

DEPARTMENT OF PUBLIC WELFARE

TO: Hon. Karl F. Rolvaag, Governor Sept. 30, 1965
Hon. A. M. Keith, Lieutenant Governor
Mr. Stephen Quigley, Commissioner, Dept. of Administration
Mr. Robert Mattson, Attorney General
Mr. John Jackson, Director, Civil Service Department
Mr. Morris Hursh, Commissioner, DPW
DPW Cabinet
Mental Health Medical Policy Committee
Children's Mental Health Committee
Citizens Mental Health Review Committee
Hospital Construction Advisory Council
Mental Health Planning Council
Mental Retardation Planning Council
State Advisory Council on Community Mental Health Center Construction
State Advisory Council on Mental Retardation Facilities Construction
Legislative Building Commission
Medical and Administrative Chiefs - All Institutions
Program, Clinical Directors and Board Chairmen, Community Mental
Health Centers
Mental Health Executive Council
Regional Mental Health Coordinating Committees
University of Minnesota - Dept. of Psychiatry & Neurology
Dept. of Pediatrics
Dept. of Public Health
School of Hospital Administration
Administrator, University Hospitals
Mayo Clinic, Psychiatry Section - Attention: Dr. Edward Litin
Mr. Virgil Shoop, Acting Regional Program Director, Mental Health
Services, 560 Westport Road, Kansas City, Missouri 64111
Veterans Administration Hospital, Minneapolis, Minnesota
Veterans Administration Hospital, St. Cloud, Minnesota

FROM: David J. Vail, M. D.
Medical Director

SUBJECT: Attached article

Attached is the copy of a paper I will be reading on October 28, 1965, at The Hospital Centre in London.

Although there is nothing here that will startle you, the undertaking is very intriguing, as it requires explaining to a British audience in a brief space how the American systems of government and nongovernment mental health care operate.

DJV:rcj
Enclosure

THE ORGANIZATION OF MENTAL HEALTH PROGRAMS
1
IN THE UNITED STATES

2
by David J. Vail, M. D.

A word of forewarning: this paper is full of the most outrageous oversimplifications. I hope I may be forgiven my sins of commission and omission, and that discussion will clarify some of the points made.

I. Historical Background

In order for someone who is not from the United States to understand how mental health services are organized in the context of health and medical care programs generally, he must at least glimpse the structure of American traditions underlying.

It is very difficult for someone from smaller, more compact, more uniform, and more thoroughly organized nations to understand how our country works. Notice that I do not refer to "older" nations, for we are the world's oldest living republic, with the longest span of survival under a single constitution. I believe the dimension of age is relevant to this discussion, however, if we consider the duration of our familiarity with welfare-state concepts, which for us dates back only to 1935, when the Social Security Act was passed.

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Paper presented at The Hospital Centre in London, England, October 28, 1965

2

Medical Director, Department of Public Welfare, State of Minnesota

Although it is pretentious to make the attempt, I should try in a very brief space to highlight a few elements in American history that are appropriate in understanding the health care scene today.

1. The tradition of states' sovereignty

We are a federation of sovereign states. The tradition of state sovereignty, or States' Rights, goes back right to the earliest colonial times; for the colonies were founded by different independent groups granted charters direct by the Crown. Each colony had its own separate governor and its own laws. This tradition ~ spanning almost as long a time as our later nationhood - was carried forward in our Constitution.

The Constitution granted to the national or federal government the external functions of international relations and certain specific internal functions such as regulation of commerce, coinage, postal service, etc., at the same time reserving other functions to the states. The Tenth Amendment, which is the final clause of the so-called "Bill of Rights," states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

Traditionally this has meant that the states and localities have been responsible for the regular stewardship functions of government; public health and safety, highways, education, care of the poor, property and voting laws, etc.

*The flavor of the States Rights' tradition is not too far removed from the British concept of Home Rule and the nationalist sentiments of Wales, Scotland, and Ireland; I think there is analogy also between our two systems if we consider that some government functions (e.g., hospital and health services) are administered separately in different parts of the United Kingdom.

Within the mental health field the role of state government was clearly defined over a hundred years ago by two developments: (1) Relinquishment, by default, of the responsibility for mental health care by the villages, towns, and counties to the states, leading to the establishment of state asylums, and (2) President Franklin Pierce's veto of a bill that would grant land to the states for asylum building sites on the then clear grounds that care of the mentally ill was a state responsibility and prerogative.

One of the important current developments is the drive to return responsibility for mental health care to the villages, towns, and counties (i.e., the "community," defined in current federal regulations as a population tract of between 75,000 and 200,000 persons) with the assistance, indeed the virtual insistence, of the federal government through laws enacted in 1963 and 1965. This thrust has the partial effect of by-passing and in a way undoing the state government responsibility. Historically, default of responsibility at the state level has been a powerful force to attract federal activity, not only in mental health but in many other areas as well.

