MENTAL HEALTH FOR THE MASSES

THE MENTAL HEALTH MARKETPLACE LOOKS, AT FIRST GLANCE, STRIKINGLY SIMILAR TO THE MEDICAL CARE MARKETPLACE. MUCH OF THE MANPOWER IS STILL SCATTERED IN PRIVATE OFFICES, THOUGH INCREASINGLY IT IS BECOMING CONCENTRATED IN THE PSYCHIATRY DEPARTMENTS OF MEDICAL SCHOOLS AND IN MAJOR VOLUNTARY HOSPITALS. FOR MOST PEOPLE, BASIC AMBULATORY AND PREVENTIVE SERVICES ARE FINANCIALLY, IF NOT GEOGRAPHICALLY, INACCESSIBLE, ALTHOUGH FREE HOSPITALIZATION AWAITS AT THE TERMINAL STAGES OF ILLNESS. AS IN PHYSICAL HEALTH, THERE IS GROWING GOVERNMENT CONCERN ABOUT THE DISORGANIZATION OF MENTAL HEALTH SERVICES IN THE FACE OF MOUNTING DEMAND. AND, AS IN PHYSICAL HEALTH, PUBLIC EFFORTS TO SPREAD MENTAL HEALTH AROUND RELY ALMOST WHOLLY ON THE IMAGINATION AND GOODWILL OF THE PRIVATE STRONGHOLDS OF PROFESSIONAL MANPOWER. AT THE FEDERAL LEVEL, WELL-SPRING OF MUCH "CORPORATE" MEDICINE, VAST SUMS HAVE BEEN EARMARKED FOR LOCAL EXPERIMENTS IN MENTAL HEALTH: COMMUNITY MENTAL HEALTH CENTERS. THE LOCAL INSTITUTIONAL RESPONSE TO THIS "CREATIVE FEDERALISM" HAS BEEN A MIXTURE OF ACADEMIC DIFFIDENCE AND UNABASHED HUSTLING.

The analogy to the medical marketplace still holds true at the city level. The City mental health agency confines its activities to writing contracts with private providers—much as the City Hospitals Department would like to do. In both departments, the ability to write a meaningful contract is seriously compromised by personnel overlaps with the private sector. What mental health services are operated directly by the City, like the City hospitals, serve chiefly the poor and the acute emergencies. In fact, both City hospitals and City-run mental hospitals hark back to a common ancestor—the town lunatic asylum.

But there is something uncomfortably different about mental health, something that still stacks of ridicule, forced detention and dehumanizing "treatments." Historically, public mental health "services" served only the community, protecting it from the disturbing presence of the "ill." The idea that the ill might also need protection and even services is relatively new and still revolutionary in its implications. For the public role in mental health is still largely a police function. And the exercise of public mental health power is, if possible, far more arbitrary than other police powers. At least in criminal cases, a person serves a fixed sentence. But the mentally ill serve indefinitely—for periods depending

(Continued Page 2)
on nebulous and shifting criteria—and sometimes adding up to more time than the maximum sentence for the same act under criminal law. Even more sinister are the potential uses of "preventive" mental health services, to weed out dissidents and other deviates. In fact, some cynical professionals see the entire community mental health "movement" as the latest, most refined style of riot control.

The differences between medical care and mental health services go deeper than public policy and politics. No one disputes the goals and few can challenge the methods of medical care. But in mental health nothing is sacred; little can be left to the technicians and the scholars. Neither the goals nor the methods of mental health services are agreed on—especially not by the practitioners themselves. What is "mental health": A state of inner strength and confidence—or blind adjustment to an insane world? And how do you get there: through pills and id-probing—or through creative struggle for social change?

Henry Stack Sullivan, the famous American psychiatrist, used to tell his students, "I want you to remember, that in the present state of our society, the patient is right and you are wrong." In the same spirit, a young psychologist said recently, "Mental health professionals are always asking 'Why do so many students rebel?' That's the wrong question. What they should be asking is, "Why don't all students rebel?" And 'What can we do to help them ready to rebel?'"

A new sense of humility is even extending to the myth-ridden "science" of individual therapy. When asked about the value of his psychoanalytic training, one seasoned practitioner answered, "What I learned was how to prescribe drugs. As for the rest—I've spent much of my career 'unlearning' it." Besides being critical of the traditional professional props—drugs, beds and couches—many mental health workers question their own personal abilities to relate effectively to patients. "I have my own middle class hang-ups," said a psychiatric resident, "Maybe in therapy I'm just trying to impose them on the patient." Some of the professional answers have a deeply anti-professional ring: "I don't think of the other person as the 'patient,'" said a mental health worker with years of experience in Harlem. "We're both in trouble. Maybe by working together, though, we can both straighten things out."

But the confusion about individual therapy is only a mutter compared to the roar of controversy over the new, "community" mental health. Does community mental health mean bringing traditional services to the community—or working on all fronts for a "healthy" community? The professionals who have ridden the Federal-funding wave into the streets are sharply divided. One camp see themselves, like Albert Schweitzer, establishing psychotherapeutic outposts in the jungle. Others see themselves as the vanguard in a trail-blazing sweep through our urban wastelands—attacking poor housing, unemployment and all the other symptoms of a failing society. It is hard to say which approach is the most arrogantly ambitious, for it is no easier to cure individuals who live in a sick society than it is to "treat" a society whose members have lost hope.

What does this professional ferment mean for public policy in mental health? Should the public pay the contending professionals for anything as vague and questionable as "community mental health"?

We really have very little choice. As long as millions of lives are wasted by alcohol, drugs or lost to mindless decay of institutional "maintenance"—we have no choice but to use the resources at hand, and to use them as precisely and efficiently as we can. But there is one lesson that we must draw from the turmoil in the mental health professions: Mental health services are not something that we can pay for and then sit back and wait to have delivered. The deliverers—the professionals—are too scarce to do the job alone. And, since we aren't even exactly sure what the job is, they cannot be trusted to do it alone. Community mental health must be a community project, involving the community people as workers, planners, administrators and evaluators.

Community-worker control of mental health services is not, then, a nasty, uncontrollable by-product of an otherwise "professional" program. Nor is it a liberal "frill"—a sort of therapeutic "extra"—to be staged and managed by psycho-social engineers. For community-worker control of mental health services is not an administrative nicety which can be negotiated. Such control, structured flexibly and democratically, is the key to community mental health.
PSYCHING-OUT THE CITY SCENE

MENTAL HEALTH MAY BE THE LAST PRESERVE of old-fashioned, laissez-faire spending for public health. Other areas of health services are groping (usually misleadingly) towards a more rational image—through "cost-benefit analysis," Program-Planning-Budgeting and other methods borrowed from the defense industry. At least in NYC, mental health remains shrouded in a Viennese fog of psychiatric and social work shibboleths, impenetrable to 19th century accounting methods, much less new-style "systems" analysis. So it is always startling to recall that mental health in this City is a big business—well over a half a billion a year is spent by or for New Yorkers for this undefinable commodity, and 80 percent of this money is public tax money.

