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Reading the NY Times and other media about the terrible state the care of the mentally ill has come to, the scandals of the supported living homes in Far Rockaway etc. it is easy to forget that NY State has a proud tradition of public care for the mentally ill in the community, a tradition of which the WHCC is an important part. It is the burden of our times that managed care has, in other parts of the community, almost erased the achievements of forty years in public psychiatry. But WHCC is one of the places that keeps it alive, and I want to celebrate that survival in these historical notes today.

I've put here on the board the names and dates of the directors of the service, for reference as to the era, and I've printed a selective bibliography of their publications in case you might want to look at a sample of the scholarly work and research that has come out of the service over the years. I did this to show that although we are sometimes regarded as the service part of a research institute, we have in fact created a large body of knowledge in our own field. As you read the abstracts of these papers, you'll realize that regardless of whose name is listed as author, this is your work – that all of us who wrote these articles and chapters learned what we know from working with you. I also made this collection to remind us all that there is a field called public psychiatry, an area of practice, study and teaching, of which we are a part, just as we are a part of psychopharmacology and psychotherapy. But one of the things that sets our field apart from those others is that ours depends on skill and knowledge in institutional politics, on knowing what is going on in the world and in our field, and on the exercise of political power. That, as you will see, is an important part of our history.

The history begins some fifty years before the actual founding of the service, with the second director of the PI, Adolf Meyer, who was here in that job, for just a few years before 1910, but they were critical years for the Institute. PI was started at the turn of the century, funded by the state of NY, and at the time it was the only thing of its kind in the US. The NIH in Washington would not be started for another fifty years. This was a rather grand thing for the legislature of NY to be funding, an Institute for basic research in psychiatry – everything from neuropathology to anthropology to biochemistry to genetics. It was very exciting, but expensive stuff. By the time Meyer was appointed director, the legislature was asking, what are the people of the state of NY getting out of this research, which seemed to be aimed to benefit all of mankind. Some of the legislators were suggesting cuts in the Institute's budget (does this sound familiar?) And in fact, one

of the reasons Meyer was appointed director was that he was one of the people in the whole country who could answer that question.

Adolf Meyer was the man who more than anyone else, defined the new American profession of psychiatry, especially public psychiatry. He's one of my heroes, and I have written about him in my book, which is partly a history of public psychiatry. He was a Swiss immigrant, a neuropathologist whose first job was doing autopsies at Kankakee State hospital near Chicago. He complained that the records were so bad that he could make no sense of his findings, and he kept complaining until they made him the director of the hospital. So he was a demanding scientist and a leader. He was also vigorously interested in the intellectual life he found in Chicago at that time, just after the founding of the University of Chicago. He became a close friend of John Dewey, the Chairman of philosophy at the university, and of Jane Addams, the social worker who founded Hull House, and who provided some of the earliest ideas about community organization in social work. Meyer learned from Jane Addams about social organization, and married a student of Addams, a social worker named Mary Brooks. When the Meyers came to work at PI, which was housed on Wards Island where Manhattan State is now, Mary Brooks made home visits to see if the families of the patients were prepared for their discharge. To set up community support for mental patients, Meyer advocated "attacking this work in small enough units of communities and neighborhoods, and making the attack at the source by community organization as well as legislation."

So when the state legislators asked Meyer what was in it for the people of New York to have a New York State Psychiatric Institute, he had an answer. It was to design and teach effective community treatment. Specifically, he proposed that PI would do epidemiology of the mentally ill, and the training of doctors. That is, we would enumerate, classify and analyze the needs of the patients in the state's care, conduct research on the outcome of their treatment, and then we would train psychiatrists to do that treatment. It was a scientific program to make treatment more effective. The legislature could see that ultimately this would reduce the cost of treatment, which was already high. The state had begun in the 1890's to operate the large state hospitals that formed an increasing part of the budget. So from the point of view of the state the Institute was supposed to be evaluating and teaching the care of the difficult patients, the expensive time-consuming patients, those that went from the communities, mostly the farms and immigrant slums, to the state hospitals.

