

HEALTH. PAC

HEALTH POLICY ADVISORY CENTER

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Editorial...

CONTROLLING THE COMMUNITY

WE LIVE IN THE AGE OF PLANS. THERE ARE PLANS TO MOVE PEOPLE, EMPLOY PEOPLE, SCHOOL PEOPLE, SERVE PEOPLE ... IN EVERY CASE, PEOPLE ARE THE OBJECT OF THE PLANS, NEVER THE **SUBJECT**. WE FIND OUT HOW WE ARE TO BE MOVED, EMPLOYED, SCHOOLED OR SERVED ONLY THROUGH THE GENEROSITY OF THE INSTITUTIONS WHO PLAN FOR US, AND USUALLY TOO LATE EVEN TO PROTEST. PROTESTS MORE AND MORE OFTEN TAKE THE FORM OF DEMANDS FOR COMMUNITY CONTROL, FOR THE RIGHT OF PEOPLE TO MAKE THE DECISIONS WHICH AFFECT THEIR LIVES. THE PROTEST WELLS UP OUT OF THE LAST IMPULSES OF DIGNITY LEFT IN PEOPLE WHO HAVE BEEN THE PASSIVE OBJECTS OF PLANS AND NONPLANS, SYSTEMS AND NONSYSTEMS, LONG ENOUGH TO KNOW THAT THE MASTER PLANS ARE THE MASTER'S PLANS.

As the case study in this BULLETIN shows, people who challenge the power of decision-making, life-controlling institutions are up against a system exquisitely designed to exclude their participation except as objects, recipients and patients. Nowhere is this more clear than in the case of health services. The health "establishment" is tightly organized. Regions are organized into private empires [see April 1969, and December 1968, BULLETINS], and empires are organized into the city-wide alliances formalized in the Health and Hospital Planning Council, the United Hospital Fund, etc. There is no "public" sector to appeal to, for that too has been integrated into the elite network of private control, and it serves its masters well. And if this massive system of political control is challenged, there is always the ancient magic of professionalism to unfold: "Only we **know** how to do it, even if we don't always do it right." Finally, if this mixture of practical and mystical power should be seriously challenged, there is the hard fact that those who control resources are in business to maintain that control. They can hold out, salaried and respected, well after the most spirited community insurgency has been demoralized and dispersed.

In health, these are the structural premises in which any struggle for community control, or even involvement, takes place. Once the struggle begins, the day-to-day strategic advantages of the "establishment" become dazzlingly clear. First, it is up to the now-powerful institutions (public and private) to set the very stakes of the struggle. The concept of community mental health centers, as described in this case study, was hammered out by representatives of the private institutions and public agencies which traditionally control mental health services. Even the pathetically tiny immediate piece of the action described here—for a mental health center—was the product of prior plans by the usual planners. Defining and limiting the stake to the planning process meant that no matter how intense the struggle, **the** implementing agencies (Columbia College of Physicians and Surgeons and the City Department of Mental Health) would never be challenged at their own gates. The struggle would take place only over a hypothetical, years-away, community mental health center edifice.

Columbia P&S and the Department of Mental Health defined not only the stakes but also their own adversary—the "community." It was the institutions' prerogative to demarcate the battleground itself, to describe and gerrymander the "catchment area" which they saw as the "target" of **their** community mental health center. Moreover their power did not end when the stakes were set and the turf marked out. In the struggle which followed, it was they who had the prerogative to set the groundrules for the game. Columbia P&S and the Department of Mental Health delineated the forms for "community involvement" to squeeze into the advisory committees, the agenda of planning meetings, the formalities of representation, and the limits of "participation." But to describe the "rules" misses the point. For the favored players, **the** ones who invented the stakes and carved out the board, also had the power to, at any point in the struggle, change the rules, redesign the forms of participation

WITH THIS BULLETIN, HEALTH-PAC makes a departure from its usual format to bring you an epic which was many months and a cast of thousands in the making. Inside you will read of the struggle for community control which pitted the residents of a New York City ghetto against the combined wealth, intrigue and manipulation of a private Medical Empire and a City agency.

and reshuffle the players.

The community described in this case is a firstful of dedicated people saw setback after setback. It spent week and months to combat 15 against, took many false trails and entered many fixed bouts. If it played along too long, seemed not to notice what now seem obvious traps, it was because, again and again, the most heart-breaking defeats came disguised as victories. To receive prerequisite for control they had to meet the standards to become a licensed

(Continued Page 2)

Community Control Struggle

UP AGAINST THE MENTAL BLOC

The first cry for community control of a health facility in New York City went up over two years ago from blacks and Puerto Ricans in the Washington Heights-West Harlem ghetto of the Upper West Side of Manhattan. The facility in question was still on the drawing boards of the Columbia University Medical Empire. The Empire was laying plans to construct and staff a "community mental health center" with public money.

The community rallied support to "stop" Columbia and changed the rhetoric of the City agency, the Community Mental Health Board, from conservative to liberal. Nevertheless, the resulting white-black-Puerto Rican mental health council—which extorted recognition as the official mental health planner from the establishment—has been bogged down for well over a year in bureaucratic hassles. At the writing of this case study of the struggle for community control of the Washington Heights-West Harlem-Inwood Community Mental Health Center, the local council is still awaiting its first grant of public funds—about \$90,000 for one year for planning.

COMMUNITY MENTAL HEALTH CENTERS were conceived in 1963, when the word "community" was still innocent of threatening political and racial overtones. To the psychiatrists, public officials and Congressmen who drafted the Community Mental Health Centers Act, a "community" was simply a geographically defined target area, target of what seemed to be a straightforward public health program. Federal money would help construct and staff these centers, asking only that local programs provide comprehensive services for a

target population of no less than 75,000 and no more than 200,000 people. [See May BULLETIN.] Community participation in the planning and operation of the centers was also mandated by law, not as an invitation to community control, but as way of ensuring acceptance of the centers by a public which was presumed to be suspicious and hostile about mental illness.

What made the program politically volatile was not, as later charged, misconceptions on the part of the public, but its inherent vagueness, which left it open to irreconcilable differences of interpretation among mental health professionals. The more medically-oriented professionals tended to see community mental health centers merely as a new package for time-tested modes of care and nothing more. Opposing this interpretation were more "liberal" psychiatrists and social workers who viewed mental illness as more a social than a medical problem. To them, community mental health centers could become staging grounds for social reform, dedicated to attacking all the environmental causes of distress—in the schools, in the courts, in the homes and on the streets.

Under the law, the interpretation and implementation of the community mental health centers program was left up to local government health agencies. For leadership, the federal government looked primarily to New York City, the region with the highest concentration of psychiatrists, voluntary mental health programs, psychiatric institutes and medical schools. Despite this dazzling array of private mental health facilities, New York City's public commitment to mental health was weak, scarcely visible, and hardly "public" at all.

The Community Mental Health Board (CMHB, renamed the "Department of Mental Health," see Box, Page 4) has,

Editorial

(From Page 1)

"clinic," to remain tax-exempt, they had to refrain from "political" activity.

But no one can play against loaded dice and a tilted board forever. In more and more of New York's sub-cities, people are demanding that they help set the stakes, define the geographical battleground, and devise the rules. In East Harlem, the Lower East Side and the South Bronx, community groups are, through programs and organizing, defining what they mean and need by way of health services, who they are as a community, and how, in terms of representative structures, they will exercise control.

The story of Washington Heights-West Harlem vs. Columbia P&S is not over. It is not over because it is not a contest for a fixed, commonly perceived, prize. What the

Columbia P&S empire wanted, what the Department of Mental Health had to offer, was first of all a building, and second of all funding support for expanded research and education activities. Service ran a poor third, and was conceived of as a by-product of training young psychiatrists. The people who challenged Columbia's control were, just as earnestly, challenging Columbia's entire concept of community mental health services. The vision which they set out to fight for was one of community mental health as a community enterprise—for street-level services which could reach people when they first needed help, and could reach into all the social and institutional sources of human fragmentation, addiction and despair.

Columbia medical empire had all the tactical advantages. But its final, debilitating strategic disadvantage was that it could not do the job the community people wanted done, because to do so would be to abandon its institutional priorities and come down from its academic towers. Columbia eventually acknowledged its indifference to mental health services and its ability to deliver them. In the end, it simply dusted off its academic robes, picked up its scattered blueprints, memos and letters, and walked off the battlefield.D

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since its inception, always served the private mental health sector far more diligently than it has served the public. [See May BULLETIN.] It operates no facilities of its own, leaving it largely to the private sector to determine who will be cared for and by what means. It's only discernible function is to sign checks, distributing State and City funds to local mental health facilities. Headed by a Board representing the most powerful elements of the private sector in mental health (philanthropic organizations, medical schools and voluntary hospitals), CMHB has consistently chosen to direct the bulk of its budget towards established, middle-class oriented private facilities. This conflict-of-interest situation extends into CMHB's civil service staff, which includes a number of people who work part-time in private agencies funded by CMHB. Not surprisingly, considering these sources of recruitment, CMHB presents a white, middle-aged, well-fed face. In mid-1968, CMHB had only three black employees (out of 170) above the clerical level.