Most public money for mental health comes from the State, and most of it is administered by the State, for the operation of eight hospitals which serve New York City residents. (Five of these State hospitals are within NYC limits: Manhattan, Bronx, Brooklyn, Creedmoor and the Psychiatric Institute at Columbia.) An increasingly hefty chunk of the public funds is administered by the City agency, the Community Mental Health Board (CMHB). Since 1961, CMHB's budget has grown five-fold, reaching now well above $100 million. 92 percent of CMHB's budget comes from public tax sources: 48 percent from the State, 40 percent from the City and a small fraction from the Federal government.

CMHB came into existence, in a sense, as a budgetary afterthought. The 1954 New York State Mental Hygiene Act made available State matching funds for local mental health programs, and established city and county "CMHB's" to review and evaluate local programs for the purposes of this State reimbursement. In New York City the programs which fell under CMHB's purview were of two types: City-operated facilities (hospitals and City-run clinics administered by agencies such as the Board of Education) and voluntary agencies (hospitals and independent clinics). As in other areas of health services, the City/private division of facilities corresponded to a class division of patients, with poorer patients falling into the City agencies, and more affluent patients seeking care in the private sector. With the creation of CMHB, liberal-leaning mental health buffs envisioned an eventual unification of sectors and sane coordination of all services.

Funnel for Funds

Operationally, what the Board does is somewhat less spectacular. The major function of the nine-member Board is to approve contracts with voluntary agencies and to incorporate into their own budget the budgets of City agencies. These duties require only biweekly meetings; the day-to-day operations are carried on by a small staff headed up by a Commissioner of Mental Health. The staff is structured along the lines of the programs CMHB channels funds to; with Assistant Commissioners for Hospital Services, school services, etc., and other middle-echelon staff assigned to voluntary agencies and, since 1964, to Community Mental Health Centers. Relative to the amount of money it handles, CMHB's staff of about 170 is miniscule: Only about 2 percent of CMHB's budget goes for staff salaries, as compared to 7 percent for central staff salaries in the Department of Hospitals. The difference, of course, is that the Department of Hospitals actually operates services, while CMHB serves largely as a conduit for funds. CMHB has taken this passive role by choice—there is nothing in the State Mental Hygiene Law which prohibits CMHB from operating its own services.

In fiscal year 1969 (the year which ends June 30, 1969) CMHB handled $110 million for expenses. (This is above and beyond money for construction, which is appropriated separately in the capital budget.)

Of this, $60 million went to Municipal agencies and $50 million went directly to private agencies. (Actually, over $12 million of the $60 million City-share went indirectly to private agencies, through affiliation contracts.) The great bulk of the money for City agencies (44 million) went to City hospitals, notably Bellevue and Kings County. Dividing the rest of the City share were the Department of Education (for the Bureau of Child Guidance), the Department of Correction (for psychiatric services to prisoners), the Criminal Court and the Family Court. Of the $50 million earmarked for the private sector, the two largest shares went to private hospitals for the care of Medicaid patients ($14 million) and to the city's 66 voluntary outpatient agencies ($18 million).

Two-Class System

Many people who are familiar with the city's mental health picture charge that this pattern of spending is heavily weighted in favor of voluntary agencies, hence in favor of not-so-poor clients. Almost all the money for inpatient care goes for the poor (who else would stay in Bellevue?), but perhaps as much as half of the outpatient money goes to private agencies who may or may not serve the poor. CMHB is extremely defensive about such charges. It answers that (1) it is impossible to know who uses what facilities (although this is routine data available to NIMH and the State Department of Mental Hygiene); (2) about half of the voluntary agencies under contract to CMHB serve poverty areas (although it is not known whether these agencies serve poverty patients); and (3) that mental illness is the great leveller—services are needed as much, if not more, by the middle class (although independent studies show mental illness to be much more prevalent in low-income groups).

Setting aside the question of who uses what, there is a clear and growing disparity between allocations for City and for voluntary agencies. Since 1961, the amount CMHB allocates to voluntary agencies has grown eight-fold, while the amount it allocates to all Municipal services has grown only two-fold. In 1961, Municipal clinics were handling 78 percent of the city's admissions and receiving 45 percent of the CMHB money for clinic care, while voluntary clinics under contract to CMHB were handling 22 percent of the admissions and receiving 54 percent of the funds. Municipal clinics continue to handle the overwhelming majority of admissions, while voluntary clinics receive the lion's share of the funds.

In a sense, though, it is unfair to compare spending for City and private mental health facilities. The two sectors serve greatly different functions. In fact, it is questionable whether many of the Municipal services can be called "mental health" services at all. Bellevue and Kings County, the two major City psychiatric hospitals, are only holding operations—stopping off places between the street and the State hospitals. Most of their patients are brought in by the police, and, once in, are given no "treatment" beyond a perfunctory diagnostic interview and perhaps a dose of tranquilizers.

(Continued Page 4)
PSYCHING-OUT

(From Page 3)

The main function of the Bureau of Child Guidance, the schools' "mental health" service, is removing "disturbed" and retarded children from the public school system. Pathetically few of the children are given any semblance of counseling, and almost none are followed up. Psychiatric services in the criminal courts exist solely to determine peoples' fitness to stand trial—-with no pretense of treatment. Little is known, even by CMHB, about what passes for psychiatric treatment in the jails run by the City's Department of Correction. In short, the Municipal mental health services openly serve what are essentially police functions.

In contrast, the 66 voluntary clinic agencies under contract to CMHB offer (at least on paper) a smorgasbord of specialized services: family counseling, psychoanalysis, schools for disturbed children, rehabilitation, after-care, pre-care, etc. Some specialize in a "disease category:" some zero in on a particular age group; many are concerned mainly with training professionals. Some of the agencies under CMHB contract serve only a few dozen patients a year; others have caseloads of hundreds. Altogether, though, they do not begin to meet the need. Only about 60,000 people a year are admitted to voluntary clinics, while hundreds of thousands more are on the waiting lists, month after month. Some of these agencies are autonomous, but many fall under the umbrella of the Jewish Board of Guardians, Catholic Charities, or a major voluntary hospital. Each has its own jealously preserved special "philosophy" of care and style of operation.

This then is the mental health scene in New York City fifteen years after the creation of CMHB: For the poor, there are no mental health services—only various degrees of detention and isolation. For the middle class patient, there exist facilities, but it is questionable that any of them will be interested in the particular set of problems the patient presents, at the time he presents them. From a public policy point of view, the system is irrational, expensive and grossly wasteful of manpower.

Fragmented Authority

CMHB's failure to live up to its rhetorical promise may be due in part to the system it finds itself in. It was superimposed on an already irrational array of services, both public and private, over which it has no administrative power. With respect to the private agencies, CMHB is frankly permissive. After all, they are run by professionals and who is CMHB to interfere? CMHB's suspicions—mild as they are—are directed toward the Municipal mental health agencies it funds, which obviously lack appropriate psychiatric guidance. But here CMHB is powerless. The Department of Hospitals runs the psychiatric hospitals. The Board of Education runs the Bureau of Child Guidance. Courts and Corrections run their own clinics. CMHB might decide to get tough about these agencies and withhold their funds from its budget, but this would probably be a futile gesture. CMHB's budget must be approved by the Health Services Administrator and the State Commissioner of Mental Hygiene, and then, of course, the City Budget Bureau. Even after CMHB's budget is approved, the State still has the power to withhold funds. Any deviant behavior on CMHB's part could be quickly checked.