The federal government has in the past thirty years entered significantly into these basic stewardship functions: highways, education, welfare, and now health care. The basic mechanism used is the grant-in-aid: money turned over in large sums to the states - impossible to refuse - accompanied by standards of qualification; regulations; almost always a bewildering bureaucracy; and often program designs that are more of the heart than the mind, founded more on impulse than on hard logic.

The large-scale entries of the federal government into these areas is viewed with distaste, even alarm, by the conservative constitutionalists. But note the final clause of the Tenth Amendment: ". . . powers . . . are reserved to the States , . . . or to the people." The modern liberal interpretation is that this means all the people – a phrase that President Johnson has used very effectively. The national sentiment now is that certain human and social rights, including good health, are so basic that they must be enjoyed by all citizens regardless of where they happen to live; regardless of their color, religion, or national origin; and – here the concept softens, I regret to say – regardless of their affluence.

2. The frontier

The second major historical factor I could mention is the persistent influence of the frontier in American life.

The frontier is many things. It is the place where anything is possible, where men cross high mountains and alkali deserts and build a life for themselves against superhuman odds. It is the place where if one interoceanic canal cannot be used, another will be dredged. It is the place where men can reach the moon, eradicate poverty, sweeten the seas, rebuild their cities, lay down a million miles of motorway, and save Asia from the Chinese, all at the same time. It is the place of American invincibility.

The frontier is the home of free men. It is run by the richest and the toughest. The best government is the least government. Indeed, "government" is personified by the revenue agent who places a tax on the land that you have

cleared with your bare hands, and by the soldiers who come out and smash the whisky still that is your private possession and the source of one of your few pleasures.*

On the frontier trade regulates itself and men rise by their own ingenuity and skill. The first draft of the Declaration of Independence read not "Life, Liberty and the Pursuit of Happiness," but simply "Life, Liberty, and Property." The frontier is anti-intellectual and pragmatic, its materialism tempered with a rough and ready, ascetic Calvinist belief in a Divine Providence.

The frontier is simple, founded on simple values and simple solutions. The values are the old virtues: thrift, hard work, honesty, self-reliance ("God helps those who help themselves"). It is compassionate in its way, for survival is impossible unless neighbors help and defend one another. But it is a hard life, with no place in it for the weak and shiftless. "Welfare" is a dirty word, "socialist" a blood insult. Problems are solved by removal: if a man doesn't like his neighbors, he moves farther west. If someone gets to be a nuisance, he is put on the next train out of town.

This is the old culture. It is a great culture, this way of the Giants in the Earth. But unmodified, without additional dimensions of flexibility and subtlety, it cannot cope with modern life: our new world of nasty, faraway jungle wars and race riots; where there are no easy victories but only a

*President Washington did this in 1792 the Whisky Rebellion, the first great test of the power of the federal government.

"long, twilight struggle"; where it is more patriotic to spend than to save; where a submerged and dispossessed fifth of the nation appears to show little motivation and less gratitude.

3. The events of 1963-65

Because of the nearness of time and emotions, it is still difficult to be objective about the Kennedy and the Johnson years and the terrible cleavage of November 22, 1963 that separated them. The assassination will prove to be, in my opinion, a major watershed in American history. For there has occurred a softening, a loosening of long-dammed currents. The massive Johnson majority in the 1964 election and his mastery of the legislative process are additional ingredients.* The result is fantastic: a string of legislation that is revolutionary – radical – in its impact. The country will never be the same.

For our purposes here the most important developments in federal legislation are the comprehensive community mental health centers bills (sometimes called the "Kennedy Mental Health Program"), companion legislation having to do with mental retardation, and of course Medicare.** Medicare has not been well taken by the American Medical establishment, which is still operating on the old frontier values. I would share with American Medicine the forecast that the present version of Medicare is only the beginning, but would at the same time predict

*For completeness one should include the new "super-spend" economics of Walter Heller, a completion of the lesson first taught by Roosevelt in the New Deal: more money circulating means greater prosperity for all; and far-reaching Supreme Court decisions in the past decade,

**The Medicare bill, contrary to popular supposition, does not simply have to do with health and medical care for the aged. It is a sweeping revision of the Social Security Act of 1935, and has deep implications for mental hospital services, medical care for the needy, upgrading institution standards, etc.

that it will be more palatable and more successful than its critics suppose. For I believe that it fits with the modes of medical practice in our country and preserves the honored traditions of medicine wherever it is well practiced,

II. The Minnesota picture

Rather than try to summarize the national field, on which my view is limited, I believe it would be more profitable to discuss Minnesota. For Minnesota, while not a "typical" or "average" state (there is none) holds the mirror to the country as a whole.

