insecticides. Once the task is finished on insecticides, they will attack the wood killers, and eventually the fungicides."

If the environmentalists succeed, he declared, "then the world will be doomed not by chemical poisoning but from starvation."

Borlaug's blast brought a few retorts in kind, including one from Sicco L. Mansholt, vice president for agriculture of the Common Market's executive commission.

Mansholt, who attended the same U.N. meeting, said that European farmers were greatly—and justifiably—concerned about the adverse effects of DDT, and that Borlaug's accusations of hysteria-mongering were themselves "hysterical." It is worth noting as well that the EPA advisory panel, in its September report, saw no such malignant motives on the part of conservationists. Speaking of the World Health Organization's continuing reliance on DDT as the cheapest and most effective agent to control malaria, the panel observed that "Even the most dedicated proponents of banning DDT appear at this time to exclude this program from their recommendations," apparently because they recognize the program's benefits "in terms of conservation of human lives and the alleviation of misery." For its part, the EPA declared, in a position statement last March, that restrictions on pesticides in this country would not affect exports of the chemicals. Ninety percent of the DDT purchased by the WHO and the U.S. foreign aid program for mosquito control abroad is manufactured in the United States.

"We do not presume to regulate the felt necessities of other countries," the agency said, and it added that control of malaria in less developed nations might reasonably require "continuing use of pesticides whose side effects would no longer be tolerable here." In 1969, the Agriculture Department banned the use of DDT against mosquitos in the U.S., except when deemed necessary for public health.

For all the fire and spittle still being flung in the debate over DDT, however, the pesticide's latent political liability may turn out to be the deciding factor in its future, when the EPA renders a final judgment next year. "Mr. Ruckelshaus is going to have to make a determination *de novo* anyway," one source in the agency's enforcement branch says resignedly. "This decision is too important to expect the White House to leave it entirely up to the agency."

Perhaps the dominant political reality in the matter of DDT is the fact that most of it is used in the South, primarily on cotton. Close observers of the pesticide scene in Washington believe that the White House would therefore regard any severe new curbs on this chemical as an impolitic gesture to Southern farmers in an election year. The prospect for drastic new controls is made even poorer by the fact that Representative Jamie L. Whitten (D–Miss.), who is both chairman of the appropriations subcommittee on agriculture and one of the staunchest defenders in Congress of chemical warfare in the cotton fields, holds jurisdiction over EPA's budget. As things stand, the White House Office of Management and Budget appears unwilling to increase the year-old agency's budget by much next year and may even cut it back. Bruised relations with the Whitten subcommittee, according to one prevalent line of analysis, would only compound this setback.

Given this state of affairs, EPA officials say Ruckelshaus' most likely course of action will be to amend his promised ban and to impose "selective" new restrictions on the use of DDT, reducing to perhaps half a dozen the number of insect pests that it may legally be applied against. Enforcement of this kind of restriction is difficult at best; in any event, EPA lawyers say, the pesticide industry can be counted on to fight any such restrictions in federal courts. By the lawyers' estimates, it may be mid-1973 or later before the fate of DDT is firmly sealed, or its survival ensured.

—ROBERT GILLETTE

Community Mental Health Centers: Growing Movement Seeks Identity

The federally sponsored community mental health centers program, born in 1963, has had a difficult youth. The centers, which represent an unprecedented attempt to combine the delivery of mental health and social services, have been swept into the social turmoils of the 1960's, and their growth has been profoundly affected by the resulting realignments of power. Now, with national systems of health care delivery and financing moving into uncharted regions, community mental health centers are entering a crucial phase.

The centers have been described as nothing short of a revolution in mental health care, but they seem to inspire the same conflicting assessments as those rendered by the blind men about the elephant. "The concept is great, the reality a disaster," says one psychiatrist. "A classic case of oversell to the public," says a National Institute of Mental Health official. "The best thing that ever happened to this country," says a center director. "The most advanced system of health delivery in the country today," says another.

The concepts behind the centers are certainly revolutionary for the United States, although they have long since been adopted by most of the world's industrialized nations. They represent an attempt to bridge the chasm between public and private treatment of the mentally ill by providing a comprehensive assortment of services, ranging from advice to hospitalization, to all persons within a given geographical area, regardless of their ability to pay. They are the proving ground for community psychiatry—a non-Establishment approach that emphasizes preventive care and getting psychiatrists and psychologists out of

their offices and into the community, not only to treat individual pathologies, but to help people change their social environment.