Over-all authority for mental health services in the city is not clearly divided between CMHB and the State Department of Mental Hygiene. According to a well-known New York City health economist, the 1954 legislation which created CMHB was "a cop-out by the State." The State could have taken the initiative to develop local services itself, through the creation of truly community mental health boards, rather than by setting up artificial city and county level CMHB's. Apparently the State began to have second thoughts about its abdication from the local scene a few years after CMHB's formation. State officials criticized the City CMHB for failing to expand local programs and upgrade Municipal facilities and for favoring the inscrutable voluntary agencies. In recent years, tension between the State and CMHB has eased considerably, largely because of their common commitment to the community mental health center program. The State still tends to forget that CMHB is the local mental health planning agency and occasionally by-passes it in important planning decisions.

Conflict of Interest

But CMHB's failings cannot all be chalked up to "the system." The agency also suffers from grave "character defects." As is well known to many community groups, many top and middle-level CMHB posts are filled by people who simultaneously work for voluntary agencies under contract to CMHB—a conflict of interest situation paralleling that in the Pentagon. Consider the composition of the Board. The situation gets even murkier as one plumbs the depths of CMHB's retinue of staff. Here precise documentation is unavailable, but it is known that a number of people, especially among the older Wagner-era staff, have worked, do work or will work in voluntary agencies under contract to CMHB. [See Page 6].

What this means in practice is that CMHB members and staff, with a few exceptions, have little incentive to do the things that CMHB is supposed to do: upgrade Municipal services, regulate private agencies, and coordinate services. In fact, some CMHB staff members view any activity other than rubber-stamping voluntary contracts as an unjustifiable infringement upon private professional prerogatives. For instance, three staff members (at about the assistant commissioner level) were questioned about selective intake policies at voluntary clinics and at a City hospital clinic affiliated with a private teaching institution. All three admitted that these clinics tend to reject the poor (you can, or at least you could, tell them by their Medicaid cards), and all three defended this policy: "The psychiatrist has a right to choose his own patients," said one. "The poor don't really have mental illnesses. They have environmental problems," said another. And, from the third, "We can't criticize these private agencies. We should be thankful that they donate their services to the public." Naturally such people vigorously evade their regulatory and coordination responsibilities. When the cost effectiveness of the 66 various voluntary contract agencies is questioned, middle-rank staff members reply: "You can't quantify mental health services," and "You can't compare one agency to another. Every one has a unique approach." Of course, such attitudes do not sit well with CMHB's job of coordinating the services of the voluntary agencies in the interests of continuity of care.

CMHB's special intimacy with the private sector tends to set it apart from other health-related agencies. (There is also an element of conflict of interest in the Hospital Department's modus operandi, whereby officials write affiliation con-

No one will ever be exactly sure what President John Kennedy had in mind when, with the 1963 Community Mental Health Centers Act, he called for a "bold new approach to mental health." But when the experts finished bickering, the program meant little more than projecting tradition-bound professionals into the community. Their mission was clear enough—to prevent and to treat mental illness in the community. Everyone, though, had his own idea about what constitutes "mental illness," how much of it is "preventable" and how much is "treatable."

Beneath liberal facades and the professional fortifications, the community mental health center program had a dollars and cents rationale. The Kennedy Administration appraised mental illness and retardation as the single most costly social condition draining the public treasury, largely because of the enormous load of long-term institutionalized patients. Half of the hospital beds in the nation are occupied by mental patients, at a cost of over $3 billion a year. The idea behind the Act was that decentralized outpatient services could prevent more serious mental illnesses, and eventually ease the load on State hospitals.

The Act provides Federal funds for both the construction and staffing of CMH Centers. For construction, the Federal share may be up to one third of the costs, though it has been running much lower since the escalation in Viet Nam. For staffing, the Federal share starts at 75 percent and de-escalates to zero over a 51 month period. A move is now afoot to pin the Feds down to steady support at 75 percent, because it is clear that local governments will not be able to pick up the tab alone.

The idea of mental health services for the masses was threatening to many psychiatrists. Most psychiatrists, whether in private practice or in State institutions, are accustomed to treating people on a one-to-one basis, and treating only those patients who are suitably "articulate." They saw the whole community mental health center idea as a power grab by upstart psychologists and social workers. Battle lines were drawn and, after the dust settled, the Act bore the clear mark of the psychiatric establishment: All community mental health centers were required to have inpatient beds in order to be eligible for Federal money. Hence all centers were to revolve around the traditional medical inpatient/outpatient core. Thus, as Columbia's Dr. Kolb has pointed out, these centers are essentially hospitals, with the added trappings of emergency services, consultation and education services and partial (day care or night care) hospitalization.

In New York City (the nation's psychiatric capital) nothing was left to chance. Psychiatric pressure was brought to bear on CMH to establish a policy of granting community mental health center funds only to hospitals and hospital-sponsored programs. One implication of this decision is that planning for these centers falls under the jurisdiction of the Health and Hospital Planning Council—which would have had nothing to say about non-hospital associated centers. Recently the door was pried open a bit when the Hunts Point Multi-Service Center obtained its funding directly, rather than through Lincoln Hospital.

tracts with, and plan construction for private hospitals that they will later work for.) Although it is one of the four building blocks of HSA (the others are the Departments of Health and Hospitals and the Office of the Chief Medical Examiner), CMHB is not a City department. Moves to make CMHB into a department of mental health, to which the Board would be only advisory, have until recently been resisted by CMHB—Board and staff. On their part, many officials in the rest of HSA express skepticism and distrust about CMHB—attitudes which the CMHB old-guard like to read as "prejudice about mental illness." City Budget officials, who have to read CMHB's 66 contracts each year, are even more cynical. One, more sympathetic to CMHB's aims than most, described CMHB as a "pork barrel operation." As long as it's mostly State money, though, no one interferes.

It may seem surprising that CMHB has avoided public scandal or official shakedowns for so long. CMHB owes its immunity, above all, to its invisibility and to the Federally legislated community mental health centers' program. These centers were to be everything that existing mental health services are not—community-based, comprehensive, heavy on preventive and outpatient care, etc. And centers were to be located in every community. Thus any criticism of existing mental health services was easily dismissed by top staff: "Of course what we have now is inadequate and inhumane, but in a few years it will all be replaced by community mental health centers anyway." The idyllic center image not only deflects public criticism, but it absorbs most of the energies of the more liberal and talented CMHB staff members.

