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I: So you are going to tell me about the community program?

JB: The community program was jointly sponsored by the mental health division and by the university.

I: What year are we talking about?

JB: '77. Started in '73.

I: Are you talking about the program that was a result of the federal legislation or prior to that?

JB: This program was funded by the state. It was actually funded on a special initiative that placed the program up here and funded three residency slots in the university program for people to rotate in Oregon community mental health centers. The current director, the guy who replaced me is, Dave Cutler, and he is probably someone you would want to interview also. We were responsible for training and supervising psychiatric residents in their community rotations. We also had a university rotation at Dammasch State Hospital, which we still have in the North OSH campus. We were also responsible for a portion of the residency training for the residents at Oregon State Hospital. They had a residency program there until some time in the mid to late '80's I think. I am not sure exactly when that program terminated. They transferred some residency slots up here. We expanded our program and the state hospital program went out of business at Oregon State Hospital. That is sort of the background but I was involved very closely with the mental health division. Early on in my time here in addition to these teaching jobs, I was interested in public psychiatry and public mental health. I was also interested in forensic programs. We worked out a consultation contract in which we members of the psychiatry department went down to Salem and spent a day a week down there. I spent many years doing that and worked on all kinds of different things for them from administrative rules to whatever issues they had at the moment. We were really very close to them over this whole period of time and had a very successful relationship between a university program and the state mental health division. We were actually one of the models in the country.

I: I know that there was a lot of training at the state hospital in Salem with this program I believe as well, right?

JB: The state hospital had a free standing residency program. It was their own program until it went out of business. We were involved with them in training their residents on the community rotation they did with us. Some of their residents came up here and did outpatient rotations here. We had seminars down there for them for the residents but that was their own psychiatric training program. At that time there were two in the state, one here and one there.

I: Did you have people come through the university?

JB: Our people were all university residents.

I: In Oregon?

JB: Yes, at this university.

I: What about the ones that were at the state hospital?

JB: They were hired directly by the state hospital so they didn't come through the university. The reason the program ended there were a number of changes in the state hospital, which was pretty typical around the country, and there were at one point in probably the 60's and 70's into the 1980's, a fair number of free standing state hospital programs. They just were not able to be sustained as time went on. The population of patients dropped and legislatures were not as interested in supporting education in state facilities so many of them around the country closed.

I: I didn't understand that distinction before. People would come from around the country and do their residency there?

JB: Yes, it was a small program. They would take physicians who had finished medical school and internship and train them in psychiatry there. People came from Oregon or they came from anywhere in the country and they accepted them in the program just as we do here.

I: You accept people from other states as well?

JB: Yes, in the university program. We have the medical school and we have what is called undergraduate medical education and then postgraduate medical education is residents. Our psychiatry residents, we take eight a year and maybe two will be from here and the rest from around the country.

I: So you train them in community mental health. What kind of training did you give them?

JB: They all spent two days a week for six months working at a community center here. That is still the program. We had money in the budget that allowed them to pretty much go anywhere they wanted in Oregon. If they went to Eastern Oregon they would fly out on Sunday and fly back on Tuesday night. Medford they would do the same thing. Other places they would drive. As long as they went to an Oregon community center they could go to anyone they wanted to go to. They worked on a contract with the center. We had the funding for the program from the state and they would participate in various activities of the center, anything from direct patient care to consultation to helping develop special programs. Then they would spend Friday morning here and we had, and we still have it, a seminar with people from the nursing school, people from our department, people from Portland State University School of Social Work. We had kind of a conjoint seminar and then we had individual supervision where we would meet with them and they would tell us what they did and what the problems were. We would help them understand the system, the dynamics of the center, administration, and budgets. Actually quite a number of the people that graduated from that program have taken part time or full time jobs in community centers in the state, region and country.

I: Is your emphasis on community psychiatry?

JB: The program was designed to emphasize ambulatory public services so yes, community services. The program also was responsible for people who trained at Dammasch. Psychiatric residency is four years of training. In the second year our residents went to Dammasch, now they go to this Oregon State Hospital program in Portland, and they spent four months at Dammasch and four months in this program. They see a different patient population than they would tend to see in these very acute services here. That was part of our program too so it wasn't just community. It was both community and inpatient.

I: You began in the system in 1977. What changes have you seen in psychiatry during that time?

