September 11, 2001, affected virtually all aspects of American life, from foreign policy and domestic security to philanthropy, social services, and health policy. Social welfare, public health, health care, and environmental issues, generally seen as separate spheres, are now increasingly understood as interrelated components essential to the mental and social well-being and emergency preparedness of a traumatized nation and city, and the opportunities to integrate these concerns are immense. The experience of 9/11 has highlighted the interrelationships between biological, sanitary, medical, social, and economic factors that together affect the well-being of populations. Perhaps more directly than any other recent event, analysts point out, September 11 has illustrated that a population’s health “encompasses a broader array of determinants of health than the field of public health has previously addressed,” making all the more critical the “emerging theory and practice of population health” — one that incorporates “the traditional concerns of public health” with “such issues as the effects on health status of . . . relative income and social status, racial and gender disparities, and educational achievement.”

This chapter is organized both chronologically and thematically. We begin by reviewing the immediate response of New York City’s Department of Health to the attack on the World Trade Center and the subsequent anthrax episode. We then analyze the difficulty of establishing responsible policies to aid the city’s and nation’s return to normalcy in the face of enormous scientific uncertainty about the potential health
hazards of dust, debris, and toxic materials in the neighborhoods and schools near the World Trade Center site. Finally, we address the special immediate threats that the disaster posed to the population’s health. Of particular importance were the social service and mental health sectors, largely organized through voluntary agencies: we discuss the immediate and longer-term responses of these agencies and the problems they encountered as they adjusted to long-term population health needs. Thus we begin with the narrowest conceptions of health as defined by the activities of the New York Department of Health and broaden our study to include the agencies and issues that affect population health policy.

The immediate response to the attack on the World Trade Center showed the surprising strength of New York City’s existing public health and social welfare infrastructure, but the attack also revealed important weaknesses that will have to be addressed in the future. Though the decentralized system of social and public health services was in some respects an advantage in responding to unpredictable and varied disasters, the need for a greater degree of centralization of services and control was nevertheless apparent. At times the political and public health leadership effectively communicated what was known and not known about the dangers to residents’ health and welfare, while at other times political leaders with differing agendas propagated a confusing array of messages, leading to uncertainty and distrust among the broader public.

The history we relate in the following pages must be understood as being deeply imbedded in ongoing political and social struggles around political power, race, neighborhood redevelopment, immigration, and the responsibilities of New York City’s largely voluntary social service system. Despite the ubiquity of the image of “a nation united” in the weeks after 9/11, in reality the depiction of the events, almost from the first minutes after the attack, was shaped by continuing social divisions between rich and poor, between black, Hispanic, and white, and even between Republicans and Democrats. For example, Joseph Bruno, the New York State Senate majority leader, was quick to compare the responses to 9/11 in the two communities most directly affected: New York and Washington. In New York, Bruno argued, an efficient and well-ordered emergency response system mobilized a vast array of resources that, under the leadership of Governor George Pataki and Mayor Rudolph Giuliani, both Republicans, calmed the public and answered the immediate needs of a traumatized community. As Bruno put it, “The leadership they provided moments after the disaster came after years of putting together an excellent response plan.” But in
Washington, D.C., Bruno maintained, the lack of effective local political leadership and absence of an emergency plan led to a confused, disjointed set of decisions that fell short in calming the public or providing needed services. He declared, “Local leaders [can] look to Washington, D.C., and New York City for dramatic examples of one city that wasn’t prepared to respond to terrorist attacks and another that was.”

Certainly, Bruno gave major credit for the success of New York’s response effort to the Republican leadership of the city and state, contrasting it with the Democratic local leadership in Washington, D.C., and effectively ignoring the unique control exercised over local government in Washington by Congress (indeed, at the time the city’s finances were being overseen by a presidentially appointed control board); moreover, he failed to mention that the attack was in Northern Virginia, while Washington itself was untouched.

Here we turn a skeptical eye on the underlying politics that have driven the city’s reaction to September 11. We take for granted that the response of the city’s political leadership was shaped by existing social tensions, as well as a physical, governmental, and nonprofit infrastructure that was put in place throughout the twentieth century — especially during the administration of Fiorello La Guardia (1934–45) and in the decades after World War II, when New York experimented with a wide range of public health and social welfare programs. In contrast to Bruno’s portrayal, which personalizes New Yorkers’ “successful” response, we argue that implicit national priorities distorted how health and welfare policies were implemented in the period following the attacks. How effectively the city and state responded to the emergency rested only in part on their political leadership, the planning done by the State Emergency Management Office (SEMO), or even the Federal Emergency Management Agency (FEMA), although all played a role.

**THE EMERGENCY RESPONSE IN THE HOURS AFTER THE ATTACK**

Although the city initially took the lead in the emergency response, certain state and federal agencies were involved in coordinating aid and resources that flowed in from elsewhere in the state and across the nation. Since 1996, New York State has had in place an emergency management office charged with responding to the natural disasters that may cripple different areas of the state. Ice storms in the Adirondacks, hurricanes in the Hudson Valley, drought relief in the apple-growing districts in the center of the state, and other emergencies caused by weather have
been its primary focus since the mid-1990s. In 2000, the anticipated computer meltdown that never occurred, “the Y2K bug,” broadened the mandate of the office beyond natural disasters. But though the World Trade Center (WTC) had been targeted by terrorists and seriously damaged in a 1993 bombing, the office was unprepared for the dimensions of the attack that occurred on September 11, 2001. Within moments, a social as well as physical disaster overwhelmed the agencies that were normally expected to deal with disaster relief.

The State Emergency Management Office helped coordinate the immediate response. SEMO called on thirty-one emergency experts from eighteen states associated with the Emergency Management Assistance Compact (EMAC)—a mutual aid agreement among states that was initially intended to address natural disasters such as hurricanes, wildfires, and toxic waste spills as well as acts of terrorism—to help manage logistics and donations. (New York was not formally part of EMAC before September 11 but joined it through state legislative action in the days after the attack.) Five other states also sent specialists in disaster relief. Through SEMO, 5,000 National Guard troops, 500 state troopers and K-9 units, 100 Bureau of Criminal Investigation personnel, and 2,500 crisis counselors were dispatched to the city. The State Department of Health provided 400 workers to the New York City Department of Health to expedite the issuance of death certificates for families of victims, to monitor air quality, and to coordinate volunteer personnel. In addition, the New York State Insurance Department, Empire State Development Corporation, Department of Transportation, and Department of Labor all provided a host of services.

**The Federal Emergency Response**

For some in the New York City Department of Health, the real “white knights”—to use the words of Kelly McKinney, the department’s associate commissioner of regulatory and environmental health services—were the federal emergency response experts who appeared in the hours following the attack. Local health officials were appreciative of experts like Ron Burger, senior emergency response coordinator with the Centers for Disease Control and Prevention (CDC), who had extensive experience with all sorts of natural disasters and who seemed unfazed by the events. Burger was among a small group of experts from the CDC and the Department of Health and Human Services that arrived in New York City on the afternoon of September 11. McKinney describes him as “sort
of geeky in a lovable way. . . . He’s got his CDC polo shirt with the pen around the neck and the emergency response I.D. card and the boots and stuff. . . . He’s done this so many times. He probably sleeps in that.” At meetings of the mayor’s emergency response team, McKinney said, rather than telling everyone what to do Burger would sit there and listen: “He’s a fly on the wall, and every once in a while he’d say something . . . and he’ll sort of nudge you a little bit [and soon] he’ll say something and then the lightbulb would go on. All of a sudden, you’d say, ‘Oh, I see.’”

The lines of authority were frequently confused and unclear as federal, state, and local officials tried to give (or had to take) orders from their counterparts at different levels of government. McKinney remembers that at one meeting, representatives from the Coast Guard and the Environmental Protection Agency (EPA) both were giving guidance to city officials. “They knew this stuff had to be done. . . . They had to get the city to request it,” McKinney recalls. “They were looking for someone to request it. Anybody that was walking by, they grabbed them: ‘Can you just request . . . this. Can you request?’ People would be like, ‘Get away from me.’” These early moments of chaos were overcome, but small and large conflicts over who had authority at any given moment would create ongoing problems in the weeks and months ahead.

The Immediate Hospital Response

In the minutes and hours following the attack on the World Trade Center, an astounding array of emergency vehicles—from fire trucks and police vans to ambulances from hospitals all over the city—gathered along the West Side Highway above Canal Street awaiting word about when to drive downtown to the disaster site to provide relief and pick up the injured. Lining the highway for blocks were ambulances from virtually every hospital in Manhattan: Mt. Sinai, NYU Downtown Hospital, New York–Presbyterian, Bellevue, and others. The ambulances sat and sat as it became apparent that few of them were needed for the anticipated massive casualties: the terrorist attack had left many victims but few survivors.

Like their ambulance services, the hospitals throughout the New York region had readied themselves for an onslaught of what they imagined would be thousands of patients who had survived the attack. They emptied their wards and rooms of all but the most seriously ill and mobilized their staffs to await the ambulances they expected would soon arrive at emergency room entrances. Hours went by as doctors, nurses, orderlies, and technicians streamed to the institutions. Yet, like the ambulance serv-
ices, they found that they were not needed. In the following days, administrators complained that their institutions had absorbed enormous costs as the emptied beds and canceled services had deprived them of revenue. Who, they asked, should bear the costs of an emergency mobilization spurred by a sense of patriotism and civic duty? In the end, the hospitals themselves bore the loss.

The city’s hospitals had, through the Greater New York Hospital Association, made an enormous effort in the late 1990s to make sure they were prepared for the potential chaos that might ensue from a city-wide crash of computers as a result of the Y2K bug. Susan Waltman and Doris Varlese, the association’s general counsel and assistant general counsel, respectively, agreed that “the extensive preparation and drilling done for Y2K were vital to the preparedness of New York area hospitals on 9/11.”

“Though at the time some criticized the amount of money and attention spent to deal with a Y2K disaster that never materialized, 9/11 proved that the efforts were not wasted,” regardless of the relatively small number of actual casualties, points out Waltman. Varlese recalls that she was with the mayor at ground zero shortly after the first plane hit and was at the fire station where the emergency headquarters was set up. “Though they did not have the technology and equipment that would have been available to them in the regular emergency headquarters,” she notes, “things functioned effectively and efficiently because everyone had been so well trained.”

The episode reveals the enormous resources available in New York and demonstrates that the institutions themselves were able to implement emergency protocols quickly and efficiently, despite all the initial chaos and the lack of clarity as to the disaster’s true extent or nature. Yet even though the state had a disaster preparedness plan on the books, observes Richard Gottfried, New York State Assembly member from Manhattan and chair of the Assembly Committee on Health, the Greater New York Hospital Association, among many others, testified at an Assembly Health Committee hearing that it “had no interaction with the disaster preparedness council that was supposed to implement the plan.” Indeed, the disaster plan had not been updated since the early 1990s and for all practical purposes “did not function” during the crisis.

The Role of Voluntary Agencies

The day-to-day efforts to meet the needs of the city fell to voluntary agencies—that is, organizations that run on a nonprofit basis, with tax-
exempt status from the state—and departments of the city government, and many were struck by the order and coordination that marked those early days and weeks. Richard Jackson, then director of the CDC’s National Center for Environmental Health, reflects: “Never in my whole career had I ever experienced a sense of superb management and seamless coordination around a series of important issues. It could not have functioned more effectively.... I hate to say this, but New York was absolutely the best place in the country for this to happen, only because the networks of personnel, knowing who your peers were, knowing how the system would work, confidence in them, seamless communications whether electronic or otherwise, really had been pretty much set up.”

THE NEW YORK CITY DEPARTMENT OF HEALTH

In the hours after the planes hit, the department’s various officials and staff were drawn into some of the most basic tasks of caring for people in crisis. Because it was located just a few blocks away from the World Trade Center, and because its staff was arriving at work at the very moment of the attack, the Department of Health was literally well positioned to mobilize an early response effort.