Basic to the discussion are two points of orientation:

(1) The State of Minnesota

We are a population of 3 1/2 million, dwelling on 88,000 square miles (about the size of Britain) in the great American heartland. Half of the population is agricultural. A third - somewhat over a million people - is concentrated in the Twin Cities area of St. Paul, Minneapolis, and their suburbs. Occupation is diverse. State traditions in politics, education, and welfare are liberal. It is one of the nation's great medical centers.

(2) The Mental Health Program in Minnesota

Though one would prefer to avoid the first personal pronoun, I must clarify my own position. I am the director of the state mental health program of Minnesota. I am also a professional public administrator, and a psychiatrist. I am, like anyone, subject to biases in my point of view which must color my interpretation of current developments.

For example, I am committed to the goals of state government: my accountability is primarily to the state governor, the state legislature and the people of Minnesota. I am relatively ignorant of programs in other states except insofar as news of their successes or failures reaches us, to warn or instruct. To say that I am unconcerned by developments in other states would be quite inaccurate; still there is a general concept that each of us* is paddling his own canoe. The state program people are fairly close together in their watchfulness of the new federal government programs, and quite close in their belief that they have not been properly consulted in regard to the federal programs.

To continue the personal account for one more moment: I am a public person, a government person: this creates not only a commitment to public goals but a kind of separation from the world of the free-enterprise medical practice system, which is the prevailing mode.

The mental health program in Minnesota is organized in the Department of Public Welfare, one of four state programs so organized.** The state programs are all organized differently, yet they all have the same problems: plus ca change, plus c'est la meme chose. State program people would tell you that whatever might develop at the national or local levels of government, it is the states that ultimately must organize and implement the public programs.

*"Us" here refers to the state mental health program directors; a singular, rapid-turnover group whose relationship inter pares is one of friendly rivalry, a sharing of concerns in a club-like atmosphere.

**In Minnesota this means, among other things, relatively loose connections with public health programs at the state and local level.

Now for the Minnesota picture:

1. Recent developments

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A simple array of statistics tells part of the story:

	<u>1960</u>	<u>1965</u>
Mentally ill(incl. inebriates)in Minnesota state hospitals	10,300	6,600
Total admissions, mentally ill	3,240	3,790
First admissions, mentally ill	2,240	2,210
Total discharges, mentally ill	3,320	4,570
Non-state hospitals (excluding University, Veterans Administration)		
No. of units	16	17
3 No. of beds	819	786
No. of Total Admissions (to above units only)	10,700	12,900
4 State beds per 1,000 population	3.01	1.87
Total beds per 1,000 population	3.25	2.10
Total beds per 1,000 population (including University, Veterans Administration)	3.74	2.46
Community Mental Health Centers		
No. of centers	13	22
No. of counties served	44/87	79/87
% of state population served	<i>34%</i>	90%
State population	,414,000	3,521,000

NOTES: 1. Figures are for June 30 of the year rounded.
Exception: figures italicized are for calendar year 1964, the most recent available.

2. University of Minnesota: 68 beds
Veterans Administration: 1200 beds approximately.

3. During the 1960-64 period, two new units opened, one closed, and others have gone up or down.

4. Refers to number of resident patients

Time does not permit discussion of the utilization of state and local nursing homes, accounting for the release of several hundred geriatric patients from both mental illness and mental retardation state institutions during this period. For reasons of space and simplicity we likewise cannot discuss the important developments in the mental retardation field.

2. Future prospects

Here I am using just a few examples to show what is going on in Minnesota. Allowing for variation, this would afford a cross-section of the kind of activity going on in all the states.

a. Utilization of federal funds for comprehensive community mental health services.

As the above statistical table shows, Minnesota has a very well developed community mental health services program, established by state law in 1957. By federal definitions, however, it is not a "comprehensive" program.** We are studying ways of making use of federal funds for construction and staffing of centers, where added staffing would bring about program expansion. At the level of the individual local operations in Minnesota, the difference between the federal and Minnesota patterns creates problems of accommodation. At the state level we are troubled by the loose goal-orientation of the federal program design and the possibility that the comprehensive centers may produce relatively little in the way of concrete solutions to major public problems.

*Federal funds for the development and implementation of comprehensive community mental health services are divided thus: P.L.88-164, passed in 1963, provides funds for construction. P.L.89-105, passed in 1965, provides initial funds for staffing.

**A "comprehensive program," by federal regulations, must contain at least in-patient, out-patient, emergency, partial hospitalization, and community consultation services. Most of the Minnesota community mental health center operations have from the outset concentrated on out-patient services and community consultation.