JB: I can give you a little chronology of that. In 1980 to '81 there was a governor's task force appointed to look at the problems of the chronically mentally ill. I served on that task force. The way I have described it to people, we had a recession in 1981 in Oregon and I have described it as the report of the task force when a recession hit on the same day. What happened was the mental health program considerably narrowed from that time forward. Prior to that it was that community programs in this country were moving toward wide ranging service programs for people with all kinds of mental disorders and basically open door policies, kind of walk-in models. One of the problems with those programs was that the problems of the chronically ill tended to get neglected. It was at a time when lots of people were deinstitutionalized out of state hospitals. There were a lot of chronically ill people in the community. That brought up the need to have this task force established. It was sort of a national emphasis to refocus on the chronically ill. What the task force intended, from my point of view, was that the community program and the state hospital program would not loose a lot of what it had before but would add a special component in relation to the chronically ill. What I think happened in actuality was they considerably narrowed the program because of financial reasons and the chronically mentally ill became the main focus of the mental health program in Oregon. They set up a system of priority patients in Categories 1, 2 and 3. We lost a broad-based program at that point. Basically from that point to this point we have had a narrowly defined, pretty well conceptualized, program for chronic illness. I have also described our programs as conceptually very sound but financially not very sound. I think the models have been good but the amount of dollars invested in mental health care has diminished proportionately. We have had a steady progression of that until you hit the Oregon Health Plan. Then we have had another iteration of major change which is kind of faced in one degree or another across the country which is a move toward managed mental health care and privatization. I think that is what we are in now so that we have a very different type of program than we had before which was basically a publicly run, publicly supported program. Now we have a publicly supported program for the most part and more private or private non-profit groups involved at the service level than we have had in the past. That is a big broad sweep of it but I think we went from a conceptually broad based program to a narrower base focused on the chronically mentally ill and we have progressively narrowed that to what we have today. Today we have a very inadequate institutional base and a variable community based program. Again, I think we always had good design and good thinking behind the programs but not great support from the state.

I: I want to get back to that but I want to check something out. It seems in the beginning in the 50's we had a very strong hospital based program.

JB: We had a large hospital based program. We had over 5,000 people in the hospital. Now we probably have of comparable patients, the largest program we have is the forensic program, we have hardly any voluntary patients and we have a very small, relatively speaking, involuntary based, civilly committed population. We have many more designated units, non-hospital and community hospital units around the state and they are very rapid turn over type units. Actually I could give you a paper we just published on that, on the changes in the hospital system.

I: Was that in Psychiatric Services?

JB: Yes.

I: Yes, I read that.

JB: That is what we have moved to. We had the state hospitals. The strategy in the 50's, the community mental health centers act that came in the Kennedy administration, really was put together to kill the state hospitals. They had that as an intent.

I: You think so?

JB: This is from that chapter I am going to give you. This is a 1958 address to the American Psychiatric Association from Harry Solomon, who was the president. This is what he said, "The large mental hospital is antiquated, outmoded, rapidly becoming obsolete. We can build them but we can't staff them and therefore we can't make true hospitals of them. After 114 years of effort in this year 1958, rarely has a state an adequate staff as measured against the minimum standards of our association. These standards represent the compromise between what was thought to be adequate and what was thought had some possibility of being realized. Only 15 states have more than 50% of the total number of physicians needed to staff the public mental hospitals to these standards. I don't see how any reasonable objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. I believe therefore that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion."

I: That is pretty clear isn't it?

JB: Pretty strong. Following this there was a joint commission on mental health and mental illness. They did a report in '61. They basically recommended the establishment of community mental health centers built for certain defined catchment areas around the country. Every catchment area around the country they required states to organize the mental health divisions, to develop catchment area plans. Oregon participated not very much in the federal effort. We only had a few federally funded centers. A pretty successful one in Eastern Oregon, as far as I have heard, I never really knew anything about it firsthand. A failure in Lane County. Then some just at the end of the funding of these things. These things all ended in the Reagan administration. That is when we went to the block grants. In '78 to '79, mental health services around Portland,

a couple in Portland, and Clackamas County got funded right at the end. We didn't participate in that. They were going to build these centers and these centers would provide a full range of services, defined services for these catchment areas. There would be a gradual dying out of the state hospitals because there would be fewer and fewer people entering. Of course, they never were fully built. They started in the Kennedy administration. Johnson put a lot of money into it. Nixon put the brakes on it and started not funding them. Ford didn't do anything. Carter's administration actually refocused on the chronically ill. Then Reagan ended it. We started from a large institutional base in the 50's and we rapidly emptied out the hospitals and more or less to a degree took up the slack in the various communities. Some places have done pretty well with it in this state and it tended to be the small. The larger the place the more disorganized it is. Portland has probably always been at the leading edge of that. Places where the state hospitals had heavy populations of chronically ill, Pendleton and Salem, always had larger problems than places that didn't have the facilities.

