Prologue: For much of the twentieth century, mental illness has been a forlorn stepchild of America’s health care system. The federal government’s interest in addressing the serious problems that arise from mental illness has waxed and waned, depending upon the interests of elected politicians, available resources, and the public’s attitude. As a consequence, responsibility for mental health care has resided with state governments. State involvement with mental illness has suffered through its own periods of neglect and difficulties in enacting reforms. Indeed, successful efforts to bring about constructive change are rare because of the political crosscurrents that make reform a difficult course. In this paper Michael Hogan describes how one state—Ohio—has approached reform of its mental health system. Through its reform efforts, Ohio has sought to achieve an appropriate balance between acute care services and community support for mental health care. Hogan was named director of Ohio’s mental health agency in March 1991, three years after the state enacted its reform legislation. Before assuming this position, he had spent seven years in Connecticut’s state mental health agency, the last four years as its director, and the eight years before that in Massachusetts’s state mental health agency. Hogan holds a doctorate in administration of special education from Syracuse University and currently is president of the research institute operated by the National Association of State Mental Health Program Directors in Alexandria, Virginia.
The mere mention of the word deinstitutionalization evokes a sense of failed American mental health policy. Yet the images called forth by this word—perhaps of disheveled, homeless people—obscure long-standing mental health policy problems. Our recent national experience involving disabled people abandoned to the streets has been so distasteful that many have all but forgotten the abuses of an earlier era of custodial asylums. Yet, in truth, problems in mental health service have existed for decades.

Where does responsibility rest for these persistent problems? Despite the broad array of federal programs affecting mental health care, the federal government does not bear primary responsibility. The federal response is so chaotic that it makes integrated care difficult to coordinate at the community level. Ever since President Pierce vetoed Congress's proposed land grant program to build mental hospitals, and crusader Dorothea Dix turned her efforts to the states, responsibility for mental health care for people with serious mental illness has rested primarily with state government.

State governments' role is complicated by the existence of interrelated private and public mental health service sectors, as well as by the patchwork quilt of categoric federal funding programs and regulations. States run mental hospitals and support a wide array of community programs—mostly targeted at poor individuals with serious mental illness. However, much mental health care is funded by employers and provided in the private sector. Recent estimates are that total mental health treatment costs are about $55 billion annually. State mental health authorities (SMHAs) and Medicaid each contribute about $10 billion of this amount. Thus, mental health has a larger public-sector treatment system than exists in other areas of health care. The private-sector role is also substantial and fragmented. For example, mental health care is provided by general practitioners as well as by psychiatrists and other mental health professionals. Given the variable course of serious mental illness, many patients also move between providers or sectors of care. Some individuals will have their first treatment contacts with private practitioners and end up reliant on public care when their insurance coverage runs out. Others may use public resources (such as income support, case management, and housing) and private care (a therapist) simultaneously.

These “discoordinated” service sectors, coupled with a scattergun federal approach, complicate state governments' role in orchestrating care. This challenge is greatest for those individuals with the most unrelenting conditions, such as schizophrenia. As David Mechanic and Richard Surles describe elsewhere in this volume, orchestrating services...
is difficult indeed. Gerald Grob’s essay, also in this volume, confirms that successful reform has eluded this country for well over a century.

How are states doing? The simple answer to this question is, Not very well. The Public Citizen Health Research Group and the National Alliance for the Mentally Ill (NAMI) have collaborated on a biennial ranking of state programs for several years. The most recent survey indicates that “in 1990, services for individuals with serious mental illness in the United States are a disaster by any measure used.”

Why do the states have such problems, and what alternatives exist? In a provocative analysis, Theodore Marmor and Karyn Gill suggest that American political structures and processes mitigate against viable mental health care solutions. They argue that “the political system places fundamental constraints on the mobilization of resources to solve the profound needs of the mental health care delivery system.” Further, the characteristic American suspicion of expanded governmental roles is particularly problematic in mental health. In this field, they argue, radical reform is needed, and only integrated, broad-scale solutions will be adequate. Yet political processes work against integrated action. Summing up this challenge, Marmor and Gill contend that recent years’ political developments have created “an environment in which large-scale innovation for the socially disfavored is practically unthinkable.” Given the importance and difficulty of change, models of successful reform at the state level bear close analysis.

