantor, combining the role of fiscal conduit for resources from many sources with the role of revenue generator, where the local authority has the ability to tax or issue bonds. Clinically, this means taking responsibility for monitoring the care of clients of the system and reaching out to enroll new clients from the eligible population.

To facilitate these tasks, local authorities experimented with various organizational forms: public agencies, not-for-profit mental health boards acting as agents of county government in “special districts,” quasi-public corporations, and not-for-profit corporations with boards of directors appointed by public officials (Exhibit 1). Although no single
type of local mental health authority clearly emerged as the model to recommend to all communities, each demonstration site sought to create an entity that provided greater flexibility in personnel and procurement procedures than is usual in government agencies. In some sites (for example, Philadelphia) private corporations were established as extensions of the mental health authority to add specialized staff (especially for planning) to increase administrative flexibility or to perform new functions. In every site a specialized housing development corporation was created as a requirement of the program grant.

The demonstration also underscored the value of local resources in the range of services that could be provided by mental health authorities. The Ohio mental health boards had a particular advantage, given their ability to appeal directly to the local community for resources through a property tax levy. The additional resources generated through this mechanism allowed the local authorities to fund services that were not financed by federal, state, or private sources. These dollars could be used to serve target populations other than individuals with severe and persistent mental illness (the priority population for state and federal funding) and/or to subsidize underfunded services to the severely ill. Other communities (for example, Austin and Charlotte) were successful in obtaining new local resources, permitting them to open innovative services to solve special local problems. Several sites (for example, Denver and Philadelphia) struggled to gain control of local resources invested in general hospitals; every site sought to gain control over resources invested in state mental hospitals.

One additional consequence of the strengthening of the role of local authorities is that it represents an opportunity to shift financial responsibility from the state to the local community. Accomplishing this cost shift would reverse a century of state responsibility, originally initiated because local communities had neglected the care of their mentally ill citizens in the nineteenth century. This is what happened in Ohio, where between 1986 and 1990, there was a measurable increase in the proportion of mental health dollars derived from local taxes. The balance of responsibility between local and state governments emerged as a key factor in the demonstration.

State Strategies

The most obvious lesson of the RWJF Program on Chronic Mental Illness was to illustrate the continued domination of the state in matters of mental health services, particularly with respect to the control of resources intended for individuals with severe and persistent mental
illness. There was little innovation to demonstrate at sites where the state was not actively involved. If the state did not support the transfer of resources from state hospitals to community budgets, there was no new financing scheme. If the state would not support a modification in Medicaid, there would be no reimbursement for case management.

State government is far and away the dominant payer for mental health services. Given the huge investment of resources in public hospitals and the limited new resources available in state budgets, community-based service systems that wish to expand look to develop arrangements to gain control of state mental hospital dollars. The Ohio Mental Health Act and the 35.50 Financing Program in Texas are examples of such arrangements that have been used in RWJF program sites. Legislation passed in Ohio during the demonstration’s life span gave local mental health authorities increasing control over inpatient as well as ambulatory care, increasing their responsibility and their budgets. Local mental health authorities in Texas were given a financial incentive (originally $35.50, subsequently increased) for each bed day below an annual utilization target at the state hospital. These arrangements became increasingly popular in the 1980s, especially in communities with local mental health authorities.

The state mental health agency provides a structure within which local mental health authorities can emerge. The state allocates the majority of the categoric resources used to provide mental health services, and it regulates the organizations that receive funding. In most of the demonstration sites, state statutes mandate local authorities and dictate their organizational forms. Deviations require support from the state mental health agency. Many of the mental health service system innovations funded through the RWJF program grants to local authorities were initiated by the state in most sites. In fact, in most sites the state played a major role in preparing the original grant application. In addition, with the exception of housing resources, the most important federal funding came through state agencies. Categoric dollars from the Alcohol, Drug Abuse, and Mental Health block grant, from the Community Development block grant, and from several McKinney Act block grants for programs for homeless persons are administered by the states. Mainstream federal dollars from Medicaid and from the SSA disability programs are managed by large state agencies.