CMHB responded to the Federal legislation by embarking in 1965 on a "Master Plan" for covering the entire city with community mental health centers. The city was divided into 51 areas tailored to fit Federal population requirements for a center (between 75,000 and 200,000 residents). Integration was the guiding principle in the design of these special "mental health communities," or "catchment areas." For instance, the East Harlem catchment area unites Spanish Harlem and the silk stocking district of the Upper East Side. Once the maps were drawn, CMHB activists saw no need for further planning. After all, the Federal law defined CMHC's—all you had to do was to find the institutions to staff them and start building.

The "Edifice" Complex

Maps in hand, CMHB's then-Comprehensive Services Director, Margery Frank (now a community mental health center planner for Columbia P&S), dashed out to "sell" centers to the voluntary hospitals and medical schools—first come, first served. Not everyone was as enthusiastic about such centers as was CMHB. More conservative departments of psychiatry were dubious about "community psychiatry," fearing that the venture would cheapen their academic reputations. One ex-CMHB staff member compares CMHB's promotion of centers with Dr. Trussell's efforts to enlist private institutions for the hospital affiliation program: The private sector was generally reticent but yielded to the promise of staff salaries and the unbeatable argument—"Only you have the expertise to do it." Of course with the mental health "affiliation" program there was an additional incentive to the private sector, the acquisition of a new multi-million dollar building. When the program began in 1964, the only thing that was certain about centers was that they were buildings.

Bit by bit, the Master Plan has been transformed into an ambitious construction program. Seventeen centers are listed (Continued Page 6)
Meet The Board . . .

HARVEY J. TOMPKINS, M.D., Chairman of the Board: Director of Psychiatry at St. Vincent's Hospital and consultant for the Catholic Charities of the Bronx and Manhattan. St. Vincent's Hospital and the clinics operated by the Catholic Charities are under contract to CMHB.

RICHARD SILBERSTEIN, M.D.: Director of the Staten Island Mental Health Society clinics and director of mental health services at St. Vincent's Hospital in Richmond. He is affiliated with the Brookdale Hospital Center and with New York Hospital. All the facilities which Dr. Silberstein is associated with receive funds from CMHB.

FRANK KARELSEN: Member of the Board of Jewish Board of Guardians, whose clinics are all under contract to CMHB.

HELEN HABERMAN: Member of the Board of the Jewish Board of Guardians.

GEORGE KENT WELDON: Active in Catholic Charities affairs.

GERALDINE MOWBRAY: M.D.: A pediatrician.

GURSTON GOLDIN, M.D.: Staff member at Columbia P&S.

The two public members of the Board are the Commissioner of Health and the Commissioner of Social Services, serving ex officio.

Four of the seven private sector representatives on the Board continue to serve although their terms have expired. CMHB refers to these lame-ducks fondly as "charter members."

PSYCHING-OUT

(From Page 5)

in the City's 69/70 capital budget, and about nine others are being pushed by CMHB for admission to future capital budgets. Thus the City has committed itself to implementing at least one third of the original Master Plan. Considering the highly personal and informal manner in which the construction plans were laid, it is not surprising that the third of the catchment areas so far selected for centers share no common characteristics, such as poverty or lack of mental health services. Recently CMHB designated as top priority nine catchment areas which are high in poverty and low in services. To its embarrassment, only three of the 17 already-budgeted projects turn out to be in any of the nine "top priority" catchment areas. On the other hand, one of the 17 budgeted projects and three of the nine runners-up fall into catchment areas now admitted by CMHB to be in the bottom 25-30 percent according to priority rankings.

The lack of rational priorities in planning these centers can be seen by a closer examination of the projects already budgeted or being pushed. Of the three already-budgeted centers which will be located in high priority catchment areas, one (Hunts Point) was until recently only a component of the Lincoln Hospital center. A second (Greenpoint) has no institutional backing and hence no prospects of staffing, so the meaning of its inclusion in the budget is unclear. By contrast, projects are planned for Greenwich Village, North Richmond, and the North Bronx. The first two are backed by St. Vincents, and the third by Einstein, which may explain why they are already included in the budget or are being pushed by CMHB, despite their being in low priority catchment areas.

None of the city agencies responsible for this expansive capital program—CMHB, the City Planning Commission and the Bureau of the Budget—seems to have had any idea of what they were getting into. Estimates of construction costs, based on bed-per-head ratios from State hospital experience, ran from below $15 million to above $20 million per center, or over $300 million for the capital budget, and about $1 billion for the whole Master Plan. What it would cost to staff these centers, once completed, was even more uncertain. The few complete staffing grant applications which have been filed run in the neighborhood of $3 to $4 million a year per center. Thus it would take about $200 million—almost twice CMHB's present annual expenditures—to operate a city-full of community mental health centers.

The Scoreboard

In 1969, though, less than 5 percent of CMHB's total operating budget went to such centers. Only three centers are "complete" insofar as Federal requirements for services go—Maimonides, Metropolitan and Soundview-Throgs Neck-Tremont. Another two—Brookdale and Lincoln—are on the verge of achieving "comprehensiveness." None of the centers in the capital budget has been completed. In fact only three—Bellevue, Metropolitan and Gouverneur—are in construction. Engineers and planners in HSA estimate that most centers now listed in the capital budget will not be open for at least ten years at present rates of progress.

This particular case of delayed action on a City program cannot be blamed on "government red tape." CMHB's involvement in center planning ended, for all practical purposes, with the Master Plan. It was up to the private institutions enlisted to staff these centers and to prepare designs and staffing proposals. The only guidelines were those set forth in the Federal Act, requiring each center to offer five basic services [See Box, Page 5] inpatient and outpatient care, emergency services, partial hospitalization, education and consultation for other community agencies. But how many people would use a center? The 2 percent who now enter a State hospital annually, or the 20-80 percent estimated to be more or less seriously impaired by mental illness? Of those who used the center, how many would need a bed, and for how long? Given a certain level of utilization, what space would be required? How many and what kinds of staff were needed?

Remolding the “Concept”

None of the private institutions involved in CMHB planning have made any serious attempt to answer these questions. And of course, as long as these questions are unanswered, no one can challenge the plans set forth in any center grant applications by private institutions. Government agency grant reviewers can't help but wonder, when confronted by widely varying plans for similar kinds of neighborhoods, whether the plans aren't based on the needs of institutions rather than those of communities. Maybe this one's staffing pattern is tailored to fit some future residency program. Maybe another one's architectural scheme was designed to accommodate private offices. After all, even the sacrosanct "catchment areas" have been gerrymandered to suit institutional tastes. For instance, much of NYU's planning efforts have been dedicated to redefining the Bellevue center's catchment area to omit poverty areas of the Lower East Side.

City Budget Bureau engineers, the men who finally approve appropriations for capital projects, express a growing skepti-
CMHB's which are to be built in already large medical centers, the capital budget could be dropped, as soon as the realization that they would henceforth concentrate on the immediate dangers such as Bellevue and Metropolitan.

Services, voluntary agencies, etc. CMHB quietly agreed with the development of services in the neediest areas first. Acknowledgment of community groups as local planning agencies. There is evidence of some receptiveness to the free-wheeling voluntary agencies and the hide-bound Municipal agencies. But CMHB must go much further.