Moving State Systems Toward Best Practices

Ohio as a case study. The state of Ohio has made major progress in reforming its mental health system, moving from twenty-third place in the 1986 Public Citizen/NAMI rankings to fourth place in 1990. Ohio is suitable as a case study for other reasons. First, it has a large population, and reform is arguably more difficult to sustain in larger systems. Second, the direction of change has been purposeful, and the pace of reform, substantial. Third, the process of change in Ohio has been well documented—because of a policy commitment to research and evaluation and because of a legislative mandate establishing an independent study committee to review changes. Finally, the changes are not primarily attributable to high expenditure levels, While the state mental health department’s general fund budget increased 90 percent from 1981 to 1991, this was an increase of only about 2 percent per year above inflation. In 1987 Ohio’s state mental health expenditures were $33 per capita, and Ohio ranked twentieth among the states in SMHA expenditures. Ohio is thus a useful test case for mental health reform.
The initiation of system change in Ohio was outlined by Gail Robinson, who studied the five-year process leading to the enactment of Ohio’s Mental Health Act of 1988. The effort involved personal leadership by the governor, a strong state mental health director, effective mobilizing of constituent support, legislative champions, political savvy, and luck. Yet enactment of laws does not guarantee success; there are many slips between law and actual service reform. Although the Ohio legislation was a significant achievement, translating it into altered systems of services and better outcomes for people with mental illness is an even more significant challenge.

Goals and provisions. The requirements of the reform legislation are broad and provide a basis for evaluating change. The provisions of the legislation can be summarized as follows:

Under the bill, community mental health boards would become legally responsible for mentally ill individuals, through commitments to the local boards rather than to the state. It would be up to the county to decide whether a person needed hospital care or could be treated in a community setting. The change in financing mental health care calls for a gradual shift of state funds currently used to operate state hospitals. These funds would be used by the local mental health boards to purchase inpatient services, in a manner similar to how boards currently contract for services provided by local agencies. Boards could purchase inpatient services from state hospitals, which would continue to operate under state control.

The proposed legislation also calls for other changes in Ohio’s mental health system that would: increase the involvement of clients and their families in the treatment process; enhance the clinical training of mental health professionals; update and strengthen the licensing requirements to assure quality housing and residential placements; put into law the components of a community support system, which includes case management; and modernize the Department of Mental Health’s organizational structure.

Implementing the new legislation. As a result of earlier efforts and the Mental Health Act, Ohio was positioned by 1988 to make fundamental changes in its public mental health system. New public policies had been articulated, a new direction set, and statutes rewritten to support this direction. This brings us to another stage of the change process. Would the reform be carried out? Would the legislation turn out to be well crafted, or would the compromises needed for passage weaken it critically? Could it survive a change in administration (a new governor and new SMHA director) as well as the vicissitudes of state budgets in an era of scarcity?

Fortunately, more than anecdotal data are available to begin to answer these questions. An unusual and positive aspect of the Ohio law is that it created a broadly representative sixty-member commission (the Study Committee on Mental Health Services) to monitor and evaluate implementation of the Mental Health Act and to issue periodic reports to the governor and legislature. Additionally, the research capacity in
the Ohio Department of Mental Health (ODMH) was focused on evaluation of the change. The linkage of reform efforts to other systems change activities (for example, The Robert Wood Johnson Foundation mental health system change initiative) eventually will provide more data on outcomes.