Under these circumstances, unless state government acted to place appropriated revenues under the control of the new local authorities and to share its constitutional mandate for the care of individuals with severe mental illness, no real progress occurred. In other words, the goals of the RWJF program for centralizing responsibility in a local mental health
authority were realized only if there was a true partnership for change.

Federal Findings

Although the RWJF Program on Chronic Mental Illness was conceived as a local demonstration with state support, the promise of federal resources served as a key motivation for participation. The allocation of Section 8 certificates from HUD to each site was especially attractive. These resources had been extremely scarce for local mental health authorities and providers; access by individuals with mental illness had been severely restricted. In addition, the sites welcomed efforts by the SSA to facilitate the process of application for disability benefits and by the Health Care Financing Administration (HCFA) to provide guidance on using existing benefit options and applying for waivers to gain added flexibility in the use of Medicaid. Congress even added language to Medicaid legislation authorizing the use of a special waiver within the sites funded by the demonstration.

Facilitated access to these federal resources had been recommended in 1980 by the National Plan on Chronic Mental Illness, and many small changes in policy were made during the 1980s that permitted some of the innovation in the RWJF program. The federal aspects of the demonstration were policy changes from which almost any community might benefit—even without grant support to create a local mental health authority. Yet implementation of the federal aspects of the demonstration were perhaps the most incomplete. Although HUD delivered 125 Section 8 certificates to each site, almost all sites could use more. Furthermore, HUD has been encouraged by the successful use of Section 8 certificates within the RWJF Program on Chronic Mental Illness, supporting their use in other programs (for example, the RWJF Homeless Families Program) and recommending them as a resource to the Federal Task Force on Homelessness and Severe Mental Illness.

The initiatives sponsored by the SSA and HCFA barely got off the ground. Except in Ohio, where there was a pilot effort, the project to facilitate access to disability benefits was not well understood by the local mental health authorities. Even where implemented, a limited number of individuals were processed through the expedited review. Outreach efforts by the SSA dissipated in the RWJF program sites after initial efforts showed little progress. Perhaps this is to be expected, given the significant efforts required to meet the basic objectives of the demonstration by creating a local mental health authority. Facilitating access to disability benefits appears to have been a lower priority.

The Medicaid initiatives (that is, expanded use of various optional
benefits and waivers) were even more difficult for the sites to put to use. In truth, some of the optional benefits (such as those for the use of the rehabilitative services) had already been adopted, and others (various budget-neutral waivers) would not have been useful to the sites. In any case, HCFA did not provide much assistance in understanding the options, and there was little or no technical assistance available in the field upon which the sites could draw.

To make the federal aspects of the demonstration successful would have taken more outreach, technical skills, and determination than the RWJF program could muster. In addition, it probably required a stronger commitment (and ongoing monitoring of the effort) on the part of the federal agencies to realize the program’s objectives. HUD continues to support the concept of collaboration between local public housing authorities and mental health authorities, but sites need more housing resources. State and local authorities continue to struggle to make Health and Human Services initiatives (such as SSA outreach and expedited claims processing and Medicaid waivers) work for them.

What About New Services?

Any discussion of the RWJF Program on Chronic Mental Illness would be incomplete without mentioning case management and housing services. Unfortunately, more than passing mention of these important features of the demonstration is beyond the scope of this paper. More than any other services, case management and housing represent the service innovation associated with the RWJF program. Every site sought to expand these services, and all partially succeeded. Every site experienced growth, but all need far more resources for both areas. In no measure could one say that each of the demonstration sites has a comprehensive system of services in which every client has a case manager (with a caseload small enough for individual attention, that is, no greater than fifteen to twenty-five individuals per full-time-equivalent staff) and in which all clients are safely and stably housed. Yet every site can boast of new services, dozens of new case managers, and scores (and in some cases hundreds) of added supported housing units.