One stumbling block in the way of centers which CMHB freely acknowledges is "the communities." CMHB had confined its "community organizing" to the private psychiatric "community"—leaving it to the center-sponsoring institutions to clear their plans with the local people. One way or another, people in the chosen catchment areas began to discover the community mental health center concept for themselves.

Up from the Drawing Board

The case of the Rego Park catchment area is almost legendary. Monsignor Fitzpatrick of Catholic Charities had his heart set on a center for St. John's Hospital. The hospital, however, was not really enthusiastic about community mental health until CMHB whitewashed the community—by dropping a black health area and adding a white one. Residents of the lucky white health area rebelled against being a part of this checkerboard game. On the grounds that community mental health could mean "addicts" and "crazies" right there in the community—Rego Parkers organized and blocked the center plans. In poor neighborhoods, the community reactions have been more favorable but no less obstreperous.

The alternative is for CMHB to become a truly public, truly community mental health agency. In recent months, CMHB has already taken a few timid steps in this direction: There is talk of decentralizing into neighborhood-based community mental health boards. There is evidence of some receptiveness to the free-wheeling voluntary agencies and the hide-bound Municipal agencies. But CMHB must go much further.

Of course, creating "integrated networks of service" was one of the things CMHB was assigned to do at its birth in 1954. Now that it has awakened from its six-year long fixation on monumental community mental health buildings, there is a chance that it will finally get to work. But it may be too late. Many of the private institutions who played along with the community mental health "movement" when a five story building was at stake are not about to "integrate" with other facilities or venture into storefronts. As the experiences of Columbia P&S and Einstein show [See "Battles" and "Lincoln," Pages 10-11], the only reward for such benevolent public service may be a swift boot out of the community. If the private institutions really get turned off on community mental health, CMHB might as well go out of business.

Community? Mental? Health?

The alternative is for CMHB to become a truly public, truly community mental health agency. In recent months, CMHB has already taken a few timid steps in this direction: There is talk of decentralizing into neighborhood-based community mental health boards. There is evidence of some recognition of community groups as local planning agencies. There are mutterings about a new hard-line policy with respect to both the free-wheeling voluntary agencies and the hide-bound Municipal agencies. But CMHB must go much further.

As demand for mental health services increases, CMHB can no longer stand by, shrugging its shoulders and asking, "But what can we do about it?" There is nothing in the law to prevent CMHB from taking the initiative and directly operating services. The enormous opportunities presented by Federal and State funding are still here, and are up for grabs. Will CMHB be able to seize them, and translate "community mental health" into an action program?

—Barbara Ehrenreich
Mental Health Outposts

WINNING THE HEARTS AND MINDS

HOW DO THE community mental health centers of the 1960's differ from the mental health hospitals and services of yesteryear? A survey of three out of five functioning mental health centers in New York City confirms that basically the same services are available to people—sometimes more available, sometimes more quickly available, and sometimes available closer to home.

[A fourth center, Lincoln Hospital Mental Health Services (South Bronx), continues to offer only skeletal services in the wake of a worker-community revolt against the center's administration. See Box, Page 11; and April 1969 BULLETIN.]

This is probably the first time the psychiatric and social worker "mentalities" have eagerly jumped at the same bait. Thus the centers have produced everything from more couches to an array of war-on-poverty type social storefronts, all with some form of advice or consent from the community.

According to law, the community mental health center must provide medical services to the mentally ill, as well as work within the community setting to promote mental health. The basic services are specifically defined—inpatient, outpatient, 24-hour emergency service, partial hospitalization and consultation and education—but the packaging and delivery of the services has been dictated by the personal style and interest of the directors of each center. [• • •]

CASE STUDY I—PATIENT MANAGEMENT: Dr. Jack Wilder, psychiatrist director of the Soundview-Throgs Neck-Tremont Community Mental Health Center (Bronx), calculates mental health by a therapist-per-patient ratio. He interprets the center legislation as primarily a mandate to treat the psychotic patient population within his area (a middle-class area with a recent influx of poor Puerto Ricans and blacks) and has used new center funding as a means of reinforcing a program he initiated several years before the 1963 Community Mental Health Centers Act. He rules a fiefdom within the walls of the Albert Einstein Empire [See April 1969 Bulletin], and regards Community "controlniks"...socially oriented professionals...and the like, as "poachers." The "center" is not a building, but rather an effort to administratively link all existing mental health facilities in the area so that when a patient comes in for mental health services, he may be referred to the proper service and seen more quickly. The center includes a ward at Bronx State, two wards at Bronx Municipal (Jacob), the Throgs Neck and Tremont clinics based at the local District Health Center, and a recently rented storefront in a Soundview shopping center.

Patients who call, or just walk into a clinic, will more than likely be given an appointment to see a "private" physician in consultation and perhaps referral to a clinic program (such as group therapy) or to the wards of Bronx State or Jacobi. An after-hours caller would be referred by an answering service. Within its limits, this "better management" approach has given the doctors more administrative control of the patient—it is conceivable that the doctor might know where the patient is, how he is, and where his medical record is at any given time.

Dr. Wilder calls anyone who disagrees with the medical model (and the prescribed approach) "revolutionaries who don't have a program...they would rather talk then get down to work." As for sub-professionals, "I don't know of a person who comes in here who would like to be treated by an indigenous person—they want to see doctors!" Sub-professional staff recently formed a "black caucus" but they say Dr. Wilder refuses to acknowledge their existence.

Where does the community come in? Each of the three geographic sub-divisions has some form of advisory board to that unit of the center. Dr. Wilder sees a real potential for community involvement in the realm of "education and consultation" and offers technical assistance, community organizers, and encouragement to social services in related fields (churches, schools, etc.). In fact, if the community gets involved, Dr. Wilder is ready to help it get a grant to do its own thing—far from his medical show.

CASE STUDY II—TAKING TO THE STREETS: Mark Tarail, D.S.W., administrator-spokesman for the Maimonides Mental Health Center (Brooklyn), is a crusader. He hopes that one day something like the "Maimonides model" will be available to all the people of New York City and the nation. Dr. Tarail is part of the social "uplift" wave. He fought psychiatric power at the time of the passage of the Community Mental Health Centers Act, helped write the legislation, is an advisor to NIMH and the City Community Mental Health Board. At Maimonides, he chooses to work within the "intent" of the law—rather than strictly within narrow Federal regulations.

The Maimonides center operates on a $2 million annual budget. (Dr. Tarail is part of a "movement" to take the word "de-escalating" out of the language of Federal reimbursement for staffing grants to community mental health centers.) Center activities emanate from a beautifully designed new glass and brick building on the campus of Maimonides (voluntary) Hospital and a recently opened neighborhood storefront. Its geographic service area is predominantly middle-class Italian and Jewish, with a small, rapidly growing Puerto Rican and black low-income grouping. (The latter is expected to jump from 10 to 50 percent of the population in 10 years.)

Traditional psychiatric care is wrapped in a new package. The four story building, with a 39-bed inpatient ward on the top floor, is therapeutically designed for openness—open doors, open stairways and open spaces. (Violent or dangerous patients are referred to a State Hospital.) Patients are encouraged to socialize. They have a choice of dining in a kosher cafeteria or may prepare their own food in an adjoining patients' kitchen. A variety of clinical services are available on a walk-in basis.