Providing Immediate Help

In the hours after the attack, Department of Health personnel provided emergency services to injured people who were streaming uptown from ground zero. Susan Blank, assistant commissioner of the department’s Sexually Transmitted Disease Control Program, remembers people coming into 125 Worth Street “truly covered in ash. Before, some people had like, yes, ash, but these people were caked in ash, their nostrils really covered in ash. People were singed, mucous membranes, people who were freaked. There were firefighters who came in here, there were police officers who came in here, there were citizens who came in here.” Although the Department of Health headquarters on Worth Street, near City Hall, “was not ever envisioned as a clinic site,” and was not equipped to deliver any direct services, the staff rose to the occasion and converted the lobby of the building into a triage center where people were treated for dust inhalation and eye irritation as well as scrapes, heart palpitations, and broken bones.

Staff was called in from a variety of clinics around the city to serve as an emergency medical corps. Lucindy Williams, the clinic manager for
STD clinics in Fort Greene and Williamsburg in Brooklyn and on Staten Island, recalls that she and other physicians from her clinic in Fort Greene immediately left Brooklyn with “a policeman and a police car escort[ing] us across the bridge to Manhattan.” 10 “We were here,” remembers Isaac Weisfuse, the Department of Health’s deputy commissioner for disease control, “and in the meantime they started bringing in casualties. That’s something we actually never really prepared ourselves to deal with, because at the Health Department we have STD clinics and tuberculosis clinics, but we’re not really a casualty” center. “Thankfully, they didn’t bring anybody with more than broken bones.” 11 In fact, there is no reason why the Department of Health should have been prepared to deal with casualties, since it is the role of city’s Emergency Medical Services and trauma systems to provide such services.

But while the department tried to adjust to the immediate demands placed on it for medical care, its major focus was, in fact, on very traditional public health issues. Benjamin Mojica, deputy commissioner of health and director of the division of health, recalls coming out of the subway, on his way to jury duty, to see people staring at the North Tower, which had just been hit by the first plane. He quickly altered his plan for the day and went to his office, just across the street in the Foley Square complex of government buildings. He called in his emergency response team and organized a meeting in the conference room on the third floor at 125 Worth Street. 12 The meeting mobilized almost every unit of the department. Their plans included monitoring air quality, coordinating with other agencies to see to the safety of search and rescue workers, tracking illness and injuries at New York City hospitals, monitoring water quality around ground zero, inspecting food establishments below Canal Street, overseeing the distribution of food for rescue workers, and surveying the impact of the blast on rodent activity.

Traditional Public Health Services

There were two hundred restaurants and other food outlets in the immediate area around the WTC, as Mojica points out, “with spoiling food. In addition to the stench . . . there’s going to be a potential for rodents to invade the area and help themselves to this big supply of food that was left behind.” Working with other city agencies to mobilize inspectors, exterminators, and cleanup crews to “abate conditions conducive to rodent harborage,” the Department of Health set about to enter restaurants that had been abandoned by owners, where decaying food was cre-
ating a tremendous insect and rodent problem. Mojica notes that he didn’t “know how many tons of food we threw out, . . . but it took us almost three weeks to” clear the restaurants, food shops, and supermarkets of huge quantities of rotting matter.

Because restaurant inspectors were called downtown in the emergency, there were no restaurant inspections or rodent control activities north of Canal Street for nearly a month. No births were registered for about two weeks in New York City. And because the department was so focused on the possibility of bioterrorism, its sole investigatory activity was to monitor infectious diseases that appeared in hospitals. According to Mojica, no “regular, routine” surveillance of non-terrorist-related diseases or conditions occurred.

In addition, the Department of Health established systems to monitor emergency departments to assess acute injuries, oversaw hospital staffing and equipment needs, watched for unusual disease patterns that could indicate a bioterrorist event, issued medical advisories to the public and medical community, and “facilitated development and coordination of environmental sampling.”13 In the hours immediately following the attack, the department began to conduct “swipings” in the area around the site to test for bioterrorism and chemical agents.

Contrary to much of the rhetoric about the impact of 9/11 on redirecting the priorities of public health, the experience in fact highlighted how essential to dealing with the emergency were traditional public health functions: record keeping, disease monitoring, pest control, water safety, sewerage treatment, and disposal and sanitation.

Environmental Health at Ground Zero

The Department of Health took charge of providing respiratory equipment to the workers who began to sift through the rubble in the days immediately following the attack. It thus had the responsibility of fitting masks and respirators to every person on every shift. Andrew Goodman, the department’s associate commissioner of community health works, recalls the “enormous effort by a team of people at the Health Department to organize the procurement and then the distribution of 20,000 to 30,000 respirators.” He adds, “We were down at ground zero trying to figure out respirators, and we would have masks from one company and filters from another and it took actually a few days before we had a system set up where we could get masks out to everybody . . . probably thousands of firefighters, police, and other rescue workers.”14
Isaac Weisfuse recalls that he “couldn’t believe how many masks and other things we were getting in... It didn’t dawn on me until a day or two later that there were thousands of new people showing up every day, who weren’t fit tested... and I think threw [the masks] away at the end of the day, thinking they didn’t have to keep them... but we went through a ton of masks.”

Susan Blank remembers the difficulties of deciding what materials could be used at the disaster site. Although donations were pouring in, each item of equipment—even bottled water, for example—had to be evaluated as to its source and safety. “There were discussions about, can we accept donated supplies? Maybe they’re laced with some agent of bioterrorism... So we can’t accept these types of donations; we have to turn them back. Yeah, but the workers are out there working but they’re unprotected. If you look at the early news pictures, they weren’t wearing masks.” Two other major concerns in the first days following the attack, points out Benjamin Mojica, were how to get potable water to the disaster site and the need to address the danger from “potential cross-contamination of the water from sewage and other effluents” following the dramatic drop in water pressure caused by the large number of hoses and fire hydrants the fire department had opened.

Goodman argues that “the infrastructure was not as strong as it could be, certainly in terms of our capability to do surveillance at the level that we truly like and really also utilizing technology that is currently available.” Some traced the problem to long-term trends in public health, as attention to chronic disease problems had grown and concern about epidemic diseases had declined over the course of the past half century. Some Department of Health officials complained that the increasing funds flowing into the hospital system and the growing prestige of medicine and medical technology (as antibiotics, polio vaccine, and transplantation, among many other biomedical techniques, were developed) had drained the public health field of resources and prestige. New York’s fiscal crisis of the 1970s led to a shrinkage of the department’s budget in real dollars, creating a major crisis that forced it to close clinics, limit its number of inspectors, reduce infectious disease surveillance, and reduce its central office workforce.

But the advent of the AIDS epidemic in the 1980s and 1990s, the shorter-term crisis caused by a spike in tuberculosis in the late 1980s, and the special attention to West Nile virus in recent years had helped draw the city’s attention to the vital role played by the Department of Health and had underscored the importance of supporting the department’s tra-
ditional functions. Still, at the time of the attack, though major improvements had occurred, some parts of the department remained weak; specifically, its laboratories, once seen as the jewels in its crown, had fallen on hard times.

The Department of Health not only had to react to the emergency itself but also had to be “anticipatory” of coming problems associated with the relationship between ongoing public health needs and the cleanup activities. Weisfuse recalls that “it was West Nile season, and there were all these hoses and water.” He and other department personnel worried, “Are all the firemen going to get West Nile?” With literally millions of gallons of water being poured onto the smoldering fires that continued to burn for months after the attack, the site itself became a perfect breeding ground. Hence, the department began to identify standing pools of water and to lace them with insecticides to ward off what might have been a massive problem.

The Anthrax Episode

While the attack on the World Trade Center highlighted the Department of Health as essential and exposed the limitations in its ability to fulfill its enormous mandate, the anthrax episode further tested its ability to respond to the city’s needs. On September 25, an assistant to Tom Brokaw, the NBC news anchor, opened a letter filled with white powder and handled a second letter that contained some kind of sandy substance, and her supervisors called the FBI. Three days later the employee developed symptoms—a “strange sore on her chest”—and her doctor, evidently suspecting anthrax, prescribed the antibiotic Cipro. The NBC employee also visited a dermatologist, and one of her physicians contacted the New York City Department of Health to test the powder; it was found to be negative for anthrax. But the biopsy of the sore was sent to the CDC, which did identify anthrax. At first the city and federal agencies failed to communicate, and the New York Times reported that “coordinating the efforts of the various law enforcements and public health officials [proved] tricky.” But the experience they had gained from running STD and TB clinics enabled city officials, though stretched to their limits, to quickly organize a method for distributing Cipro and providing other services necessary to identify victims and find sources of infection.

The strengths and weaknesses revealed in the city’s public health infrastructure by the mailing of anthrax to NBC became manifest on a
national scale when postal workers were discovered to have been exposed to the deadly substance. Neither the CDC nor the Defense Department nor any other agencies could cope with the escalating demands to test suspicious powders or secure sites thought to be contaminated. In particular, the city’s own laboratory was overwhelmed by the huge number of samples flooding it and was made inoperable by the lack of trained staff. Although only four cases of anthrax were identified, New York City could not keep up with the thousands of tests it needed to run on matter from humans and from the environment; and because the staff as well as the police and others who brought in samples lacked training or experience, proper handling of the material was difficult and sometimes impossible. Indeed, at one point the department’s laboratories at East 26th Street were themselves contaminated by anthrax; they became functional again only after the army brought in its own mobile emergency laboratory, which was set up in the lobby. Though members of the laboratory staff were working twenty-four hours a day and doing an extraordinary job, they became the scapegoats because they were not returning specimens quickly enough. “We were really overwhelmed by the response from the community,” Ben Mojica recalls, “and the number of specimens we received in the laboratory. There were thousands of them.”

A semblance of order returned to the labs after the Defense Department intervened and established a mobile laboratory, following requests from the mayor to Secretary of Defense Donald Rumsfeld. But new tensions emerged, as officials feared the possible “militarization” of public health activities. The anthrax episode, an emergency requiring an immediate response to the threat of bioterrorism, created an uneasy alliance between military and public health cultures. Public health generally has been a methodical, sometimes slow, science of investigation, and new demands, especially for speed, were being made on it.

Further, the experience with the postal workers in the midtown Manhattan mail handling facility (and in the Brentwood facility in Washington, D.C.) exposed the flaws in a decentralized public health system. There were no clear national guidelines for who should be tested for anthrax, who should be given Cipro as a preventive measure, what should be done after anthrax spores were identified in a facility. As a reporter noted, “The individual incidents where anthrax has actually been found have been handled differently by health and law enforcement officials on each scene, leading to confusion and anger in some areas.”

Though the infrastructure itself was at times immobilized by the
demands placed on it, the city’s population reacted with remarkable calm to the events that were being reported daily over local and national television and other news media. In some measure this can be attributed to Mayor Rudy Giuliani’s handling of the anthrax episode. The mayor held daily press conferences that provided relatively full and accurate information about the scope of the problem, giving a detailed account of what was being done to deal with the threat; he avoided speculation while offering a degree of reassurance to a nervous city. In essence, he “appealed to people’s most rational selves” and counted on the public to reach reasonable conclusions about the real scope of the threat and on public officials to act responsibly and appropriately.21

In the days after the hijackers’ attacks, federal officials were lauded for their efficiency and organization. But during the anthrax crisis, the story was very different. As the New York Times put it, “In their initial handling of the anthrax crisis, [federal] government leaders did almost everything wrong.” Secretary of Health and Human Services Tommy Thompson, who had little credibility on health matters, was designated the spokesperson on anthrax rather than the director of the CDC or a senior doctor at the National Institutes of Health; and “health and law enforcement authorities made confident statements that later proved false, tried simultaneously to inform and reassure, and limited the flow of information to the public.” The Times cited one of Thompson’s “most egregious lapses”: he said that the initial anthrax victim might have contracted the disease by drinking water from a stream in North Carolina.22 Matters improved when Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, began taking charge of communicating with the public.