The primary purpose of the centers is to lower the population of state mental hospitals by providing care to disturbed people within their own communities. The idea is to intervene before a person has gotten so sick that he requires hospitalization, and to treat people who would otherwise be hospitalized because no alternative procedure was available. In a way, the movement completes the cycle begun in 1773, when the insane were taken out of their local jails and poorhouses and deposited in state asylums. Subsequently, Sigmund Freud, psychoanalysis, and the concept of mental disorder as a curable disease radically altered society's attitudes toward the mentally ill. In the last 15 years, the wide use of psychotropic drugs has completely reversed the outlook for many people who were otherwise doomed to lifelong confinement. Yet, while treatment of the mentally ill has changed, the structure of the public treatment systems has remained essentially the same as it was in the 19th century.

Congress Acts

Federal legislation was born of a combination of blossoming theory and burgeoning crisis. By the end of World War II, state mental hospitals, already crowded with alcoholics, the senile, and other social outcasts, were becoming alarmingly jammed. In 1955, the year this population reached an all-time high of 558,000, Congress set up a Joint Commission on Mental Illness and Health. After 5 years of study, the commission came out with a report recommending that the focus of treatment be shifted from hospitals to the community. Among other optimistic projections, it predicted that, if such a program were adopted, public mental hospitals could be almost entirely phased out within a generation.

The commission's words dropped on fertile ground, namely a Congress in which health czars Senator Lister Hill (D–Ala.) and Representative John Fogarty (D–R.I.) wielded over health affairs an influence unparalleled by any individual members before or since. President Kennedy responded in 1963 with the first presidential message devoted entirely to mental health, in which he called for the "bold new approach" outlined in the report. With strong congressional backing, plus the efforts of high-powered philanthropist Mary Lasker, the program sped through the legislature.

The centers program, administered by the NIMH, was designed to serve a large population whose only resort in case of mental crisis was the state hospital. Services are required to be geographically accessible, which means they must be physically located within their "catchment" areas—arbitrarily designated to encompass populations between 75,000 and 200,000; available to all people in the area, regardless of their financial condition; and "comprehensive." To be comprehensive, a center must supply five basic services: inpatient care, outpatient care (which includes aftercare for ex-mental hospital patients), partial (or day) hospitalization, 24-hour emergency care, and "consultation and education." The last, a key element of the program, is intended to involve the centers in such "preventive" activities as counseling schools and police forces and establishing liaison with other community service agencies.

In 1965, the first year that funds were released, Congress appropriated $35 million for the construction of centers. In subsequent years, amendments were added to include money for staff salaries, then for treatment of alcoholics and drug addicts, and finally for children's services. Some 300 centers are now in operation; another 180 are in the design stage.

The legislative branch, where the program originated, has been a far steadier source of support than has the Nixon Administration, which decided that in fiscal 1971 no more money should go for construction and only those centers already in possession of construction grants could get staffing money—moves that would have strangled the program. (It was around this time that NIMH director Stanley Yolles was fired, accusing the Administration as he was hustled out the door of "abandonment of the mentally ill.") Congress redressed the situation the following year. For fiscal 1972, $15 million was appropriated for construction (a comparatively small figure that reflects a new emphasis throughout the health world on throttling down on "bricks and mortar," while pushing for better use of existing resources); $135.1 million—$45 million over the previous year—was allotted for staffing; and $10 million for staff for children's services. The centers also have access to some of the $38 million for drug treatment and $76.8 million for alcoholism that NIMH now has to disburse.

To date, the federal government has committed about $700 million to the program, matched by an equivalent amount from state and local governments. One reason the "movement" has spread so rapidly is that public mental health care has lagged so far behind other health care. Bill Goldman, director of the highly regarded center run by San Francisco's West Side Consortium, says it is also because mental health professionals (including psychiatrists) have traditionally been more oriented toward public service and social responsibility than have most doctors. Says Peter Bourne, the psychiatrist who created Atlanta's first center, mental health "is the one area that can be socialized without the medical establishment becoming upset."

Now that the system is set up, the centers have also been way ahead in exploiting the more recent trend common to all health professions: new reliance on the use of outpatient facilities and paraprofessionals, which have been necessitated by the rocketing costs of hospital and physicians' care.

Indeed, use of indigenous staff members is crucial to the effectiveness of urban centers and centers dealing with minority groups, where general suspicion and racial and ethnic barriers would otherwise hinder their activities.

Future Vague

The limitations of most health insurance mechanisms mean that the centers get only about 10 percent of their income from patient fees; for the rest, they must rely on federal, local, and private contributions. For this reason alone, their future is precarious. Even more serious, however, are the problems centers have encountered in trying to apply the sweeping concepts of the program to operational realities. The NIMH guidelines say, in effect, "Do whatever is necessary to improve the mental health of the people within your catchment area." In practice, the center administrators must decide whether to adhere to basically clinical modes of care or to try the more risky and novel approach of involving themselves in all of their community's

problems through various programs not directly related to therapy.