Minnesota was one of the first two states* to have its centers construction plan approved by the federal government. Thus it is in a relatively advantageous position, A brief review of individual projects coming on sooner or later might be illustrative.

1. Two of our centers, high on the priority list, have decided to "go it alone" without utilizing federal funds. A third has dropped out, at least temporarily, because of problems at the county level of government.

2. Two centers, one relatively quite early in planning stages and the other relatively advanced, would establish comprehensive-type programs, including in-patient services, in remote areas over a hundred miles away from the nearest state mental hospital.

3. One program - the nearest to realization - would tie together under almost ideal circumstances the services of a community mental health center and a private** hospital in a semi-urban area of 120,000 population.

4. One very large-scale undertaking involving two juxtaposed private** hospitals in Minneapolis poses many problems which must be solved if the project is to get underway. Among them the most interesting and challenging is the unfamiliar confrontation of the public and nonpublic sectors of the mental health care establishment.

*Modesty prevents us from claiming to be the first; though Minnesota was the first state to submit an approvable plan.

**"Private" here is used in the sense of voluntary, nonprofit community general hospitals similar to many in Britain prior to 1948.

b. Developments in the mental retardation field

Mental retardation programs are at the threshold of really exciting developments in Minnesota. This encouraging prospect stems from large-scale planning efforts made possible by federal funds; federal funds for construction and hopefully also staffing of local facilities; an effective parents' organization; powerful support and leadership from the Governor's office; a breakthrough in state legislative support in 1965; and the continuing work of the Department of Public Welfare, which is the state agency responsible for administration.

c. Medicare

Tucked away in the medicare bill are provisions that will have strong though unpredictable effects in geriatric programs in state mental hospitals. Medicare will broaden the access of borderline and needy families to quality medical care, including psychiatric care, and will no doubt allow the private insurance companies, the labor unions, and other carriers to extend coverage into as yet uncovered fields.

III. Manpower

Where will the people come from to staff all of these programs? This is a terribly vexing question, for which no satisfactory answers are in the offing. Psychiatrists are in the most urgent shortage,

The basic problem, exemplified most seriously in psychiatry, but extending to other mental health professions, is the low prestige accorded to public service; Also the fallacy in supposing that training and manpower production based on private enterprise concepts and the values of the professions themselves will somehow automatically or by osmosis solve the urgent public problems of the day.

Ways of dealing with the situation are:

1. Early exposure.

We are, for example, developing recruitment literature and techniques aimed at high-school students.

2. Continuing pressure on the training programs.

This is especially appropriate with regard to training programs based in public institutions, Pressure is applied also on the National Institute of Mental Health, which is now supporting a very large segment of the professional training establishment,

3. Plunder of other programs at home or overseas.

This is the most futile and self-defeating approach, but the most commonly taken. It is based on a spiraling demand market and uses all manner of selling techniques.

4. Utilization of manpower skills and delegation of responsibility.

Examples: In-service training and utilization of front-line professional groups at the local level (welfare workers, clergy, teachers, public health nurses, etc.); use of volunteers; use of nonmedical administrators, etc. Minnesota has been a leader in these areas, though there are those who believe we have gone too far. We touch here on American invincibility; if we don't have psychiatrists, we will find ways of running our programs without them. Still there are serious questions of how far psychiatric responsibility, and more basically medical responsibility, can be delegated away.

In summary, we stand at a turning point: much has been accomplished, and much remains to be done. In my view the outlook is optimistic, the American Dream within our grasp.*

*The American Dream is both real and unreal. It has found political expression in slogans: "Normalcy" (Harding), "Prosperity" (Hoover), "New Deal" (Roosevelt), "Fair Deal" (Truman), "New Frontier" (Kennedy), "Great Society" (Johnson). A compact and lyrical expression is the poem America the Beautiful, by Katherine Lee Bates:

O beautiful for spacious skies,
For amber waves of grain,
For purple mountains majesties
Above the fruited plain!
America! America! God shed His grace on thee,
And crown thy good with brotherhood
From sea to shining sea!

O beautiful for pilgrim feet,
Whose stern, impassioned stress
A thoroughfare for freedom beat
Across the wilderness!
America! America! God mend thine every flaw,
Confirm thy soul in self-control,
Thy liberty in law!

O beautiful for heroes proved
In liberating strife
Who more than self their country loved,
And mercy more than life!
America! America! May God thy gold refine
Till all success be nobleness
And every gain divine!

O beautiful for patriot dream
That sees, beyond the years,
Thine alabaster cities gleam,
Undimmed by human tears!
America! America! God shed His grace on thee,
And crown thy good with brotherhood
From sea to shining sea!