I: How has the Oregon Health Plan affected all of this? Lets talk about the quality.

JB: I have been away from it. I have been in this office for six years and I don't feel like I really have firsthand view of the quality. I think the Oregon Health Plan has been a great addition from the health side. On the mental health side I just don't know enough. I know more about the health side now. I am always concerned on the mental health side with all the carve outs and all the various types of ways that people try to make money from these plans. I don't think it would be fair for me to really characterize the quality of it. One of the things in that paper, Psychiatric Services, you have a very large number of components in this system now, public and private. I think one of the points we made is it is very difficult for Barry and company to adequately conduct oversight of all these different places that public patients go to. You know with 2,000 patients at Oregon State Hospital and half the number of staff and you couldn't get accredited or you could get accredited but you had a problem. Now the patients are sort of disbursed in nursing homes, hospitals, non-hospital facilities and community centers, I think the oversight problems would probably be ten times more difficult than they were when you had people congregated. At least it was there and it was very hard to avoid seeing Dammasch State Hospital. It is probably a lot easier now to avoid seeing these small pockets of population. I would just assume it is very hard to do the oversight because I also would assume that nobody is giving them to much money to do it.

I: When you were involved with that, I believe it was funded by NIH, the three or four year plan that was developed in the 80's? Is that what you were talking about for mental health centers for community mental health?

JB: No. The original plans were in the 60's and 70's. I was on the governor's task force in the 80's, which was a state task force. I think it was Governor Atiyeh that focused on re-establishing or asserting programs for the chronically ill.

I: Do you know what precipitated that?

JB: Yes. Again, I said that kind of traces to the Carter administration, kind of refocusing on the problems of the mentally ill. A lot of the criticisms of the community centers that had been

built up until that time and operated generally were criticized for not focusing enough on the chronically ill patients. Large numbers of people now were kind of loose in the community and now very much focused. From the federal level, prior to the governor's task force, there were some changes in Oregon statutes that focused on after care. The task force was an attempt, I think largely successful, to really highlight the needs of chronic patients in the community and develop programs. When the recession hit in 1981 it was at the same legislative session so the task force report and the programs for the chronically ill became the program, the whole program, or a big chunk of the program. Other things fell by the wayside which was the care of the non-chronically mentally ill.

I: I saw in the files that I have been going through that during that time there were severe budget cuts.

JB: Yes, there was a big, big recession in '81.

I: Brought about by what?

JB: Just a plain old recession. The next big recession was brought about by Measure 5 and that was a recession in the public sector.

I: Your emphasis has been on training primarily?

JB: My emphasis was on training and we had a training program. My areas of interest and research are on forensic law and mental health. I was very interested in all of our various laws. I have written a lot on the psychiatric review board.

I: I would like to see some of that if it is available.

JB: Yes. Mary Leverit has it all. We wrote a lot of stuff on the review board, a lot of stuff on civil commitment. It was all very intimately tied up with the division because that is what they do. The division, a big chunk of what it does in a sense is involuntary care. Care of the involuntary patient whether civil or not. We are one of the only states that I know of, probably from the mid '80's on, that did away with voluntary treatment at Dammasch Hospital. We have been very much focused on the involuntary person here.

I: One of the things that seems to be true is that in some ways legislation dictates policy and the kinds of services that are going to be available to people. Would you say that is true?

JB: Every session there are mental health bills. I personally am very interested in that part of the process also. Every two years we have a slug of bills of one kind or another and the bills where they are coming from. The division would have a certain number of bills. Interest groups, which we have an interest group here. The professions, psychiatrists, nurses. The tensions between the different groups. The different scope of stuff. I don't think anything big ever happened here, in my experience, without it coming from the division, without it coming from the state. Whether it came from a task force, and usually it would come from a task force, not

such much from the division per se, but the division was always heavily involved in the task forces.

I: The governor would order the task force?

JB: You could have a task force either from the governor or from the legislature. They might have an interim study group and the division was intimately involved in it. I don't think there were ever any big, big things that happened that didn't involve them. There were plenty of little things that happened each session. There are always little attempts from one side or another on the civil commitment. There is always scope of practice stuff. The psychiatric association and a coalition of associations has been trying to get a mental health insurance bill passed, a parity bill, going nowhere. The big things came from the government. The division was never excluded, they were always pretty active in it. People like me would be part of the division for this kind of stuff.