The built-in flexibility has permitted some centers to become extraordinarily effective as they have molded themselves to a community's needs. But others have been rent by strife as they have attempted to follow the conflicting demands of the community, federal and local governments, and the agencies—such as universities, private corporations, or county health departments—through which they are administered.

On top of financial stress and administrative complexity have been political conflicts in communities where the poor and downtrodden have begun to assert themselves. When it comes to dealing with individual crises and the problems attendant on poverty and alcoholism, urban and rural centers have equally complex assignments. But urban centers are really the vanguard of the movement—as well as the objects of most praise and blame—because they have been forced to create a more inventive array of programs than rural or suburban centers, and because their racial conflicts and administrative

The Great Race: Virus Find Awakens Hope for Sufferers

A nationally celebrated team of scientists this week announced a discovery that may change the face of the 1973 budget now in preparation, and may even advance the frontiers of knowledge as well. Because of the dilatory schedule of academic journals (none of which could guarantee publication before the week after next), the scientists were obliged to publish their results in the form of a press release, together with high quality micrographs which were distributed to those attending the press conference. Following is a transcript of the press conference held this week at the Center for Duplicative Results.

DR. ROLAND WAGONBAND (director of the Center for Duplicative Results): Gentlemen, today I have the pleasure of describing to you a light-year leap made here in the institute's laboratories. The scientific aspects of the discovery are rather complex and I will try to explain them in layman's language, which will any of you stop me if you don't understand. A team of our researchers led by Dr. Gunnar Jumping here has for the first time isolated a long-sought virus from human brain cells. Although proof is not yet absolutely conclusive, we in the institute have good reason to believe that the virus is the causative agent of nobelitis, the incurable frenzy that afflicts so many prominent people in the scientific community of this and other nations.

Q: Dr. Wagonband, could you explain the relevance of this discovery, if any at all, to the clinical treatment of nobelitis?

WAGONBAND: Well I think you would err to say in your story that as a result of this finding we are now within reach of developing a one-shot vaccine that will relieve hundreds of sufferers from their affliction and immunize thousands of others—but I don't entirely rule out that possibility.

Q: Dr. Wagonband, is it not true that a virus was isolated from a nobelitis patient 2 months ago by Dr. Medea Courter at the Institute of Fundamassing Research? How does your discovery differ from hers?

WAGONBAND: Five separate research teams under contract to this institute have determined that the enzyme in Courter's so-called nobelitis virus exhibits what biochemists call noncompetitive inhibition. That rather rules it out as a cause of nobelitis, wouldn't you agree?

Q: Hundreds of viruses are now known to cause pretentious nobelitis in lower animals, but, despite several years of very intensive search, no one has yet found a true nobelitis-causing virus in man. Do you think, Doctor, that this is a goose chase that has now run wild? After all, pursuit of the virus tends to divert attention from the dozens of known nobelogenic substances that are daily injected into the environment by the manufacturers of pipe dreams and other noxious products.

WAGONBAND: Bear in mind that the politicians have been encouraged to stake a lot on the virus theory—there's the President's Nobelitis Knockout Campaign, for example—and we may not be entirely happy about it, but it is just something we have to live with, and in fact we are living quite well off it.

Q: Could Dr. Jumping tell us how he isolated the virus?

JUMPING: Well we've spotted under the e.m. certain particulate inclusions in these cells which are quite possibly not artifacts but viral in nature . . .

WAGONBAND: To put that in layman's terms, what Dr. Jumping is telling you is that the virus he and his team have discovered provides yet another piece of evidence for the Wagonband theory of nobelogenesis.

Q: Just what is that theory, Doctor?

WAGONBAND: The Wagonband theory postulates that there is a cause and effect relationship between the phenomenological manifestations of nobelitis and their etiologic antecedents. This means, in effect, that nobody can discover the cause of nobelitis without my having predicted it, which is one advantage of the theory. The other is that it cannot be disproved.

Q: Why are you announcing these results at a press conference before they have appeared in the scientific literature?

WAGONBAND: They have already appeared in the scientific literature. You will find an abstract in the current issue of the Center for Higher Education And Training's medical school newsletter.

Q: Finally, Dr. Wagonband, could you tell us the name of the patient from whose brain cells this nobelitis virus was isolated?

WAGONBAND: As a matter of fact, his name is Roland Wagonband.—NICHOLAS WADE

struggles have given them an identity as a political force.

Brief accounts of the evolution of two large urban centers show what can happen when someone sets out to try to meet what is referred to as the "unmet needs" of a community.

The Albert Einstein Medical College, affiliated with the Bronx's Lincoln Hospital, has many outreach programs, and in one way or another sponsors almost all of the public health programs in the Bronx.

