Interstate Cooperation for Mental Health

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IN recent years, with the rapid expansion of psychiatric programs throughout the country, a number of issues, often administrative in nature, have required considerable attention and resourcefulness on the part of those responsible for their successful resolution. Among these problems are the necessity of planning and developing community-based services, new approaches to the perennial manpower problems, and, inevitably, the financing of services.

Since mental illness is not limited by State boundaries, problems concerning care and treatment are common to all States. Although the principle of interstate cooperation is accepted, desirable, noncontroversial, and utilized in many ways, there is no established pattern on a national basis for dealing with some of these issues related to mental health and illness. However, for the past 8 years a regional association, the Northeast State Governments Conference on Mental Health, has addressed itself effectively to problems of interstate concern. Because of its nature, the organization is not well known, even in the Northeastern States. It is laudable that so much can be accomplished quietly and informally. Nevertheless, a narrative summary of this association, its structure, function, and accomplishments may be of interest and some value to others with similar problems.

Structure

The Northeast State Governments Conference on Mental Health is a symposium of persons officially connected with the mental health programs of 10 Northeastern States, the Public Health Service, and the Council of State Governments (*1a*). Since the organization is concerned with public psychiatric programs, it obviously represents services to large numbers of persons at a cost of many millions of dollars.

Its historical forerunners were meetings, beginning in 1949, between consultants of the Public Health Service and representatives of State mental health authorities in New England, concerning development of community mental health programs. In 1953, New York, New Jersey, Pennsylvania, and Delaware were invited to join the New England States. Concurrent recommendations for regional associations of officials responsible for State mental health programs were made by the Association of State and Territorial Health Officers at their December 1953 meeting and in the 1953 report of the Council of State Governments, in a resolution entitled "Training and Research in State Mental Health Programs." The first National Governors' Conference on Mental Health, held in Detroit in the spring of 1954, recommended encouragement of regional associations. In 1954, at Hartford, Conn., with the support of the 10 Governors of the Northeastern States, the regional committee officially adopted the name, "Northeast State Governments Conference on Mental Health." Since the conference was supported and sponsored by the 10 State Governors, it was appropriate for the Council of State Governments, with its Inter-State Clearing House on Mental Health, to become a regular conference participant. Over the years the staff of this council has compiled and published the conference proceedings.

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The major meetings of the conference are held twice yearly for a 2-day period. Generally there are one or two formal presentations, and subsequent sessions are spent in small group workshops discussing the content of the formal addresses. The meetings rotate among the States on a regular but informal pattern. The official invitation to the conference is extended by the Governor of the host State for each meeting. An address to the conference by the Governor is customary.

The States send as participants professional mental health personnel (psychiatrists, psychologists, social workers, nurses), legislators, members of the executive branch of government, and, depending on the conference theme for the year, other appropriate persons (budget officers, business managers, public information staff) sharing program responsibility in nonclinical areas. Additional participants are consultants of the Public Health Service and representatives of the Council of State Governments, a combination making a unique triad concerned with medical and psychiatric programs from an administrative rather than a clinical point of view. No other mental health forum has such a broad interdisciplinary representation on a regular basis.

Each State is limited to 10 participants, although the host State may have 25. Generally attendance varies from 90 to 125. This has proved to be a manageable group for general sessions since it can be divided into convenient smaller units for group discussions and is not so large as to inhibit rapid integration of new members at subsequent meetings.

The formal structure of the organization is quite simple. Three officers (chairman, vice chairman, and secretary-treasurer) serve yearly terms. In addition, there is an executive committee consisting of one representative from each State and representation from the Public Health Service and the Council of State Governments. The officers and executive committee are the core that maintains continuity between the larger spring and fall sessions, determines program themes, and conducts any other conference business. All this is done within the framework of six rules. Necessary common costs are provided by a registration fee, but in general each State makes its own financial provision for its participants. Since expenses are thus shared, no accurate data are available, but for 100 persons meeting twice yearly for 2 days, the estimated cost of this conference is $10,000 a year.

Accomplishments

The Northeast State Governments Conference on Mental Health is the only regional association concerned exclusively with public mental health programs. Three related groups, within the framework of interstate compacts, are the Southern Regional Education Board, the Western Interstate Commission for Higher Education, and the New England Board of Higher Education. These compacts are primarily concerned with education. However, they represent a somewhat different cooperative approach among States than that of the northeast conference. For instance, in contrast to the northeast conference, each carries out specific action programs as an organization. At a 1955 meeting of the northeast conference, a representative of the Southern Regional Education Board described his region's efforts in mental health training and research. Subsequently, some consideration was given to developing a similar council, but such proposals did not find favor with conference delegates. The Western Council on Mental Health Training and Research, described by Vaughan (*2*), is also directly responsible for carrying out certain action programs in training and research. More formal in structure and more limited in scope than the northeast conference, the council still serves admirably to meet a specific need in a geographic region.

The Northeast State Conference is primarily deliberative and has no responsibility for proposing, developing, or carrying out action programs (*1a*). This is not to say that no action results from the deliberations; quite the contrary is true. However, the conference, as such, carries out no action program directly, nor are conference recommendations binding on any State. Each State is free to implement suggestions in the light of local needs and situations. The conference has, on occasion, made recommendations for specific action to other appropriate agencies such as the Public Health

Service, the Council of State Governments, and the Association of State and Territorial Health Officers. The fact that conference resolutions are not binding on any member State is deliberate and constitutes one of the very strengths that makes this organization unique in composition. Marsh correctly pointed out that if "Conference resolutions were binding on states, the opportunity of inviting legislators would be lost" (*1b*).