But the other hero of American Psychiatry also made his appearance at the same time. Sigmund Freud gave his lectures on psychoanalysis in 1909, at a conference that Meyer also attended. Meyer gave a paper on environmental influences on the course of schizophrenia, and Freud gave the five introductory lectures on psychoanalysis that changed the course of American psychiatry. By 1911 the first American psychoanalytic Association was formed in Boston. And that is a story we all know, but there is one point about it that I want to make here because it relates to our history. Psychoanalysis was a

therapy designed for a different class of people, a middle and professional class that was unlikely to end up in the state hospital, but instead could afford to come 3-4 times, or even 5 times a week to the private offices of the psychiatrist. So American psychiatry was itself split into two classes. Those who continued to work in the state hospitals and their city clinics were the alienists, the nut doctors and hospital superintendents, as distinguished from the analysts who treated the "interesting" patients and wrote the interesting books about them, that were read in all the universities by the writers and philosophers from the 20's up to the 50's.

This class split was embodied in the PI as the years went on. The Institute moved from Wards Island to Washington Heights in the 30s to become part of Presbyterian Hospital and to become the psychiatry Department of Columbia University. It also became the home of the Psychoanalytic Institute that was started by Sandor Rado in around 1940. What was a psychoanalytic institute. doing in a state research facility? At the time it seemed like the most natural and efficient arrangement. Not only was psychoanalysis the main theory of psychiatry, if not the only theory, on which research could ultimately be founded. It was also obvious that residents, at least distinguished residents, would not come for training unless that training was offered by a faculty also distinguished for their contributions to psychoanalysis. And so it was that the psychoanalytic institute. was supported by state salaries and housed at state expense, and the patients on the wards were selected for their suitability for psychodynamic treatment if not full-dress psychoanalysis. They were "interesting" patients, and stayed a year or two to train the residents.

What happened to the less "interesting" patients who appeared in the Presbyterian Hospital emergency room? They were shipped to Bellevue, the Bedlam of Manhattan, and from there, or sometimes directly if Bellevue was full, they went by a great fleet of ambulance buses to some of the huge buildings now built on Wards Island, or even further out to those in the country, in Wingdale, at Pilgrim State or Rockland County.

Thus in 1955, the year of the invention of thorazine, and the year I went to medical school to become a psychoanalyst, the vision of Adolph Meyer for PI was on paper only – certainly it was not a reality. We were not treating the state's patients. Now I, as a would-be analyst was of course also heading for the classy literary and more "interesting" kind of work. But unknown to me, behind the scenes at places like PI there were other ideas beginning to circulate. For one thing, something had to be done about the state hospitals. They were full to overflowing. And a generation of psychiatrists had come back from World War 2, and were beginning to appear as young instructors in departments of psychiatry. These war veterans had learned about a different kind of treatment from analysis on the couch. Group therapy and milieu therapy and rehabilitation in relief stations behind the lines had introduced the idea that some serious conditions can be improved by changing the patient's social situation, giving him/her different people to talk to, different models of adaptation, different behaviors to learn. Group therapy, which

was invented in a British hospital for soldiers in World war 1, was developed further in ww2 and milieu therapy, also British in origins, was an extension from the talking group to the daily living group -- learning from life on the ward. These ideas were in the air.

The man who started the WHCS, Al Mesnikoff, was a chief resident in psychiatry at PI in 1955. He had received the classical education in the treatment of "interesting" patients, but when he was hired as an attending psychiatrist on one of the in-patient wards, he could see that sending patients to the state hospital after a brief stay on the ward was a bad idea. He put together instead the two basic good ideas that are the foundation of public psychiatry: catchment area responsibility and continuity of comprehensive care. The first says that you are responsible for a population of people living in an area, and the second says that you will remain connected with them, so that you and they together can learn from your successes and failures. And having learned, you do for those people whatever it takes to help them, including housing and political organization. (You can hear the thoughts of Adolf Meyer echoing in these modern ideas.)

In order to keep patients on the ward and not send them to the state hospital, Mesnikoff made the ward treatment more efficient. He applied the principles of milieu therapy to the whole service, both in-patient and outpatient, and promoted continuity between the two. He established a day hospital for discharged patients that was run in the middle of the in-patient service, so that recently admitted patients could listen to more experienced and recovering patients talk to each other about their experience with their illness.

One of his most controversial innovations was "open report." Instead of beginning the day with a closed meeting in the nurses station where the nurses passed on the report of the previous day's events, the report was given at an open meeting of the whole ward, where the patients could challenge the account, give their own versions, and there could be a group discussion of the significance of the events and what to do about them.