CMHB's interpretation of the Community Mental Health Center Act was entirely consistent with the institutional interests of its Board and staff. First, CMHB required all community mental health centers to be "affiliated with a teaching hospital or medical school, [and] closely related and located within a reasonable distance to a general hospital." CMHB would not, of course, operate any centers itself; it would merely "stimulate" private hospitals and medical schools to do so. Part of the stimulus offered by CMHB was the prospect of a multi-million dollar building. From the start in 1964, CMHB interpreted mental health centers strictly as buildings (rather than as networks of services in existing space)—buildings which medical schools and hospitals could use for private office space as well as "community mental health." Thus, in the mid-60's, CMHB staff planners divided the city into 51 mental health "catchment areas," each to have a center, and each center to be operated by the local medical empire.

Columbia-Presbyterian Medical Center was an inevitable candidate for a community mental health center, at least for a center as defined by CMHB. The medical school and its affiliated hospital, Presbyterian, enjoy world-wide prestige as well as unchallenged medical dominance in surrounding Washington Heights and nearby Harlem. But to most residents of the area, a Columbia community mental health center sounded like an automatic contradiction in terms. Those circumstances which have linked the words "Columbia" and "community" have been tense, when not actually violent. Black and Puerto Rican residents of the area do not see Columbia as a community resource, but as a union-busting employer [see September BULLETIN], as a landlord, and above all, as a real estate empire.

The Gym Rebellion *Background:*

Community resentment of Columbia peaked in early 1968 over the issue of the gym in Morningside Park. Columbia University had purchased, in 1961, a piece of public land in Morningside Park, for construction of a new gym. Since the gym would have cut deeply into one of the few islands of green in all of Harlem, there was considerable pressure on Columbia to build in recreational space for community residents. But in the architectural plans prepared by Columbia, only 15 percent of the gym space was set aside for community use. Worse yet, there were separate entrances planned

for community users (black) and student users (white). A number of Harlem community organizations, and even the City's Commissioner of Parks, had protested the gym plan, but to no effect. The gym became one of the two major issues which propelled Columbia students into revolt in April, 1968. With the spectacle of more than 800 protesting students, many brutally beaten by administration-summoned police, the university's image in, the upper Manhattan community sank to an all-time low.

The Columbia Medical Center has earned a large measure of community resentment entirely in its own right [see December 1968 BULLETIN]. Situated on the edge of blackest Harlem, the Columbia empire is one of the richest medical centers in the world, with the hospital reporting a net profit every year for the last ten years! This is in spite of the fact that the empire spends an inordinate amount on real estate acquisition, buying up scarce housing in Washington Heights and West Harlem at the rate of about \$500 per hour. Very little of all this wealth flows down to the community as health benefits. Private patients take priority at the center itself, and its affiliation with Harlem Hospital has been marred with charges of "using people as guinea pigs for research" and "raking money off of Harlem."

Mental Health Vacuum ^{^ O ^ ^) ^}

Before its involvement in the community mental health center program, the Columbia mental health division had failed to provoke much community resentment, largely because it was virtually **unknown** to the surrounding community. A hold-out of hardline Freudianism, Columbia's psychiatric department has emphasized the training of psychiatrists for private practice, and the care of "articulate," middle-income patients. At Columbia-affiliated Psychiatric Institute, only one 60-bed floor is reserved for "community people," while the rest of the floors draw on middle-income patients from throughout the city. Therapy on the community floor is heavily drug-dependent, in line with the Institute's active involvement in testing for drug companies, while treatment on the other floors is more talky and psychoanalytic. Low-income community people, however, have a low risk of entering any Columbia-run mental health programs, since the intake procedure is designed to select the kinds of patients which doctors-in-training are **likely** to encounter in their future private practices.

In spite of its poor record of community service, Columbia has considered itself to be in the vanguard of community psychiatry. Dr. Kolb, head of the Columbia Department of Psychiatry, and Psychiatric Institute, claimed in 1968 that "Columbia founded community psychiatry 15 years ago." The reason why residents of Washington Heights had been unaware of this breakthrough, in fact, often unaware that Columbia offered any mental health services, was that Columbia's community psychiatry was a strictly academic development. Columbia did indeed offer one of the first residency programs in "community psychiatry," but this was tacked on as a subspecialty, to be studied only after the first three years of residency was completed, and not as an integral part of the training program. As designed by Columbia, training in community psychiatry consists much less of encounters with community people than with courses in administration of mental health facilities.

What role the community had to play in Columbia's com-

Bold New Approach?

Last summer the once powerful Board which dictated the often questionable policies of the City's mental health agency was officially disbanded. The Board, which represented most of the private psychiatric interests in the city, lost control of mental health policy when the City's autonomous Community Mental Health Board (a misnomer which describes Commissioner and staff as well as Board) was taken under the wing of the Health Services Administration.

The new Department of Mental Health and Mental Retardation, officials say, is going to be different from the tyrannical Board. In an effort to meet charges of "unaccountability" the Department will attempt to democratize and decentralize its own structure. First, a new "advisory" board to the Commissioner will be named by the Mayor. Some old faces from the old Board will still be there, but "consumer, mental retardation and geriatric" interests will gain a foothold, officials promise. It is possible that when the Board lost its power—in the old days the chairman of the Board, not the Commissioner, ran the show—that many of the private psychiatric powers were not only willing, but anxious to move over and out to greener pastures.

Regional directors are being hired to head the four new mental health regions. Manhattan, Bronx and Queens are each defined as a region, with Brooklyn and Richmond (Staten Island) being combined as the fourth. Program and fiscal teams will work at the regional level "to develop closer contact with the agencies under contract with the Department. Officials say they hope to use "funds as a lever" to get the 90-odd private agencies under contract to "plan and work together to develop relevant services." In the past these agencies merely wrote their own ticket and the Community Mental Health Board paid the bill with public funds.

MENTAL BLOC

(From Page 3)

munity psychiatry program was spelled out by the head of the community psychiatry department, Dr. Viola Bernard, in 1964:

A local community adjacent to the Medical Center has been delineated as a lab for longterm studies of various therapeutic techniques . . . The population of the Washington Heights Health District, with a population of 269,000 (sic), constitutes the "laboratory community."

With this vision of the community—as a passive reservoir of pathology—it is not surprising that Columbia leaned to the far right in the controversy over the role of the community mental health centers. Community mental health centers, were strictly medical undertakings, in Kolb's words:

It is interesting that the [community mental health] legislation, in defining the structure of a community mental health center, is in fact defining a hospital . . . Yet the words "community mental health center" convey none of that to the general public. Both professional and lay groups seem to be unclear about the functions of such centers. Some have the impression that they are centers for social and political action . . .

If community mental health centers had a more general social mission than other hospitals, it was, in Kolb's view, to prevent, rather than to foment social action:

Administrators and deliverers of mental health services will have to sharpen their perception and recognition of their responsibilities in maintaining social homeostasis. They bear a social responsibility much in the same way as the courts and other law enforcement agencies do in the support of a healthy community environment for all . . . {emphasis added!}

Although willing to give the federal community mental health legislation the narrowest possible reading, and inter-

pret community mental health centers as hospitals, Kolb expressed opposition to another requirement for community mental health centers: that they relate to single catchment areas. In a speech given in 1968, he based his argument on the presumed recalcitrance of consumers, who would always shop for the best facility, even if it meant traveling out of their communities or having to "hoard and save to pay for the best." But he hinted at a much more serious source of difficulty with strict geographic assignments—that they would conflict with institutions' established "clinical and organizational patterns." Commenting on Kolb's clearly "illegal" feelings about catchment areas, a Columbia psychiatric resident wrote recently:

Perhaps the most threatening [to Columbia] aspect of catchment areas is that they define institutional responsibility. Given a catchment area, an elite private institution such as Columbia is assigned to a community which it must relate to, a public which it must account to . . . But Kolb's uneasiness about geographical responsibility may stem from an even deeper fear—the fear that his institution could not fulfill this responsibility even if it could accept it. Institutions such as Kolb's Psychiatric Institute have very little to offer a community which is demanding mental health services, as opposed to mental illness "removal".

For an institution such as Columbia, about to embark on a community mental health center of its own, the question of what a community mental health center was to be was, of course, far from academic. What Columbia's psychiatric policy-makers were endeavoring to make clear in the papers and speeches quoted above, was that a Columbia community mental health center would be, as much as possible, identical in philosophy and operating style to Columbia's existing mental health facilities. These facilities were hospital or hospital-based, hence Columbia's community mental health center was to be a "hospital." These facilities were highly selective for patients compatible with research and training programs; the Columbia community mental health center should have the same freedom. As for community participation, the existing facilities were accountable to no one but their trustees (and it is doubtful that even they have much to say about how the facilities are run). Hence, a Columbia community mental health center would go no further in the direction of community participation than would be necessary to prevent the hostility which a community mental health center patterned after Columbia's existing facilities was sure to encounter. In a 1968 article Kolb wrote of the necessity for a "citizens council," to mediate between the community mental health center and its "target population," and hopefully to clear up any misconceptions about community mental health centers which the community, in its ignorance, might be entertaining

Historical Incest

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Through all the years of planning the Columbia community mental health center, Columbia's narrow—if not actually arrogant—conception of the community mental health center was never challenged by CMHB. Columbia had in fact always had an especially close relationship with CMHB. Back in 1954, with the formation of CMHB, Columbia Presbyterian Hospital had received one of the very first CMHB contracts for State funds. The ties were tightened in 1961 when Marvin Perkins came to New York and concurrently accepted the positions of associate professor of community psychiatry at Columbia and the directorship of CMHB.