In short, the responses to 9/11 and to the anthrax mailings highlighted some of greatest assets of the public health infrastructure: “9/11 revealed the strengths in individual people” and the much-maligned civil servants who maintain the system, remembers Steven Rubin, deputy director for sexually transmitted diseases, one of the programs of the city’s Department of Health directly involved in responding to bioterrorism. He adds, “So many people in this agency responded so quickly and put in so many dedicated hours.” The events “revealed the real strengths of the public health infrastructure . . . in that most people came in the next day, the day after, and just showed their commitment to doing the job.”23 But they also illuminated some of the department’s most glaring weaknesses and profound needs—to train doctors, nurses, police, and firefighters in bioterrorism emergency response; to expand laboratory capacities suffi-
ciently to handle possible surges in demand; to improve methods of communicating information to emergency personnel; and to maintain the facilities required (including a supply of beds) to cope with a possible emergency.

**SCIENTIFIC UNCERTAINTY AND PUBLIC HEALTH COMMUNICATION**

Over the weeks and months following the World Trade Center attack, failure to keep New Yorkers informed led to a severe breakdown in public trust, as ambiguous, often contradictory information was communicated and miscommunicated to residents near the WTC site, undocumented workers responsible for cleaning nearby buildings, and parents of children who attended neighborhood elementary, intermediate, and high schools—notably Public School (P.S.) 89, P.S. 150, P.S. 190, P.S. 234, P.S. 875, Intermediate School (I.S.) 289, and the High School for Leadership and Public Service. The case of Stuyvesant High School, one of the elite public schools in the city and indeed the nation, is particularly revealing, as officials and public health experts failed to acknowledge uncertainty and therefore confused the public by sending incoherent messages. Stuyvesant is located five blocks north of the WTC, and most of the students witnessed the planes crashing into the buildings and people jumping and falling from the towers before their collapse.

**Stuyvesant High School**

David Klasfeld, deputy chancellor for operations at the New York City Board of Education, vividly recalls the confusion and uncertainty that marked the first moments following the attack. He watched the scene from his office at 110 Livingston Street in downtown Brooklyn, and then with Chancellor Harold O. Levy; and the administrators at the Board of Education were unsure of what to do. As they met with the chancellor, they raised questions that had never before been addressed. Should the board send all 1.1 million children home from school? No, because doing so would undoubtedly create mass confusion and panic among hundreds of thousands of parents at work and unable to get to their children, who would therefore be wandering the streets alone. Should it order the schools around the WTC site to evacuate? to send the children in a particular direction? to stay in place?

“I don’t believe that we were immediately in contact with [the principals],” Klasfeld says.
The actions of the principals and the teachers in those schools was extraordinary. Remember, this is September 11... It's the third day of school, the fourth day of school. Some of these people are teaching for the first time. It's their third day of work, their fourth day of work. Many of them are young. The board is not one of these places that encourages people to think their own thoughts about what to do. The evacuation plan for those schools south of the World Trade Center was to go north. That was the plan. Instead, they had the sense to go south. North was where danger was.

The board was far away from the scene, leaving the central administration feeling completely helpless, and even at the scene itself principals were at a loss. “You didn’t know what to do.”

Yet individual principals and teachers took initiative. The High School for Leadership and Public Service, on Trinity Place just below the Twin Towers, moved its children to Battery Park, safe from the falling buildings. “The [most] amazing story to me,” declares Klasfeld,

is the woman who is the principal of Leadership, a woman named Ada Rosario Dolch, whose sister died in one of the buildings. She certainly knew that [her sister] was working there. She takes her kids south, puts them on whatever ferry is there — ferry to New Jersey, ferry to Staten Island — gets them off the island. [She] sends teachers with them. There were kids overnight in New Jersey. Cannot get in touch with the chancellor’s office, and walks. The only thing on her mind was to tell the chancellor that her kids were OK. She and her secretary and one other walk from Lower Manhattan across the Brooklyn Bridge to 110 Livingston Street, so she can report to the chancellor that she got her kids out.

The staffs of the city’s schools were on their own, and in the weeks ahead the board would find that its personnel were in some cases truly heroic. Security personnel, custodians, and other employees played crucial roles in maintaining the schools following their abandonment. Klasfeld points out,

Our custodians, our much-maligned custodians, stayed on the sites of their schools. A number of them, particularly the custodian at Stuyvesant, did a fabulous job. He immediately turned off all of the air systems, so that debris was not sucked into the school at Stuyvesant. . . . One of the issues [that the custodians were concerned about] was nothing that I would ever think about. . . . If it rained, it would be a big problem with the roofs of these buildings. You had all of the ash and stuff. If it rained, then it hardened. So we had our custodians on roofs cleaning off debris, so that that wouldn’t happen. So we had our own people at the schools responsible for protecting them.

Immediately after the disaster, and after the children were evacuated, Stuyvesant was taken over by emergency workers and made unavailable
for school use. Classes for the students resumed less than a week later at Brooklyn Technical High School in split sessions with shortened class periods. Initially, many parents mobilized to press for an early return to Stuyvesant’s very modern and technologically advanced building, arguing that it was important for the children to resume their normal routines. The parents, many of whom were among the city’s most sophisticated professionals, including a good number of lawyers and doctors, recognized from the start that health hazards might be present; they hired their own experts to evaluate the safety of the school, which the city planned to reopen on October 9, less than a month after the attack. The city also was intent on returning the students to other schools in the area as quickly as possible.

The city began testing for asbestos, lead, and other toxins and concluded that the air within the building was safe. It hired two eighty-person crews to vacuum air ducts, replace carpets, hose down the ten-story building, and clean all surfaces. In addition, it installed monitoring devices to sample the air quality on a regular basis.25

David Klasfeld recalls the heated emotions that engulfed the Board of Education and “wary Stuyvesant parents [who] have enlisted their own experts to determine if the school is safe.” Parents began to worry as they heard reports of asbestos-laden dust samples in P.S. 150, a few blocks away; moreover, dust samples taken by the EPA right outside Stuyvesant on September 19 found above-normal levels of asbestos. The city, and particularly Mayor Giuliani, claimed that the tests, with the exception of a few idiosyncratic results, showed that “the air quality [was] safe and acceptable.” Parents, however, began to argue that the individual samples were not outliers but reflected a reality obvious to anyone who visited the area and smelled the air: whatever the readings, the smell alone indicated that the air was dangerous for the children.26

The students reentered Stuyvesant on Tuesday, October 9, with a mixture of fear and excitement.27 But students looking out a north window soon noticed huge barges, less than a hundred yards away, carrying debris from the WTC site to the Fresh Kills landfill on Staten Island. Dump trucks carrying WTC debris continuously traveled right past the school, and large plumes of dust covered the bridge that connected Stuyvesant to Chambers Street. As one parent put it, walking to school was like “walking through a construction site.” Children likened it to a war zone.28 At the Stuyvesant High School Parents’ Association meeting in November, angry parents were assured by Board of Education officials that all was safe and that virtually all tests for lead and asbestos, the two substances regularly monitored, showed levels well below acceptable standards.
But rumors began circulating among the students themselves that they were all being poisoned, and some began to stay home from class. In the ensuing days and weeks, parents noticed that their children were developing bronchitis, asthma, rashes, coughs, and tremendous anxiety. Children came home with watering eyes and coughs.29 “I’ve had bronchitis for the past two weeks. . . . Everyone’s coughing,” one student observed. Some students wore paper masks to school, and the New York Daily News reported that nearly half of the respondents to its informal poll had “some kind of health complaint.”30 While parents and some in the popular press began to conclude that Stuyvesant and the surrounding schools were unsafe, the Board of Education and its experts argued that none of the tests gave any indication of possible danger to the children at Stuyvesant and other local schools. “All the tests showed that the [Stuyvesant] building is safe,” commented Jacqueline Moline of Mt. Sinai School of Medicine.31 The only problem that could be documented was slightly elevated levels of carbon dioxide.32

The distance between the parents and the Board of Education kept growing. In large measure the board depended on expert opinion and air monitoring as the basis for declaring Stuyvesant High School safe, while parents relied on their own senses and on those of their children, many of whom were experiencing a variety of symptoms, as they questioned the safety of the environment in and around the school. Throughout the winter and spring, new studies that appeared—far from reassuring parents—served only to fuel the distrust. A CDC study in May 2002 documented that “more than half the employees at Stuyvesant High School suffered respiratory problems after returning to their school on the edge of ground zero in October.” Teachers in the school told of their own anxieties, describing what they had “put [their] bodies through.” And many complained of depression and high levels of anxiety in addition to physical illness. Twenty-three percent of the staff showed signs of possible post-traumatic stress disorder.33

Before the end of 2001, a reshuffling of the parents’ association brought in new leaders who more readily accepted the official test results; but other parents formed a new organization, whose members picketed outside the school and called for more and better tests. The board’s reassurances were seriously undermined when extremely high readings for asbestos were found in the auditorium, where students, faculty, and parents regularly meet.34 The conflict continued into the next school year, which began twelve months after the attacks.

The struggle over Stuyvesant came to symbolize a larger battle over
who should have the authority to judge the long-term health impact of the 9/11 attacks. A variety of pressures from the city, state, and federal bureaucracy to return Lower Manhattan to something approaching a normal state collided with the public's continuing sense of anxiety as well as individuals' everyday perceptions of the local environment. David Klasfeld recalls the implicit and explicit pressure that came from numerous sources, but most directly from the mayor's office: “There was enormous effort on behalf of the mayor, the governor, the president, to return to normalcy as quickly as possible, so that it was moved from 14th Street to Canal Street, the parts of the city that were open, and then Canal Street, further down. Again, schools, as part of the infrastructure of the city, are important and seen as an important component of normalcy. So there was this push to sort of reopen those schools that we could, as soon as we could.”

Expert opinion in this case served neither to resolve the scientific issues nor to allay the fears of those who worked, lived, or went to school in the area. In fact, one victim of the struggle between the Board of Education and the parents was the authority of science itself. In the months after the initial school crisis, a much broader debate about environmental health and the dangers posed by contaminants arose, and it fundamentally challenged how danger and risk were understood. After the catastrophe at ground zero, officials from the EPA and other agencies immediately sought to reassure populations who lived, worked, and went to school in the area that the environment, particularly the air, was safe. Depending largely on tools, instruments, and ideas developed to assess dangers to workers in industrial environments—the nation's factories, mines, and mills—experts and officials took air samples, gauged the size of asbestos particles, and measured the amount of lead, then compared the results to the known threshold limits.

But statements that values were below the acceptable thresholds did little to silence the growing complaints of those whose children came home from school with coughs, watering eyes, and burning lungs, and their protests ultimately forced the officials and scientists to reevaluate their tools, instruments, and assumptions about the applicability of their science to this completely new and unexpected experience. Barbara Aaron, director of many 9/11 projects at the Department of Epidemiology at Columbia University’s Mailman School of Public Health, notes the profound rift that led many to distrust official pronouncements and even government itself. Indeed, she calls the actions of the city “a terrible political mistake and betrayal.” She continues, “Even if you think of it in the most clinical terms, it was such a mistake.
Probably morally, it’s terrible to pretend to know what you don’t know, and say things are OK when they’re not. To send children back to school in a toxic environment. But I think that politically, how dumb do you think [people] are? I don’t believe that there were terrible poisons everywhere. But I do believe that crushed gypsum and concrete and dust in the air made people really, really sick and contaminated their lungs. . . . The fact that it wasn’t acknowledged was really terrible.”

The Neighborhood around the WTC

In the aftermath of 9/11, the workers cleaning up the site as well as residents and merchants in the neighborhood around the WTC were potentially exposed to a wide range of dangers. For the Department of Health and specifically for Kelly McKinney in Regulatory and Environmental Health Services, the immediate concerns centered on the possibility that the attack might have released radioactive materials (from the airplanes and the buildings) into the air. The department sent “two of our inspectors down there with radiation-detection equipment so that they could see whether there had been a release of radiation” from the planes, from dentists’ and doctors’ offices in the area, and particularly from X-ray machines.