This kind of change in the environment has interesting effects. The old nurses report had been in the private language of the professions. What this new and open kind of discussion required was a common language in which experiences had to be intelligible to everyone, and meaning had to be achieved that had positive consequences for the patients. This pressed the staff towards a new kind of interpretation, a new kind of speech about actions, meanings and consequences. Thus, changes in the administrative environment produced changes in thinking about therapy.

Mesnikoff also established a half-way house, a residence in the neighborhood for discharged patients without home support, under the direction of a young nurse named Barbara Sacco. Nurses and aides on the service visited patients at home and met with their families. In ways quite novel for the time, the service provided social support, and between that and the other prime ingredient, continuity of care, the service was able to

reduce the number of patients sent for long-term care to distant state hospitals to an all-time low.

Essential to Mesnikoff's success was the backing of the PI's director, Lawrence Kolb. Kolb wanted a community service, and obtained a federal hospital development grant that resulted in the official founding of the Washington Heights community service in 1966.

These changes had consequences for everyone on the service, but I'm especially interested in two: the nurses and the doctors. The nurses had previously prided themselves on running an elegant hotel for the "interesting" patients, and as their job was re-defined to running groups and making home visits, and stretching their experience to include the lives of some of the more challenging citizens of Washington Heights, both in and out of the hospital, some of the nurses accepted the challenge with interest, and others moved on.

The doctors had a different problem. They had to simultaneously invent new techniques and teach them to the residents. There was a lot of worry that residents who wanted to be analysts would not be interested in this kind of work, and for some that was true. But for the most part, residents were interested in learning anything that was well taught. They responded with interest to the possibility of following patients in the community through many phases of their illness. Mesnikoff wrote a paper about this (quote).

The excitement of community psychiatry was a surprise to many, and it drew to the service young faculty members such as the next director of the service, Marvin Hertz. Hertz began his career with an interest in psychopharmacology. You can see this continue as he wrote papers about intermittent drug therapy and the timing of medication response to prodromal symptoms. But Hertz also investigated the effectiveness of the day hospital and many other social psychiatry subjects, so he was a community psychiatrist of the 80's – the scientific, epidemiological, publishing kind. As a further instance of this, he hired me in 1975 to teach family therapy and hold meetings about the ward milieu.

That moment of entering the service was an interesting time for me because I had come from 12 years of work at Bronx State Hospital where we were placing clinics and residency training programs in the community. And here was the WHCS facing the question of whether to move its outpatient services to the community. It was a move in which I became actively involved.

During Mesnikoff's time, the problems of race and class began to move to the forefront of the service's consciousness, and as we accepted two health areas as our catchment area, local political leaders pointed out that the two we had taken were those with the fewest black and Hispanic patients.

So, before he left, Mesnikoff moved to take that third area as part of our responsibility. This was an improvement, but it dramatized the fact that the outpatient part of the service remained inside the cliff fortress of the PI. This gave patients who crossed over from the areas east of Broadway and south of 157th St. the feeling that they were crossing a class and color boundary. Apart from the inconvenience of travel, there was something about entering that building, with its medical uniforms and its sense of hierarchy, with the mostly white doctors at the top and the mostly black attendants at the bottom, that was at odds with the egalitarian and culture-conscious assumptions of community psychiatry.

So Hertz, and Steve Reibel who had come from St. Luke's to organize the outpatient services, and I, began to meet together in 1976 to plan our actual move into the community. We found some office space over McDonald's, which sat on the triangular island that breaks the flow of Broadway at 171st St. and as the space was being prepared for us, we prepared ourselves to move into it. There was for some of us a very real sense of fear of the unknown, and some the people of color on the service took us around to explore our new neighborhood and see that it was possible to walk around safely and even get a good meal out there. In a few months we moved in, set up a day hospital, group therapy rooms, a friendly reception area, a one-way screen room, whose construction I was delighted to supervise. We started, for the first time, to think about what kind of way we wanted to arrange our space to meet with our clients, whose needs and concerns began to move to the front of our awareness.

To mention just one of the many discoveries we made about the importance of the environment, being upstairs from McDonald's is very helpful in dealing with some long-term problems. Since the price of a cup of coffee entitled one to a respectable seat in a public place for up to half a day, it became a sort of staging and meeting area for the day hospital. Patients who did not want to meet with a psychiatrist were often willing to meet over a cup of coffee, and even family consultations could be carried out in neutral territory under the rules of having a meal.