The next formal alliance with Columbia was forged when CMHB sought the collaboration of the Columbia School of

Public Health and Administrative Medicine in the spring of 1963 to do a household survey on the public image of mental health services in New York City. A budgetary tie-up at CMHB delayed the project for a while, but CMHB turned to the New York City Health Research Council (a conduit for primarily public health research monies) to pick up the tab. The project was reviewed and approved without a hitch. Such an eager reception could have been predicted, since Harvey J. Tompkins, M.D., CMHB Board Chairman, and Ray E. Trussell, M.D., New York's Commissioner of Hospitals, were both voting members of the Health Research Council. Dr. Trussell had been holding simultaneously the job of Commissioner and his old job (on leave) as associate dean of Columbia's School of Public Health since 1961. The public images survey which was completed in 1965 helped cement the CMHB and Columbia relationship.

The rivalries inherent in the prestigious American Psychiatric Association (APA) played a further role in welding the personal relationships within CMHB and with the psychiatric elite at Columbia. Commissioner Perkins felt slighted when Dr. Tompkins, as APA president in the mid-60's, did not appoint him to any influential committees. Perkins found a friend in, and gravitated to Dr. Kolb who succeeded Dr. Tompkins as APA president. Subsequently Kolb became a behind the scenes confidant of Perkins.

Mental Health Missionary

But the one person who provided the communication link among several interests—psychiatric power, academic strongholds, City and State government, and the mental health crusaders—was the woman who more than any other individual "sold" community mental health to the private sector. Mrs. Marjorie H. Frank, a philanthropist, came to CMHB in 1963 on assignment from the State to head up the City's Regional Mental Health Planning Committee. The committee's recommendations which were published in 1965 essentially laid the groundwork for CMHB's approach to community mental health—that the voluntary sector can best do the job. Mrs. Frank was not new to the world of mental health and medicine. She headed a family foundation which had given heavily to psychiatry and over the years the foundation had awarded grants to both Trussell and Tompkins. As a personal friend to Tompkins, Kolb and Trussell, she was the intermediary for essentially hostile forces which resided in CMHB and Columbia. She moved on to Columbia early in 1967 to become Kolb's assistant, and now teaches in the Department of Psychiatry.

For Columbia the big pay-off for its years of intimacy with CMHB came in 1965, when New York State passed its own Community Mental Health Act in response to the federal legislation. According to CMHB, Columbia was not only to have a community mental health center, but it was to have one built entirely with public funds. (Some voluntary hospitals, such as Brookdale and Maimonides, put up much of their own construction money for their community mental health centers.) After working out an informal agreement with Dr. Kolb that Columbia's Division of Community Psychiatry would accept the community mental health center, Commissioner Perkins proceeded to enter the project into CMHB's 1966-1967 Capital Budget request. Lest the CMHB Board, headed by Dr. Tompkins, balk at the \$18 million request, New York City Commissioner Trussell made an unprecedented personal appearance before the Board to plead

for the community mental health center and the approval of an affiliation contract between Columbia's Department of Psychiatry and Harlem Hospital, a Municipal hospital. Trussell's efforts were instrumental in pushing the Columbia center through as one of the first to be entered in the New York City Capital Budget. (Three weeks after his appeal to CMHB's Board, Trussell resigned his City post and headed back to the deanship of the Columbia School of Public Health, which, along with the Columbia Department of Psychiatry, jointly administers the Division of Community Psychiatry.) Commissioner Perkins then recruited the psychiatrist with whom he shared a private office in Scarsdale, Dr. Sheldon Gaylin, to administer the planning for Columbia's center.

CMHB trumpeted the Columbia community mental health center as a "model for the nation," which would be one of the first concrete implementations of the so far nebulous Community Mental Health Center Act. Justification for the choice of Columbia as the managing institution was couched in terms of the community mental health center's potential for integrating service, training and research.

The site of the center, if not the choice of Columbia to run it, was clearly defensible. There was never a question of the need for primary health services in the Washington Heights-West Harlem area where, by the mid-60's, problems such as drug addiction and alcoholism were reaching epidemic proportions. The catchment area includes the section of upper Manhattan from 115th Street to 181st Street and from St. Nicholas and Bradhurst Avenues to the Hudson River. Of the 166,433 people who reside in this catchment area, about 45.7 percent are white, 41 percent are black, and 13.3 percent are Puerto Rican. About 20 percent of the families have incomes under \$3,000 and 59.6 percent have incomes of under \$6,000. Statistics show that 13.4 percent of the families reside in substandard housing. Records from 1966 show 1236 terminations from psychiatric clinics and 489 admissions to State Mental Hospitals. S

*Common
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Enter Inwood

The only questions on which Columbia and CMHB disagreed during the early stages of planning was on whom exactly the center should serve. CMHB had specified that the center should serve residents all the way down to 125th Street, thereby taking in the heavily black and Puerto Rican area of West Harlem. The uppermost tip of Manhattan, the primarily white area of Inwood, was to be served by a community mental health center eventually to be developed by Jewish Memorial Hospital. Dr. Kolb expressed to Commissioner Perkins Columbia's preference for reaching northward towards Inwood rather than southward towards Harlem, but CMHB would not budge from the original catchment area boundaries. The joke going around CMBH staff was: "Next thing Columbia is going to want is money to put a fence around its catchment area."

In 1966, the architects (a private firm, under contract to the City) and Columbia planners unveiled their plan for the "model" community mental health center. The plan was never made public and was, in fact, later suppressed by both Columbia and CMHB, but because of its sumptuous proportions, it has become legendary in City planning and budgeting circles. It included 407 offices for the private use of Columbia psychiatrists! The actual services, if not only an afterthought,

(Continued Page 6)

MENTAL BLOC

(From Page 5)

were at best far from innovative. At the core was a good-sized hospital—200 inpatient beds. The other federally mandated services appeared to have been designed from a federal "how-to-do-it" guidebook with little attention to whatever special needs or tastes the community might have. There were a token 10 beds for drug addicts, a slightly smaller service for alcoholics, and no program whatever to utilize the supportive services of existing community service agencies in the area.

Struck by the probable expense of this monumental community mental health center, the State Department of Mental Hygiene did not directly challenge the 407 private offices, but only suggested that 200 beds (which in theory justified the office space) were more than enough for two catchment areas. The State proposed that the Inwood catchment area be attached to Washington Heights-West Harlem for a total catchment area population of 281,330, to stock the 200 beds. In order to conform to the federal law limiting catchment population to 200,000, the Columbia community mental health center's plans were revised to provide for two "separate but equal" sets of services under the one roof: one set for the predominantly black and Puerto Rican Washington Heights-West Harlem, another for mostly white Inwood. Columbia of course was delighted with this "solution," since they had preferred to look northward in the first place.

By any standards, Inwood was a low priority area for a community mental health center. At a time when the Lindsay Administration was reserving social action dollars for the city's ghettos, Inwood was respectably white and middle-class. Though there had been some influx of blacks and Puerto Ricans, Inwood remained primarily a "staging area" for middle class whites on their way to the suburbs. From 1960 to 1965 the white population fell from 92 to 87 percent, while blacks gained from 5 to 9 percent and Puerto Ricans from 3 to 4 percent. Compared to Washington Heights-West Harlem, Inwood has only half as many families earning less than \$3,000, and only one sixth as many tenements considered substandard.

Exit Freud

Until the talk of a community mental health center—and the ensuing possibilities of reorganizing the patterns of mental health services to meet the needs of a ghetto community—few had questioned Columbia-style mental health services. The limited inpatient service through Columbia's affiliation with the State Psychiatric Service and outpatient services through Vanderbilt Clinic were organized along traditional lines, providing one-therapist-to-one-patient verbal treatment. Such consultation, even if the communication barrier could be overcome, was scheduled for the convenience of the doctors and made no attempt to adapt itself to the life styles, the social, cultural or political fabric of the community residents. Traditional mental health services, at best, could only treat the symptoms of destructive social and economic conditions. But those community people who were concerned with the mental health of the blacks and Puerto Ricans of Washington Heights-West Harlem saw the need to attack the source of the problem:

The major concern is the mental health of the community itself with preventive programs, early detection, treatment, and an effort to change conditions in the community Mental illness is to be seen and treated as an intrapsychic, social and political problem, rather than exclusively a psychological or biological one

During the mid-60's, the War on Poverty money which flowed into the black and Puerto Rican neighborhoods of the Heights and Harlem served to whet the appetites of a community hungry for social services of all kinds. When a community action-type struggle failed to turn the tide of decay, residents began to look more closely at the ebb and flow of poverty funds. Militancy grew around the demand for direct control of funds as people realized that poverty program monies—as paltry as they were—were siphoned off by pre-packaged social service programs, which were, in the case of these neighborhoods, often served up by Columbia University.