For weeks after the attack, McKinney’s unit focused on providing proper respiratory equipment for the workers involved in rescue and recovery efforts at the site, though the data he was accumulating indicated that the workforce was in greater danger from accidents and injuries on the job than from the air. Even so, McKinney recalls, “We wanted them to be in respirators, and we pushed for respirators . . . . We knew there was a lot of stuff in the air. I would never say that the air quality was good down there, because it wasn’t.” But the science led him to believe that it presented no immediate danger. “We had [a] big problem. Because the data looked good, we wanted to communicate the risks but we didn’t really want to communicate the data per se, because the data was so good a lot of savvy workers would say, ‘Look, if the data is that good, why do I have to wear a respirator?’” The policy seemed incoherent. On the one hand, the department thought it prudent for workers to use respirators; on the other hand, the substances being tested for did not exceed accepted safety levels. (Over the next year, it became clear that even if toxins were not present at dangerous levels, other substances in the air posed serious health risks to workers at the Trade Center site.)
For about two months following the attacks, environmental and health officials in the New York City Department of Health and at the federal EPA and Occupational Safety and Health Administration (OSHA) insisted that “there were no indications of serious long-term health risks” to residents of downtown Manhattan. The city’s Department of Health stated that “the general public’s risk for any short or long term adverse health [effects is] extremely low,” and EPA Administrator Christine Todd Whitman declared, “There’s no need for the general public to be concerned.” Both agencies had developed what they presented as “an intricate network of tests, standards, and procedures that they said were intended to ensure the safety of those working at the site as well as those living and working in Lower Manhattan.”

According to the New York Times, Jessica Leighton, assistant commissioner for environmental risk assessment in New York’s Department of Health, noted that “while tests had recorded occasional spikes in the levels of various contaminants, including asbestos, at some locations at or near the site, long-term health risks are associated with consistent exposure over a 30-year period.” But such reassurances were often unpersuasive, even to the professionals in nearby city offices.

In fact, the story was much more complex. Confusion about the meaning of scientific data was compounded by “complete bureaucratic bungling,” in the words of U.S. Representative Jerrold Nadler, whose district encompasses the World Trade Center. Nadler speaks emotionally about what he calls the “illegal actions” of the EPA in refusing to implement the National Contingency Plan (NCP) of the Comprehensive Environmental Response, Compensation and Liability Act. The Superfund Act, as it is more commonly known, would have put the EPA in charge of indoor as well as outdoor cleanup. Nadler argues that the release of chemicals “should have triggered the NCP, which should have given the EPA immense powers. The EPA can enter any premise with no warning in order to inspect and decontaminate.” Instead, the EPA (and the State Department of Environmental Protection) referred to the New York City Department of Health those residents who asked whether it was appropriate to move back into their apartments and how to clean them. The Department of Health, in turn, foisted responsibility for the decision to move back onto apartment dwellers themselves. Further, according to Nadler, the department suggested that residents clean their homes with “a damp cloth,” advice Nadler condemned as “reckless and illegal.”

In late October and early November, as residents began to return to
their homes to inspect damage, and as the schools reopened and Wall Street businesses and the New York Stock Exchange sought to return to normal, public perceptions began to seriously conflict with official pronouncements. On October 26, 2001, Juan Gonzalez of the *Daily News* published the first in a series of articles that challenged the claims being made by city, state, and federal officials and disseminated by the *New York Times*. In an article titled “A Toxic Nightmare at Disaster Site,” Gonzalez drew on EPA documents to charge that “dioxins, PCBs, benzene, lead, and chromium are among the toxic substances detected in the air and soil around the WTC site by Environmental Protection Agency equipment—sometimes at levels far exceeding federal standards.” Well into October, benzene levels were between sixteen and fifty-eight times higher than OSHA’s permissible limit.41 Local political representatives, including Representative Nadler and New York City Council Member Kathryn Freed, started to give voice to local residents’ concerns and held hearings about the environmental impact of 9/11. At issue was the growing distance between the scientific measurements that had become the bedrock for official pronouncements of safety and New Yorkers’ personal experience with the coughs, colds, and smells that accompanied the cleanup. One community board member put it bluntly: “Just because [the measurement of a given contaminant] doesn’t reach a certain level is really irrelevant when people are sick.”42

By November, residents’ private doubts were emerging as very public issues. New York City Council Member Stanley Michels, chair of the council’s Committee on Environmental Protection, held a hearing that “raised more questions than it answered.” Sounding a theme that would become pervasive in subsequent months, he said that “the various tests and standards . . . may be fine for things that have happened in the past, but we don’t know if it applies here because the situation is so unique.” He recognized the need to keep residents and workers from panicking, yet he qualified his statements by arguing that such reassurances could be given only “if the confidence is due. But the jury’s still out on that.”43

In late November, the *Daily News* reported that according to EPA officials and “public health experts,” “government agencies monitoring the air quality near Ground Zero had lost much of their credibility with the public.” Their “argument that the air is safe is not registering with the public—particularly those who have felt irritation from smoke and dust near Ground Zero.” George Thurston, an environmental scientist from New York University’s School of Medicine, worried that reliance on the measurements was undermining the credibility of the science itself,
while Philip Landrigan of the Mt. Sinai School of Medicine was concerned about misuse of the data he and others were collecting: “Risk communication is more than spin. If you think it’s spin, then you’ve lost the battle already.” Increasingly, the scientific community tried to introduce subtle distinctions lacking in declarations from the political establishment. Thus Thurston summarized the scientific evidence: “I think it is premature to tell people it is safe, but we can tell people we don’t see a danger.” Madelyn Wills, chair of Community Board 1, drew the opposite conclusion: “The air may not be toxic, but the air is not safe. There is a distinction here,” she argued, because, for example, residents of Lower Manhattan were experiencing marked increases in rates of asthma.44

Government officials had initially concentrated on the lack of danger from exposure at ground zero, but their argument shifted in November and December as they began to distinguish between the short-term and long-term health effects of breathing the air and absorbing toxins. Though the immediate effects of exposure were obvious — increased congestion, tearing eyes, and headaches — they were, officials insisted, also temporary, and the long-term impact was negligible. Only those with existing respiratory problems or asthma need worry about any serious damage to their health, if the contact was brief.45 The scientific community was doing what it could to document the possible dangers long recognized by environmental and occupational physicians, and, by and large, its findings were at worst troubling and at best mildly reassuring. But since only a few air samples showed elevated levels of known toxins such as asbestos and lead, many public officials pronounced the environment around the WTC site acceptable.

The Need for New Methods of Evaluating Environmental Hazards

Some scientists began to suggest that a new framework was needed to understand the health effects of this disaster. First, Stephen Levin, medical director of the Mt. Sinai–Irving J. Selikoff Center for Occupational and Environmental Medicine, claimed that the older techniques for evaluating danger might not suffice for this new situation. Second, he argued that the residents’ complaints could not be easily dismissed, regardless of the tests’ results. Coughs, nosebleeds, and respiratory ailments were being triggered by the dust and debris in the air. He declared, “This wasn’t about breathing dust” — that is, tiny particles. “It was breathing chunks of material.” Standards had been developed for specific chemicals
but few if any existed for measuring the impact of the variety and interactions of chemical materials released in the burning and collapse of a hundred-story building. One industrial hygienist complained that scientists were “not looking at the incredible number of plasticizers, fire retardants, fillers. You have 210 floors of carpets, wallboard, furniture and computers burning. We have no idea what this will do.”

Thirty thousand gallons of transformer fluids containing PCBs, 180,000 gallons of fuel, hundreds of thousands of fluorescent bulbs each containing small amounts of mercury, and millions of pounds of other toxins introduced a level of uncertainty that the scientific apparatus for measuring lead and asbestos could not even begin to evaluate. One reporter for the London Guardian likened the effect to that of “a major explosion in a giant chemical works,” with “thousands of tons of pulverized asbestos and heavy metals . . . leaving an estimated 2m[illion] cubic meters of dust covering [16 acres].”

A major problem was the inadequacy of the scientific tools traditionally used to gauge danger. Threshold limits for dangerous substances were established for industrial workers, assumed to be exposed for eight hours a day. “The permissible levels for asbestos, for example,” says Ekaterina Malievskaia of Queens College’s Center for the Biology of Natural Systems, “are based on linear extrapolation from effects resulting from heavy occupational exposure in the past. These risk estimates are highly uncertain.” And even those estimates were generally understood to be guidelines rather than hard-and-fast standards. “There are essentially no conclusive prospective human studies on the safe levels of [environmental] exposure,” she continues.

Unions, tenant groups, contractors, and New York political leaders hired independent scientists and physicians — many of whom had served in the past as consultants to the EPA — whose tests revealed much higher levels of toxins than the official results. One newspaper described their approach: “Taking hundreds of samples, many inside apartments, offices, and condos, these experts used the newest electron microscope technology and fiber-counting protocols” and found levels of asbestos comparable to those at the Superfund site of Libby, Montana. One EPA scientist said, “It is unfathomable to believe that EPA can stand behind antiquated science when the report on Libby, issued by the same agency, irrefutably documents the validity of the new methods.” While the Department of Health told residents that “asbestos-related lung disease results only from intense asbestos exposure experienced over a period of many years, primarily as a consequence of occupational exposures,” EPA and CDC experts acknowledged a different reality. Their research had
shown that “a ‘single burst, heavy dose’ of asbestos could be enough to cause lethal disease.”

Steven Markowitz of Queens College’s Center for the Biology of Natural Systems lamented, “What’s most striking to me [is] that I can’t begin to answer [basic] questions. . . . For all the thousands of air quality samples, here we are eight months out and there’s such limited health data.” The problem arose in large part, as the New York Times reported, because many substances created in the WTC disaster “had never been seen in nature or in the laboratory. Metals and glass from windows and computers and girders were turned into mist by the intense heat and pressure of the collapse, and those mist particles then bonded with larger pieces of concrete, creating billions of tiny hybrid fragments, each coated with a sheath created from the elements of destruction. Asbestos was pulverized into pieces so tiny that ordinary tests devised to track the fibers missed them.”

By early February 2002, according to the Times, about three-quarters of the 20,000-odd people who lived within half a mile of the site had returned to their homes. Yet local and federal agencies had done little testing of the air quality within the apartments, and even those tests had not been made available to the residents or the public. At congressional hearings held by Jerrold Nadler in February, the agencies found themselves under intense pressure and scrutiny as their assurances of safety and efficiency were rejected. The day following the hearings, the State Department of Environmental Protection (DEP) sent out notices to landlords to “clean up the public areas of their buildings.” But they did not require landlords to clean up apartments or ventilation systems. Also, the state allowed landlords to “self-certify” their own work. At a subsequent hearing, Nadler reports, the DEP head argued that “the insides of the buildings had been cleaned” and, according to Nadler, “the entire room, four hundred people, erupted in laughter.”

“There was no government database, no handy list of indoor air monitors to pull down from a website” that would tell returning residents whether or not their apartments were safe. The Natural Resources Defense Council reported that “because no one government agency was in charge of the overall environmental impact . . . issues of residential indoor air quality fell between the cracks, and because of the emphasis on long-term risks, the impact on susceptible populations was not emphasized enough.” The cleanup inside the buildings was left “to building owners and managers — some of whom might have had an interest in minimizing the risk, or have limited resources to clean what they find.”
Largely neglected in the months following the event was the inspection and decontamination of office buildings and apartments in the area. Finally, in May 2002, the EPA accepted responsibility for inspecting homes below Canal Street, but by then this response was deemed inadequate by Nadler’s office and residents in the area, as well as others outside it. Trust had dissolved, as Nadler explains, and suspicions about the limited scope of the EPA’s efforts abounded. Nadler himself attacked the EPA for ignoring residents above Canal Street and for focusing only on asbestos, not other materials, in its testing and remediation. “The agencies have [sought to leave] the impression in the public’s mind that it’s safer than it really is,” claimed Joel Kupferman, director of the New York Environmental Law and Justice Project. “This whole thing about returning to normalcy has gone too far.”