We were just beginning to learn how to do all this when there was a fire in McDonald's over a weekend and our end of the top floor, furniture, case records and all, went up in smoke. This devastating experience, after which we had to conduct our outpatient work including our day hospital in the PI library for almost a year, had two unexpected benefits. One was that for the next accreditation inspections, we had no records to inspect, so it was much easier to pass. The second and more important one was, that having committed ourselves to this move to the community, we did it more thoughtfully the second time, and had a longer discussion about the design of the space.

The space we found on Audubon Avenue had two available floors, and we lived on one and designed and rebuilt the other for almost a year, and then we moved into our designed environment. The only private office was the director's. Everyone else worked in large rooms designed to promote the collaborative work of clinical teams. Individual

and group or family interview rooms were furnished with one-way windows so that it was easy to teach, learn and consult on the clinical process. Teams or groups of clinicians trained each other by interacting as teams with groups of patients or their families, or watching each other through the windows of these rooms.

Another thing that the arrangement promoted was cultural sensitivity and diversity. I have two examples of that.

The Day hospital space was large and sunny and had two connected rooms. Somehow, perhaps because Dr. Henry McCurtis was the director for a while, but I think even before that, the African-American staff of the Day Hospital became a defining factor in the routines and activities of the Day Hospital. The pace and atmosphere of the place was welcoming and friendly, and I realized that my own behavior as The Director changed when I went over to talk to someone in the Day Hospital. So it wasn't only people of color who felt welcome and at ease. There was a lot of good cooking and a lot of gardening going on – people even raised tomatoes in the summer. I can't point to any clinical statistics, but I had the distinct impression that long-term patients were profiting by the atmosphere of the place. I felt we were getting the benefit of many years of practice handed down from aide to aide on the service.

The second example was the Hispanic clientele. Spanish-speaking aides, mostly women of a grandmotherly age, had always been important as translators for working with Spanish-speaking patients. But here in this environment, where no one had offices, and therapy took place wherever you could find the room available, these aides developed their own style of looking after their clients. It was full of affectionate concern, of practical help, of advice, of *caridad,* even sometimes resembling *compadrasco,* a kind of almost-family relationship. Some of the traditionally trained professional staff worried about ways in which these two somewhat unsupervised spaces of the service, the Day Hospital and the Spanish-speaking conversations, were encouraging "dependency" and it was my job, and that of the other staff, to model a kind of culturally sensitive supervision which is a whole topic in itself.

Now I have to get back to the succession of directors because I want to bring this history up to date and come to a conclusion. Marvin Hertz left in 1977 and I was acting director for less than a year while a search committee found the next director, Manuel Trujillo. Trujillo was a native of Seville, and so of course was Spanish-speaking, a first recognition of the importance of that growing constituency of mostly Dominican patients we were seeing. Although he was not from the Caribbean, Trujillo had earned his social psychiatry spurs at the Lincoln Hospital residency that had trained so many of my colleagues in the Bronx. He stayed less than a year -- helped us to get through the catastrophe of the fire, and he made some other important changes on the service. The one with the most lasting significance was, I think, his championing of Francine Cournos as his successor.

Francine had, during all these years, been the outstandingly versatile and ingenious director of the in-patient service, who not only inspired great loyalty, but also demonstrated the value of having a real medical psychiatrist in charge of the place where the most acute problems needed supervision. As director of the whole of WHCS, she would be the first woman to direct a major clinical section of the Institute. I won't speculate about the significance of having a woman director in terms of feminist politics, but I do want to note a few facts.