Enter The Community, Finally

Historically, the local social service agencies of the ghetto have provided a breeding ground for social activism. Not only are people in the agencies most aware of the magnitude of the problems facing lower class clients, they are also often politically sophisticated groups organized specifically to extract services from the establishment. By 1967 there was a proliferation of such agencies, often run on a near volunteer basis by men and women who have been victimized by the conditions of the ghetto. A conservative survey of Washington Heights reveals more than a dozen organizations devoted to tenant and housing problems and another half dozen neighborhood improvement and service groups, and scores of special interest groupings ranging from ethnic clubs to senior citizen and youth groups. These fiscally starved storefront agencies usually provided residents with their only access to help whether it be in the search for a job, information on drug addiction treatment, or dealing with "downtown" welfare or housing agencies. The people who ran these local agencies—professional or non-professional—were looked to by service-starved clients for political leadership by virtue of their bargaining position with the power structure. A number of local service agencies had banded together to form an elected, "representative" community corporation which could be the recipient of anti-poverty funds. As the funds dwindled, the agency leaders began to cast a sophisticated eye around for other possible sources of money.

Community agency leaders first learned of the Washington Heights-West Harlem "Community" Mental Health Center in March 1967 through an article in the Sunday New York Times. [Hereafter the black and Puerto Rican community described includes the southern portion of Washington Heights and West Harlem. For brevity it will be referred as the "Washington Heights Community".] Residents working in the community action program were angered because they had not been consulted—they saw such a unilateral decision as a violation of the integrity of the community corporation. Those who were working in social service agencies which provided on-the-street services to drug addicts, alcoholics, etc., were insulted that they, the only ones in the community who had any real experience in dealing with the mental health of the residents, had not been involved in the planning (which ultimately meant they would be shut out from receiving funds).

It was predictable that when representatives of the black and Puerto Ricans from Washington Heights began gearing up

to take on the CMHB and Columbia, they would attack their racist and exclusionary records. In the spring of 1967 they contacted the City Commissioner of Human Rights, William Booth, and asked for an investigation of discriminatory practices of both. Both Columbia and the City CMHB were vulnerable. The mental health militants attempted to expose the lily-white composition of the CMHB Board and the racist practices of Columbia University—placing particular emphasis on the nature of the white community mental health center planning staff, which aspired to "organize" the black and Puerto Rican communities.

CMHB had little patience or money for blacks or Puerto Ricans. Not only had CMHB shut out the small service agencies by refusing to give them funds, the Board itself wore a white face. After months of ineffectual demand-making, the Washington Heights contingent contacted the Office of Civil Rights of HEW in late 1967 and requested a thorough investigation of the discriminatory practices of CMHB. Specifically, they asked for inquiry into their practices with respect to appointments of blacks and Puerto Ricans to the Board and their contracts with agencies, including medical schools, that discriminate in employment, selection of patients served, and discriminatory behavior in admissions policy to educational facilities. The Office of Civil Rights had little appetite for exposing a public agency. They took the easy way out by conducting a cursory review of CMHB's activities and, in the hope of appeasing the minority group dissidents, then informally acknowledged the existence of discrimination. It was, they insisted, "difficult to pin down."

Columbia Exposed

The Washington Heights social service agency militants had indisputable goods on Columbia's racism. A document had been "liberated" which left no questions about Columbia's disrespectful treatment of the community. The document was a community organizing proposal which requested \$92,000 of CMHB to organize the community to become the recipients of mental health services to be provided by a Washington Heights community mental health center. The plan contained two blatant mistakes/Tirsi^ft carefully dissected the black and Puerto Rican "target population" and identified problems of the community on a racial basis only, consistent with its policy of treating the minority population as a passive organism on which to perform research or to utilize as teaching material. With this perspective it was natural for Columbia's white planners to make their^ecomUalal mistake—they assumed the ghetto, which looked chaotic to their middle-class eyes, to be unorganized. Such ignorance in black and white added the final spark to a community which had been seething with resentment for Columbia for years. (Ironically, it was later revealed that the Columbia community development proposal was actually written with the assistance of a CMHB staff consultant.)

Columbia displayed its arrogance by supposing that first of all the community wasn't organized, and secondly, that Columbia itself had the resources and the right to organize it. The document made a special effort to discredit those who might assume community leadership—particularly, the heads of local organizations:

There is little contact or interaction between groups for a variety of reasons including cultural differences, antagonisms, rivalries, or apathy . . . There is no broad based organization which speaks for substantial numbers of the population . . . A low rate of participation characterized

[all] existing organizations. Therefore, the leaders of such organizations are not necessarily representative spokesmen for the community. These factors of fragmentation, low participation, and limited representativeness of the leaders indicate a lack of ready-made channels of communication through which to establish contact with local residents for involvement in joint planning of needed services . . .

The leaders of the local social service agencies wrote a rebuttal to the Columbia plan in which they voiced a concern "that the improperly informed invade our community . . . They have submitted incorrect data to secure funds to set up programs on the basis of ignorance, when they should have consulted with leaders in the community." They specifically indicted Columbia for its racism and questioned its legitimacy as a "community" institution. In their point-by-point counterattack, the leaders of the community organizations condemned Columbia for:

(a) your philosophy, (b) your right to be knowledgeable participants in the role of the sole and only owners, creators and planners, (c) your inferences in terms of (racist) demographic factors, (d) your rationale. It is incredible that any report has separated West Indians in this area from other Negroes and Puerto Ricans; we note there is no effort to indicate the percentage of Irish Americans; (e) the statement 'fragmentation', in terms of being a community that is poorly organized, (f) your divisive factors and statements in terms of the Negro and Puerto Rican in this area which, granted, does not present one-structure (we have different interests, tastes, etc.) but there is no reason why you infer that we should be against each other; we have learned to appreciate this as other communities do not; (g) the conflicting, often irrational statements in which you initially state that there is no organization fabric in this area and then discredit and deny same by stating you have made lists of a great number of organizations in the area . . . It appears that this is a decision and almost criminal attempt at pitting one group against another, a factor which is obviously not for mental health but for mental illness. Who is sick? the doctor or the patient?

This was the first time, in over a decade of planning "community mental health services, that CMHB had ever been seriously challenged by a community. CMHB's first move was to ascertain just how serious the challenge was. Commissioner Perkins, his personal staff and a bevy of Columbia planners traveled uptown to meet the natives, and discovered they were a force to be reckoned with. Local agency leaders had reproduced and circulated more than 1000 copies of the Columbia community organizing plan throughout the community, and the storefront meeting site was jammed with representatives of numerous organizations. The community attack, articulated most clearly by Dr. Anna Hedgeman, a black woman considered to be the "Eleanor Roosevelt of Harlem," dealt with both the control and the content of mental health services. If there was money for mental health, she said, the community and not Columbia, should get it. Furthermore, the Columbia community organizing proposal proved that Columbia was in fact not capable of creating mental health services appropriate to the black and Puerto Rican community. Dr. Perkins was forced to acknowledge at least that Columbia should not come in and organize the community. Ironically, the strongest condemnation of Columbia's proposal which he made was that it was "unprofessional."

Great Hop Forward?

In its response to the demands raised at the meeting, CMHB dismissed the substantive criticisms of Columbia as a mental health resource and concentrated on the community's demand for a share of the power. If the community wanted to be "let in" then Commissioner Perkins prepared to make room for them. He proposed two forms for community in-

(Continued Page 8)

MENTAL BLOC

(From Page 7)

volvement. First he informed the group that the terms of two positions on the CMHB Board were about to expire, and that the community should consider submitting names of blacks and Puerto Ricans for appointment to these high policy-making posts. Secondly, he mandated the formation of an Ad Hoc Advisory Committee—to be a tripartite group including Columbia's community mental health center staffers and representatives from both the Washington Heights and Inwood communities—which would provide a channel for community participation in planning for the center. The two CMHB staffers who were assigned to work with the committee were a black to act as community liaison and a Puerto Rican researcher to work as technical advisor.

The war-on-poverty-weary community people had little confidence that CMHB would follow through on either of these two proffered points of participation. Within a few days after the meeting with Perkins about 50 Washington Heights people staged a sit-in at a CMHB Board meeting—the first public demonstration ever staged at CMHB's headquarters. All the demands, however, dealt with Columbia. In addressing them to CMHB, the community showed that it still looked to CMHB as a public agency, and as a possible ally against Columbia. The demands themselves dealt solely with ethnic representation in the planning of the mental health center—that Columbia hire black and Puerto Rican planners and directors for the center, etc.—demands which could probably have been met by Columbia with little difficulty. Nevertheless, all the demands foundered shortly after the sit-in. When Commissioner Perkins attempted to direct Columbia to hire blacks and Puerto Ricans for certain staff positions, he was told by the City's Corporation Council that any such directive would itself be in violation of the States anti-discrimination law. Columbia took the opportunity to keep the doors shut to blacks and Puerto Ricans.