Dr. Tarail is not satisfied with sitting in the center and waiting for patients to come in, however. When the center opened the staff went door-to-door and introduced themselves—and now a professional team (its members vary according to the situation) is just a phone call and a few minutes away from any resident within the center's domain. Dr. Tarail sees the necessity for re-training and re-humanizing professionals to better meet the mental health needs of the people. Medical vestments have been shed and each professional must spend at least a third of his time on some type of community mission. Such public exposure has met with some professional resistance—one of the more traditional psychiatrists (he has retained his brown vinyl couch).
is still campaigning for some kind of a shade for his street level office window (in the meantime, he insures privacy by making do with cardboard and scotch tape).

Does Maimonides offer "new careers" for indigenous workers? "We're not going to make the same mistake they made at Lincoln. We don't tell people they can start out as mental health workers, and in five years they can be psychiatrists," says Dr. Tarail. Subprofessionals at the center are paid more than comparable positions in the main hospital. And furthermore, they are called by titles that describe the work they do." No longer the demeaning job titles of "maid" and "porter," but rather "housekeeping staff" workers. Administrative inflexibility is blamed for the fact that these subprofessionals have not been able to shed their traditional garb of the blue dress with white trimmings and the dark green work shirt and pants. The center administration has instituted a limited academic upgrading program, but the idea has met with reactions ranging from disinterest to hostility by established medical and academic institutions.

There has been a real push by the center to involve the community—much in the style of the community action program during the heyday of the war on poverty. The one storefront operation was opened in the area's poverty pocket—Castle Hill. Though the center still controls the purse strings, it has not dictated the program of the storefront. Local residents decided they would like it to contain representatives of each social service in the area, such as welfare and housing specialists, and the mental health center remains in the background as one among many services. Indigenous persons are employed by the Maimonides center to run the store. Other organizing efforts recently produced a large streetcorner rally to protest the budget cuts which faced the hospital and the center.

CASE STUDY III—A FEDERATION OF FREE ENTERPRISES: The Community Mental Health Center of Metropolitan (City) Hospital has raised great hopes in East Harlem—among division heads of the Department of Psychiatry of New York Medical College (who staff the hospital and center through an affiliation contract)—among staff for both personal and social reasons—and among the people of "El Barrio," one of Manhattan's ghettos.

So far, the Center has been an extension of the Department of Psychiatry—so much so that if a new "center" building were not going up next door to the Hospital, it would be business as usual. All that building has meant so far is that heads of an array of very independent divisions have had to attend "cabinet meetings" called by Chairman Alfred Freedman, M.D.—to fight over floor space and division budgets.

The concept of sharing the operating budget for the center, or of a unified philosophy of mental health—would not occur to top level cabinet officials. This is understandable. When Chairman Freedman set out to build a Department of Psychiatry, he sought out division heads who could pay their own way. Each division became a one-man show of grant-hustling and demonstration projects which would insure NIMH, State and City public tax support. (One division, Martin Deutsch's famous child development unit, became so successful that a few years ago Dr. Deutsch picked up and moved lock-stock-and-computer to a more exciting institutional base at New York University.)

With such a federation of unrelated and unaccountable services being dictated from the top, it is not hard to imagine why workers—professional and non-professional—find it difficult to deliver service in an effective, let alone comprehensive, or responsive, fashion. Each service functions independently—at the command of isolated division heads—wasting much manpower through duplication of effort. Such fragmentation is an administrative horror: Patient records—if the patient should move from one service to another—often don't follow the patient.

Add to all this the general teaching priority of the institution, and service drops even lower on the scale. The center's services are manned, for the most part, by young residents-in-training and students who are interested in making it as traditional psychotherapists and psychoanalysts. They naturally have little interest in problems endemic to a ghetto community. Psychotherapy may be fine for the middle class, verbal patient who comes into the center from below 96th street. (The area served by Metropolitan stretches downtown to the mid-70's.) But how effective or relevant is traditional psychiatric treatment to the immediate community? How relevant can it be, for instance, to: the depressed and suicidal, 23-year-old Puerto Rican mother of three children, living on ADC in the (now clichéd) rat-infested apartment on 102nd Street, whose addict husband deserted her.

The same authoritarian "enlightened trusteeship" which "knows best" for the patient, treats the staff with a "we know best" attitude. The staff has little knowledge of what goes into decision making at the "cabinet level"—and they are told nothing beyond their immediate assignments. A few months ago a "black caucus" of the partial hospitalization program (a therapy-oriented day hospital) drew up and presented a list of demands for more involvement of blacks in the decision making of and in the direction of the division and called for the involvement of the surrounding ghetto community in designing new services to meet its needs. The demands were quietly received. Since then, some say, there has been a deliberate effort to further isolate the staff from the community.

Many staff members would say the center should pay equal attention to preventive mental health services and education for the whole community, rather than focusing almost entirely, as is now the case, on that 5-10 percent segment of the population with psychiatric illness—to which the center serves up an often "too late" treatment. Such community-oriented staff members feel that equal time and attention to community needs will happen only when the real community becomes involved in setting the center's priorities.

In less than a year, the many mental health service divisions will move under the common roof of an $15 million center building. This brings more sharply into focus the problem that the entire community mental health center is only marginally useful to most of the residents in the hospital's service area. Many don't even know it exists. The center's planners have yet to hear from the people of the area, or their organizations and institutions.

All planning for the center, thus far, has been entrusted to the Division of Community Mental Health (primarily an education and training unit which gives little actual service). To the dismay of many of the staff, although the paper concept of a community mental health center is integrated, comprehensive community mental health services, this Division has not yet permitted the other services to participate even in the discussion of the plan. Staff, not only at the lower levels of the hierarchy (and hierarchy is very important at Metropolitan), but also at the higher levels are totally in the dark at this late stage in the development. Naturally, there is little enthusiasm for something which very few feel in any
Local Insurgencies

BATTLE FOR HEADS, BEDS & TERRITORY

NO ONE WOULD DENY that it took the community to put the word back into ‘community’ mental health. Skirmishes over community mental health centers in New York City have erupted sporadically since money was appropriated in 1964. What was initially seen as a battle among mental health professionals over beds, heads, and territorial rights has been preempted by civil wars between community residents and medical institutions.

It now appears that the City Community Mental Health Board (CMHB) and the State Department of Mental Hygiene (DMH) have launched a full-fledged pacification program in certain strategic hamlets—Washington Heights (bordering on Harlem) and Bedford Stuyvesant in Brooklyn. [Thus far, CMHB has taken a tougher line with the rebellious Lincoln Hospital mental health workers. See Box, Page 11.]

These two ghetto communities had for years been seething with resentment about the way planning for centers was taking place without any involvement of local service agencies, let alone the “target populations.” The CMHB proceeded with singlemindedness: New York City was divided into catchment areas, planning grants were made to designated institutions, and architectural programming began.