The implementation period of the Mental Health Act continues (the funding formula is to be phased in over a six-year period ending in 1995), and a number of the studies and reports critical to an overall evaluation are far from completion. Nonetheless, it is not too soon to look at implementation progress, early successes, and warning signals. In this essay I discuss three broad areas: (1) fiscal impact, including shifting of resources from state hospitals to community services; (2) system reform efforts, including realigned state/local responsibilities; and (3) service impact, including placement of mentally ill people from state hospitals. Clearly, services impact on individuals is the most important area for evaluation but also the most complex. Such assessments require detailed analyses over time, such as the research being conducted by ODMH. However, even in this area, some initial trends are apparent.

**Fiscal Impact Of Reform**

The backdrop. Although the Ohio Mental Health Act has many facets, its central strategy is fiscal incentives to local mental health authorities ("boards"). The law allows boards annually to divert an increasing percentage of state funding away from state hospitals toward locally managed community alternatives. A consolidated budget account ("408 account") was created to combine state hospital resources with some new community funding under the Mental Health Act. Beginning in 1990, boards could elect to use up to 10 percent of their allocated funds for community services. This ceiling rose to 20 percent in 1991 and then by 20 percent annually. By 1995—the final year of the anticipated implementation period—boards will be able to use up to 100 percent of their allocated funds for community services. Each board must also plan for and “buy” whatever state hospital services it uses.

In a significant compromise, boards were allowed to choose participation in the new approach. “Opt-in” boards would accept increasing dollars for community care but would be financially at risk for hospital use. “Opt-out” boards would not be financially at risk for hospital use but would not have access to any “408” funds. A risk fund was also created to soften the financial risks associated with excess hospital use. To balance the goals of community placement with the problem of varying preexisting community funding patterns, the funding formula was to be
adjusted annually. The act provides for a gradual trend toward allocations based on enrollment of severely mentally disabled persons, and away from historical state hospital use patterns.

Several other financial dynamics are at work in Ohio's mental health system. Local boards can raise funds via tax levies, and the years before and after the act saw substantial increases in local investment, as communities "geared up" for their expanded responsibilities. In the 1990–1991 budget, ODMH sought a significant funding increase in the 408 account to "prime the pump." Only a portion of the requested increase was achieved; the ODMH budget was increased 8 percent from fiscal year 1989 to fiscal year 1990. Since boards would be encouraged by lower hospital charges to opt in, the department used some of these new funds to subsidize hospital care and thus artificially reduce the inpatient costs that would be charged to boards.

Finally, the community care of "forensic patients" (those with criminally related legal status, such as individuals found not guilty by reason of insanity) was not deemed clinically adequate or politically acceptable for immediate inclusion in the incentive funding formula. Thus, board financial responsibility for hospital care of forensic patients was delayed. During the early years of implementation, ODMH would retain financial responsibility for care of these individuals in state hospitals.

An overriding theme of the literature on mental health system reform is that funds must be redirected from hospital to community care. This has proved difficult, and the most recently available national data show that over 60 percent of funds controlled by SMHAs remain directed to state hospitals. Many analyses of this problem emphasize sociopolitical constraints and resistance by hospital constituencies to losing resources. Of course, a practical problem is that funds cannot be in two places at one time. A sensible approach, not always practiced, is to fund community programs before hospitalized patients are discharged. Funding community care via reallocated state hospital dollars requires that state hospital budgets be phased down for transfer while patients are still hospitalized. Since adequate care is difficult to deliver without adequate funding, this typical stalemate is more than a political problem. It reflects one of the substantial challenges in reform. This issue was addressed in Ohio partly via state "pump-priming" investments, partially by an effort to increase Medicaid payment for relevant treatment, partially by local fund generation, and partially by the use of incentives.

Results to date. Most initial reviews of the financial changes in Ohio's mental health system are positive. Most boards did elect to participate in the act's funding formulas, used new funds to develop community services, and reduced their historical reliance on state hosp-

These overall results confirm the generally positive experience of early Mental Health Act implementation. By 1991 forty-two of fifty-three local board areas were participating, funding had increased for community services, and state hospital use was decreasing. However, state budget woes reached Ohio as implementation of the act reached its crucial middle years of fiscal years 1992–1993. A new governor took office in January 1992, bringing with him a new director of mental health and facing a biennial state budget deficit estimated at over $1 billion for fiscal years 1992–1993. A lean budget was adopted for the department, with essentially level ODMH funding for fiscal year 1992 and an overall 3 percent increase for fiscal year 1993–an increase that is currently threatened by the continuing recession and concomitant budget cuts.