Protecting Undocumented Workers

Great care was taken to protect as fully as possible the workers clearing ground zero, but those hired to clean up private residences and other office buildings in the area were given less consideration. Right after September 11, there was a determined effort to reopen the Stock Exchange as part of the broader policy to return Lower Manhattan to “normal” and to stabilize the city’s and the nation’s financial sector—an agenda that often came into conflict with health issues. Ekaterina Malievskaia, a physician who worked with the Latin American Workers’ Project at the scene in the months following the attack, recalls the drive to “open up Wall Street,” noting that “one of the [cleaning companies] told me that in the beginning . . . they employed up to 1,800 day laborers for cleaning purposes. It’s just one corporation. And there were about thirty major cleaning companies involved in efforts to clean up [the buildings] around ground zero.” She describes how the companies recruited their workforce: “They got all these illegal immigrants on every corner [of the city] and they threw them into the buildings and gave them rags and sometimes paper masks and that’s it. They cleaned for twelve, fourteen hours a day without any protection, without knowing what they were exposed to. And Wall Street got opened on time. So it worked out in a sense.”

Not only were the workers hired and thrust into dangerous jobs indiscriminately, but companies actually went out of their way to deny workers adequate protection. Malievskaia relates that some of the workers had earlier received licenses to remove asbestos, since for undocumented
laborers this is one of the few avenues to relatively high-paying jobs. Asbestos removal, she explains, “is a dirty job that Americans don’t want to do, and [trade schools] don’t ask whether you’re legal or illegal.” When these trained workers, who had their own respirators, were cleaning buildings near ground zero, “they were asked not to wear these respirators by the employers so they wouldn’t scare the rest of their co-workers off.” Those who sought to use their own respirators “were not given filters. And if they had a couple of filters [of their own] and kept on reusing them, it [made] things even worse,” because the used filters would become a repository for dangerous materials that the worker ultimately breathed in.

By December 2001, the danger to the day laborers hired by private companies to clean apartments and offices was becoming a public issue. The New York Committee for Occupational Safety and Health joined with the Latin American Workers’ Project and the Center for the Biology of Natural Systems at Queens College to identify and evaluate the health effects of the cleanup effort on the hundreds of nonunion and largely undocumented workers hired to clean buildings. The groups approached the New York Community Trust and the September 11th Fund for money to undertake the study. “It was an incredible turnaround . . . about three weeks” between submission and funding for such a screening project. Initially, according to Malievskaia, the methods of identifying World Trade Center cleanup workers were informal and often haphazard. “In the beginning [the workers] heard the announcement on the radio. But what got the program going was the word of mouth. They told their neighbors, workers. It’s the nature of their job that they shape up on the corners, and while they’re standing in line waiting for jobs they have nothing to talk about other than just describe the program . . . and it was, you know, a great demand.” They had originally hoped to “serve 150 to 200 people,” she recalls, but they ended up seeing more than 400 workers.59

The workers had been put in an insupportable position. As Steven Markowitz, the head of the project, put it, they “were looking down on ground zero, seeing people wearing respirators, and they’re working indoors in a confined space, and they don’t have them.”60 By May, the Queens College Center had uncovered nearly universal respiratory and systemic health problems; symptoms included difficulty in breathing, nasal congestion, coughs, headaches, difficulty in sleeping, and numbness.61 A year later, as noted above, the EPA agreed to take over responsibility for cleaning apartments and other buildings in the area. Even
today, arguments about the possible health effects suffered by workers, students, and local residents exposed to various contaminants from the WTC site continue.

In rushing to normalcy, the government had not waited to gather evidence before reassuring citizens that ground zero and the community around it were safe. Hence, schoolchildren, residents, and workers were put at risk. In August 2003, the EPA Office of Inspector General issued an “evaluation report” that concluded that at the time when the EPA had announced—a week after the attack—”that the air was ‘safe’ to breath, it did not have sufficient data and analyses to make such a blanket statement. At that time, air monitoring data was lacking for several pollutants of concern, including particulate matter and polychlorinated biphenyls (PCBs).” Moreover, the report criticized the White House Council on Environmental Quality for shaping the agency’s recommendations, influencing “the information that EPA communicated to the public through its early press releases when it convinced EPA to add reassuring statements and delete cautionary ones.” Thus, only years later did the EPA admit what critics had insisted at the time: “A definitive answer to whether the air was safe to breath may not be settled for years to come.” Rather than give in to those with whom it collaborates, the “EPA needs to be prepared to assert its opinion and judgment on matters that impact human health and the environment.” Although the report determined that the EPA had not violated any regulations in ceding authority to local authorities, it suggested that the “EPA could have taken a more proactive approach regarding indoor air clean-up.” Despite the repeated demands from local community groups, better and more accurate information was late in coming.62

This acknowledgment of the EPA’s shortcomings stimulated further discussion of the federal government’s actions in the weeks and months following the attack. In August 2004, the Sierra Club issued a comprehensive report—titled “Air Pollution (and Deception) at Ground Zero”—that details how the EPA and other federal agencies “failed to take important actions after the attack to prevent more exposures to contaminants. . . . Independent researchers found a group of toxic pollutants that cause cancer and other genetic effects, while EPA wrongly claimed that it did not detect the presence of these pollutants at all. . . . The federal administration’s reckless disregard for the toxic hazards generated by the attack had disastrous consequences for many people who served on the front line of terror response in Lower Manhattan’s recovery.”63
SOCIAL SERVICES

The Immediate Relief Effort

Much as the experience of 9/11 challenged assumptions about risk and how to measure it, its aftermath presented a tremendous test for the voluntary social service agencies that traditionally have had the responsibility of caring and providing for the city’s dependent and poor. Thousands of large and small agencies, churches, community groups, foundations, and individuals poured time and money into the relief and recovery effort. This vast charitable enterprise, which won wide praise for its inclusiveness and the breadth of services provided, was also notable because it implicitly challenged the existing social service model, which required that strict criteria be established to determine who should receive benefits.

Our analysis of social services is divided into two broad categories: the short-term responses to the crisis and the longer-term impact of 9/11 on how services are organized. In the short term, 9/11 highlighted the sector’s extraordinary ability to mobilize and distribute resources to the immediate victims of the attack and to populations throughout the city whose lives were grievously altered or disrupted. In the long term, certain assumptions that have traditionally dominated the delivery of social and mental health services were seriously challenged.

One major weakness was revealed in the wake of September 11 when the thousands of frail and disabled people who lived below Canal Street and even in the rest of Manhattan found themselves without assistance. In the immediate aftermath of the tragedy, many workers who provided services to the homebound in the downtown area could not get to their clients. “A lot of the home care workers who go into people’s homes don’t live in the ground zero area,” points out Igal Jellinek, executive director of the Council of Senior Centers and Services of New York City. “So there was a blockade, you couldn’t get through. There was no system of photo identification, of how to get in and out.”

Representative Jerrold Nadler recalls that “there were seven hundred senior citizens trapped in Southbridge Houses, just below the Brooklyn Bridge. They couldn’t get food in or their prescriptions in. . . . In fact, all the pharmacies were closed, so they had to arrange for a runner and get one of the pharmacies open. Then they had to get the governor to waive the public health provision that says the pharmacy can’t fill a prescription” without verbal or written instructions from a physician. Patients themselves were the authority
when coming to the pharmacy. Nadler helped set up the Ground Zero Elected Officials Task Force, which assisted in fulfilling these needs for local residents and thereby helped relieve the already overburdened communication system.

Elsewhere in Manhattan, the Meals-on-Wheels program was crippled because, as Jellinek noted, “the trucks that brought in the food were stuck out in Queens, with the bridges and tunnels shut down.”65 The social service agencies had to scramble to find alternatives. For example, food for the Stanley Isaacs Senior Center on the Upper East Side was normally brought in from Queens, but the normal procedure was now impossible. In that case, says Jellinek, “What they did is they went to some of the fanciest restaurants on the East Side, who really came through for them and prepared the meals and helped them deliver” the food to the elderly residents.

As Jellinek explained to a special committee of the U.S. Senate, being cut off from the usual deliveries was not just a nutritional issue but quickly became “an emotional one as well, as isolation, fear, and panic set in, all with terrible consequences for the homebound person.” Thus, while closing down the bridges and tunnels may have been important for safety reasons, “it sent senior services providers without local emergency backup scrambling to cover the necessities that we took for granted before the attack of 9/11.” As a result of that scrambling, the elderly clients had to come to senior centers and other “congregate facilities” because of their need “to be in touch with someone — anyone — to stave off the terror of isolation amid a disaster of such earthshaking proportion.” In the experience of 9/11, Jellinek found five lessons for the social service community, which needed to get “services to the homebound and the disabled”; to ensure that “seniors have adequate food, water, and shelter”; to ensure “adequate transportation” of people, services, medications, and food; to guarantee “360-degree communications with staff, seniors, their families, and emergency organizations”; and to take care to address “the mental health issues that arise for everyone.”66

Interestingly, at times the roles of clients and staff were reversed, as some of the seniors had lived through disasters and wars and were able to put the events of September 11 into a larger perspective. Jellinek remembers that “some of the seniors were coping very well” with the emotional anguish that affected most New Yorkers. When he called one center in Jamaica, Queens, he found that “the seniors were comforting the staff.”
Private Aid and Public Needs

Because 9/11 occasioned such an immense relief effort, it highlighted major problems in how to handle the outpouring of giving that ensued. The instant response to September 11 was a flood of assistance by individual agencies that provided money, shelter, food, and social services to the families immediately affected by the disaster. Most of that money went to the American Red Cross, but it also was directed to the Twin Towers Fund (for families of rescuers who died), the Uniformed Firefighters Association’s Widows and Children’s Fund, the New York Times 9/11 Neediest Fund, and dozens of smaller social service agencies. The effort on behalf of the smaller agencies was soon coordinated by the September 11th Fund, an organization started by the New York Community Trust and United Way of New York City. As of March 1, 2002, the fund had made 181 grants totaling $205 million to dozens of social service agencies.

Because so many organizations were collecting huge sums of money, politicians and the media were concerned that all the funds might not be used to directly aid the victims of September 11. The largest relief organization, American Red Cross, came in for harsh criticism when it announced, and later retracted, a policy “not to immediately distribute all of the hundreds of millions of dollars it raised as part of its Sept. 11 response.” After accumulating $543 million, the Red Cross had set aside $264 million for its reserves. Further, it had decided to provide only $154 million as direct assistance and put $150 million toward other programs, such as improvements in its system of supplying blood. Its admission that moneys were being socked away for future use came at a time when smaller agencies throughout the city were beginning to complain that their fund-raising was drying up because all the charitable giving was going to September 11 relief, and these actions of the Red Cross were perceived as a gross injustice. New York State Attorney General Eliot Spitzer called the Red Cross’s decision to put aside more than half of the moneys gathered for support of programs not directly linked to September 11 “totally unacceptable,” adding that it “breaks one’s heart to know the funds are there but yet they are not traveling.” A week after Spitzer’s attack, the Red Cross reversed course, announcing it would spend the entire $543 million fund on the victims themselves as it “apologized to the public for its earlier decision to reserve some of the money for other uses.”

Yet the Red Cross had acted in response to what the broader social...
service community saw as the necessity to plan for the long term as well as to respond to immediate crises. This was a perception that personnel had taken away from the experience of Oklahoma City, where domestic terrorism had destroyed the Alfred P. Murrah Federal Building a few years before. Igal Jellinek describes one discussion at a board meeting of the National Association of Nutrition and Aging Services Programs that took place a few weeks after that attack, during which one member from Oklahoma “kept telling us, ‘Don’t spend all your money up front,’ because there’s long-range ramifications and there’s all sorts of issues that are going to come up. In Oklahoma a lot of money was spent early and therefore there wasn’t the money” later to address the long-term mental health and social service needs that began to emerge.