The Old Committee Trick!

The formation of Perkins' proposed Ad Hoc Advisory Committee did much to defuse the frustrations built up by the fruitless sit-in, but ultimately generated even more serious frustrations. As time dragged on, it became obvious that the process for participation had been created. Instead, Columbia "continued to" grind out plans—architectural and programmatic—all without even making the pretense of consulting their "advisory" committee. Blacks and Puerto Ricans were not even an equal partner within the Columbia, CMHB, community trioka. The injection of the Inwood community representatives strengthened Columbia's hand because Inwood more often than not defended Columbia's paternalistic role. Basically, white, middle-class Inwood residents would be happy with more of the kinds of traditional therapy that Columbia had to offer. When disgruntled Washington Heights representatives began to question whether Columbia was the proper medical facility to be affiliated with the community mental health center, representatives from Inwood jumped to the defense of Columbia, saying "the contract is with Columbia and this committee does not have the right to question that."

By late fall of 1967, the Washington Heights mental health militants had decided the Ad Hoc Committee wasn't "where

it's at." The establishment had neither let them in by sharing decision-making power, nor had it given the black and Puerto Rican community any increased services. The group decided to ignore the Ad Hoc Committee and to move on to new fronts. First, they would try to get immediate mental health services into their community by submitting their own proposal to CMHB. The community's proposal, submitted to CMHB by the Puerto Rican Guidance Center, ran exactly counter to CMHB (and Columbia's) conception of community mental health services. The proposal called for decentralized non-professionals—all, of course, independent of Columbia or any other medical center. CMHB rejected the proposal with what seems to have been unusual vehemence, on the grounds that the Puerto Rican Guidance Center did not have a valid license to operate a clinic, and did not have an adequate professional staff. CMHB went on to recommend that the Guidance Center affiliate itself with Columbia's mental health center, which was expected to be ready for occupation in mid-1970:

Shout

// there is indeed a valid (professional) team available (at the Puerto Rican Guidance Center), I am quite certain the Washington Heights Mental Health Center would snap up any offer of affiliation they might make. The proposal though is long on ideals and short of details. That is, it says a great deal about the why and where and practically nothing about the what and how. Because of this lack of detail, it is difficult to determine the depth of thinking of the people involved in developing this program other than their wish to do something very needed and very worthwhile.

The Washington Heights community was irritated not only by the paternalistic tone of the rejection, but by the fact that the rejection was not mailed directly to Dr. Ruben Mora, director of the Puerto Rican Guidance Center but to Mora's (white) superior at City College, where Mora taught psychology.

Enter Supporting Cast

With the rejection of the Puerto Rican Guidance Center's proposal, the Washington Heights community activists temporarily abandoned hope for creating immediate services, and turned to more overtly political tactics. The struggle for community involvement in health services had by this time taken on city-wide dimensions, with at least a dozen scattered groups battling over health or mental health centers around the city. It seemed possible to meet CMHB's and Columbia's power with a broad-based, political force. In early November, 1967, the Washington Heights people called for a meeting of minority group health activists from around the city—from Harlem, from the Lower East Side, from the South Bronx and from Bedford Stuyvesant, where a black community group was challenging St. Johns (Episcopal) Hospital's plans for a community mental health center in a struggle parallel to that in Washington Heights. The meeting was packed and excited. Groups from ghetto areas all over the city spoke of their frustrations and pledged to support each other's struggles through common actions. Out of the new sense of strength and confidence came a new organization—the Citywide Health and Mental Health Council, which was to lead the struggle for minority groups' involvement in health for a year to come. It called for the City to:

Shift the balance of power from private interests in health and mental health to the interests of the people and involve the diversified segments of this city in POLICY MAKING, PLANNING, DISTRIBUTION OF FUNDS AND CONTRACTS, AND IN WATCHING FOR THE MAINTENANCE OF THE PUBLIC INTEREST

This development was not viewed with unanimous displeasure by the "downtown" health bureaucracy. To Dr. How-

ard **Brown**, top officer of the City's new Health Services Administration superagency, the emergence of a seemingly organized constituency for health services was a potential godsend. Ever since his appointment in early 1967, he had been struggling unsuccessfully to bring together the entrenched health, mental health and hospital bureaucracies under the common administration of the Health Services Administration. Having alienated most of the private medical establishment through charges of irresponsibility, Brown's only hope for leverage over the health agencies he headed was from a consumer constituency. As a guest at the founding meeting of the Citywide Health and Mental Health Council, Brown listened attentively to the community charges against CMHB. Whether inspired by the crowd or by his own agenda, he told them, "Go to the Mental Health Board and sit there and tell them . . . they have the power!"

CMHB Meets the People

Following Brown's suggestion, people from the Citywide Council—including residents of Bedford Stuyvesant, the Lower East Side, Queens, and Staten Island—about 50 strong, descended on the CMHB and sat in at the Board meeting in mid-November. The Board was taken by surprise and the demonstrators stayed for hours to make their points, of which several were reiterations of discrimination and community involvement demands. The demands centered, however, around the complaints about the recent appointment of a Columbia psychiatrist to the CMHB Board, and demands that a black and a Puerto Rican be appointed to soon-to-be-vacated seats on the Board. They said:

We also want you to endorse the appointments of new [black and Puerto Rican] members to fill forthcoming vacancies . . . We don't want people with legalized conflict of interest sitting here. We want all members of this Board who are on the payroll or on Boards of contract agencies [to] resign immediately. Their stay means that this government maintains opportunities for corruption.

When he was finally allowed to speak, Dr. Tompkins, chairman of the CMHB Board, stated dramatically: "this is a time in which we have learned more in two hours than in a whole lifetime. Our goals are your goals." He assured the groups that the two vacancies at issue (because of the expiration of the terms of two members) would be filled by a black and Puerto Rican. However, in the next few hours Dr. Tompkins quickly relearned the habits of a lifetime. In the Board meeting that followed the exit of the placated demonstrators, Tompkins recommended the reappointment of the two Board members whose terms were to expire. His recommendation was accepted by the Board.

Even though the Citywide Health and Mental Health Council was further embittered by this stunning brush-off, in a way the Council had made its point. The sit-in and the subsequent coverage in the media had made a deep cut into CMHB's shell of secrecy—a cut which has never completely healed. For the first time, CMHB had been dragged out from its behind-the-scenes coziness with the private sector and publicly charged with corruption. Deeply shaken, CMHB issued a public statement claiming that "virtually all" of its budget/ was "directed toward the financially disadvantaged." The statement was quantitatively false, but was at least accurate in terms of CMHB's social attitudes: CMHB had missed the point that the minority groups were demanding that the money be directed not just toward, but by the recipients of service.

The Citywide Council had gained nothing concrete through

Out of Control

The Atomic Energy Commissioner (AEC) has discovered what the AMA, the State Insurance Commission, and the medical empires have reluctantly been learning for the last year—consumers are insisting on a say in decisions which affect the health and safety of their families and their neighborhoods. At the AEC's "public hearing" on November 18, where Columbia University sought approval to operate its already constructed nuclear reactor, militant community residents and a newly formed student group, Ecology Action, repeatedly interrupted the formal hearing to question:

- Columbia's failure to confer with the community before building its reactor (initiated in 1959, according to Columbia documents);
- Conflict of interest inherent in the AEC's dual role as both promoter and regulator of atomic energy;
- AEC's requirement that people wanting to speak at the hearing apply nearly three weeks in advance, stating their names, their "interest" in the matter, and what they planned to say;
- Both Columbia's and the AEC's failure to adequately inform the community about the reactor itself and about the public hearing.

The AEC responded to the last two objections by permitting anyone present to sign up and speak and protesting that indeed the public had been sought out—notices had been placed in the Federal Register and in public notice columns of New York and New Jersey newspapers. Amid cries of "then where are the people," the number of people was forcibly reduced by police.

Among the points at issue is the Argon 41 gas which will be emitted during normal operation of the reactor. While Columbia claims that all the Argon 41 breathed in is breathed out in the next breath, the Scientists Committee for Public Information claims that a significant portion of the Argon 41 inhaled passes into the blood and accumulates in human tissues. The effects of long term accumulation are not known.

At an Ecology Action-sponsored teach-in the previous day, scientists and other speakers had debated both the technical and political issues surrounding Columbia's reactor. Scientists disagreed sharply about the safety of the reactor, the advisability of allowing even the promised low levels of radiation into the air, and the risks involved in transporting nuclear fuels and nuclear wastes. Other speakers questioned the need for a reactor at Columbia when other existing reactors provide the same or better facilities for training and research. They questioned possible links between Columbia and Con Ed, whose Board Chairman is a Columbia trustee. (Con Ed wants to build nuclear reactors in New York City to supplement those already planned and underway in the area.) They asked about the propriety of the AEC's ruling on a reactor its own funds had helped to build; and about the absence of community involvement in the entire process.