These developments increased tension in Ohio’s mental health system and raised both old and new funding problems. During legislative consideration of the fiscal year 1992–1993 biennial budget, debate focused not on overall mental health funding but on whether resources were being shifted out of hospitals quickly enough. This focus is arguably a result of the new focus on shifting funds, perhaps described as a distribution problem rather than a sufficiency problem. Unable to subsidize state hospital costs with additional funds as it had in fiscal year 1990, faced with inflation in inpatient costs despite major staff reductions, and because of reductions in patient days, ODMH was forced in fiscal year 1991 to adjust upward the per diem rate charged to boards. Faced with escalating hospital and community costs in an environment where overall funding was not increasing, boards continued to emphasize increased community placement to increase community funding and reduce hospital costs. Maximization of third-party revenues (particularly Medicaid) became an even greater priority. For fiscal year 1992 the department determined that the planned funding formula shift toward an emphasis on the “SMD count” rather than historical utilization would cause more harm than good: It would reallocate funds between communities, causing unplanned cuts in some areas that had just expanded community services for former hospital patients. Therefore, this element of the formula was frozen for fiscal year 1992. For fiscal year 1993, faced with similar tensions, the department and boards developed another interim strategy that also softened the redistribution effects of
the law but increased board participation, as of this writing, to all fifty-three boards.

In the meantime, meeting budget goals to support reallocation of funds from hospital to community required major staff reduction in hospitals, following inpatient census reduction. This dramatic reduction in staffing allowed ODMH to stay on budget and support reallocation. The dramatic staff reductions are not perceived to have reduced the quality of inpatient care; in fact, overall staff-to-patient ratios improved during the initial implementation period of the act. However, these data raise a troubling long-term trend. Since total compensation costs per employee exceed $40,000, the estimated staffing reduction from 1989 to 1993 (approximately 2,000 positions) will save over $80 million each year—perhaps $90 million, if other hospital savings are included. Yet the increase in general revenue funds for community services from fiscal year 1989 to fiscal year 1993 is only about $45 million. Thus, only about 50 percent of hospital savings are being reallocated to community mental health programs. The rest are being lost to the mental health system. Funding for community health care from other sources is increasing (for example, Medicaid and county tax levies). Yet the loss of state general revenue funds is a significant concern. I return to a discussion of these disturbing trends later.

Given overall state fiscal problems, debate is now centered on the needs and priorities of different sectors (boards, community mental health agencies, state hospitals, and ODMH). The debate may threaten the coalition that fought for the Mental Health Act. While progress continues, the long-term consequences of these financial changes are uncertain. In reviewing this situation, the study committee noted, “The Mental Health Act did not appropriate new funds for the mental health system, but rather shifted funds to be available in the locations of people being served by the system. The process of shifting funds is difficult to balance, particularly as funds available for the support of hospital services are reduced.”

Systems reform. The full range of procedural requirements in the Mental Health Act is extensive. The legislation required transfer of responsibilities from the state to county boards, created new expectations for boards and ODMH, and set standards for the participation of consumers, family members, and minorities in the mental health system.