The outpouring of money and effort, haphazard as it might have been, was effective in addressing the immediate needs of most families of those killed at the World Trade Center. But as the Red Cross imbroglio soon made clear, there were different definitions of what constituted “assistance.” Some saw it as the provision of cash and cash substitutes to the families of victims for rent, food, clothing, and other necessities. Others took a much broader view, arguing that a portion of the money should be set aside to support long-term mental health services and to develop the public health infrastructure.

By December 2001, it was becoming apparent that the various agencies’ lack of coherent aims and their inability to set joint priorities were hurting the long-term relief effort. Although the city’s various charities and social service agencies are coordinated at least nominally through the efforts of Jewish, Protestant, and Catholic umbrella organizations as well as the United Way, a new organization was formed—the 9/11 United Services Group (USG), with Robert J. Hurst of Goldman Sachs as its CEO—with the sole purpose of planning and coordinating future activities. Its chief program officer, Jack Krauskopf, notes that it was intended to oversee “the social service agencies that [were] assisting people affected by September 11.” In addition to the Salvation Army and American Red Cross, other organizations forming the backbone of the USG included the Asian American Federation, the Hispanic Federation, Black Agency Executives, United Neighborhood Houses, Safe Horizon, the Mental Health Association, and the Human Services Council. Initially started with a seed grant from the September 11th Fund, Krauskopf explains that the new organization had a mission of working with “social service agencies [to help] them to be more effective in serving people [and] to cooperate better than they otherwise might have.”
Attempts to Coordinate Services

Eliot Spitzer brought together a number of the major charities and asked them to establish a database to track the moneys that were coming in and going out. Two and a half weeks after the attacks, Spitzer criticized Bernadine Healy, president of the American Red Cross, for statements that her agency “would not share information with other agencies on people it had helped, out of concern for their privacy,” and he sought the Red Cross’s “help with [the] proposed database.” The lack of coordination among the agencies and the growing suspicion that supposed privacy concerns veiled resistance to oversight increased pressure on the organization until, at the end of October, the Red Cross reversed its policy and opened up its records to the attorney general. The New York Times applauded the efforts to “create a database of charitable organizations as well as a companion database of victims.”

On December 15 Spitzer joined others in announcing that with the aid of IBM and other large New York firms, a shared database would be created; the 9/11 USG would run it and coordinate services to victims. The USG established a service coordinator network and worked on ways to share information and integrate training for new staff and to improve technology. In particular, it sought to centralize the process of applying for aid to ease the burden on clients who previously were forced to travel from agency to agency to match their needs with a specific agency’s goals. Immediately after 9/11, Krauskopf explains, “each agency operated fairly independently, and while it was great that a lot of services and assistance was given, it wasn’t given as efficiently or certainly as would be ideal for the kinds of clients and the stress that the people were under in those days.”

Private Philanthropy and Long-Term Assistance

The crisis highlighted not only the lack of coordination among the various agencies but also the inadequacy of private philanthropy to cope with the long-term effects of such a massive disaster. According to Jack Krauskopf, the 9/11 USG found “that both the impressive short-term efforts that the agencies had and were making to assist people and the need to respond to longer-term needs for employment assistance, mental health, and other problems were essential.” As a 2002 study noted, the agencies recognized that “even the generous $1.5 billion plus in charitable contributions made in response to September 11 represents only a
small fraction of the federal government’s pledge of tens of billions of dollars in disaster relief. Moreover, the government earmarked hundreds of billions of additional dollars for defense expenditures, internal security measures, and potential economic stimulus provisions to help individuals directly and indirectly affected by the terrorist attacks.”

Yet government money could not make up for the vast economic losses. Krauskopf recognized that there were “a lot of needs that aren’t being met . . . particularly the economic needs. . . . The number of people that are unemployed or underemployed is well beyond the resources to serve them. And part of that is because there hasn’t been much of a government response to economic needs as there should be.” The voluntary agencies provided cash assistance and direct services right after September 11. But “that had to come to an end at some point . . . and the gap has not been picked up by unemployment insurance and FEMA assistance and some of the other forms of government aid that should be there.”

The huge amounts of moneys that were pouring in and the nature of the 9/11 tragedy forced a public discussion about who should receive the cash and services that were being provided, the families of victims alone or the broader community of New Yorkers, rich and poor alike, who had been traumatized by the attack — workers at the scene, members of the hastily gathered cleanup crews, children in the schools closest to the WTC, appalled witnesses to the explosions, communities in which the victims lived, communities directly and indirectly affected by the economic impact of the closings of small businesses and services, and undocumented workers whose family members sought aid. A Cleveland newspaper noted the far-reaching issues facing the organizations: “Should charities focus primarily on helping direct victims of the attack even if some are wealthy already and likely to get large payments later from government and private sources? Or should they focus on the neediest people, even if they weren’t affected directly by the attacks? Should charities set aside some of the money for future attacks, or should they just assume that Americans will respond as generously if terrorists strike again?”

Even the seemingly obvious method of defining immediate victims — geography — was challenged. By June 2002, it became clear that the needs of Manhattan’s Chinese community, just a few blocks to the north and east of the WTC site, were being neglected. As the New York Times observed, “Families who live in Battery Park City, where the median household income is $125,000, are eligible for grants of $14,500.” But
“in Chinatown, where streets were also blocked and garment factories shut after Sept. 11, household income is only a third of that in Tribeca. Yet families there are eligible for grants that reach a maximum of $7,750. The many Chinese families and others in a smaller zone north of Canal Street are eligible for a maximum grant of $1,750.”

The attempt to provide relief and support was complicated by the attacks’ devastating impact on the economy of Lower Manhattan, and indeed all of New York City. In early 2002 the new mayor, Michael Bloomberg, announced that his proposed budget for the fiscal year 2003 had to address a potential $4 to $5 billion deficit. But as Bloomberg pointed out, the economy had been weakening before 9/11, and the destruction in Lower Manhattan only added to what was already a grim fiscal outlook. From October to December 2001, unemployment in New York City rose by 2.3 percent, almost three times the national increase of 0.8 percent. The WTC disaster was projected to cost the city about $21 billion through June 30, 2002, a figure that did not include the loss of about 115,000 jobs. According to the New York Times, the city lost “nearly 80,000 mainly low-income jobs in the month of October alone.”

Of the 35,500 workers in the twenty-five hardest-hit occupations, 18,000 were in jobs that paid less than $10 an hour; another 10,000 people earned less than $15 an hour, including restaurant workers, janitors and cleaners, maids and housekeepers, sewing machine operators, salesclerks, counter attendants and bartenders, cashiers, and other service workers. Ironically, the loss of jobs and income was felt most severely in Brooklyn, Queens, and the Bronx, not in the neighborhoods closest to the disaster site itself.

Long-Term Problems Exacerbated by 9/11

The effects of 9/11 were made even more severe by the welfare reform of the 1990s. The Personal Responsibility and Work Opportunity Reconciliation Act (or Welfare Reform Act of 1996) fundamentally changed a sixty-year-old program by effectively limiting the time that families with dependent children could remain on welfare rolls. Welfare eligibility was generally capped at five years over a recipient’s lifetime (making October 2001 the termination date for many), and the application process became more onerous for thousands of city residents. By the year 2000, the city’s welfare rolls had been reduced by 50 percent, a reduction that saved the state $1.5 billion.

Mimi Abramovitz, professor of social work and social welfare policy
at Hunter College School of Social Work, sees this welfare “reform” as an abdication of responsibility by the state and city that forced the city’s nonprofit agencies to shift much of “their time and resources away from social services.” She concludes, “As New York City’s Human Resources Administration has reduced the amount and quality of information and guidance provided to welfare recipients, nonprofit agency staff have had to put aside core service responsibilities in order to help clients understand the new entitlements process.” Workers at more than three-quarters of the agencies reported that advocating for their clients was requiring them to devote substantial amounts of their time to talking with public agency representatives by telephone and in person. Workers at food pantries and homeless shelters throughout the city found that their resources were stretched to the limit. Abramovitz notes, “Emergency food providers alone turned away more that 48,000 during 2000. Meanwhile, workers at other agencies are engaged in a continual and often discouraging search for new resources to help an expanding cohort of clients deal with hunger, illness, and homelessness.”

Even before September 11, agencies complained that their “workers are running uphill trying to fix the problems created by welfare reform.” Welfare experts anticipated that large numbers of clients would be pushed off public assistance, and that some inevitably would find their way to the voluntary services provided by various agencies associated with the United Way, United Jewish Appeal, Federation of Protestant Welfare Agencies, and Catholic Social Services. At the same time, according to a 2001 report, a number of philanthropies were already concerned about their ability to soften the economic downturn’s impact, because “the value of their assets had dropped significantly” as the stock market fell. Further, as the recession ate into corporate profits, many companies were “reducing the dollars they could devote to supporting charitable nonprofits” and thereby cutting a major source of support. Because the October deadline coincided with the national recession and the more severe local downturn, local charities expected their caseloads to increase dramatically—particularly since the low-level service jobs that the Welfare Reform Act anticipated would be available to ex-welfare clients were the very jobs most affected by the attack on the World Trade Center.

Igal Jellinek of the Council of Senior Centers and Services notes the complex forces that were unsettling his clients both before and after 9/11. The problems within the city’s Department for the Aging (DFTA) were long-standing. In 1980, 77 percent of its budget was provided by
the federal government. In 2003, Washington provided 17 percent of that department’s budget, now much larger, and New York State provided 6 percent. “The rest is kicked in by the city, and if the city doesn’t have money, this is a system that is at risk.” Adding to the risk was inconsistent support, both financial and administrative, for social service agencies from the city’s DFTA itself. During the Giuliani administration, those in the social service world recognized that the mayor himself appeared to support services for seniors, but that was not enough. As Jellinek puts it, “While the mayor was very supportive of seniors, this support lost some momentum as it worked its way down through the ranks. In other words, money was available, but the voices of seniors and those working with them were not always heard. Today, with the downturn of the economy, budget cuts mean that tough decisions have to be made, and the elderly are not always seen as a priority.”

The social welfare community was in crisis not simply because clients lacked income but because they needed housing, food, and health services as well. Most low-income workers had no savings, and those who lost their jobs soon found themselves unable to pay their rent. As the city as a whole had gentrified in the 1990s, the stock of affordable housing available in the outer boroughs, where many of these workers lived, dropped sharply. The welfare community had to prepare to offer eviction prevention services, financial planning assistance, community mental health services, and support for the thousands of documented and undocumented immigrants not eligible for city aid. The importance of the last is clear when we consider New York’s demographics: 40 percent of the population is foreign-born, and this percentage is expected to increase in the coming years. Even before the terrorist attacks, the recession had begun to affect the ability of residents in poor communities to volunteer at local food pantries and shelters. Further, a nonpartisan coalition observed, “food banks have experienced significant drops in corporate food contributions since midsummer [2001], when the first impacts of an economic slowdown were being felt—and at the same time they are experiencing a rapid increase in demand for food supplies.”