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its sit-in in the shakfHjp within CMHB which foNowed the sit-it| the Washington Heights cause actually seemed to lose ground. In mJd-November Commissioner Perkins resigned under pressure and a little-known psychiatrist, Dr. Herbert Fill, was named Acting Commissioner. Fill immediately reorganized his cabinet (the commissioner's inner circle) with the only significant change being the exclusion of the black CMHB staffer (and Washington Heights resident) who had served as

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Handwritten: A large arrow pointing from the text "In the Board meeting that followed the exit of the placated demonstrators, Tompkins recommended the reappointment of the two Board members whose terms were to expire. His recommendation was accepted by the Board." down to the text "In the Board meeting that followed the exit of the placated demonstrators, Tompkins recommended the reappointment of the two Board members whose terms were to expire. His recommendation was accepted by the Board."

MENTAL BLOC

(From Page 9)

liaison to the community. Within a week, Fill also recommended that the Board accept the "resignation" of the Puerto Rican who had been assigned to relate to the Washington Heights group as a technical advisor. The "resignation" was accepted, although it had never been submitted. With the few CMHB people who had been friendly to the Washington Heights cause removed from policy-making positions, the community activists gave up on CMHB, and turned to the immediate enemy, Columbia.

The message of the fall's offensive against CMHB had not been lost on Columbia. The university's mental health center planners determined to improve their image, but without loosening their grip on the controlling reins. In a hastily composed letter issued on December 16, 1967, to "Community Members," Columbia's "community organization" expert Dr. Gaylin wrote, in part:

By this time you have probably heard about the mental health center to be built in this area. In some cases this letter may represent our first contact with you. Those of us responsible for planning the Washington Heights Community Mental Health Center have been trying to meet with all community groups and their representatives; no doubt we shall accomplish this eventually. But for the time being, an advisory council that is as representative of the community as possible offers the best means by which we can become aware of the community's needs, discuss with it our mutual concerns, problems and progress as well as plan the programs of the mental health center. For some time now a small group of interested citizens in the area have organized as an ad hoc advisory committee and have been meeting to discuss various problems related to the development of the mental health center . . .

Within two weeks after sending out the community greeting, they had made another unilateral staff appointment. They exercised some discretion in naming the "community organizer" in that he was black. But almost simultaneously, CMHB's Marjorie Frank was named assistant to Dr. Kolb, with special responsibility for planning the Community Mental Health Center. This was interpreted as a blatant racist gesture by the Washington Heights community which identified Mrs. Frank with the discriminatory "two entrances" building design.

Behind the Columbia Curtain

In the months that followed, Columbia made it very clear that it was not about to cooperate with, or even talk with, the Washington Heights militants. When the near-defunct Ad Hoc Advisory Committee responded to Columbia's community mailing with a request for information on the status of the plans for the community mental health center, Columbia responded that it had no plans to disclose. This answer was true only in the sense that Columbia had no final plans—the architectural plans had proceeded only to the stage of schematic drawings, which Columbia was loath to throw open for community discussion. By this time the plans included not only the two entrances for Inwood and Washington Heights and the plethora of private offices, but an expansionary dream for the development of a "super-block which shall encompass the mental health center and other institutions such as the International Institute for the Study of Human Reproduction, the Institute for Nutritional Sciences, etc...."

In the spring of 1968 the remnants of the Ad Hoc Advisory Committee abandoned their attempts to deal with the lower echelon Columbia planners, such as Dr. Gaylin and Dr. Viola Bernard, and went straight to Dr. Kolb. In a letter to Kolb

signed by more than 4000 Washington Heights residents, they said:

[Secrecy has created distrust] compounded by arrogance and misunderstanding of community groups which are increasingly active in becoming responsible partners in the development of mental health services . . . We have asked for disclosure, discussion and review of the center's plan and for agreements to revisions so that they may be responsive to our needs. We have found serious impediments to these reasonable requests . . . Dr. Fill who is Acting Commissionr of CMHB . . . also disclaimed responsibility. Who is then responsible? Who has the conviction, the courage and the capacity to work out solutions with us as coequals? . . . For these reasons we have appealed to you. It is no surprise to us that the Columbia staff reports no emergency to you. Obviously, they are not sensitive to the crisis nor to the proportions that it may reach. We do have a sense of emergency and will act accordingly.

Kolb's response was even more evasive than the center's planning staff's had been. First, he acknowledged receiving the letter, but denied that 4000 signatures had been attached. As for the letter itself, he answered that it "should be addressed to the New York CMHB," for Columbia had only a developmental grant from the City and was not under contract to manage any community mental health centers. (Naturally, Columbia would not have been under contract for managing the center until it was built.) H. Houston Merritt, Dean of Columbia College of Physicians and Surgeons, reiterated Kolb's agnostic stand in a letter to the community, and hinted that Columbia was not exactly eager to run a community mental health center anyway:

There has been great concern in the Faculty of the Medical School as to whether we would be able to recruit the personnel or whether we could satisfy all the requirements needed for the management of such a Center. There has also been considerable doubt as to whether the Trustees of Columbia University (there are many over-lapping trusteeships with the medical school) would feel that they were able to take on this additional obligation.

Contrary to Dr. Kolb's suggestion, that the community address itself to CMHB, CMHB had decided that it was longer going to mediate between community activists and voluntary agencies. Instead of taking a leadership role in setting up a process by which communities would be assured a role in plans for community mental health centers, CMHB called upon the voluntary hospitals to organize their own community advisory boards. CMHB did make the gesture of preparing guidelines for the voluntary hospitals to follow. The guidelines, prepared in the late spring of 1968 by the program director of a middle-class community mental health center in Brooklyn, indicated that two separate committees should be set up as advisory groups to relate to the centers during both the developmental and operational phases. One group would represent the various health, education and welfare agencies providing direct or indirect mental health services to the catchment areas. The other would consist of representatives of every social, political, paternal, business, parents, religious, labor and other people's organizations in the catchment area.

Committee Trick, No. 2

This division of community into agency and consumer groups sharpened the resentments which had been simmering for months over Columbia's repeated refusals to divulge any information of their plans for the mental health center. Black and Puerto Rican members of the old Ad Hoc Advisory Committee wrote:

CMHB's guidelines are a trick to divide the community . . . an attempt to rob the community from their own

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frank

Handwritten notes and signatures on the right margin, including "H. Houston Merritt" and "Dr. Kolb".

professionals and rob those professionals from their community base. The legitimate community contains professionals as well as anybody else who lives and works with and in the community, not as white planters in a colonial situation, but as equals.

Dr. Kolb understood the political implications of the guidelines as well as anyone, and was careful to adhere to them to the letter. He called for an "other than agency" community meeting in mid-July, and an agency representative meeting to follow in the fall. To be doubly sure that the division would be maintained, Columbia mailed its "agency" list a special letter de-inviting them to the July meeting. Nothing, of course, could have been better calculated to provoke a confrontation. When the July meeting arrived, Kolb faced an audience containing the de-invited agency representatives and an equally hostile collection of parents, ministers, businessmen, etc. Kolb and his guest, CMHB's Dr. Fill, gave speeches on the concept of community mental health. As soon as they opened the floor to questions, voices rang out charging Columbia with racism and colonialism. Dr. Mora of the Puerto Rican Guidance Center rose and delivered a fiery manifesto, which in part said:

The Washington Heights Center is a worse offense to this community than the gym in Morningside Heights; because here is involved the mental health care of our people, and they are going to have separate facilities within the same building for us in Washington Heights who are a majority of blacks and Puerto Ricans and for Inwood which is mostly white. This is today gone from the DEEP SOUTH but started as an "INNOVATION" by the Mental Health Board: SEPARATE BUT EQUAL FACILITIES. Just like in SOUTH AFRICA. We will not tolerate the white power structure to break us. When we want to go SEPARATE we will do the job ourselves with dignity for our people. Tonight we will end mental health colonialism and tokenism in Washington Heights and throughout this city . . .

Kolb's response was far more incendiary than Mora's speech. As if presenting a lecture to his students, he projected a slide on a screen giving the number of Columbia employees who are white, black or have Spanish names. Insulted by this visual-aid production, a large segment of the audience got up and stormed out of the meeting.

Community Actors Regroup

Late in the summer of 1968 the community learned that the architectural plans for the center were being completed. At this point the local agency people who had been leading the struggle realized that if anyone were going to stop Columbia and CMHB, it would have to be them. The dissidents began lining up allies for the showdown meeting of local agency people in mid-September 1968 where Columbia hoped to set up an election procedure by which a permanent Area Mental Health Advisory Council would be chosen. The rebels called for support from the Citywide Health and Mental Health Council members from the Lower East Side, Bedford-Stuyvesant and the South Bronx. Locally, they approached Harlem CORE, which had begun talking about community control of Harlem Hospital (a Columbia affiliate). And, in perhaps an unprecedented move, they asked members of SDS and the radical student movement on Columbia's Morningside campus to join in their struggle. Radical students had closed the University down in the spring of 1968, and in the fall of 1968 the student militants were trying to regroup by calling another strike around the issue of amnesty for those students who had been arrested and/or suspended.

