Evaluating the Robert Wood Johnson Foundation Program on Chronic Mental Illness

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THIRTY YEARS AGO THE MILBANK MEMORIAL FUND published several influential monographs on decentralized mental health services (Milbank Memorial Fund 1960, 1962). These documents, published prior to the passage of the community mental health center legislation, described innovative models for delivering community care to severely mentally ill individuals. They were referred to as "decentralized" because the services were spread out in the community away from the state mental hospital, which was the center of care and treatment. Some of the innovative services were based in community agencies; others were operated by mental hospitals, offering a range of services outside of the hospital's inpatient services. The models were characterized by integration of service delivery between hospitals and community agencies. These innovative systems enjoyed considerable control over clinical and administrative decision making and a single budget.

In the 1960s, with the expansion of community mental health centers and other community care services, decentralized services became common both for state mental hospitals and for community-based services. The term "decentralized," however, went out of fashion in favor of

The Milbank Quarterly, Vol. 72, No. 1, 1994
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"community-based" services. The hospital, from which the community services were decentralized, lost its centrality. Most of the expansion of services proceeded without the integration of hospital and community services that had characterized the decentralized models of the Milbank monographs.

During the past three decades of service expansion, the process of decentralizing services has become so extreme that care has been poorly coordinated and fragmented among a multiplicity of providers. Fragmentation has occurred among mental health service agencies and between these providers and agencies in the larger social welfare system. With the advent of the community mental health centers program, cities were divided into catchment areas without recognition of the need to provide citywide (or countywide) services. Community mental health centers developed with little or no connection to public mental hospitals. A whole array of community support services was created in some areas but not in others.

By the mid-1970s there was a call to centralize administrative functions again, this time under a single authority *other than* the public mental hospital: either a community mental health center, or a community support system "core service agency," or a mental health board. Only a few models emerged in the 1970s, so that a decade later the call for centralization under a local mental health authority became urgent.

The Robert Wood Johnson Foundation (RWJF) Program on Chronic Mental Illness (PCMI) was a response to that call. In 1986 the foundation initiated a five-year demonstration program in nine U.S. cities. The linchpin of the PCMI was a "central mental health authority," an organization in each city or county with centralized administrative, fiscal, and clinical authority for mental health services. Administratively and fiscally, the authority was expected to assume responsibility for planning, funding, and coordinating care and for expanding services and resources, including a range of mental health services and housing opportunities. Clinically, the authority was expected to provide oversight of care and treatment services (Aiken, Somers, and Shore 1986; Shore and Cohen 1990).

In a sense the goal of the PCMI was to return to the integrated systems of mental health services described in the earlier Milbank monographs, models that helped to launch the era of community care. In fact, some of the models that influenced the PCMI were based in state

mental hospitals, including the Massachusetts Mental Health Center, whose superintendent, Miles Shore, directed the demonstration for the foundation.

This Milbank monograph presents the quantitative findings of the national evaluation of the PCMI, including two articles on the changes in organization and financing of care, three articles based on assessments of the impact of these system-level changes on individuals with chronic mental illness, and an article assessing the impact on their families. This introductory article provides background on the evaluation and some of its accomplishments. It also addresses some of the limitations of the evaluation, some of its contributions, and some of the problems in interpreting its findings and turning them into policy.

The Demonstration

In its 1985 program announcement for the PCMI, the RWJF identified the goal of its service demonstration: "to help the chronically mentally ill function more effectively in their everyday lives." To accomplish this objective, in November 1986 the foundation provided $29 million in competitive grants over a five-year period to nine of the sixty largest cities in the United States. These demonstration sites (Austin, Texas; Baltimore; Charlotte, North Carolina; Cincinnati, Columbus, and Toledo, Ohio; Denver; Honolulu; and Philadelphia) were expected to transform their mental health systems by creating a mental health authority to centralize administrative, fiscal, and clinical responsibility for individuals with chronic mental illness.