The impact of the WTC disaster on smaller social service agencies, coming in the midst of a broader crisis caused by the recession and welfare reform, was therefore severe. From soup kitchens to neighborhood clinics, they had few resources and found it difficult to survive, much less expand their services, in the wake of 9/11; larger organizations, in contrast, which had significant cash reserves as well as a broader donor base, often found that their income from various sources remained virtually unaffected but
that their priorities had changed. Twenty-five percent of agencies surveyed in one study refocused their efforts on a larger number of outreach programs dedicated to religious tolerance as well as on mental health services and projects addressing the threat of bioterrorism.90

The WTC Disaster and the Outer Boroughs

Little of the outpouring of donations for social services and social welfare reached the outer boroughs. At St. Ann’s Church in the Mott Haven section of the Bronx, for example, Mother Martha Overall saw her church’s food pantry overwhelmed as the numbers of those seeking assistance increased by 30 to 40 percent in October and November 2001. But “outside help was shrinking.” She noted that “the charitable donations [following 9/11] went Downtown instead of Uptown.”91 An editorial in the New York Times pointed out that “Food for Survival, the city’s largest supplier of emergency food, estimated that more than a million New Yorkers were relying on soup kitchens, food pantries, and shelters to avoid going hungry.” Although the true extent of dependence on these charity services is difficult to estimate, the New York City Coalition against Hunger also reported a dramatic upsurge in demand.92

The city’s short-term response to the crisis—providing emergency shelter and support for the families of WTC disaster victims—drew praise as generous and efficient. But one food service provider asked, “Why can’t that happen in other times in dealing with poverty?”93 In October, a business reporter observed the “tremendous concern, verging on panic, among nonprofits not directly related to emergency relief efforts. Most operate with few reserves and uncertain cash-flows. They face an economy that was deteriorating before the attacks and is declining rapidly since; a huge drop in the portfolio values of individuals and foundations, reducing their ability to give; cuts in city and state funding as governments struggle to keep budgets balanced; and the possibility that donors will feel ‘tapped out’ by giving to disaster relief.”94

The impact of September 11 on the city’s charities has been far-reaching, in ways both concrete and conceptual. The pressures placed on the various agencies led to significant upheavals in the administrative structure of the system as well as a growing theoretical debate about the basis for providing services to individuals and groups. Throughout American history, philanthropies and the government have separated the “worthy” from the “unworthy.” Thus, in the Social Security Act of 1935 legislators
distinguished between the elderly, who were in effect automatically entitled to Social Security benefits (Old Age Assistance), and poor single mothers and their children, who had to prove that they needed and deserved assistance. These moral distinctions were carried forward into the Medicare and Medicaid legislation of 1965. But post-9/11, the voluntary sector has begun a vibrant and potentially important discussion of how one distinguishes between individuals and among groups. In a thoughtful paper, Eugene Steuerle (writing for the Urban Institute) has laid out the practical issues that the World Trade Center disaster raised for large and small voluntary organizations alike. Were benefits to be given out on the basis of earning potential, or should a principle of horizontal equity be applied? Should resources be given to the most needy or to all who were affected, irrespective of income? Did charitable agencies have the right to decide who was most deserving? But hopes that the response to the immediate crisis would change the basic assumptions governing who receives care—poor or rich, working or unemployed—were dashed. As soon as the crisis passed, old distinctions between those considered worthy and those not resurfaced, once again determining social policy for the voluntary as well as the public sector.95

**Mental Health**

In the immediate aftermath of the World Trade Center tragedy, the city responded as generously to mental health as to social needs, providing an amazing array of services to people without regard for traditional financial or moral criteria. But the experience with mental health highlights longer-term weaknesses that appear more difficult to overcome than those in the social service sector, and that may have much more profound implications for public policy.

Barbara Aaron of Columbia University’s Mailman School of Public Health immediately became involved in attempts to estimate the dimensions of the mental health problems that the city’s population would face in the coming weeks, months, and years. The overwhelming dimensions of the problems began to emerge as she visited workers at the WTC site. Several months after the attack she went down into the “pit,” now seven stories below ground. She recalls, “It was a little bit wet in spots but it was mostly dry . . . and I saw these football-field-size areas, and there would be a row of men that I realized were firefighters.” They were sitting in chairs.
sort of slumped, in rows, on either side of this long field, if you will, and a front-haul loader would come and scoop up a big pile of dirt and debris from this huge mountain and would back up between the two rows of men and sift it down, creating an incredible amount of dust in the air. And these guys would sort of heave themselves to their feet, and with rakes and picks and shovels they would just pick through it. And after about ten minutes they would stop and they would sort of slump down in their seats and a bulldozer would come and push it away. And the process would repeat itself endlessly all day.

Aaron describes the physical effects of being in the pit for just a few hours: “My eyes were infected for two weeks after that one day, and I [developed] a really terrible cough. . . . So this [was one of] the cleanest, probably most pristine moments down there, and it was awful. It was loud, it was unpleasant, it smelled bad.”

However stressful the physical environment, the emotional strain on the people working in the pit was in some ways worse. Aaron calls it “a grim place, and it was just like the people there were serving some kind of sentence or some kind of penance . . . and this wasn’t like a big traumatic moment. But it was very, very grim.” When, at a morning meeting at the trailer on-site, she described the services project in which Columbia was engaged, she found that the workers were generally receptive: “They don’t say that much, they stare and they nod, and some of them, you know, you see emotion in their faces, and then afterward, they all expressed regret to the guy I was with that they hadn’t said more. But they were afraid to say it in front of each other. But people come up and put their arm around you — firefighters come up and say, ‘We’re OK, but the workers, the workers don’t have the support we have. And they do everything we did.’ This was a classic response — ‘I’m fine, but that guy . . .’”

**The Growing Debate about Long-Term Services**

Even as a remarkable array of short-term services were being provided by a variety of agencies, institutions, and professional groups, mental health professionals recognized that a substantial proportion of those directly and indirectly affected by the attack would need ongoing and long-term care. In August 2002 the September 11th Fund announced that the provision of mental health services, unlike most social services, would substantively change toward more inclusiveness rather than being primarily needs-based. This shift hints at a series of broader consequences that the response to the crisis may have for health policies at the state and federal levels.
In the days and weeks following September 11 the various health agencies, hospitals, and medical and public health schools established a mental health network to counsel those directly affected. According to a press release from the New York City Department of Mental Health, “Within 24 hours of the World Trade Center collapse, DMH informed the media that its mental health counseling and referral information line—LIFENET—was up and running in English, Spanish, and Asian languages.” Staff members were sent to the mayor’s Family Assistance Center at Pier 94 and to the morgue.

Throughout the city, different agencies established counseling centers, opening their doors to anyone who came in. Health professionals flooded Lower Manhattan—sometimes to the consternation of officials at ground zero, many of whom told volunteer therapists to go elsewhere. One therapist recalls going to tables set up near the site to organize volunteer professionals; desperately wishing to do something useful, she demanded that she be allowed to “help,” even though the people staffing the tables were obviously swamped with offers of aid from scores of other therapists driven by the same impulse. Within two weeks of the event, the New York City DMH had established its own network, offering services at Pier 94, at ground zero, in the Emergency Operations Center at Pier 92, via mental health hotlines, and through 230 community-based mental health agencies throughout the city. The department estimated that it was running 988 programs aimed at providing emergency mental health services for those dealing with “feelings of grief, confusion, and anger” in the weeks after the disaster. The Greater New York Hospital Association’s member hospitals, including NYU Downtown Hospital, St. Vincent’s, Cabrini, Beth Israel, Mt. Sinai, New York–Presbyterian, St. Luke’s–Roosevelt, and many others, along with the city’s public institutions, launched a wide variety of outpatient emergency services.

Counseling, of course, was a major component of the services offered. St. Vincent’s Family Resource Center saw an estimated 6,000 people in the twenty-four hours following the attack. Several hundred families arrived at Cabrini seeking relatives and friends lost in the attack and were provided counseling as well. Beth Israel sent staff to ground zero to provide grief counseling to workers at the site. According to an official of the Greater New York Hospital Association, Mt. Sinai operated a twenty-four-hour hotline for two weeks, using eight phone lines to offer telephone counseling to community residents “too frightened to leave their homes.” New York–Presbyterian Hospital helped a variety of
companies and organizations to provide onsite group counseling and follow-up counseling to their employees.\textsuperscript{99} Though the DMH’s LIFENET played an essential role in the weeks immediately following the attack, it was primarily a referral system and could not guarantee the quality or appropriateness of the care received.

Despite the outpouring of immediate assistance from individuals, private organizations, and public agencies, it soon became clear that planning was needed beyond the short term. Neal Cohen, a psychiatrist and New York City’s commissioner of health at the time, announced just a week after the attack that it was “now time to turn to tackling the longer-term impact of this tragedy.” For workers engaged in cleanup and recovery, ongoing mental health services had to be provided at ground zero as well as at other sites. Further, some mechanism for coordinating the vast range of agencies and services in the city was essential. Cohen sought to convene planning meetings with the federal Substance Abuse and Mental Health Services Administration, the New York State Office of Mental Health, the United Way, the Coalition of Voluntary Mental Health Agencies, and the Greater New York Hospital Association, among others. The DMH promised to help train mental health professionals, with a special focus on the effect of the WTC event on children.\textsuperscript{100} “Project Liberty,” the federal and state emergency program set up to fund emergency services and counseling at workplaces, schools, and homes in the metropolitan region, provided $22.7 million, with $14 million reserved for New York City itself.\textsuperscript{101}

But as administrators and researchers alike focused on this planning, fundamental problems emerged almost immediately. It was obvious that offering even minimal short-term care was an enormous undertaking, given the area’s large population and the lack of definition regarding what constituted an emergency or acute problem. An attempt to provide long-term counseling would magnify the required effort almost beyond comprehension. Some estimated that up to 10 percent of the city’s population would suffer from symptoms of post-traumatic stress disorder.\textsuperscript{102}

Barbara Aaron observes that the people working in cleanup and recovery “were facing trauma of their own in that they were doing recovery of body parts for a very, very long time in a toxic environment. A very grim job, a very dangerous job.” Unlike police and firefighters, she points out, the other workers “had no preparation, no service or support network, and they were having big problems. . . . They were disconnecting from their families, because most of these people would protect their spouses and children from the experiences they had. So effectively, they
kind of sealed themselves away from their families. They weren’t able to provide the support or get the support. So marriages fell apart, children were in trouble, and these people moved into a different reality—they approached their job with mission and zeal.” During the task itself, special ties held these workers together, but “with the ending of that experience . . . suddenly, without a whole lot of [preparation] it was over. You see the divorces, the suicides, the people who don’t have jobs, they’re in big trouble.”

As late as June 2002, Jack Krauskopf of the 9/11 USG was concerned that although there was a system “for crisis counseling and short-term mental health assistance,” it was “not clear if there is enough support for the long-term counseling and treatment needs that people who have been severely affected emotionally have.” Studies estimated that up to 10 percent of New York City’s 1.1 million public school students required some sort of immediate or long-term care. Aaron praised Christina Hoven, an assistant professor in the Department of Epidemiology at Columbia University’s Mailman School of Public Health, for “design[ing] this unprecedented, amazing study that the Board of Education conducted on 8,300 schoolchildren across the city looking at a very broad spectrum of disorders as outcomes.”

Even before the disaster, professionals had noted “a huge, unmet mental health need in the city schools throughout the New York City area.”103 But because the schools lacked sufficient money and trained staff, not even minimal counseling of students was feasible. The economic crisis overtaking the city pitted children’s mental health against the need to cut spending; reductions in school budgets were already under way before September 11. Schools that sought to develop art therapy projects for traumatized children found that their art programs had been eviscerated and their staff dispersed because of cutbacks.104

More generally, the massive number of individuals affected and their great needs—both for short-term therapy and, in some cases, for treatment of post-traumatic stress disorder—humbled the professional world. One major problem was the limitations of public and private insurance in dealing with mental health; this failure to effectively cover services made any realistic planning for long-term psychotherapy almost impossible without a huge influx of federal and state moneys. The existing system for the delivery of extended-care services was under enormous strain. “Mental health services were already stretched to capacity before the WTC disaster,” argued Patricia O’Brien, associate vice president of the Greater New York Hospital Association. “Patients were already
waiting in inpatient settings because appropriate alternative levels of services were not available. . . . The development of outpatient services has been repeatedly thwarted by the state’s refusal to approve new services if they will expand Medicaid costs.” Even those with insurance could not expect to be completely covered for psychotherapy. She worried that “treatment for mental illnesses related to the disaster will be limited in some cases by restrictions on mental health insurance benefits.”