In the interim review by the Study Committee on Mental Health Services, the results of systems reform were judged positively. The report cited the following accomplishments: (1) promulgation of rules on consultation with constituencies; (2) participation of boards, agencies, consumers, and families in development of the funding formula and
community plan guidelines; (3) integration of the dual system of care into one system, with the board as the local mental health authority; (4) development of the basic components of community support systems throughout the state, insofar as resources are available; (5) development of nineteen State Operated Services (SOS) Programs to operate in the communities; (6) improvement of clinical training of providers, through both preservice and in-service education; (7) increased participation of consumers and family members in the mental health system, via the authority of ODMH to appoint local boards; (8) establishment of the office of the ODMH Medical Director; and (9) adoption of certification standards for Community Mental Health Agencies. In reviewing these accomplishments, the study committee concluded that “the systems and structural changes required by the Act have been implemented.” While this conclusion may be somewhat glowing, it does reflect substantial progress in achieving administrative reform.

Services impact. The Mental Health Act of 1988 has rapidly and substantially altered patterns of service for people with serious mental illness in Ohio. The most apparent shift is in the redirection from state hospital to community care (Exhibit 1). The most significant trend apparent from these data is the reduction in state hospital use as communities develop alternatives. This trend is clearly attributable to the Mental Health Act; the reduction in inpatient utilization accelerated subsequent to its passage and as the new funding formula was phased in.

The reduction in state hospital use is mostly due to the community placement of long-stay patients. Approximately 79 percent of the overall census reduction from 1987 to 1992 derives from the reduction in patients with a length-of-stay exceeding ninety days. While the rate of admissions declined from 1987 to 1992, only 21 percent of the hospital census reduction is attributable to the decline in census of patients with

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### Exhibit 1
Patterns Of State Hospital Utilization In Ohio, 1987–1992

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Average daily resident population</th>
<th>Admissions</th>
<th>End of year inpatients by length-of-stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>First</td>
<td>Readmissions</td>
</tr>
<tr>
<td>1987</td>
<td>3,953</td>
<td>5,112</td>
<td>9,335</td>
</tr>
<tr>
<td>1988</td>
<td>3,524</td>
<td>4,615</td>
<td>8,543</td>
</tr>
<tr>
<td>1989</td>
<td>3,638</td>
<td>4,626</td>
<td>8,636</td>
</tr>
<tr>
<td>1990</td>
<td>3,167</td>
<td>3,612</td>
<td>8,232</td>
</tr>
<tr>
<td>1991</td>
<td>2,820</td>
<td>3,511</td>
<td>8,390</td>
</tr>
<tr>
<td>1992&quot;</td>
<td>2,405</td>
<td>2,451</td>
<td>5,675</td>
</tr>
</tbody>
</table>

Source: Ohio Department of Mental Health.

*Data as of February 1992.*
short/intermediate length-of-stay (ninety days or less).

These patterns generally make sense from a clinical and policy perspective. While the vast majority of state hospital admissions in Ohio are judged appropriate by utilization review criteria, there is generally little treatment benefit in state hospital stays exceeding a year. Furthermore, the community services developed in Ohio have emphasized housing and case management supports targeted at longer-term patients. One illustration of these trends is the expansion of case management services (Exhibit 2). The patterns of state hospital reduction are thus consistent with investment patterns and priorities in community services. Longer-term patients have been emphasized in service planning, and these services have resulted in many fewer long-term inpatients in state hospitals.

It is apparent that both the philosophical and programmatic thrust of the Mental Health Act and a variety of fiscal resources that were brought to bear on community services have had an impact on the development of community services and reduction of state hospital use. Exhibit 3 tracks funding from all sources and illustrates that the funding trends involve more than reallocated state hospital dollars.

The decrease in state hospital use has tracked increases in community mental health funding. Yet even when state funding did not increase (such as from fiscal year 1991 to fiscal year 1992), the reduction in state hospital use continued. It appears that both financial resources and other factors are contributing to changes in patterns of services. It is also

<table>
<thead>
<tr>
<th>Exhibit 2</th>
<th>Case Management Services In Ohio, 1985–1991</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thousands of service units</strong></td>
<td></td>
</tr>
<tr>
<td>1,400</td>
<td></td>
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<tr>
<td>1,200</td>
<td></td>
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<tr>
<td>1,000</td>
<td></td>
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<tr>
<td>800</td>
<td></td>
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<tr>
<td>400</td>
<td></td>
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<tr>
<td>200</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ohio Department of Mental Health.
Note: Data are for fiscal years.
apparent that state funding is serving as a catalyst rather than as the primary driving vehicle. Local funds raised through board levies, as well as third-party revenues (principally Medicaid), are increasing faster than state funds. This raises the question of whether a combination of the Mental Health Act and the state budget crisis is inadvertently conspiring to transfer the financial burden of care to local governments. This key question will require continued attention.

