

## EASTERN REGIONAL MENTAL HEALTH BOARD

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### MERGING PROBLEMS CREATES MOE PROBLEMS

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Chairmen Slossberg and Spallone and members of the Government Administration and Elections Committee. I am Dr. Robert Davidson, Director of the Eastern Regional Mental Health Board, a non-profit planning and evaluation agency for mental health programs. By training I am a sociologist of professions and organizations, so proposals like this are exactly what I studied as an academic and tried to make work in 20 years in mental health agencies. I share your frustration with inefficiency, but I cannot imagine a *worse* remedy than to merge five state agencies. It will drown the best and reward the worst. It will paralyze initiative in a web of approvals. It will even worsen cooperation on shared clients by raising obstacles that had been walled off behind agency lines.

Merger *might* make some sense with new agencies or at a local direct service level. But state agencies operate at a policy level, with different professional and organizational traditions, **beliefs and values**. Merger would violate those values and trigger a moral outrage. Bureaucrats would fight each other, but *clients* would be the casualties.

Thirty years ago I wrote my dissertation on a group of scientist-administrators that was demoralized by an alien regime. It was sad to see these dedicated men and women so angry and lost at what they saw as a violation of the *values* of good science, but what their new bosses saw as mere administrative inefficiency. The focus there was block grant mechanisms and merit review of proposals, but it was really a *religious war*. Your proposed merger will trigger the same kind of response from people who believe that infidels are in their temples.

Most staff entered their fields wanting to help people. They can accept new procedures and programs when presented in those terms. We often do the right thing (closing hospitals) for the wrong reasons (saving money), but as long as we develop alternate professional programs we can swallow it. We want to put client interests first, but we differ on how to do it because our clients have different abilities and resources. Recovery and autonomy are different for someone with an intellectual disability, someone with a mental illness, and someone with an abusive family. Our paradigms have taken on a life of their own. It is hard enough for people with professional legitimacy to change these paradigms and impossible without it. It *cannot* be done by legislation.

Today, e.g., DMHAS and DCF are continually refining protocols for teenagers approaching their eighteenth birthday. It is new territory for both sides and the arrangement has become more elaborate and effective over the years. It works as well as it does only because each side can work at the point of tangency and bracket the norms behind the policy. If we were all in the same agency, we would have to resolve differences we can now let each side resolve internally. The result might ultimately be better—if we adopted *my* set of norms—but by the time we did so the client would no longer be a teenager, the two staffs would hate each other, and the compromises we could agree on would be bland and ineffective. The masters of bureaucracy would easily outmaneuver the rest of us.

Merger would infect the whole organism with jealousies that are now quarantined below the service. Any agency can be improved—some could be improved a lot—but not this way. First appoint new client-oriented, up-to-date, commissioners and managers who will modernize agency norms. Move the sinecure-seekers away from clients and programs. Then, *maybe* you can merge agencies that share norms as well as values and a *majority* of clients, for good *clinical* reasons. That worked for mental health and addiction services, but slowly. Until then, **merger will hurt everyone, but clients most of all.**