According to the program theory, centralized mental health authorities would expand resources and services, and such services would improve continuity of care and quality of life. There was little or no emphasis on specific clinical or social services, other than case management, which was intended to improve the coordination of services. The demonstration focused particular attention on creating housing opportunities. The foundation provided access to a low-interest loan of $1 million to leverage additional housing development resources, and the U.S. Department of Housing and Urban Development (HUD) provided each city with 125 Section 8 rental subsidies (valued at $75- to $80 million) to assist clients to rent their own apartments.

A national evaluation of the PCMI was funded jointly by the RWJF, the National Institute of Mental Health (NIMH), several other federal agencies, and the Ohio Department of Mental Health, through a series of grants to a group of collaborating investigators from several academic centers, coordinated by the University of Maryland Center for Mental Health Services Research. The overall evaluation design has been published elsewhere (Goldman et al. 1990), and some of the qualitative findings of the evaluation have been presented in other publications (Goldman, Morrissey, and Ridgely 1990; Goldman et al. 1992). This issue of the *Milbank Quarterly* offers the first collection of the quantitative results of the evaluation.

The National Evaluation

As described in detail elsewhere (Goldman et al. 1990), the evaluation is divided into two main components: a site-level study, in which the nine cities are the unit of analysis, and a client-level study, in which clients and their families are the unit of analysis. The site-level study was conducted in all nine sites; the client-level study was divided into a series of substudies conducted in differing combinations of sites.

This evaluation effort was unusual in the diversity of its collaborating coinvestigators and the cooperation among them. In addition to the substantial resources afforded to the core evaluation, the NIMH supported related studies through its regular competitive mental health services research grant program. The investigators agreed to collaborate voluntarily, meeting periodically, sharing data and analytic strategies, and discussing findings and conclusions. The evaluation attempted to address a number of important scientific issues (methods and research questions) at the same time that it tried to provide some salient answers to critical policy questions essential to assessing the demonstration. The goal was to advance the field of investigation as well as to provide guidance about the feasibility and impact of the complex intervention characterizing the PCMI.

The evaluation was unusual also because it began early in the demonstration, almost simultaneously with the initiation of the PCMI itself. The evaluators, however, were not involved either in site selection or in the design of the quarterly report format adopted for program monitoring. Involvement in both of these activities would have strengthened the

evaluation. The program office provided easy access to information about the sites and their activities and decisions.

The task of the evaluation was to conduct a summative evaluation and not a formative one. To the extent possible, the evaluators were not to become part of the demonstration, which meant that communication about the PCMI during the demonstration flowed primarily from sites and program office to the evaluators. Following the demonstration and at the end of the evaluation, the investigators returned to most of the sites to present some of the findings and to discuss them with grantees. Feedback from the participants about the findings helped us to interpret the results of the evaluation, and feedback about their performance increased the likelihood that the program sites would be able to use the results to improve services.

Several technical assistance projects have been launched to further the aims of the PCMI demonstration by sharing program models and housing development strategies with other communities. The RWJF has sponsored such an effort under the direction of Martin Cohen. The federal Community Support Program has sponsored a housing center coordinated by the Center for Mental Health Services Research at the University of Maryland. The center provides states and local mental health authorities with technical assistance on housing development based on the PCMI experience.

Overview of the Qualitative Findings

Although many of the qualitative findings have been discussed over the past three years (Goldman, Morrissey, and Ridgely 1990; Goldman et al. 1992), they are summarized here as background to the articles that follow. The very fact of the demonstration and its sponsorship by the RWJF and HUD assured that the problem of chronic mental illness would not disappear from the public policy agenda in the 1980s and 1990s. Mental health issues had not been central to either the foundation or HUD during the 1960s and 1970s, the period of expanding mental health care services. NIMH and other public mental health agencies had provided national leadership on services and had sponsored most of the reforms and demonstration programs.