Just at the time the Washington Heights community mental health militants were actively seeking broader support both within and outside the community, information leaked out of the City which would provide the fuel to fire the passions of

both blacks and Puerto Ricans and radical students. The City Department of Public Works had purchased the Audubon Ballroom on 166th Street and planned to raze the building so that Columbia could construct its mental health center on the site. A cry went up to "Save the Audubon Ballroom." Many residents considered the Audubon a shrine to Malcolm X, who was slain there. But, perhaps of equal importance, the community and the SDSers from downtown drew a parallel between the "separate entrance" mental health center and the ill-fated "two entrance" Morningside Park Gymnasium. An SDS leaflet entitled "Remember Malcolm X" attacked Columbia's racism and asked:

What kind of mind practices this policy of segregation and condescension towards the poor? President Cordier gave an indication of his attitude this Monday in a talk at the University Medical School of Physicians and Surgeons: "As I walked up College Walk this morning," he said, "I spoke to the gardeners and told them how I appreciated what they were doing." Meanwhile, Columbia continues to encroach on Harlem and now plans to destroy one of its most sacred monuments to black dignity. President Cordier continued, "I'm going to lead a revolution of my own" to make Columbia more human. Yet, Columbia's counter-revolutionary leader approaches his gardeners like a colonial master.

The militants were ready to take their stand—and wage another turf battle with Columbia if necessary. Everyone was unified around one central demand—and the rhetoric was straight from the black and Puerto Rican communities which were immersed in the decentralization of schools battle: "**Community control** of the Washington Heights Mental Health Center!" No longer were they begging at the door to be a co-participant with Columbia and CMHB. The decision was made to confront Columbia at its meeting to organize agency people. The meeting had been called at 10 a.m. on a week day—which in effect eliminated many working residents—in the auditorium of the prestigious Psychiatric Institute. When the day came, Dr. Kolb, who was presiding, appeared to be unaware that at least 70 very angry blacks and Puerto Ricans had scattered themselves throughout the audience. As soon as he stepped to the podium, the community invaders challenged his leadership, and quickly elected a member of their group to chair the meeting. Their choice, Bill Hatcher, was a quiet spoken black man who, as a volunteer, ran a storefront which was a referral center for drug addicts and for housing and tenant problems in Washington Heights. Hatcher proceeded to conduct a two-hour teach-in about the problems of mental health and the need for immediate services in the neighborhood. Most of the people in the auditorium were third or fourth echelon agency professionals (from district health and welfare offices) who had settled back for what they had assumed would be another boring, agency-type meeting. Within minutes after the takeover the room was tense with anticipation—and before long, turned on by the spontaneity of the community people, many of the sedentary agency people started leaping up to make comments about the problems and the system.

Not a Matter of Semantics

All through the "teach-in" there was a certain ambivalence about what community control meant. The more radical among the community mental health agitators talked of the necessity to change the society. The change, they said, would come about by organizing a grassroots constituency to take action to enhance positive mental health by modifying environmental conditions and institutions which deter positive human

(Continued Page 12)

Abortion Laws: American Way of Death?

When Judge Weinfeld entered his chambers on October 28, he was probably shocked to see the courtroom filled with women, several holding wriggling babies. The women were there to watch the first legal steps of a suit against the New York State abortion laws.

Most women know that money can buy a safe abortion. With \$400 to \$1000 and a sympathetic family doctor you can either leave the country, have a "therapeutic" abortion in a private hospital or go to an expensive established illegal abortionist. But without the money and the contacts your chances are not so good. Less well-off women are forced to use all sorts of methods to end unwanted pregnancies. Anyone who has worked in the emergency room of a city hospital has seen the many women who are seriously injured because of unsafe and unsterile attempts to abort. Eighty percent of all deaths from unsafe abortions occur among black and brown women.

Recently the California Supreme Court ruled the California abortion law unconstitutional because of its vagueness in defining the conditions for legal abortions. The District of Columbia Court went even further and ruled that the DC Law may be unconstitutional because it violates the right of privacy. Heartened by the California and DC victories, New York women have gone to the courts to demand change of the archaic abortion system. On October 28, four law suits, raising similar constitutional issues but from different perspectives went before the Federal District Court, asking for a three judge federal panel to rule on the constitutionality of their case. The major arguments were that the current abortion laws are unconstitutional because: (1) they deny women their right to privacy in their

personal sexual associations; (2) women are denied their right to life and liberty because they do not have the right to control their own bodies; (3) the laws discriminate against poor and non-white women since under the current laws the few legal abortions performed are almost solely for the benefit of rich white women; (4) the laws interfere with the rights of free speech and association of all persons who wish to give and receive information concerning competent medical care for the termination of unwanted pregnancies, and; (5) the existing laws are vague in defining conditions for legal abortions.

One of the suits, filed in behalf of more than 300 women plaintiffs, argues that it is only the woman involved who can decide whether she wishes to raise a child and therefore she must be the only one to decide if she should bear the child. This suit was organized by a group of women patients, lawyers, and doctors to demand that their rights as women be protected. The women involved are using the suit as opportunity to talk to women about the abortion issue in particular and women's health care in general. Thousands of people, both men and women, have signed petitions supporting the suit.

The first battle in the fight to repeal all abortion laws has been won. Judge Weinfeld agreed to convene a three judge court to hear the case. He based his action on the belief that sufficient constitutional issues had been raised by the arguments. The women lawyers for the two hundred and fifty women plaintiffs requested that a woman judge be appointed to the three judge panel. As was expected, this request was not granted but the denial left the door open for arguments in support of the legal points raised by the suit

MENTAL BLOC

(From Page 11)

achievement and fulfillment. But at the same time they were demanding to be part of that oppressive system. "Community control" was defined as setting policy for and administering mental health services Columbia-style—in other words, taking responsibility for perpetrating mental health services which had been shown to be not only inadequate, but irrelevant to the Puerto Rican and black community. By so doing, they accepted the definitions of mental health services which had been designed (over many generations) by the community's oppressors. They still saw the psychiatrist as the "expert" and declared that "community control must exclude Columbia from policy making and recognize that professionals must be used as technical assistants and in advisory capacities."

A few Columbia medical students and young psychiatric residents had already been acting as "technical assistants" to the Washington Heights mental health dissidents. Dean Merritt of Columbia's P & S had warned the students that if they attended the meeting at Psychiatric Institute they would be subject to suspension, and Dr. Kolb had sent out a memo with a similar warning to residents in the Department of Psychiatry. Columbia College of Physicians and Surgeons had never been a hotbed of radicalism or student activism and when students and residents in training defected to the ghetto community's side to make demands on their patrician institution, it was understandable that their mentors would try to nip such impudence. Even though they were shut out of the

meeting they wrote and circulated the community's case against Columbia among the medical students:

As students in a medical center in the Washington Heights community, it is essential that we become involved in the health and mental health needs of the people in the area . . . people in the community have no access to the decision-making in institutions which are set up to serve them . . . they are asking for the power to set priorities for their communities and contract to meet the needs the people recognize . . . Our first responsibility, it seems, is to look at the health and mental health problems of the area from the point of view of the consumers of care, not the providers of care.

The mental health militants had reached the zenith of their radicalism. Even by the end of the meeting at Psychiatric Institute, the groundwork had been laid for moderation and co-optation. In the moment of victory, someone suggested that the Ad Hoc Advisory Committee should be revived and used as a base from which to build a representative community board. This committee—which was riven with divisive elements from Inwood and from Columbia itself—projected a coalition framework within which the more militant community control advocates would never gain ascendancy.

The Loyalist Lobby

The very first meeting of the group—which came to be named the Washington Heights-West Harlem-Inwood Community Mental Health Council—on October 4, 1968, gave some indication of what was in store. Attending were over 200 people, ranging in interests from Dr. Kolb and a large faction of professionals from Columbia, to white moderates from Inwood who were sympathetic toward maintaining a relationship with Columbia, to officials from City and local

agencies, to students, to minority professionals, to political activists, to community dissidents. The meeting in the Church on the Hill took on an aura of a political club election hall—there were caucuses and huddling in the hallways. Even Dr. Kolb entered into the electoral spirit and circulated among the various groupings, pushing for "professional responsibility," and denouncing persons he described as "politically dangerous." Bill Hatcher was immediately elected chairman by acclamation. The posts of secretary and treasurer were voluntarily filled and went to the head of psychiatric social work at Psychiatric Institute and to a radical psychiatrist who worked at the Puerto Rican Guidance Center. The composition of the officer posts themselves built in opposing forces which would immobilize the Council in the year to come. The spirit of the leadership would not be one of militancy, but rather of acting in good faith with all factions and interests involved in the Council to find a workable middle ground.

A Long-Winter's Wait

By mid-November 1968 the Council had made all of its demands on the establishment. In a series of letters to CMHB, the State Commissioner of Mental Hygiene, the National Institute of Mental Health, and the Office of Civil Rights of HEW, the Council demanded that Federal, State and City mental health funds be withdrawn from the Columbia University College of Physicians and Surgeons. After making the request of Columbia and CMHB for all the plans, proposals and contracts for mental health services in the catchment area, the Council ceased to take the offensive. The Council settled down for a long winter of waiting to be recognized by the establishment as the official planning body for the development of mental health services in Washington Heights-West Harlem-Inwood.