I: Would the division bring information to the legislature or to the governor? Where would the concern begin so that these task forces were created?

JB: It was usually some build up of pressure from a variety of places. I don't know that the division was the prime mover in getting something started. I would say that they were always well represented in their views, which after all were the views of the executive branch of the government, they were always well represented. I don't know that they were ever big initiators of things. They have had interim study groups also. That is another way of getting things started. For example, I think the big governor's task force came about from people pressure, the beginning of the parent's movement, the colleges together with the psychiatrists and psychologists and professional groups from time to time the Oregon Medical Association, they would be the big initiators for the most part. The division would be right in there pitching as part of it. I think it was a little more grass roots. I would be interested to hear what Barry thinks of that. To me, it was a little more grass roots here. I think that most of us in a public agency here of a certain kind tend to not want it. We did a big thing a couple of years ago. We got reorganized as a public corporation, the Health Sciences University. That is something we initiated. For the most part, we tend to keep our head down in legislative sessions unless it is some thing you can't avoid and start talking too much. I never felt that the process was particularly hostile to the division. I always thought we did pretty well and represented things pretty well.

I: In terms of changes in the mental health system or mental health practices, the division is not the great leader? Is that true?

JB: There were certain major legislative events. They redid the civil commitment system. This governor's task force reset the focus of the division. The Oregon Health Plan which I think the division was a little bit late in jumping on board with it and also had tremendous opposition, both from the community programs and it was very threatening to a lot of people. The big, big changes don't come about that often. Maybe once a decade. Then you are dealing with housecleaning and housekeeping stuff all the time of which they might initiate a change or we might or the psychiatrists might and those are more typical. Big changes in policy just don't. I

have been on a couple of these things and these are huge planning efforts and commitment and time to get the things done, to get stuff written, to get the bills written, it is a huge thing. I don't think people are up to it much more than once a decade.

I: As someone fairly new to this state and just going through the records sort of blind and coming across these, it was hard for me to know if they were meaningful but in fact it sounds like they were very meaningful.

JB: Some weren't. Right now we had a group of people appointed by the attorney general to look at the civil commitment law this last interim. Same kinds of pressure groups starting with the families and this group will have met for two years and I don't think they will have one thing passed because it was a poorly put together group from my point of view and in one way the division wasn't part of it. The division is on the sidelines and not very interested in it. The psychiatrists were on the sidelines and not very interested in it. They constructed a committee that was a committee, as far as I am concerned, from hell in the sense that there were so many competing forces on it that if you came up with one recommendation it would have been a miracle. It was just constructed to have a stalemate and they had a stalemate. There have been other examples of that. People who put a lot of time in and it goes into a blind alley. If they get the right combination which includes the division as a key partner in it then I think stuff happened. This will be an example where I don't think they will get one thing through. If they do it will be a damn surprise to me.

I: I have the impression that the division is under funded. Would you say that is true?

JB: Yes. That is the Oregon model.

I: Why?

JB: Because we have an inadequate tax system. We have a very strange tax system in that we have no sales tax. We have a capped property tax. We have a high income tax and need, I believe, a balanced tax system to try and make the thing work. What we have been doing ever since we have had Measure 5 here has been under funding the public agencies, under funding higher education. Now they are in this tremendous battle over K through 12. Oregonians have defeated a sales tax eight different times. They will never pass a sales tax here. We have an antiquated tax system here. We don't take any advantage of the tourists and we have a lot of tourists. It is completely insane. One time someone was talking about a 3% sales tax in the constitution, which would mean it could only be changed by 75% vote of the people or something like that and the legislature couldn't get its bloody hands on it, and they wouldn't even consider that. If we had a 3 or 4% sales tax we would be doing pretty well.

I: Do you see that it is going to change?

JB: No. I don't think so, not in the immediate future because we don't have everything lined up in a way that it can change. We have a tremendous fight between the governor and the legislature and they aren't going to cooperate to change anything.

I: What about Eastern Oregon and Portland. Is that another issue?

JB: I think that is a pretty typical rural-urban issue and there is a lot of resentment to Portland in the legislature. The governor has talked about the tax structure here and I think he has the brains and skills to do it. To conceptualize it I don't know that in this environment that we are in right now that anything is going to happen. I don't see any immediate changes in the way things operate here whether it is in the division, the medical school or the university.