1. Except for me – and I was only the acting director -- all the previous directors had gone on to become the chairman or head somewhere else. Hertz to the Chair at Albany Medical College, Mesnikoff to Direct South Beach Psychiatric Center and then to be Regional Director, and Trujillo to direct NYU Bellevue. Each of these men headed for the top of their particular escalator as soon as the opportunity appeared. Francine did something different. She has stayed as director of the community service for 24 years, and when her help was needed in the regional office to be the medical director, instead of moving up, she did both jobs at the same time.
2. One of the things that made that possible was the way she organized her directorship. Previous directors had run the service by themselves, with a cabinet of the other male heads of its divisions, whose conflicting ambitions had to be managed. Under Hertz, it was a bunch of busy men thinking about administration in their spare time. Francine created the position of administrator of the service and advertised nationwide for candidates. Out of 16 applicants she picked Rich Herman, who had been a director of social services in Madison, WI. By appointing Rich as her administrative director, she gave serious attention to the organization of leadership and the exercise of power. It's been one of the things that has enabled her to be in several places at once, which some women would say is an ability they learned in a hard school of life experience. It is made possible, I understand, by relying on collaborative relationships at the top rather than trying to be the top yourself. Francine has extended this practice by having Stephanie LaMelle, a second psychiatrist, as associate director. There is a model of teamwork at the head of the service, and at the same time a model for the exercise of power.

   Out of the many stories I would like to tell from Francine's years as director, I have to choose only two, so we will have time to talk about some of your questions and responses to all this. They both have to do with the exercise of power, when to use it vigorously, and when to lie low.

   Before Hertz left, Edward Sachar was chosen to succeed Kolb as director after a long interregnum of Sidney Malitz as acting director. Sachar promoted the new biological psychiatry, already a distinguished part of the institute's history, as the dominant task of the institute. It was clear that this would consume a larger share

of beds, time and money. Sachar, himself an analyst, gave as his first grand rounds talk an elegant discussion of the philosophical basis of psychoanalysis, and then in the next breath seized the assets of Otto Kernberg's fifth floor service. Kernberg left for Cornell-Westchester, and a half-century tradition of treating "interesting" patients on the wards of the Institute ended abruptly.

The Community Service only lost half its beds to the new regime, and we made up for it by greater efficiency in the outpatient department, so that in an odd way, as in Mesnikoff's time, pressure on our resources resulted in learning lessons we needed to learn anyway.

The first story could be called, "surviving in turbulent times" Al Mesnikoff had become regional director after a brilliant period as director of South Beach, which included half of Brooklyn. He had demonstrated that an integrated, comprehensive control of all services, city and state, led to great efficiency and invention in that environment. So as regional director, he invited his old service, the WHCS, to demonstrate the same thing. He challenged Sachar to take over the wards and services of the North Manhattan part of MPC as well, running them from PI. The alternate was that MPC would run us. There was a huge uproar and political battle about this idea. And this was the atmosphere in which Francine became director. It was clearly better to run this new amalgam than be run by it, so we accepted the challenge. Fran acquired two wards at MPC and Inwood clinic plus 50 lines. In the end, the consensus was that the collaboration wasn't working, and it went back to its old shape. Except for two important changes. The first was that we kept Inwood clinic and some of the extra lines, thus doubling in size and having a force more adequate to the task of our catchment area responsibility. The second was that the conflict had demonstrated the tendency of PI services to steal from one another. Francine secured a separation between the PI and WHCS budgets that insulated the service from its predatory colleagues. We remain to this day the only state service with this kind of comprehensive and specific local responsibility. I think that Adolf Meyer would have applauded. Incidentally, thinking of Adolf Meyer, the other thing he would have liked was our continuing to train residents. No matter how short the resident's rotation on the service has been cut – and we do have to compete for resident time with the biological establishment – we have still had them consult to outpatient groups so that they have a chance to learn what happens to the patients they see on the ward after they return to the community. Many residents have told me that this is one of the most important parts of their training.

The final story is entitled "the reward of virtue, or doing the right thing" – something else that has come to be regarded as a feminist value. It's a very simple story. Seeing that a large number of our patients prefer to speak Spanish as the language of their personal lives, and very few of our staff, especially the

professional staff, could speak it with them, Fran and Rich decided to make new hires Spanish-speaking. They took people who were fluent in Spanish in preference to others of greater seniority or equal qualifications, who did not. They got a lot of trouble for this, especially from the union, and from the Columbia tradition of hiring from the inside. But it was the right thing to do, and at present we see a half of all the Spanish-speaking State patients in New York City. Not only was it the right thing to do, it put Francine in a position to say, in the face of one of the most severe threats to cut staff that we have had, that she could not lose staff in the face of this responsibility, and in fact, we were not cut, but gained a few.

This brings my story up to date, and instead of making a summary, I think we should turn the discussion over to you, to see what questions and comments all this raises for you. Thank you.