The approaches to organizing case management services vary from site to site and offer important examples for the field to examine and explore for local adaptation. The same holds for the approaches to housing development, as described by Martin Cohen and Stephen Somers. These service development and organization issues will be the topic of a subsequent paper. What we introduce here is what was learned about the limitations experienced by demonstration sites in their attempts to
create comprehensive systems of care.

Just as the local mental health authority is no panacea for all of the problems of service integration and system development, neither is case management. Even a full complement of case managers (or community treatment teams) cannot provide all of the services needed by an individual with severe and persistent mental illness. The “broker” and “linkage” roles of case management mean little when there are no other services in the community to be brokered or linked. Without additional services, case managers are expected to provide the clinical services themselves—for which they often are ill trained and unprepared. Furthermore, caseload sizes set with a brokering model in mind are much too large when filled with needy clients who cannot be served by other providers and who become the case manager’s responsibility alone. In one site clinical positions were eliminated from agencies and replaced with case managers. In many settings the response to the lack of basic services for clients has been to “let them eat case management.” In a similar fashion, even if each site could develop all of the needed units of housing in the community, they might be unable to provide all of the support services needed by their residents.

Local mental health authorities, case managers, and supported housing all improve integration of services and provide assistance to clients, but over and over in each site we were told, “Our clients do well if we can get them into services, but there are not enough services for everyone who needs assistance or the services are not intensive enough to meet client needs.” From the outset, one of the sites determined that the new resources offered by the RWJF program were not sufficient to effect comprehensive change in its system of services and decided instead to identify a few areas of need for innovation and fund only those activities. The rest of the system remained basically unchanged (and very underdeveloped) throughout the demonstration. Although this site may not have improved its capacity for systemwide service development, in the final analysis it may not be materially different from the other sites that invested in system reform and citywide service development but still fell far short of a comprehensive system of care. On the other hand, perhaps the “slow and steady” sites that accomplished some system reform will eventually have their complete systems, while their selective fellow sites will never get there. Only time will tell.

In general, the RWJF Program on Chronic Mental Illness probably underestimated the need for additional resources. The hope was that reorganization and system reform, coupled with selective resource enhancements, would result in a comprehensive system of services. The main problem with a demonstration predicated on an integration of
services strategy, which provides far fewer resources than appear to be necessary, is that the separate and joint effects of coordination and resources will be indistinguishable. Although there appears to be some benefit in the strategy, there is no panacea in integration of services, and it is clear that new resources are an essential addition to the strategy.

Summing Up

We will have to wait for more data before we have confidence in our conclusions. The results of the periodic key informant surveys will measure perceived changes in the mental health authorities and the system of care over the life of the demonstration; the findings of the interorganizational analysis will quantify changes in organizational relationships, including centralization and integration. Individual client and family cohort studies will assess the impact of the demonstration on functional outcomes and quality of life. Specific substudies will examine the impact of the housing component of the RWJF Program on Chronic Mental Illness, the impact of various financial incentives, changes in Medicaid use, and changes in the acquisition of Social Security benefits.

Awaiting the results of these quantitative studies, we propose to summarize our current views. Overall, the RWJF Program on Chronic Mental Illness was successful in that it stimulated intended organizational change with a relatively small amount of resources. Local mental health authorities were created or strengthened in virtually every site; administrative, fiscal, and clinical responsibility was centralized. Individuals with severe and persistent mental illness were identified as the priority population for public mental health services in each community. In addition, the basic objectives of the program’s housing component were achieved. Development corporations, established in each site, have accounted for more than 1,000 units of housing. Hundreds of individuals have been placed in independent housing using Section 8 certificates provided by HUD. The focus on housing made the RWJF program unique; its successes provide important lessons for the nation.

Most of the limitations of the demonstration, in terms of achieving its original objectives, were due in large part to unrealistic expectations. The responsibility of the evaluation is not to pronounce a global verdict but to demonstrate what has been learned. And there is much to be learned even from falling short of unreasonable expectations. For example, we observed that implementation of local mental health authorities proceeds slowly. Although authorities may be necessary to system reform, they are not sufficient to yield a comprehensive system of care. Their structure and function reflect adaptation to local conditions; in
the end no single model of local mental authorities emerges to recommend to the field. Perhaps this is both to be expected and a good thing. It suggests that local communities can respond to a challenge in a flexible way with guidance and incentives but without regulatory prescriptions.

