DEPARTMENT OF PUBLIC WELFARE

April 19, 1966

TO: Hon. Karl F. Rolvaag, Governor
Hon. A. M. Keith, Lieutenant Governor
Mr. Robert Mattson, Attorney General
Mr. Ray Lappegaard, Commissioner, Dept. of Administration
Mr. John Jackson, Director, Civil Service Department
Mr. Morris Hursh, Commissioner, DPW
DPW Cabinet
Mental Health Medical Policy Committee
Children's Mental Health Committee
Mental Health Planning Council
Mental Retardation Planning Council
Citizens Mental Health Review Committee
Hospital **Construction Advisory** Committee
State Advisory Council on Community Mental Health Centers 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
Rochester State Hospital Utilization Committee
University of Minnesota - Dept. of Psychiatry and 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, Regional Program Director, Mental Health Services,
601 East 12th St., Kansas City, Missouri 64105
Veterans Administration Hospital, Minneapolis, Minnesota
Veterans Administration Hospital, St. Cloud, Minnesota
Mr. Ralph Keyes, Minnesota Assn. of Counties, 1821 University Avenue,
St. Paul, Minnesota 55104

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

SUBJECT: Statement to Congressman Paul Rogers

Attached is the statement which I have given at a hearing held by Congressman Paul Rogers of the House of Representatives Committee on Interstate and Foreign Commerce. I appeared before the Committee on April 18, 1966. I would appreciate any comments which you might have.

DJV:rcj
Enclosure

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

TO: Hon. Paul Rogers April 11, 1966
Chairman, Special Subcommittee on the
Department of Health, Education and Welfare
Committee on Interstate and Foreign Commerce
House of Representatives
Congress of the United States

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

SUBJECT: Observation on public humanitarian services in the United States

STATEMENT

I am Dr. David J. Vail, Medical Director of the Department of Public Welfare of the State of Minnesota. I represent the Commissioner of Public Welfare, who is the State Mental Health Authority of Minnesota. The Commissioner of Public Welfare is also designated as authority for both mental health and mental retardation facilities construction under P.L, 88-164, and under state law is charged with the administration of institutions for the mentally ill and mentally retarded, and the development of community mental health programs.

First, I express my appreciation to you, Mr. Chairman, and to this Committee, for this opportunity to bring to you my observations on the administration of public service programs.

Next, I must identify myself not only by name and title but along certain other dimensions. My reason for this is that views expressed on health, mental health, and related matters will vary, among other things, in relation to the profession of the witness, his bureaucratic status, his personal political philosophy, and other commitments. Therefore so that you will understand my position, I should make these points very clear:

1. I am a public administrator.

2. I am a psychiatrist.

3. I work for the State of Minnesota.

4. I work comfortably in a setting in which the field of public mental health is, so to speak, subsidiary to the more general order of public welfare. This means that my view of the public service world will differ, for example, from that of one who views mental health as subsidiary to public health or, in contrast, an entity unto itself.

5. My orientation about the field of public "mental health" is inclusive rather than categorical. That is, I regard the problems of mental illness, mental retardation, alcoholism, forensic psychiatry, child guidance, etc., as part of the same general order rather than separate issues. Here again, you will encounter different points of view depending on who appears before you.

6. In political terms, I would be viewed as somewhat in the center, which still puts me to the left of the great majority of my brethren in the medical profession.

Despite the above qualifications, I have reason to believe that, generally speaking, my sentiments are not far removed from those of other state administrators in the human services field.

One reason I am glad to have this opportunity is that I am worried not only about the particular programs in which I directly participate, but also about the implications of current trends in the public services field for the future of this country. I quote from the final section of my editorial which will appear in the April, 1966, issue of the Minnesota Mental Health Newsletter:

> We have been warned about the dangers of a technocracy surrounding the military-industrial elite. Are we seeing the start of a new elite, a new technocracy in the human services field? If this were coupled with management practices that pit the federal and state governments against each other, the consequences to constitutional government in the United States could be very grave indeed.

Rather than demean these proceedings by simply airing gripes, I have organized my presentation into three main parts, which greatly interlock: (I) Problems specific for the field of public mental health, (II) Problems general for the humanitarian field, and (III) Recommendations.

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I. Problems specific for the public mental health field

The problems are spelled out in some detail in the Minnesota Mental Health Newsletter editorials of February, March and (unpublished) April, 1966. I submit these for the record, and will be pleased to read all or parts of them. In very broad terms, the issues, in order of increasing importance, are as follows:

1. Excessive paperwork

The Minnesota plan for comprehensive community mental health centers construction, written according to the official instructions, was clocked out when we submitted it in December, 1964, at over 600 pages and a total weight of 5 pounds 10 ounces per copy — and it was judged to be incomplete at that. This production job would have been less frustrating if we could have seen its intrinsic connection to other public mental health, or, for that matter, public human services efforts; or even to the other state plans submitted by our own division, by the Department of Public Welfare, or by other state departments.

2. Bureaucratic manipulation

This is covered in the Newsletter editorials, especially that of March, 1966, entitled Government Games.

3. Problems of logic and ideas

This is also covered, though incompletely, in the Newsletter editorials.

II. Problems general for the humanitarian fields

1. Goals

Goals are now being defined not in output terms of reduction of public problems but primarily in input terms of services to be provided. This puts a premium on activity rather than accomplishment.