I: Or in the community services. What have been the major changes in psychiatry since you started?

JB: Psychiatry, like many fields in medicine, has been under fire in a lot of ways. There are a lot of people in mental health fields and the rolls of individuals in various individual provider groups are sometimes blurred. Psychiatry operates in an environment with lots of potential competitors. It is not like cardiac surgery.

I: Or like it used to be?

JB: It hasn't been this way for many years.

I: Forty years?

JB: Probably shorter than that. Probably twenty-five years, twenty years. I think psychiatry initially was extremely altruistic in terms of training and wanting larger roles for people and realizing you couldn't do the whole mental health care business for everybody. What has happened in psychiatry is that the areas that were traditionally part of psychiatry like psychotherapy have been eroded. There is nothing special in many people's minds from psychotherapy or a psychiatrist or a psychologist or a social worker. A major part of psychiatry which was in psychotherapy I think is eventually gradually kind of melting away as something part of psychiatry. Psychiatrists are moving more in the way they operate toward a neurological model. The psychiatrists I think twenty years from now there won't be any difference between psychiatrists and neurologists. We are the same with the American Board of Psychiatry and Neurology. I think we have continued to have a single board. Twenty years from now I think it will be the American Board of Clinical Neuroscience. I think the diseases are different to a degree but in a lot of ways there is not a lot of difference conceptually now between multiple sclerosis and schizophrenia.

I: It is all a disease?

JB: They are all central nervous system diseases involving both behavior and mood and some involve memory. There are similar kinds of diseases. The boundaries that grew up between psychiatry and neurology are melting. I see psychiatry kind of moving more toward a medical specialty and more toward neurology. Neurology in some ways moving toward psychiatry and both of them moving away from the psychotherapies and the kinds of things that characterized psychiatry forty years ago. I think that in time we won't have the kinds of separation that we have had in my practice time.

I: Will psychiatry disappear?

JB: I think that psychiatry, the distinction between psychiatry and neurology, will disappear. Many of the functions that psychiatrists do will be physician functions with brain diseases. That is not going to disappear. Diagnosis and treatment and more and more intervention and maybe gene therapy of brain disorders. It is going to be a very different thing. It is going to go in that direction and psychotherapy and all of the various approaches to problems of living and learning is going to go in a different direction. I think this is a reasonable evolution. I don't think it has a value judgment to it but it is going to be very different. I think what we are seeing in psychiatry now, the psychiatrists are quite functional in the managed care world because they are pretty efficient. They can do a lot of things and they can do it with one person, not two or three people. They have value in the managed care world but it is more toward functioning as a physician than as a psychotherapist or anything like that. I would see that is what has changed and that is a major change from when I started in psychiatry. I spent years learning psychotherapy.

I: Did you think that it was effective in working with the patient population?

JB: It depends on what we know now. I also spent years learning the psychotherapy of psychosis. There certainly are studies showing that problem solving types of psychotherapy are helpful to people with psychosis. Certainly there are many. I think psychotherapy can be quite effective. In combinations of medications and psychotherapy generally prove to be the most effective treatments for example of acute depressions. I think there is a place for psychotherapy but I don't know that it is going to be within per se medicine.

I: It seems like, after you go through medical school, and then especially in psychiatry, to do psychotherapy when I as a social worker was trained to do some kind of psychotherapy, I can probably learn as much about that as you could but wouldn't have all that background and wouldn't need that background, would I?

JB: I don't know. The thing about the psychiatric training model that I experienced was extremely intensive. It was four years. It was many, many patients and all kinds of different psychotherapies. Most intensive training. I think that was probably more meaningful than the fact that I was a psychiatrist in relation to psychotherapy, that I was a physician, the intensity of it. I don't know how to respond to it other than that. I think that people can learn psychotherapy and it is not necessarily dependent upon being a psychiatrist. I agree with you on that.

I: For that narrow part?

JB: For that narrow part. The thing I always liked about the psychiatric training was the intensity of it. I think that there are few other disciplines that have that breadth and length and supervision. That also was very dependent on where your residency was. A more standardized neuro-psychiatry is much easier to achieve than a standardized intensive training in psychotherapy. I actually believe that the physicians, psychiatrists and neurologists would be better off to shed a lot of the psychotherapy image because so much of it is quackery now that it would be better to get away from it.

I: It seems in some ways not time efficient. Medications, overseeing the patients general health, making some recommendations perhaps, but not actually having one to one sessions.