As noted above, integration of services seems to have improved conditions needed for systems reform, but not one site can demonstrate the creation of a comprehensive system of care with the capacity to meet existing demand. Although they are diminished as problems, failures to provide aftercare services, waiting lists for services, excessively large caseloads, homelessness, and inadequate support services are still observed in every site. Boundaries between catchment areas have been eliminated or at least rendered more permeable in many cases, but citywide services are still not available in all sites.

No site has an adequate supply of case managers. Most sites need at least as many more Section 8 housing certificates as they received initially. Although the program demonstrated clearly that significant numbers of clients can be placed in scattered-site housing with only external support services and no staff living on site, individuals remain for whom this strategy does not work or for whom it is prohibitively expensive.

We learned that a local demonstration can really only succeed with state and federal support. As noted, the promise to free up federal resources was only partially realized, leaving the state in its historical role as the major payer of mental health services. Unfortunately for local authorities, most states cannot yet generate enough new resources to implement local innovation and cannot free up the resources from their investment in state hospitals (although hospitals in two of the sites closed during the program). Resource transfers from state hospital budgets to community mental health budgets did occur, but not to the extent expected. Although it is still a strategy with some clinical, administrative, and fiscal merit, the closure of state mental hospitals is unlikely to provide all of the resources needed to expand and maintain community-based services. Substitute services are expensive, and mental health agencies do not always keep the savings associated with hospital closure.

Although it took a long time in the larger, older cities, some form of local mental health authority was created in every site. We now have nine approaches tested in the real world of program implementation, available for other sites to examine. Each is an example of adaptation and sociopolitical opportunism to guide future innovation. This demonstration deepened our understanding of the functions as well as the structures of local mental health authorities. Administrative, fiscal, and
PROGRAM ON MENTAL ILLNESS

Clinical authority is part of the language of mental health administration and policy in the 1990s. The “local mental health authority” remains a viable concept and has become a popular strategy for mental health planning and policy. At least two states have already adapted the local mental health authority concept to statewide reform. Washington State has created a system of “regional support networks” to function as local authorities, and Maryland has established “core service agencies” in many of its counties, following the model of Baltimore Mental Health Systems, the RWJF Program on Chronic Mental Illness local authority.

We hope that the considerable body of quantitative data that comprise the evaluation of the RWJF Program on Chronic Mental Illness will shed more light on this important demonstration. We are convinced, however, that its greatest significance has been realized already—that the problem of caring for individuals with severe and persistent mental illness has remained part of the public consciousness and has been placed before the mainstream of health and social policymakers. Furthermore, the recent report of the Task Force on Homelessness and Severe Mental Illness reflects the importance of the RWJF Program on Chronic Mental Illness in its recommendations and suggests that the 1990s will continue the fourth cycle of mental health care reform.²⁵

The authors acknowledge the helpful comments on earlier drafts provided by Alan Cohen, Martin Cohen, Marjorie Gutman, Jonathan Keck, Krista Magaw, David Mechanic, Mark Olfson, Thomas Plaut, Miles Shore, and Stephen Somers. This research was supported by grants from The Robert Wood Johnson Foundation and the National Institute of Mental Health. The views expressed here do not necessarily represent the views of the funders.

NOTES

2. The observations of Miles Shore and Martin Cohen are featured in the GrantWatch essay in this volume of Health Affairs.
6. A. Walsh and J. Leigland, Public Authorities and Mental Health Programs (New York:


10. Goldman et al., “Form and Function of Mental Health Authorities.”


17. Goldman et al., “Form and Function of Mental Health Authorities;” and Frank et al., “The Structure of Economic Incentives.”


25. *Outcases on Main Street*. 