A Commentary on the Robert Wood Johnson Foundation Program on Chronic Mental Illness

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WHEN THE ROBERT WOOD JOHNSON (RWJ) Foundation first focused its attention on the problem of chronic mental illness (CMI) in 1984, state mental hospitals recorded 400,000 fewer patients than they had some 30 years earlier. Nearly everyone agreed that the concept of deinstitutionalization was a good thing, but a consensus was also emerging that its implementation was seriously flawed (Robert Wood Johnson Foundation 1986). Communities across the country, especially our major cities, were largely unprepared to provide needed services to people with severe mental health problems.

In response, the RWJ Foundation announced in December 1985 one of the largest privately initiated programs ever launched to improve the care of people with CMI. The goal of this program was to strengthen the potential of individuals with CMI to live independently. The program was cofunded by the U.S. Department of Housing and Urban Development (HUD) and was formally supported by the National Governors' Association, the U.S. Conference of Mayors, and the National Association of Counties. The nation's 60 largest urban centers were invited to apply for funding, and nearly every one of them did so. Ultimately, an amount surpassing $100 million in grants, loans, and rent

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subsidies was provided to nine communities (Austin, Baltimore, Charlotte, Columbus, Cincinnati, Denver, Honolulu, Philadelphia, and Toledo) to develop centralized mental health authorities offering a broad continuum of services.

The quality of life for people with CMI in those nine cities corresponded to the picture we had formed in designing the program. The evidence—much of it gathered during the ill-fated effort by the Carter administration to develop a comprehensive national plan for the chronically mentally ill (U.S. Department of Health and Human Services 1981)—showed how deeply the nation had failed to fulfill the implicit promise of deinstitutionalization: provision of a full array of community-based clinical, psychosocial, and supportive services to replace the analogous services in state hospitals. This failure occurred even though model programs had demonstrated the feasibility of providing care in community settings for patients who in earlier years would have been institutionalized (Gudeman and Shore 1984; Stein et al. 1980). The successful community-based programs incorporated (a) a comprehensive set of services; (b) clear lines of clinical responsibility for the well-being of clients residing in the community; and (c) clear lines of administrative and fiscal control over mental health expenditures. Both the inadequacy of services, especially supportive housing, and the tangled bureaucratic webs were most problematic in our nation's major cities, in part because many people with serious mental illnesses congregated in them.

Ironically, while the foundation was embarking on this project, data underscoring the most visible evidence of the failures of deinstitutionalization were emerging from the evaluation of our 19-city program, Health Care for the Homeless (cofunded by the Pew Charitable Trusts). The results showed that approximately a third of the homeless people being seen by providers in the shelters, clinics, and outreach teams had serious mental health problems (Wright 1990). Some had been deinstitutionalized; some would, in years past, have spent time in public mental hospitals. The increasingly familiar sight of disturbed men and women living on the streets underscored the urgency of the problem for our partners at the federal level and in the nine sites.

We brought together the nation's leading experts on mental health to advise us, to assist the nine selected cities and oversee their progress, and to evaluate the program's overall effectiveness. This volume is devoted to their reviews and findings. We learned a great deal about the complexity

of the systems problem, particularly the need to involve all interested parties—consumers, state as well as local governments, and private-sector leadership—in attempts to solve it. We also learned that it is possible to connect previously alien service sectors, particularly mental health and housing, to produce dramatic improvements in community-based options. Finally, we learned that there are countless consumers, providers, bureaucrats, and others without whose continuing commitment very little would be accomplished on behalf of individuals with severe mental illnesses.

From these and other national initiatives to build community-based services for people with AIDs, physical disabilities, and the frailties associated with old age, the foundation has forged a renewed commitment to improving systems of care for all people with chronic health conditions. Clearly, the kinds of service integration, innovative case management, supportive housing, and fiscal and administrative leadership demonstrated under the CMI program can serve as a model for other constituencies and communities struggling to help people with chronic conditions to live more independent and satisfying lives.

References

Gudeman, J.E., and M.F. Shore. 1984. Beyond Deinstitutionalization: A New Class of Facilities for the Mentally Ill. *New England Journal of Medicine* 311:832–6.

Robert Wood Johnson Foundation and the U.S. Department of Housing and Urban Development. 1986. *Program for the Chronically Mentally Ill.* Princeton, N.J.: Robert Wood Johnson Foundation.

Stein, L.I., and M.A. Test. 1980. Alternative to Mental Hospital Treatment. *Archives of General Psychiatry* 37:392–412.

U.S. Department of Health and Human Services. 1981. *Toward a National Plan for the Chronically Mentally Ill.* DHEW pub. no. 336-094. Washington.

Wright, J.D. 1990. *Under the Safety Net*, eds P. Brickner et al., 15–31. New York: W.W. Norton.

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