kind in Georgia, is regarded as an illegitimate intrusion, while at the same time competing groups struggle for its control.

► Lincoln Hospital center, the Bronx, New York: The area, whose health services have been dominated by the Albert Einstein College of Medicine, is largely Puerto Rican. Although many indigenous nonprofessionals were trained to work at the center, many became frustrated at their inability to move up the career ladder. When the center started retreating from its original community emphasis to a mostly hospital-oriented operation, frustrated and angry nonprofessionals staged a "revolt" and took over the whole project. This spotlighted an ongoing conflict in many centers: Who decides what's best for the people, the professionals or the community members themselves?

► North Oakland center in Pontiac, Michigan: The center is at the isolated and forbidding location of a state hospital. The catchment area, whose political and economic life is dominated by General Motors, excludes the poorest sections of Pontiac, and seems to be oblivious of tensions seething among the auto worker population created by frustration with their robotlike work. They are manifesting themselves in racial antagonism, increased drug abuse, and a high suicide rate.

From the impression given by the report, community mental health centers have proved to be the kind of program that is prey to every pitfall a public social program can have. Ironies abound. First, and perhaps most fundamental, there is little agreement on just where the lines should be drawn. Should priority be given to dealing with severe and clearly defined disorders, such as schizophrenia and alcoholism, or should a center be a resource for the "problems of living," which range over the lot from housing and unemployment to the question of getting residents of a poor, powerless neighborhood politically organized? There is the question of quality of care: Highly trained professionals can deliver best in their areas of expertise, but mistrust between them and the community can destroy any effectiveness they have. On the other hand, if poorly trained people who have close ties with a community are in charge, the center can degenerate administratively and become little more than a political battleground.

If a center is connected to a university or hospital, procedures tend to be more orderly, but frequently these places are physically isolated from a community and develop a clinical aura which scares people away.

The major fiscal irony of the centers is that those which operate successfully within their budgets tend to take a large number of privately referred, paying patients and hence are not following their mandate to serve their entire catchment area (arbitrarily designated by NIMH as between 75,000 and 200,000 people).

At the same time, the centers which are seriously trying to provide comprehensive services to the poor and problem-ridden find themselves overwhelmed. And the more controversial a center becomes—which happens if it is deeply involved with a community—the more likely it is to antagonize local governments and other sources of money.

Basically, community mental health centers have been given a mandate so broad that it may be unrealistic. They are expected both to perform conventional psychiatric services—within a medical model—and to reach out and help people with what is vaguely called the problems of living.

The Nader report says that, if the most urgent human needs are to be dealt with, the "medical model" must be dispensed with and the centers should instead evolve into "human service centers" where people can come for help or referral in housing, unemployment, and legal problems as well as for psychological aid. (NIMH officially disagrees. "I stand firm that our responsibilities are in both [medical and social] arenas," said director Bertram Brown in a statement on the report).

At any rate, the report makes suggestions aimed at pushing psychiatrists back to work which uses their medical as well as their psychiatric training and advises that other physicians should be used only as consultants to screen out medical problems. The report enforces the division between the medical and social service approach by recommending that the proposed National Health Insurance should not include coverage for psychiatric care except for people who suffer from medical disorders. Separate mechanisms, such as some form of "social insurance" or subsidies for social support programs should cover the rest. [This idea will be hard to sell in some quarters. Many persons involved with the centers told *Science* last fall (see *Science*, 10 and 17 December 1971) that the movement was near collapse unless nonmedical psychiatric services were covered in National Health Insurance.]

The report contains a number of financial suggestions directed at beefing up the paraprofessional work force and throttling down on new construction (the "bricks and mortar" projects that Congress loves to vote for). It also calls for more flexibility in federal funding, so that poor areas can be guaranteed long-term support.

Whatever their failings, the centers at least have brought to public notice the huge numbers of people who are beset with staggering combinations of emotional, health, financial, legal, and racial problems for which conventional social agencies are totally inadequate. Congress has recognized this fact by supplying fairly steady support. The Senate will soon vote on an authorization bill which would make $669 million available for the centers over the next 2 years.

But as one NIMH official says, "centers have been treated [by federal officialdom] as relatively sacrosanct, like motherhood. . . . On a day-to-day basis there's been damn little discussion of basic issues." Now that they have matured enough to bear fruit, they, like motherhood, may be in for some serious reevaluation.

—CONSTANCE HOLDEN

RECENT DEATHS

Elmer G. Butler, 72; professor emeritus of biology, Princeton University and former president, American Institute of Biological Sciences; 23 February.

Howard C. Case, 69; former president, Boston University; 20 February.

Lowell E. Noland, 75; professor emeritus of zoology, University of Wisconsin, Madison; 3 January.

Russell S. Poor, 73; former provost, health center, University of Florida; 17 February.

James S. Potter, 70; research scientist, Carnegie Institution, Rhode Island; 6 March.

Sydney J. Segal, 38; professor of psychology, City College of New York; 31 December.

Robert B. Witmer, 72; dean emeritus, College of Arts and Sciences, University of North Dakota; 21 February.