Introduction

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ALTHOUGH THE INITIATIVE TO REFORM MENTAL health service systems by creating central authorities was not supported by research data, the Robert Wood Johnson Foundation (RWJF) nevertheless decided to launch its Program on Chronic Mental Illness based on the collective wisdom of a wide range of individuals who were experienced in the care of persons with serious and long-term disorders. Additionally, research indicated that, in well-known model programs, service integration had some positive aspects.

The response to the announcement of the project gave further weight to the significance of system change as the focus of the demonstration. The nation's 60 largest cities—those with populations over 250,000—were eligible to apply. To do so, they were required to prepare a proposal that had to be ratified by public officials at state, county, and local levels; mental health authorities; service providers; and advocates for service recipients. It was a major undertaking. Further, although the project reflected a generous commitment by the RWJF and the U.S. Department of Housing and Urban Development, the amount of money available to each site was modest compared with the expenditures already in the system. That 56 cities submitted 55 applications (Los Angeles and Long Beach, California, combined their proposal) was a measure of their intense interest in improving dysfunctional systems. Their response also

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reflected the energy and creativity that was available to change the status quo when given even a modest financial stimulus (Aiken, Somers, and Shore 1986).

It is important to recognize that this enterprise was not undertaken as an experiment to evaluate the efficacy of a centralized mental health authority. It was, rather, a national demonstration project to stimulate the creation of a range of programmatic solutions to service delivery problems (such as financing, continuity, range of services, and housing) organized around the core idea of a consolidated administration. The project sites were chosen for diversity rather than uniformity. They were also encouraged to develop local, idiosyncratic programs with the expectation that the resulting variety would offer a rich harvest of possibilities that could be copied by other cities. The most important procedural factor was that the evaluators were not involved in constructing the demonstration; instead, they were selected after its guidelines were determined and the project had been set in motion. As a result, the evaluation team had a difficult assignment: to devise a methodologically sound study of a geographically dispersed, multiply directed set of programs that continued to evolve and change direction, even as the evaluators sought to capture these events in their data (Goldman et al. 1990).

There was an additional complication: implementation of the demonstration was guided by a national program office located in the Harvard Medical School Department of Psychiatry at the Massachusetts Mental Health Center in Boston. The office was staffed by a part-time director (Miles F. Shore), a full-time deputy director (Martin D. Cohen), and a director of communications (Diane D. Barry). They provided technical assistance with a host of day-to-day problems ranging from political impediments to clinical innovations; they monitored the program's finances; and they were responsible for communication between the sites and with local and national media (Shore and Cohen).

The relationship between the National Program Office, the sites, and the evaluation team was crucial for the success of the evaluation. The initial, and perhaps strongest, relationship was between the sites and the National Program Office. The evaluation team and the national program staff had known one another in other contexts, and they worked cordially together within the constraints of an agreement not to allow the emerging evaluation data to affect how the demonstration was carried out. This required particular restraint on the part of members of the evaluation team, who were also clinicians and experienced in program development. In general, the agreement to quarantine the evaluation

data was remarkably successful, with little contamination of the results. The relationship between the sites and the evaluators was also cordial, but more ambivalent, as there was a natural concern about how the sites would be rated in the final reports.

Because the evaluation team was studying a demonstration project that comprised intentionally diverse, constantly changing programs, the context of the evaluation results, and of the articles published here, should be clarified.

In the first place, the evaluation data could not answer the tempting, single question, "Were the central authorities a success?" Instead, the evaluation team chose a "logic model" that set out, through a series of steps, to determine whether centralized authorities could be established, and if they could, what would be their effects in selected sites on outcomes like continuity of care, quality of life, clinical state, the movement of money among financing systems, and the development of housing, to name only a few. Consequently, the usefulness of a centralized authority in a city other than the nine demonstration sites is not predictable by the evaluation results alone. Instead, the data, like the qualitative experience gathered by the sites and the National Program Office, indicate both conditions under which the model may be useful and a variety of instructive caveats.

For example, these studies do not support the perennial hope, endemic among public officials, that a service reorganization like the central authority might make it possible to avoid the need to expend public funds for the care of persons with mental disorders. As Shern and his colleagues demonstrated, the central authority in Denver could not maintain its early gains in the face of a budget crisis. Obvious as it may seem, money is required to fuel this innovation. Similarly, in Ohio, Lehman et al. demonstrated that case management and continuity of care alone will not improve clients' quality of life and their clinical state. Instead, it is likely that mental health services are also necessary. Again, although these conclusions might appear obvious, they serve to counterbalance the hope, stirred by the mystique of case management, that the expensive arcana of professional treatment can be eliminated, to be replaced by the ministrations of kindly nonprofessionals.

How does a project like this influence public policy? Everyone involved publicized its goals and its ongoing experience widely. The communication effort funded by the RWJF at the National Program Office worked diligently, and effectively, to attract media attention to the innovations taking place in local sites. Research projects by other teams of

investigators were also successfully spun off from the original studies. In the project's mature phase, publications in the professional literature presented the initial findings (Goldman, Morrissey, and Ridgely 1990; Goldman et al. 1992; Shore and Cohen 1992).

As the project is completed, certain inevitable problems arise in translating and applying its findings. A serious drawback is the time lag between launching such an ambitious undertaking and the publication of the evaluation data. For one thing, people forget about the project. Faced with the daily strains of conducting complex mental health services in a turbulent political and fiscal climate, it is difficult for program managers to look back several years to a completed national project for guidance. Fortunately, the RWJF has funded a continuing effort to provide technical assistance to any city wishing to replicate the central authority model.

A second problem is overreliance on research data for the development of public policy. Public officials, fearful of criticism, tend to study proposals endlessly, demanding increasing amounts of data to justify complicated, expensive projects like the creation of central mental health authorities. It is important to stress that research, even when it is as courageous and ingenious as that reported in this issue of the *Quarterly*, is not the sole source of guidance for administrative decision making. The collective experience of people working in the sites and at the national level can provide useful guidance.

Aristotle expressed the view that "it is the mark of the educated person to call for only as much precision as the subject matter admits of." People who are responsible for the care of patients and the stewardship of public funds would do well to remember those words and to exercise courage in moving ahead with innovation, guided by their own and others' experience, fortified by as many data as possible, without waiting for the definitive study. In that spirit, the following articles can be of inestimable value in making sorely needed changes to improve the care of persons with serious mental disorders.

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