Although everyone in the establishment from the National Institute of Mental Health on down claimed to be interested in backing the enthusiastic community participation in mental health displayed by the Council, CMHB did not get around to officially recognizing the Council as mental health planners until March 1969. Furthermore, CMHB did not cut off the developmental funds which were continuing to go to Columbia until about the same time.

Recognition of the Council as the official mental health agency for Washington Heights-West Harlem-Inwood was in reality not a victory, but a defeat. When it became the responsibility of the Council to actually develop services, the Council became enmeshed in bureaucratic hassles which would deal death blows to community participation. As soon as the Council received the official word of CMHB, it went ahead with plans to incorporate so that it could legally receive public or private funds. Incorporation, which would normally take about one month to complete, got bogged down at the State level. As a matter of course, before the State Attorney General's office would approve the legal certification of the Council, the application for incorporation went to the Department of Social Services. Quibbling over words began, and finally boiled down to a major issue. The Council had included the possibility of running a clinic (although they had no intention of doing so initially) and were told that before the incorporation papers could be approved, they must produce a license to run a clinic. And, of course, before they could run the mythical clinic it would have to be inspected in order to be licensed. The incorporation papers were hung up until November 1969, and only began to

move, after months of stalling, when a group of radical civil liberties lawyers took over. ~~Meanwhile~~, CMHB said: We would love to give a grant to the Council, but we must wait until they can be held legally responsible.

The long awaited CMHB sanction, in reality, meant very little in terms of transference of power to the community. In fact, both CMHB and Columbia continued to bypass the Council. For instance, in January, 1969, Kolb, even though he was fully aware that the Council was seeking to have funds to Columbia cut off, wrote up a proposal for using the remainder of the grant and sent it to CMHB. More insidious than this blatant by-passing of the Council was the content of the application—Columbia wanted to hire two "community representatives," one to work with the Council and the other to organize independently. Members of the Council accused Kolb of trying to split the community. Kolb answered:

It will always be the policy of this department to work with any interested group in the community to further the much needed community mental health services, and this policy should not be construed as encouraging rivalry.

He neglected to explain why he didn't send the inquiry for assistance to the Council for prior evaluation and approval.

CMHB was very quiet. Though they called Hatcher in occasionally to see how he was doing, they didn't even offer the services of their legal counsel during the hassle with the State over the incorporation. Their greatest effort during this time seemed to be geared toward making sure that no more such messy insurgencies happened. CMHB's director of community affairs called a series of meetings with "community organizers" from the five community mental health centers which are functioning in New York to see if the community was involved. Then, with Washington Heights-Columbia in mind, they designed a document, in the form of a legal affidavit in which applicants would list names of individuals and organizations with whom the applicant (for community mental health center funds) had been in touch. This, says the director of community affairs, "is one source of 'evidence of community/consumer involvement in the planning of proposed programs'." Though CMHB's rhetoric had been revised to include the community, its interest in maintaining the mental health status quo was apparent in the letter of recognition it sent to the Council in February, 1969:

. . . the Council will work meaningfully with all groups and professional agencies in that area to bring about a cooperative assessment of needs and development of plans which are both desirable from the point of view of the community and feasible in their implementation . . . and that you will establish a strong professional Advisory Board to assist the Council in the professional program aspects of the planning . . .

Divide and Conquer?

The Council was intrinsically weak—the enemy had remained within—and any possibility of black and Puerto Rican residents taking militant action in their own political self interest was destroyed. The attempt at coalition within the Council set up an arena of unresolvable and continuing battles between the colors, the classes, and between the interests of the institutions and the people. (Several smaller institutions had for years been trying to get some of the mental health money and power away from omnipresent Columbia, and saw the Council as a vehicle for doing that.)

Columbia's interests, even though amply represented in the Council, were often articulated by the representatives from the Inwood community, who played much the same role that they had in the ill-fated Ad Hoc Advisory Committee a year

(Continued Page 14)

MENTAL BLOC

(From Page 13)

before. Before the move to incorporate was agreed to (by a narrow margin) the Inwoodites put up a strong fight to stick with Columbia, which they thought could more quickly deliver up the services. In addition, the conflicts among the professionals—who had become the majority of the Council membership—had become disabling if not destructive. The more traditionally oriented, institutionally-bound professionals would willingly compromise with the establishment in order to get, in all likelihood, traditional mental health services for the area. The more militant professionals and small agency leaders were never able to muster enough strength to get the Council to begin to think and act outside "the system." The undecided fell between the boards.

Waiting For Godot

The Council found itself trapped in a vicious cycle—procedural hang-ups and bureaucratic delays imposed upon them by the establishment meant the loss of interest of the grassroots residents, which in turn made the Council's interests more and more ingrown. The first few meetings of the Council attracted hundreds of people, many of them low-income blacks and Puerto Ricans. But once the glitter had worn off the militant cry for community control, the masses drifted away. The narrow interest factions within the Council became more and more defensive. During a particularly bitter fight over the goals of the Council, representatives of the conservative institutional-interest group moved to purge the students and radical agitators from the Council. (The only requirement for voting up to this point had been evidence of an address within the catchment area.) The conservatives, though they lost by a narrow margin, wanted to institute age, employment and taxpaying status as membership criteria.

Once the pressure was off Columbia and CMHB—and the Council was engulfed with the problem of trying to get a program off the ground—the establishment sat tight. Though CMHB had promised to give the Council the meager funds left in Columbia's account (about \$9,000), it had the excuse of waiting for the Council to get incorporated. The Council had difficulty in even scraping together enough money to send out mailings to its membership regarding meetings. Columbia had benevolently picked up the tab while it still had the grant, but lost interest as soon as the funds dried up. In desperation, the Council turned to CMHB for help, but even stamps were not forthcoming without a battle. As the historic first anniversary of the Council approached, its chairman Bill Hatcher acknowledged: "Time is on the side of the establishment—they can afford to wait it out." The fate of the Council had been predicted in the spring of 1969 when Columbia's Dr. Kolb appeared as a guest speaker before the Council: "CMHB is waiting for you people to get yourselves organized. Nothing is going to happen until then."

But the Washington Heights episode had made more impact on CMHB and Columbia than they may have been willing to admit. The recognition that there was, somewhere out there, a "community"—highly structured, vocal and capable of raising the same kind of community control demands which were paralyzing the New York City school system at that time—meant a profound re-thinking of community mental health

for both CMHB and Columbia medical empire. For both, the Washington Heights incident had been their first sustained encounter with any kind of organized consumer constituency. For CMHB, the climactic take-over incident came at a particularly trying time: the Mayor had been stalling for nearly two years over appointing Acting Commissioner Fill as Commissioner, and, through the Bureau of Budget, the Mayor was beginning to question the City's over \$200 million commitment to construct a total of 14 community mental health centers.

Pressed from City Hall to come up with a fiscally responsible community mental health program, CMHB brought one message home from Washington Heights: Community mental health centers did not have to be buildings. Ghetto communities could not wait 10 or so years for centers to be built; they wanted immediate services, in whatever space was available. In a top staff meeting held three days after the Washington Heights take-over meeting, Dr. Fill exhorted his staff to begin to think flexibly of "integrated networks of service" rather than of "centers." CMHB's 1969 Program Proposal to the Budget Bureau, expressing this new, cheaper concept of community mental health centers, met warm praise from the Mayor. However, CMHB's new intentions had no effect on its ongoing plans for the construction of 14 centers throughout the City, including the one for Washington Heights. It is doubtful, of course, whether CMHB would have had any notion of how to entice the city's voluntary psychiatric institutions into community mental health programs without the lure of expensive, publicly financed new buildings.

Columbia: Exit Stage Right

Columbia for one was not going to step down into the streets in any loose "network of services." Its response to the community revolt and to the less cooperative stance of CMHB was to gradually disentangle itself from any commitment to community mental health services in the Washington Heights area. In mid-1968 contacts with Washington Heights community representatives, Dr. Kolb had denied that Columbia had any long-term commitment to the community mental health center. As the months passed and the struggle sharpened, he began to question the whole concept of community mental health. In an October, 1968, speech at a professional meeting, Kolb questioned whether psychiatrists should support continued Federal funding to the community mental health centers program. He further questioned whether it was realistic to ever hope for the kind of redistribution of services implied by the Community Mental Health Centers Act:

... there are clinical and organizational patterns, not always recognized, that militate against what we might consider the rational distribution of medical care of any kind, and perhaps especially of mental health care.

In his presidential address to the American Psychiatric Association in May, 1969, Kolb did not even mention the community mental health program, but questioned at length the program's fundamental tenet—that patients could be dealt with, in large measure, in their own communities. To CMHB, Columbia made it be known that it would have to be asked—if not pleaded with—to renew its waning interest in Washington Heights community mental health center.

—Barbara Ehrenreich and Maxine Kenny

EDITOR'S NOTE: The above story is an abridgement of a HEALTH-PAC case study prepared in the summer of 1969, the entirety of which—with extensive documentation—will soon be available.]