While a number of studies are under way to assess the impact of Ohio reforms on individual consumers’ outcomes and satisfaction with services, not much can yet be said with certainty about these ultimate success factors. The Study Committee on Mental Health Services, in its preliminary report assessing progress under the Mental Health Act, described changes in service patterns; including more use of case management services; increased focus on persons with severe mental disabilities; expansion of community services for seriously emotionally disturbed children and youth; and statewide movement toward systems integration. “By May, 1990,” the report stated, “the number of persons discharged from state hospitals who had seen their case managers rose to over 80 [percent], up from 22 [percent] in April, 1988.”

Thus, an interim review of services impact seems to indicate that targeted community services are being developed, that state hospital usage is decreasing, and that longer-term patients are primarily the ones who are benefiting from community services development.
Discussion

Developments in Ohio confirm that large-scale change can be successfully initiated in public mental health systems. Despite the complexity of these systems and their low political priority, professional and political leadership can galvanize diverse constituencies to initiate reform efforts such as Ohio’s Mental Health Act.

The early implementation of these massive changes in Ohio also has been generally positive, as measured by increased community investment, expanded community services, stronger local responsibility, and decreased reliance on state hospitals. At the same time, implementation has been affected by budget problems. Tight resources have increased conflict among mental health constituencies. This is a troubling development. As discussed earlier, less than half of the state general fund resources saved by hospital downsizing in Ohio are moving to the community boards, while more than half of the savings are being lost out of the mental health budget. Despite success in generating alternative sources for community care, this trend must change for long-term success. It may thus be that Ohio’s community-oriented strategy will act over time to reduce mental health “market share” of the state budget. Arie Schinnar and colleagues have found that mental health resource transfers from hospital to community threaten mental health’s share of state budgets. This raises long-term financing concerns regarding Ohio’s plan.

Future of state hospitals. These issues also relate to unanswered questions about the future role of state hospitals in Ohio’s system. On the one hand, the Mental Health Act envisioned that the state would retain a role as a provider of services. On the other, ODMH leadership promoted a view that state hospitals should be closed or consolidated, and several hospitals were closed within the past decade. Responding to this context, the study committee indicated that “ODMH cannot, under these circumstances, maintain the existing number of hospitals.” Despite this conclusion, the ultimate role, function, number, and costs of state hospitals have not yet been determined. A task force has been assembled by ODMH to evaluate “hospital futures” and recommend long-term directions. It is critical to note that no national consensus has been developed on the question of state hospital roles. Debate continues on public responsibility versus private-sector efficiency, on clinical mission (that is, acute versus longer-term care, civil versus forensic patients), and on the state’s role and responsibility as a provider of last resort. An Ohio solution to this dilemma will need to address clinical, systems, cost, social, and political factors. The fact that state hospital
downsizing appears to reduce the mental health budget must be considered and resolved, but the “community imperative” calls for continued movement.

**Side effects of success.** Another set of issues arising in Ohio emerges from the very pace of progress. In general, these problems seem to revolve around growth in community systems and downsizing in hospitals. A paradoxical factor in community service expansion is that growth can cause problems. In various communities, problems include management overload in expanding agencies, competition for staff resources, and increased complexity of community systems. The current budget problems—if they are temporary—may prove beneficial by limiting growth-related problems in community services.