The college set up a mental health clinic with three storefront centers with some OEO (Office of Economic Opportunity) money in 1964. During the ensuing few years, it became known for its innovative programs, community orientation, and special program for hiring and training local people as mental health workers. In 1967, the OEO money was replaced by an NIMH grant, the storefront centers were phased out, and the center retreated to more conventional, hospital-based care. Paraprofessionals became increasingly dissatisfied with the center's role in the community and with their own inability to advance up the career ladder—almost all of the professionals were white, despite the fact the catchment area population of 200,000 is 65 percent Puerto Rican and 25 percent black. In early 1969, after the failure of numerous attempts to get the college to yield more power to the community, an army of some 150 indigenous staff members and community leaders, supported by a handful of professionals, invaded the center, hustled out many professionals, and proceeded to run the whole show themselves for over a month. Subsequent sit-ins and confrontations with the college and city hospital agencies resulted in a number of arrests and the suspension of 67 of the 203-member staff. Community and staff pressure finally induced the hospital to reinstate the suspendees, allow the establishment of a community advisory board, and upgrade training for nonprofessionals. A number of white professionals were replaced, including, ironically enough, center director Harris B. Peck, who had previously predicted approvingly that true community self-assertion would include the booting out of persons such as himself.

The center administrator is now a Puerto Rican, and the director is Pedro Ruiz, a Cuban psychiatrist. Whether or not the revolution culminated in a true community victory is in doubt. Ruiz, in any case, thinks so. He says that services have been decentralized throughout the neighborhood, and outpatient visits have tripled to 25,000 a year. Ruiz is helping to push responsibility out of the purview of Albert Einstein and into community hands. Recently, for example, he turned over $350,000 to a private community corporation to run one of the center's outpatient clinics (annual budget for the entire center is $3.5 million). Now that the revolution is over, says Ruiz, "We have been running beautifully."

Philadelphia Story

Another story of passion and tumult was played out at the center sponsored by Temple University in Philadelphia. According to one account, the university set up the center as a base for teaching community psychiatry and as a means of providing public health orientation for medical students. The North Philadelphia catchment area of 220,000 is mostly poor and black. After a couple of years in operation, certain decision-makers on the staff decided that the center was simply not doing its job, either in the number of people treated or in the kinds of problems. Alcoholics, drug addicts, and geriatric cases (a group that is probably still the most ignored) were not getting appropriate care because of the aversion of most staff members to treating difficult cases, and a distaste for getting involved with what might generally be regarded as the dregs of humanity. The staff spent a great deal of time discussing what to do. The center, being the only "open door" in the community aside from the police—that is, the only agency compelled to deal with whomever sought its services—was swamped with people plagued with a vast array of social and psychological problems. The staff found itself confronted with difficult decisions on every level. Should it, for example, care for drug addicts who came into the center, or should it go out and develop associations with a teen-aged gang that was known to contain many addicts? Each funding agency had different ideas: the state, for instance, was interested in the narrow goal of reducing the population in mental hospitals; the university wanted a setup that would fit in with its psychiatric training program; NIMH complained whenever one of its five categories of care was not being attended to; the community was becoming increasingly dissatisfied with the university.

When the center hired two black militants to improve its liaison with the community, the center became increasingly alienated from the university. Many meetings were held. Sit-ins, demonstrations, and confrontations succeeded only in creating a more volatile situation, in which everyone connected with the center became polarized—on the side of the university or the side of the community. Ultimately, the university contrived a vast reorganization, which resulted in the departure of a large portion of the staff, including the director. Now, according to this account, the community has been assuaged by the appointment of a black director and a community board, but decisions are still controlled by the university, and the center has withdrawn to a fairly traditional model of health care.

The Lincoln and Temple upheavals involved drastic responses to extreme situations. Other cities are beset with other difficulties. In Milwaukee, for example, the county mental health director says the catchment areas arbitrarily chop up neighborhoods and clash with county services. Because the county board decided it could not afford to subsidize staffing for six separate areas, Milwaukee County is divided into six triangles, each with its apex touching the same central facility.

The flexibility with which community mental health centers was conceived is perhaps their greatest virtue; it has also made them vulnerable to a dazzling array of problems. Some people think a few centers should have been carefully monitored for several years before the program was allowed to proliferate across the country, but others maintain that the experience of a few prototypes would be of limited value, since the success or failure of each center hinges on its ability to deal with pressures and problems unique to its area.

Partisans of the movement feel that the centers are now in a kind of holding operation while they wait for the rest of the health delivery system to catch up with them. If it doesn't, they may be stranded.

—CONSTANCE HOLDEN

A second article will describe two centers that seem to work and will postulate some future directions.