2. Categories

In my view, there is an overabundance of categories of federal programs, each of which, in varying measure, entails special offices at both federal and state levels, advisory committees, written plans, budgets, etc. For example, the Medical Services Division of the Minnesota Department of Public Welfare now has to contend with all this machinery in regard to general community mental health, comprehensive community mental health centers construction (a separate category), community mental health centers staffing (another separate category), and (slightly variant) mental retardation facilities construction. The Minnesota Department of Public Welfare as a whole is charged with the following additional categories of federal grant programs: public assistance, crippled children, tuberculosis, blind services, child welfare, and most recently Title XIX of the Medicare Act. The Minnesota Health Department has

hospital construction, material and chili health. And so it goes. On the positive side, it should be said that certain federal programs force interdependence among the state agencies, which is all to the good; examples are mental retardation facilities planning and M.D.T.A.

3. Multiple convergence

This is related to the problem of categories. The federal agencies are in a position to establish staff positions as soon as a federal agency or sub-agency is created. The states move more slowly. The resuit is that a single state agency may be the target for not a single counterpart federal agency but rather for a group of federal agencies or teams which may sometimes appear to be in competition with one another. This is burdensome and perplexing to the states.

4. Squeeze

This is a complex phenomenon which stems from too rapid proliferation of programs at the federal level, inadequate administrative machinery at the state level, and stimulation of pressure locally — from below, so to speak — through publicity and other forces generated from Washington. Typical examples are the November 10, 1965, missive from the National Institute of Mental Health and the P.L. 89-10 fiasco. The story of the resignation of Dr. Fred P. Roessell from the Minnesota Department of Education is a perfect case in point (Minneapolis Tribune article of April 7, 1966, submitted for the record).

5. Absence of dialogue; confusing messages

The state agencies are ultimately called upon to implement programs. Discussion between state and federal counterpart agencies has been inadequate. Related to this and to other factors is a serious problem of confusing messages.

6. Downgrading the states' effort

Federal programs may be formulated, justified, and brought forth with heavy emphasis on states' failure to solve the problems. While this position may be accurate in some respects, it is not pleasing to the state agencies and not calculated to win their cooperation; especially when the state agencies may be bypassed in new efforts or required to perform under conditions of degradation and/or beyond their capabilities.

7. Cross-referencing

Sometimes, either in law or regulations, it is made clear that Category A funds will be withheld unless standards in Category B are upheld. One wonders whether such practice is always appropriate, wise in the long run, or for that matter fair.

8. Manpower

New programs will not only drain available manpower sources for direct services (e.g., social workers, nurses, etc.) but also competent administrators.

9. Emotional strain

Let us not overlook the human element. The work of setting up and administering the programs is done by human beings. The resulting strains may be overwhelming. Show me a state man who has worked up a new program by federal standards and I'11 show you a case of traumatic neurosis.

III. Recommendations

I divide these comments into two groups: (A) Those consonant with current federal practice, and (B) those that would depart from current federal practice.

A. Consonant with current federal practice

1. Accountability

We uphold the principle that the states should be accountable for program performance in qualifying for moneys received. In fact, we believe that accountability for results should be strengthened and improved.

Below I make more concrete suggestions about new ways in which accountability systems might be organized,

2. Non-substitution

We uphold the principle that federal grants of whatever land should not be used to substitute for state effort, but to supplement it, to help advance capability.

B. Departing from current federal practice

1. Planning should be based on the reduction of public problems.

2. Categories for grants should be trimmed back as much as possible. I personally favor the idea of lump-sum grants. I think you will also find the so-called Heller plan quite attractive to state-level workers.

3. Whatever else is done, paperwork must be reduced. The present situation is simply ridiculous.

4. There should be clear and uniform policies allowing for support of costs of administering federal grant programs; current practice appears to be inconsistent.

5. Dialogue between the federal and state agencies should be enhanced. Stated in another way, those who are entrusted with the implementation of programs should be included in the discussion of the programs before their enactment, and as programs get underway better feedback channels should be provided than now exist.

6. Programs must start where they are. An old rule in chess is, Do not try to get a piece out of trouble by getting another piece in trouble. Do not try to solve problems by creating new problems.

7. Work in the humanitarian fields should be decentralized. Can we hark back to the wisdom of the Constitution? Extramural functions of the nation, such as defense and foreign relations, are quite properly in the jurisdiction of the federal government. But the evidence seems to be accumulating that the intramural functions of regular stewardship — protection of the public health, safety, and morals, for example — must be reserved to the states; otherwise, considerations of political philosophy aside, it just won't work.

8. We should try to remodel existing administrative systems connecting the federal and state governments along imaginative and if necessary novel lines. For example, why not require only one state plan per agency, not according to preconceptions about program jurisdictions within agencies, but simply taking the state agencies as they exist? A controllable number of plans could then be put together into a total plan for the state by a state planning authority in the governor's office.

   Patterns of program consultation might be greatly modified. At the present time regional offices are the headquarters of consulting staff teams organized by program categories. Might it be more feasible to station federal consultants directly in the states themselves on a full-time basis, to function as generalists in relation to the state agencies as they exist? The personnel for such a system could come from thinning out and not adding to existing federal agency staff. Incidentally, and curiously, there is a precedent for this approach in one area — fiscal — in the person of auditors employed by the federal government and stationed permanently at the state offices to go over all the federal accounts in a given state agency. It would be interesting to see if through setting up similar mechanisms in program areas the superior quality of fiscal control could somehow be transmitted to program control.

   The above is offered as one of many possible ideas that should be looked at and discussed.

Finally, I would offer as examples of moves in the right direction Title XIX of the Medicare bill and the recently-introduced S.3008.

As to the Department of Health, Education, and Welfare, I would pursue the above lines of approach in favor of an integrationist philosophy. That is, I think that the Department should be forced in a department and not allowed to bumble along as a special professional interests arcade as it is at present.

Civilian rule should be maintained at HEW just as at the Pentagon.

Education, health, mental health, public welfare and related fields are now a multi-billion-dollar industry. We should, as an enterprising people, apply to this industry the same management talent and techniques — that is to say, the best available — that we would apply to any other industry.

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