In state hospitals, the problems are associated with maintaining quality while downsizing. The uncertain future of state hospitals, coupled with continual shrinkage, affects employee morale. Staffing reductions during the fiscal year 1990–1991 biennium reduced state hospital payrolls from approximately 5,900 to 5,000 employees; an additional 200 state hospital staff were redeployed to community services work. During this same period one state hospital was closed via consolidation, and thirty-four hospital wards were closed. Each closure of a ward displaces staff and patients, breaking up treatment teams of staff and affecting continuity of care. Additionally, patterns of staff separations affected stability and quality. Approximately 450 long-term hospital staff left under early-retirement incentive programs, taking with them approximately 10,000 years of state hospital work experience. Given an effort to avoid layoffs during the early years of the Mental Health Act, other work-force reduction was accomplished via attrition. Frequently, employees in valued positions (that is, direct care) left employment but could not be replaced for budget reasons.

During fiscal year 1992, attrition rates dropped amidst a declining economy, given employees’ concerns about other job opportunities. Therefore, layoffs were necessary to meet budget targets; approximately 190 layoffs were scheduled during fiscal year 1992, in a total of seven facilities. Layoffs in almost half of the ODMH facilities will have an uncertain effect on morale.

The problems of managing community program growth and hospital reductions illustrate some of the complexities of achieving systems change. To date, however, these issues do not appear to have compromised progress fundamentally; all state hospitals remain accredited by the Joint Commission on Accreditation of Healthcare Organizations, and community program expansion is usually cited as leading to improved quality of care.
Concluding reflections. The decade-long change process in Ohio’s public mental health system confirms two perspectives on reform that seem obvious but are sometimes forgotten. First, change can be initiated in public mental health systems, which so frequently are in such drastic need of reform. Initiating a change process requires strong leadership, at least in the SMHA director and preferably including the governor as an active player. In addition, a coherent alternative vision must be developed as a catalyst for reform, and the typically splintered mental health constituencies (public union, families, private agencies, local officials, and consumers) must be brought together in a coalition for change. The efforts by the prior Ohio SMHA team of Pamela Hyde and Martha Knisley encompassed these strategies and succeeded in focusing concerted attention on Ohio’s mental health system, achieving fundamental legislative reform and indeed some new funding.

The second observation is that initiating change and carrying it out are two different matters. The reform process in Ohio has been going on for almost ten years and might be characterized as half complete. While major structural changes have been made and are affecting service patterns, the refinements needed to complete the work (such as ensuring an adequate quality of community service, knitting community programs into coherent local systems, and changing the operating mission of the SMHA) remain incomplete.

Several observations on sustaining or completing change grow from the Ohio experience. One is that change itself creates problems that require resolution. Often, these secondary consequences may not be predictable and may cluster with unforeseen challenges. In Ohio the problems of coping with community program growth and hospital shrinkage are examples of problems caused by progress. Getting beyond “change” to institutionalize desired new systems requires different skills, time, and luck. These new systems must also be self-monitoring and self-correcting, to address ongoing reform. Hyde and Knisley privately believed that their primary service strategy of case management would itself require reform, and this is proving true. Rehabilitation and other treatment is inadequate in many Ohio communities, while much care and coordination is delivered via case management.

A final lesson in reforming state systems is that the change process must be carried out across gubernatorial and SMHA administrations, and despite inevitable state budget difficulties. Hyde’s tenure was more than double the norm for SMHA directors. Given the finding of Schinnar and colleagues that high SMHA director turnover is predictive of a higher investment pattern in state hospitals than community program, stability at the top appears to be key in sustaining change.
The Ohio reform was built on values of community inclusion and local control, which have been embraced by a new governor and SMHA director. Thus, continuity was addressed by linking reform values to community values. This is an adaptive strategy.

Andrew Scull observed that the main policy problem in American patterns of care for persons with serious mental illness appears to be the choice between “inside” and “outside” asylum. The Ohio reform attempts to create a more positive alternative. While early results look promising, only time will tell if this grand experiment will succeed.

NOTES

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16. Schinnar et al., “Public Choice and Organizational Determinants of State Mental Health Expenditure Patterns.”