In September, 1968, Puerto Ricans and blacks from Washington Heights had had enough of begging at the door to be heard, and they packed a meeting called by Dr. Lawrence Kolb, Director of the New York State Psychiatric Institute (located on the grounds of Columbia University School of Medicine). Dr. Kolb is also chairman of the Medical School’s Department of Psychiatry. He had called together a selected group which was to organize the community in support of Columbia’s plan for a community mental health center for Washington Heights and Inwood. (CMHB guidelines for community mental health centers call for community involvement in the planning stage.) The community invaders took control of the chair from Dr. Kolb, challenged his leadership, called the plans illegitimate, and declared that henceforth the community would plan for its own mental health needs.

Persons close to the CMHB say that this incident, almost to the hour, foiled a change in tune from the Board. No longer would the agency talk of “centers” (i.e., buildings), but rather “networks of service” to meet immediate needs. Up to this point, the CMHB had collaborated in Columbia’s plans to purchase and raze the Audubon Ballroom, which many Harlem residents consider a shrine to Malcolm X who was slain there; architectural plans which provided separate entrances and facilities—one for the black and Puerto Rican population of Washington Heights and the other for the white, middle class of Inwood; and programs and service planning without the involvement of any lay or professional persons from a minority group.

When CMHB suddenly extended a congratulatory hand to the insurgent Washington Heights-West Harlem-Inwood Community Mental Health Council, the gesture was viewed by the community with some suspicion. They recalled that only the year before, the Commissioner of Mental Health of CMHB and a Columbia planner had been an hour late arriving at a meeting because they couldn’t find their way Uptown.

The Council received recognition from CMHB and the State DMH as the new mental health planning group for the area, and they are pointed to with some pride by both agencies. What planning monies will be available to them from CMHB is not clear; nor is the CMHB definition of a planning agency clear. The $93,000 contract made to Columbia almost three years ago will expire in June. Only about $9,700 of the grant remains. The Council has demanded that this money be given to them immediately; at the same time, Columbia has requested CMHB’s permission to hire two community liaison persons—one would be assigned to work with the Council. Thus far, CMHB has not agreed to end the contract, and it appears it will die a natural death, i.e., quietly expire.

There is no sign that Columbia or Dr. Kolb has given up hope of getting a part of the community mental health center action. After all, community mental health centers are required by law to provide traditional inpatient care. Therefore, after the Council has attempted to coordinate all existing mental health agencies and identified the service gaps and rounded up some community persons to work as subprofessionals, they will have to come back to the medical empire for psychiatric beds and services. Community cynics allege that during the last three months, Columbia and Knickerbocker (a floundering voluntary hospital) have been meeting to divide the spoils—agreeing that a less tainted Knickerbocker will offer inpatient services and that both institutions will share the short-term care patients from the Council’s “center.”

Almost simultaneously, the CMHB gave a tip of the hat to another community-based mental health council—the Community Health Committee of the Central Brooklyn Coordinating Council. They too were given the go-ahead, and told they were the official mental health planners for Bedford Stuyvesant.

Winning Minds

(From Page 7)

way responsible for.

Such “cloak and dagger” planning has thus far forestalled community involvement of any kind—positive or negative. Certainly no real community enthusiasm for the center is evident. Even in nearby Washington Heights and Harlem communities where there is vigorous community opposition to Columbia P & S and Harlem Hospitals’ plans for centers, there is more genuine enthusiasm for the development of services.

There is a widespread suspicion that the leadership is more interested in avoiding “problems” like the Lincoln Community Mental Health Center experienced (i.e., worker-community coalition) than it is in developing comprehensive community services. [See Box, Page 11.]

In any case, the situation has boiled down to the fact that most of the “community” groups in the area who have been consulted (the social service agencies, etc.) are less the consumers of services than they are the deliverers of service to the community. In other words, they are on the same side of the fence as the community mental health center.

The real question is yet to be answered. Will any staff and community involvement develop over the next few months, before the center is crystallized (rigidified)? Or will the Metropolitan Community Mental Health Center be just another high-powered purveyor of traditional services with minimal benefit resulting to the community as a whole?

—Maxine Kenny
Unlike the Washington Heights group, the Committee had begun to organize residents as early as 1965 and within a year were ready to meet the community mental health center promoters more than half way. The Coordinating Council, representing about 120 community agencies and organizations, staged several sit-ins at CMHB meetings before convincing reluctant board members of Bed-Stuy's need.

Since the community initiated the effort to get a mental health center, they did have a say in what hospital should sponsor their center. But because of scarcity of health services in that depressed area, one could hardly say they had a real choice. It was a tossup (from the community standpoint) between two local hospitals—St. Johns Episcopal and St. Marys-Catholic. Both hospitals would have liked the facility—CMHB had allocated $21.4 million for construction—but after talking to officials of both, the Committee felt St. Johns had been the least negative to the community in the past and would be more willing to provide immediate mental health services. [Even this "choice" was not possible without a fight. CMHB had promised the center to the expanding Catholic Medical Center. As a consolation prize, as runner-up, St. Marys psychiatric services received a hefty monetary boost from CMHB so that it might better serve Ocean Hill.]

St. Johns promised to staff the clinic subject to community approval and to work closely with the community to further develop the center's program. But, within a few months, the honeymoon was over. The hospital summarily dismissed the clinic's director, a black psychiatrist who had been recommended by the community, charging him with "administrative insubordination." The hospital steadfastly refused to discuss or negotiate the matter with the local committee.

The deteriorating communication between the black community committee and the white hospital administration was aggravated by the hospital's decision to paint the clinic brownstone building white. The Committee, which had taken responsibility for both interior and exterior decoration of the clinic as a way to get more community involvement, saw this as a slap from the "lily-white medical establishment."

An angered community called upon CMHB and the State DMH to step into the fight on the people's behalf. CMHB, through its acting commissioner, Dr. Herbert Fill, cautiously replied with a letter recommending that the Committee and St. Johns work out specific personnel practices and establish guidelines and job descriptions. In order to pacify the natives, the State DMH went a step further and dug up 21 job positions at Brooklyn State Hospital and suggested the community fill these positions so as to expand available psychiatric services for Bed-Stuy. These were hardly positions that a new planning agency could make use of, let alone fill (they had been without takers for years). After much haggling over civil service requirements, etc., the community recently elicited a verbal promise from DMH that it would try to make the job descriptions more flexible so as to make some use of a part of the $250,000 represented in those 21 budget lines. The community, which has withdrawn its support from St. Johns as the sponsoring institution for a Bed-Stuy mental health center, hopes the State offer will be the core of a new, community-planned mental health center.

The pacification program was not without political motivation. Acting Commissioner Fill, who had been quietly soliciting support for months, has become Commissioner Fill. And the State DMH, which had been under fire to investigate allegations of conflicts of interest and misspent public funds by CMHB, can take a breath while the communities wrestle with the problem of coordinating "networks of services." The community councils are willing to give the new CMHB "liberal line" a chance to unwind—but they are prepared to continue the fight for real public services which they control.