The "new federalism" of the Reagan era had reduced the national leadership role to a minimal level just at the time when the problems of individuals with chronic mental illness peaked in large U.S. cities, reflected most clearly in the tragedy of homelessness. In spite of limited resources and fiscal conservatism about social welfare, the 1980s proved to be an era of considerable favorable incremental change for individuals with chronic mental illness (Koyanagi and Goldman 1991, 1992).

The concept of the local mental health authority achieved considerable currency during this period, in part as a result of the PCMI. The importance of centralizing administrative, fiscal, and clinical responsibility became recognized in mental health policy circles. (For example, several states, including Georgia, Maryland, and Washington, have sponsored local mental health authority initiatives in the last few years.) The PCMI demonstrated the feasibility of creating and improving mental health authorities. It also described a number of organizational configurations for such authorities, indicating that there is no "one best way" to solve the problem of service fragmentation and diffusion of responsibility. Rather, organizational solutions must be adapted to the political and service economy of each community.

The PCMI also demonstrated that a mental health authority might be necessary, but was not sufficient to create a comprehensive system of services. Most of the cities improved the availability of services, especially case management, but none had a truly comprehensive system of community support services by the end of the demonstration. Several important lessons surrounded the continued centrality of the *state* mental health authority in local innovation. As the major payor and as the coordinator of federal resources, the state remains the key to local program change and expansion. Although local dollars played an increasing role in the PCMI sites during the demonstration, the state remained the most important funder of services. Furthermore, although many of the sites responded to incentives to shift resources from state mental hospitals to community budgets, these resources were not sufficient to develop the services needed to complete a community support system.

A unique feature of the PCMI was the emphasis on developing housing. Each site created a housing development corporation as an outgrowth of the local mental health authority. As a result of the PCMI, hundreds of units of housing were developed or acquired for use by individuals with chronic mental illness. Furthermore, the PCMI demonstrated that it was feasible for the sites to use the Section 8 mechanism

for subsidizing the housing for this population. The critical importance of having sufficient supportive services, especially when using a scattered-site approach to independent housing, was reinforced by the demonstration. These and other site-level observations are discussed by Newman and Ridgely (1994).

In summary, a great deal was learned from the PCMI, and there were many successes associated with it. Surely not all of its goals were realized, but it has already had an impact on mental health policy. As noted above, several states (Georgia, Maryland, and Washington) have encouraged the development of mental health authorities. Financial incentives for reducing state hospital use are discussed in many state mental health agencies. Housing development corporations are being created in communities throughout the United States. Individuals with chronic mental illness are widely acknowledged as the number one priority population in planning for public mental health services. Concerns about people with chronic mental illness have even entered the debate on health care reform (Schlesinger and Mechanic 1993). The findings of the evaluation are just now being published, but mental health planners and policy makers want advice now.

Summarizing the Quantitative Findings

As the articles in this issue of the *Milbank Quarterly* illustrate, the demonstration succeeded in advancing its structural goals and in improving continuity of care. Although the client studies also indicate that satisfaction with services and quality of life were high, the structural changes were not accompanied by specific *improvements* in quality of life for individuals with chronic mental illness. The continuity of care effects, however, indicate clearly that the site-level accomplishments had a parallel and intended impact on individual clients. Additionally, Tessler and Gamache, in their article, demonstrate that family burden (for coresiding relatives) is decreased when there is continuity of care, and Newman and her colleagues find significant improvements in the quality and independence of housing and a decline in the length of hospitalization when individuals use Section 8 certificates. The fact remains, however, that, as Lehman et al. and Shern et al. report in their analyses, no general improvement in quality of life occurred over the course of the PCMI.

What is the implication of these findings for the mental health services field? How do we explain this general finding? A number of methodological limitations of the studies may account for the lack of expected client-level effects. Actually, the service system in some of the demonstration sites did not change that dramatically between 1989 and 1991, the times of the client-level comparisons. Some of the sites, particularly in Ohio, had already achieved many of the site-level goals of the demonstration earlier than 1989.