Ezra Susser, chair of the Department of Epidemiology at the Mailman School of Public Health, stresses another failing: “Thinking of it from a systems point of view, what characterized it more than anything else was fragmentation and to some degree inertia. They really weren’t able to bring together the different service systems in the city, nor the research facilities. There was a lack of leadership, I would have to say.” Susser believes that the New York State Office of Mental Health, “while . . . slow to respond, they did respond . . . they did try to introduce some coordination to the process. But they are not the main player here in the city. And the Department of Health was never able to exert leadership on the mental health side.”

By August 2002, the September 11th Fund had established policies for financing mental health services that enabled all those directly affected by the 9/11 tragedy and their families to receive long-term coverage.

Exemplifying the myriad problems encountered by those trying to coordinate services are the persistent roadblocks to gathering basic epidemiological information about the scope and degree of mental health problems affecting workers, schoolchildren, and residents in the immediate neighborhood of the World Trade Center and in the city as a whole. Susser sees the process of conducting research as “characterized by fragmentation and rivalry. There’s no means for communication among the different people doing research. Not even IRBs [institutional review boards] communicate. There must be three hundred studies at least going on in the city now in mental health and research and nobody can even list them for you. They often approach the same people. It’s just complete chaos.” And yet, he acknowledges, “there have been some great studies done.”

The long-term effect of the crisis on the provision of social services is still uncertain, but two somewhat contradictory tendencies have surfaced. On the one hand, traditional distinctions between the “worthy” and “unworthy,” the “truly needy” and those “not truly in need,” that have governed the distribution of welfare and charity services by government and social service agencies alike for the past two centuries were sus-
pend—though only in the short term, reemerging as the immediate crisis passed. On the other hand, the crisis has forced the social service community to confront whether making such traditional distinctions between groups of needy or dependent people will hamper planning for future emergencies.

The Need to Protect the Public Health Infrastructure

The emerging focus on bioterrorism in public health has had the unexpected effect of reinvigorating the drive to support and strengthen the public health infrastructure in New York City and throughout the nation. Some have argued that only by buttressing their basic functions will health-related agencies be able to deal effectively with the special cases of chemical warfare, bioterrorism, or even destruction on a scale as massive as that of the World Trade Center. Andrew Goodman, New York City’s associate commissioner of community health works, suggests that the efforts behind a city’s health are rarely in the forefront of people’s consciousness: “Every day we drink the water and assume it’s safe. What people don’t realize is there’s an ongoing activity to ensure that that happens.” It is only during a moment of crisis like the anthrax episode “that people appreciate the need for ongoing surveillance and ongoing capability around some very basic functions.”

Benjamin Mojica, former deputy commissioner of health and director of the division of health, sums it up this way: Emergencies are the kinds of events that

we in public health do not generally think of as something we have to deal with. . . . We have to rethink our mission, and find out exactly where we fit [into] all of these emergencies. We have not really thought of ourselves as responders to anything like this before, because we thought that was the Department of Environmental Protection, that’s environmental conservation, that’s transportation, that’s law enforcement. But there’s always some public health impact with this kind of disaster. There is post-traumatic stress syndrome. . . . We need to look at these things and see what kinds of ramifications they may have in the health of the public.

Although health department officials were assured in the midst of the crisis that resources would be made available for planning, there is now a real fear that the city’s and state’s budget crises will undercut the health infrastructure. Despite new moneys available from the federal government, units of the Department of Health were instructed to trim their budgets, and a hiring freeze was put into effect in 2002. The administra-
tors of all divisions were informed that they will be able to replace only one of every two workers. There seemed to be little immediate affect on services; for example, Lucindy Williams has seen a slight reduction in the clinics’ budget of the STD clinics she manages but no substantial impact on their ability to serve their clients. Nevertheless, it is not clear which force will prevail: the new awareness of the breadth of health services needed, which would logically lead to an expansion in the purview of the Department of Health or other agencies of local government, or the imperative to cut budgets in the face of local and state money woes.

**The Need for City-State Coordination**

Cooperation between the city and the state in response to the WTC disaster was extensive, but observers noted that in the immediate aftermath of the attack there was “intermittent confusion as to which state or local agency was ‘in charge’ on any given issue.” In contemplating changes in the legal structure for future public health emergencies, Wilfredo Lopez, general counsel of New York City’s Department of Health, acknowledged that in New York both the mayor and the governor have the power to declare a state of emergency. He feared that new legislation would strengthen the state’s powers at the expense of the city’s and urged that “the fundamental structure of New York’s existing law, which mandates to local government a primary role in emergency response, should not be altered.” Indeed, in his view the ability of the city’s health department to respond to health dangers quickly and efficiently is a strength of existing law: “The health officer needs to be able to act without waiting for a situation to be recognized as terrorism or to escalate to an emergency.”

Yet this struggle for power between city and state is occurring in the larger context of the past half century’s emphasis on individualism, local control, and dependence on the private sector, which has led to a disintegration of the sense of community — and that, in turn, has undercut public health-related activities and authority. The crisis highlighted the delicate balancing act of the health agencies. On the one hand, many of them, including the Department of Health and private social welfare agencies, looked for direction to public officials, who tended to unite around a common program of returning the city to a sense of normalcy. On the other hand, the agencies had a responsibility to the public to be as accurate and honest as they could in providing information.
Department of Health was alternately praised and condemned for trying to reconcile these two obligations in the anthrax case. But in monitoring the air in Lower Manhattan, when information was ambiguous and public perception of the potential hazard was not, the city’s health agencies were less successful. Andrew Goodman says that the situation in Lower Manhattan taught the Department of Health “the need that the public has for the public health people to really be there in a very physical, consistent way, to address a lot of concerns.” Similarly, the Board of Education too closely identified itself with the larger political and economic objective of returning Lower Manhattan to normal, thereby incurring the wrath of parents in the schools around the WTC.

Public Trust and Public Health

At the local level, one important theme that emerges from various discussions of the responses to 9/11 and to the anthrax incidents is the contradictory pressure exerted by officials: they urge us to return to a sense of normalcy and routine while at the same time encouraging us to maintain our vigilance and a heightened state of preparedness. In the arena of public health activities, the dual demands for normalcy and vigilance have played out in strange and sometimes conflicting ways. Most concretely and immediately, as the cases of Stuyvesant High School and Lower Manhattan illustrate, our lack of certain knowledge about environmental threats posed by exposure to the chemicals, minerals, and gases created by the explosion and collapse of the towers heightened the suspicions of policy makers, scientists, and the public toward one another. At a time when government, business leaders, and the press were urging a return to everyday activities, the smells and dusts perceptible to every New Yorker served to undermine popular trust in the statements of experts and government officials.

Perhaps the key conclusion that can be reached is that for future population health policy to be effective, those with authority must open up, not shut down, the flow of information to and their communication with the population as a whole. Policy makers and health officials now understand that maintaining public access to trustworthy information is essential. As Susan Blank of the Department of Health points out, one of the lessons she learned is “the importance of communicating with the public regularly . . . the importance of being able to say, ‘We don’t know. We just don’t know. We’re going to have to take it step by step.’ I think that those are some of the major things that are going to be different.”
Social Welfare and Population Health

While the city’s public health department needs to buttress its traditional activities and become more open, the welfare system has found some of its basic assumptions challenged by recent events. It may ultimately find its leadership moving away from age-old principles, particularly the presumed need to distinguish between the “worthy” and “unworthy” before distributing resources to clients.

Despite the increasingly stringent requirements of federal welfare policy and the constriction of resources, local social welfare agencies saw a new and enticing model for delivering resources in the response of the social welfare community to the World Trade Center disaster. Mimi Abramovitz of Hunter College’s School of Social Work describes how New York Times reporter Nina Bernstein responded to the Family Assistance Center at Pier 94, which she visited shortly after the attack: she declared, “It was as if the welfare state had stumbled into paradise.” Bernstein meant, according to Abramovitz, that victims had “every service anyone in that situation needed. No red tape, hardly any questions asked.” It showed Abramovitz that “when we want to we can provide a good service delivery system in a way that would really meet those needs” (as America had during World War II and, earlier, during the flu epidemic of 1918).

Of course, this shift was viewed by many in the social service arena as temporary, made necessary by an emergency. “A greater willingness to help people who are victimized by trauma of this horrible kind” was not accompanied, according to Abramovitz, by a similar commitment to “help people who are victimized by daily traumas of poverty, racism, and violence.” She says, “So it’s disturbing to watch the outpouring of generosity—which was ‘we can take care of everybody,’ and this paradise welfare office, and then underneath it all, afterward, we see the old dichotomies and the old divisions reappearing.” In the end, the aftermath of 9/11 intensified the problems created by federal welfare reform. Getting people “from welfare to work” depends on the existence of low-paying jobs, but such jobs were the first to disappear under the pressure of the recession and the WTC disaster. Abramovitz calls it “a triple whammy. . . . The increased demand from the World Trade Center, the increased demand from the recession, the chaos because of people losing their benefits. . . . That to me is what September 11 . . . was really about. It really intensified all those things together.”

Gail Nayowith, executive director of the Citizens’ Committee for
Children, one of city’s most venerable child welfare advocacy organizations, is especially insightful regarding the impact of 9/11 on welfare services for children. The rhetoric of creating a cohesive, responsive, and inclusive system of welfare services that emerged in the months following the attack is coming up against the historical reality of a very fragmented and disorganized system of separate agencies, each with its own agenda. Further, the resources needed to rebuild and improve the social service infrastructure so that it can serve new clients and meet new demands seem likely to be diverted elsewhere. On the one hand, there is what Nayowith calls the “core thing”—the recovery effort and the rebuilding of Lower Manhattan. On the other hand, there is “the school system and the child care system, child welfare and juvenile justice, and the family court system over here with nothing. It’s like, we have to balance our budget but we’re going to have to rebuild the city. Well, how does that work?”

According to the September 11th Fund, the money coming in to nonprofits was primarily (49 percent) earmarked for distribution directly as cash assistance for clients. As a result, agencies were unable to hire new staff and obtain other essential infrastructure needs despite the new demand on the services. Only 13 percent of the money raised went to fund services provided by community organizations.

Nayowith emphasizes the disjuncture between short-term responses and longer-term needs, which threatens to badly weaken mental health services for children and, more broadly, the mental health system as a whole. “The government responded in a way that was both impressive and alarming,” Nayowith argues. “I think from a crisis perspective, [the government] really stepped up and brought people together and tried to figure it out.” But “to layer a trauma crisis response on top of a pretty creaky infrastructure . . . doesn’t really make for a long-term solution that’s going to be good for kids and families.”

Certainly, one general problem that confronted all agencies and actors after the terrorist attacks was the conflict between the desire of politicians and bureaucracies to calm a terrified population and their obligation to describe honestly and forthrightly what was and was not known. This issue becomes particularly pressing when we consider the enormous uncertainties about what environmental dangers might be associated with possible chemical, biological, or radiological attacks. One clear lesson from 9/11 is that the integrity of the agencies responsible for seeing to the population’s health outweighs the dubious value of reassurances that are flimsy or are contradicted by people’s everyday experience.

The city’s experience in the months following the attack illustrates the
difficulty of establishing responsible policies when we lack scientific knowledge about the potential health hazards of dust, debris, and toxic materials in the neighborhoods and schools near the World Trade Center site. Further, given the immediate threats the disaster posed to the population’s health it is important to note the innovations both in programs and thinking that occurred right after the attacks. Particularly crucial was the swift (though temporary) shedding by (mostly) voluntary agencies in the social service and mental health sectors of long-standing social welfare practice and ideology so that they could deliver services to those in need, irrespective of social class, ability to pay, and judgments of moral worth. It is unfortunate that some of the lessons learned after September 11 were forgotten soon after the crisis had passed.