—Maxine Kenny

Lincoln Brigade II

The mental health workers of Lincoln Hospital Mental Health Services (LHMHS) have returned to their posts at Lincoln, but the fight is far from over. The struggle for community-worker control of the mental health services continues, and the veiled positions of the overlords, Albert Einstein College of Medicine-Yeshiva University, shift from day to day. [See "Taking Care" April 1969 BULLETIN.]

The workers—both professionals and paraprofessionals—seized the administrative offices March 3 and began running the services. The occupation ended two weeks later with the arrest of 19 workers. (The charges were subsequently dropped.) They were suspended for over two weeks without pay along with 48 co-workers. A law suit, brought on behalf of the workers against Yeshiva on the basis of the illegal and arbitrary suspensions, will demand back pay for the workers who returned to work April 9.

Meanwhile, Einstein-Yeshiva is beginning to deliver on promises made to the workers over a year ago. A community board for LHMHS has been formed with representatives from the Lincoln Hospital Community Advisory Board, the Hunts Point Multi-Service Corporation, the Federation of South Bronx Agencies and LHMHS workers. A Policy Planning and Review Board (an internal workers' board responsible to the community board) is now being instituted.

The directors of the LHMHS have resigned, but it is unclear who will take over their task, and to whom they will owe their allegiance. Some people (including officials of the City Community Mental Health Board) think that Einstein-Yeshiva is anxious to get out of the community and back into the hallowed halls and behind ivy walls. This could mean a cut-off of Federal funds to LHMHS. Many of the workers see this behavior as further indication that the community and workers must be responsible for their own mental health services, and they are ready to demand the money to run community-worker controlled services.
Meanwhile, Back At The ‘Old School’

UNLIKE MUCH OF COSMOPOLITAN American medicine, in which the medical school deanship and the medical center administrators have begun to gain ascendency over the private practitioner forces, the psychiatric establishment appears to remain firmly in the grip of the psychoanalytic elite. Though this balance has been shaken some by the forces set in motion through the Community Mental Health Centers Act (1963), the conservative psychoanalytical powers still dominate.

New York is the “Vienna of the new world.” It has five major psychoanalytic institutes and many minor break-away schools. However, only three of the New York institutes are recognized by the American Psychoanalytic Association: the New York Psychoanalytic Institute, the oldest, most staid group has no medical school or university affiliation; the Psychoanalytic Clinic for Training and Research is associated with the Department of Psychiatry of Columbia Medical School and the Division of Psychoanalytic Training, the third institute, is an integral part of the Department of Psychiatry at Downstate Medical School. Other off-shoots which are judged respectable, but do not follow a strict “freudian line” and therefore are not recognized by the APA, include the William Alanson White Institute and the Karen Horney Institute.

The large number of psychoanalytic associations gives the impression of democracy and decentralization within the psychiatric establishment. Nothing could be farther from reality. In fact, one interpretation of the proliferation of schools of psychoanalysis is that they are a reaction to a monolithic New idea that cannot be accepted by the captains of psychiatric thought are forced to set sail on their own. Because of the non-medical (unscientific) mode of therapy and because Freud was a Jew, he and his psychoanalytic methods for training and treatment were excluded from the university. Increasingly these excuses for the seclusionary posture of the psychoanalytic institutes are becoming inapplicable, yet there is little to suggest that psychoanalysts will be less defensive in the future.

In New York City, all seven of the medical schools have departments of psychiatry. These departments have responsibility for teaching medical students and maintaining residency training programs and are staffed by psychiatrists, many of whom have been through the psychoanalytic institutes. Post-residency training programs remain controlled by the psychoanalytic institutes. The autonomy of both training programs is maintained by a separation of leadership. Thus at Columbia, Dr. Lawrence Kolb is chairman of the Department of Psychiatry (also current president of the American Psychiatric Association), while Dr. George Goldman is head of the Psychoanalytic Clinic for Training and Research, and Clinical Professor of Psychiatry. Founded in 1945, the Psychoanalytic Clinic at Columbia prides itself on being the first psychoanalytic institute to be affiliated with a university program. Some view this trend optimistically, seeing opportunities for the “academicization” of the psychoanalytic approach; others see it as prolonging psychoanalytic dominance of university programs.

Structurally, the national psychiatric establishment consists of three main groups. The American Psychoanalytic Association represents the psychoanalytic institutes and private-practicing doctor-analysts. The American Psychiatric Association is oriented more to university-based psychiatric training programs and doctor-psychiatrists. The Orthopsychiatric Association embraces an interdisciplinary group including social workers, psychologists and psychiatrists with many different therapeutic orientations. Though it is difficult to draw clear lines of political power within this psychiatric establishment, it is not difficult to see the overarching result of the psychoanalytic emphasis on the profession—a private practice, elitist orientation based on a sickness model of mental health.

Psychiatric practice is largely private practice. In the nation as a whole, over 50 percent of all psychiatrists are in private practice. In New York City alone, over 66 percent of all psychiatrists are in private practice. Money isn’t the only attraction. Private practice allows for the selective treatment of upper-middle-class white people and affords a kind of seclusion, in which the psychiatrist’s work cannot be reviewed or evaluated by third parties. Also, psychiatrists are pushed into private practice by training programs that deny intensive analytic experience during the residency years, and emphasize the need for such training in the post-residency period through the psychoanalytic institutes. Residents are hounded during their first year to make a commitment to an analytic program and are regarded as mavericks unless they comply.

The pervasiveness of the medical and psychoanalytic approach results in an elitist posture toward the problems of manpower shortages in the mental health field. Take for instance, Dr. Lawrence Kolb’s analysis: “Only psychiatrists command the full depth of diagnostic and therapeutic skills. . . . More than a larger number of professionals in mental health, we need a functional analysis of diagnostic and therapeutic procedures and of the capacities of different professionals to carry out various treatment procedures. . . . All measures that call for somatic as well as psychological procedures will remain the responsibility of physicians, nurses and physical therapists. Other measures, such as activity therapies, psychological tests and procedures, and group work, may be delegated to other suitably trained professionals, who must of course be able to recognize symptoms that call for direct medical intervention and who will promptly seek medical consultation.” Such medical-psychoanalytical elitism suggests psychiatrists will not lead a “new careers” movement.

A third manifestation of psychoanalytic domination of psychiatry is the fixed attention that psychiatrists have paid to sickness models in mental health. This preoccupation has resulted in a paucity of plans for preventive models in psychiatry. In New York City, less than 1.5 percent of all psychiatrists view their work as primarily preventive. Perhaps this sickness orientation has prevented psychiatrists from leading the movement to abolish mental hospitals.

For that matter, the psychoanalytic framework appears to create a bias against “movements for change.” Typifying the profession’s attitude toward social change, one psychoanalyst said: I have learned to be patient. I have seen how long it takes to change the individual patient. I have experienced the longer amounts of time required to change families. It is hard for me to imagine how much longer it must take to change institutions. We must be patient with social change.” Psychoanalytic training prevents psychiatrists from seeing that changing institutions can change thousands of people and that the process of struggle is itself therapeutic.

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