We suspect that this set of results may reflect the lack of attention to improving clinical care services in the design and conduct of the PCMI. From the beginning of the demonstration the focus was on structural change and continuity of care—not on developing specific clinical services, other than case management. Given that focus, *the PCMI largely achieved its objectives.*

It was assumed that the state of the art in clinical and social care was available in each of these communities. Initially, there was some concern that the evaluation design focused too heavily on client outcomes and that the design would not permit a rigorous assessment of the impact of the PCMI on individuals with chronic mental illness. The design emphasized practical outcomes and quality of life, theorizing that they would be positively associated with continuity of care. The results indicate that continuity of care was achieved without the apparent effect on quality of life. The instruments are sensitive to change: on average, individual clients improve in functioning and quality of life over the course of the demonstration. Improvements, however, are not significant when comparing either early and late cohorts (Lehman et al.) or a panel in a demonstration site and a panel of clients in a nondemonstration site (Shern et al.). We conclude that *the PCMI demonstrated that structural change reforming mental health service systems for individuals with severe and persistent mental illness is not sufficient to produce improvements in quality of life.* To achieve improved quality-of-life outcomes we believe that there is a need to focus on clinical and social care as well as on structural change in the organization and financing of care.

The qualitative data and the article by Morrissey et al. underscore the feasibility of implementation and the achievements (as well as some of the limitations) of the local mental health authorities. Their article also indicates the positive changes in the patterns of interorganizational linkages in the demonstration sites. Although the development of community support systems was slower and less complete than the governance

and other structural changes, there was considerable measurable change in the direction of increased centralization, increased coordination, and decreased fragmentation. The site-level achievements may help to explain positive client-level effects on continuity of care, but the limitations in service system development also help to explain the lack of quality-of-life improvements.

The financial analyses by Frank and Gaynor draw attention to the importance of viewing each local mental health authority in the larger environment of state government. They document the increase in local dollars over the course of the demonstration and highlight the failure of state resources to keep pace with the growth in local mental health resources. Local successes may come at the expense of continuing state support. The cost shifting that has characterized mental health care policy for more than a century (Grob 1991) plagues service systems to this day.

Taken together, the qualitative and quantitative findings of the evaluation of the RWJF PCMI tell a complex story of innovation and challenges for future mental health service development. In the simplest terms and for a variety of reasons, we feel that the demonstration was "successful" because of the positive change it initiated, the models it has offered to the field, and because we think the field and policy makers can learn from some of its limitations and shortcomings. It meets the most important test of a "demonstration"—to show to others that the interventions *can* be implemented with positive results.

Problems with Interpreting the Evaluation

We conclude that the PCMI was successful as far as it went, but that it failed to see the need to develop clinical services and individual-level social care in these (and other) communities to improve client functioning and quality of life. Such a flaw is not fatal if we learn the lessons of the demonstration.

The evaluation of the demonstration illustrates the utility of the local mental health authority concept and describes nine separate models. The experience with the PCMI recommends that each community seriously consider developing a local authority or strengthening existing efforts to centralize administrative, fiscal, and clinical responsibility for individuals with severe mental illnesses. The expected benefit is in decreases in service fragmentation and increases in interorganizational cen-

tralization and density, reflecting greater contact with the broader social welfare system.

The PCMI demonstrates the feasibility of implementing large-scale expansions of case management services, but it also shows that improvements in continuity of care without concomitant access to high-quality services (e.g., assertive community treatment with sufficient physician involvement on the team) may not yield improvements in quality of life. The lesson for the future is to attend to quality of care at the same time as systems change: case management alone is not sufficient.

If these are simple lessons, then we can expect to see better services in the future. It is likely that implementing systems and services change will remain a challenge for the next decade. Health care reform offers a new promise. To those who see the glass half empty, we say that seeing the glass half full in 1993 is more likely to help fill the glass by 2003.

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Acknowledgments: This paper is based on research supported by grants from the Robert Wood Johnson Foundation, the National Institute of Mental Health, and the Ohio Department of Mental Health.

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