Although the backgrounds and experience of the northeast conference participants are varied, the support and active participation of commissioners of mental health and other administrative psychiatrists has insured psychiatric leadership for the scope and focus of program content. In addition to the subject of community mental health progams, conference themes have included alcoholism, retardation, services to children, mental health manpower, economic aspects of mental health, the relation between State and community, and the relation between psychiatric and nonpsychiatric programs. A recent conference theme was long-range planning for mental health programs. Emphasis on planning activities was continued in the 1963 meetings.

The subjects have been timely and often ahead of developing trends. In 1954 and 1955, conference participants were briefed on the New York Community Mental Health Act, its trials, tribulations, and accomplishments. Conference interests have paralleled the work of the Joint Commission on Mental Illness and Health, and many of the Commission's officials have addressed the meetings.

Although the Northeast State Governments Conference does not engage directly in continuing action programs, it stimulates action through some other organized body. Certain specific accomplishments directly traceable to conference deliberation are worth noting for their broad regional or national influence. The first fruit of conference cooperation was the Interstate Compact on Mental Health, which essentially provides that care and treatment for mental illness and retardation be based on patient needs rather than legal residence. Following preliminary discussions, a working group of psychiatrists, legislators, social workers, attorneys general, and administrators met in conjunction with the Northeast State Governments Conference on Mental Health in Burlington, Vt. (*3*). The proposed Interstate Compact on Mental Health was approved September 30, 1955, by the conference in a strong resolution urging early consideration and ratification by legislatures in the northeast and other areas of the country (*4*). It is noteworthy that 7 of the 10 members of the northeast conference became signators within less than 2 years of the resolution for adoption of the compact (*3*). By June 1962, 25 States had ratified the compact, indicating their intent to establish procedures designed to serve the best interests of the patients, their families, and the States.

Of equal importance is the development of community mental health legislation paralleling activities of the Northeast State Conference. Although Connecticut had enacted some legislation of this type before 1954, it did not stimulate the national interest and attention evoked by the New York Community Mental Health Services Act. It was in 1954 and 1955 that Hunt reviewed the law and the New York experiences at meetings of the northeast conference (*5*). Although similar legislation has been enacted in different parts of the country (*6*), of the States having such enabling acts at the end of 1962, 6 (40 percent) of the 15 are in this 10-State area. This high ratio is directly related to the opportunities for communication on mental health matters through the conference.

Another development of 10-State cooperation was the initiation of interstate seminars or workshops. For some time the National Institute of Mental Health has given financial support to single States for special workshops known as technical assistance projects. Through the joint sponsorship of the Northeast State Governments Conference, a host State, and the National Institute of Mental Health, a number of interstate regional technical assistance projects were conducted in communication, nursing, alcoholism, manpower, and volunteer services. Other interstate technical assistance projects have since been conducted elsewhere.

Some intangible benefits also flow from the deliberative nature of the conference. From the beginning the conference has assumed that

the free exchange of ideas among participants is, in itself, a desirable goal. In view of the rapid changes in the entire field of mental health during this past decade, the conference has provided a special periodic learning experience for administrative staff. Such learning may be an opportunity to develop a new outlook on old problems, to develop administrative skills through special on-the-job training opportunities, and above all to develop the broad perspective that transcends professional disciplines and colloquial bias. At the highest level, conference resolutions, although not binding, do facilitate the development and strengthening of lateral administrative ties. If, for example, 9 States voluntarily embark on a course of action, the 10th may be influenced to follow. A commissioner's life can be a lonely one when he presents his program for legislative approval. Regional support of this nature may be helpful.

One of the unique features of the conference has been the inclusion of members of State legislatures as participants on a regular basis. No other forum exists where legislators and mental health professionals from several States can meet, mingle, discuss, and speak freely on subjects of common interest, where no immediate decisions are asked or expected and where no action is binding. This experience has been enlightening for both groups. That the conference has value to these elected officials may be inferred by the continued active participation of a number of them over several years. For the professional disciplines, too, the repeated personal contacts over several years have facilitated rapid and easy communication of ideas. It has been possible to exchange information concerning program developments before reports appeared in the literature, and, of course, to communicate the informal details about practical matters which may never be written.

The 10 Northeastern States participating in this regional association differ in many ways. Even to contrast the States on a large versus small basis is inadequate. There are differences and similarities of geographic size, population, climate, and rural or urban development. None of these factors has been of great moment, for the issues of mental health and illness are common to all. The continued participation of all these States implies that the Northeast State Governments Conference on Mental Health has been a satisfactory and valued forum for both large and small States. Whether in Rhode Island or the State of New York, the problems of staffing, standards, salaries, the best use of professional manpower, therapeutic techniques, consultation services, and many other matters differ little, and solutions to problems are similar. One underlying factor has made this association meaningful and effective. Given the multifaceted, multidisciplined makeup of the participants, there has been no lining up by professional categories, no reliance on the status of title. Instead there has been an unspoken but ever present dedication to the goals of the conference, so that each participant's status is measured solely by his contribution to these goals. This has been the organization's strength.

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