JB: We were willing to sacrifice income for time. People went into psychiatry and part of our problem generally is that people keep wanting to sell their time for more and more and it makes these systems very expensive.

I: I started working in the field probably in the late sixties and the medical model was very prevalent and the psychiatrist was really the leader of the treatment team. Then over time there was some erosion of that and community psychiatry seemed to come into play. Now, I did a lot of work in rehabilitation and the psychiatrists in some way almost became our, I don't want to say enemy, but didn't always work with us because they didn't see the validity of what we were doing. I am thinking about the training I have done with people in state hospitals and something would come together with the treatment plan with all the providers and the psychiatrists would say, no, I don't think that will work, and all that planning would be gone. However, it seems like if people have a good training in community psychiatry then there is more of the team effort that you talked about and that seemed to work but now there is a movement away from that with all the new medications, greater understanding of the brain, it seems like the psychiatrists in some way should pull out and maybe just be a consultant to that group of people.

JB: That is happening in a lot of places. It is hard to know what the right practice models are now in any situation because there is a large emphasis on teamwork and all the medicine. Anything we do with time, use of time and efficiency, I have fears that with a lot of the team efforts you have nobody responsible. It is very diffuse. I have seen some bad situations result from nobody, I am just doing my job which is a segment of this segment of this segment and nobody knows the patient.

I: At least the psychiatrists used to be in charge.

JB: Used to be. But the psychiatrists used to have a responsibility to a patient. Somebody had the final responsibility for the patient. I am not just talking about psychiatry here. This is the way a lot of medical teams work and it is hard. I think that there was a greater quality in medicine, a feeling of responsibility in the past than there is now. I can't conceptualize it very well but part of it has to do with the diffusion of responsibility. I don't know what ultimately medicine is going to look like in twenty years but I am sure it is going to be quite different also. It is easier to be a consultant than have responsibility.

I: I am thinking in my own health care. I have a nurse practitioner here at OHSU and I said, who is my doctor? If you are my nurse practitioner, who is my doctor? I work with a number of different doctors. There is no pinning down.

JB: Your doctor is your nurse practitioner and she is an independent practitioner and that is who you are going to. That is your equivalent of a doctor.

I: Not in my mind.

JB: But that is what you have chosen.

I: That is what I got.

JB: You don't have to get that. You could say you want to see a doctor. Is this a family medicine program?

I: I have talked about it and been discouraged from it but we're not talking about that but it is just an example of I think, who is responsible? If I get very ill and need specialized care, who is responsible? It is that same issue.

JB: I have an internist as my doctor and if I get very ill he is responsible. He has to get me the proper care. You have chosen the equivalent of that. She has to get you the proper specialist.

I: So theoretically she is the person in charge?

JB: Yes. She is.

I: In the community mental health system I would think it would be the case manager who has that responsibility, wouldn't it be?

JB: It is at times hard to figure it out but yes, wherever you go there is a clinical system and if you go to a particular clinic and the case managers all work for a supervisor and the psychiatrists or the nurses are all consultants then that is the clinical line of responsibility, the case manager.

I: I used to do some work in one of the state hospitals in Maine and they had one main psychiatrist. He felt responsible for each patient in the hospital. That was his responsibility. It was the final say. Everything went to him. It is just hard to find that now. I think that is one of the points you were trying to make.

JB: It is hard to find it. It is hard for people to do it. Not very many people would want to do that.

I: It is a lot of responsibility. I am looking at policy funding practice and facilities. We have talked mostly about policy and practice and I think that is probably what we need to talk about. I am not sure facilities and funding. We have talked a little bit about the health plan, about the tax base. That was very helpful. Do you have anything to add that I haven't thought of to ask you that comes to mind in terms of the evolution of policy or practice in the times that you have been in this state?

JB: Not really. I have seen very, very little in your list there in terms of facilities. I can't hardly think of any investment in facilities. That was the same problem we had here. We were a state agency and under higher-ed and they never took depreciation into account. It took us fifteen years to get some new OB services here. Since we are a public corporation we can issue our own bonds and we can get money and do things. Facilities just have been sort of a chronic

problem. With privatization the state is in effect either renting or paying for facilities through contracts. I don't know if we will ever see another state facility. We will see prisons. We will see prisons being built but they don't even want to do that and they probably shouldn't but they have to. The time I have been here there was a need for years and probably still is for some children's facilities and adolescent facilities. We have that old, dumpy place in Salem for kids and adolescents but I can't think of one thing that was ever built.

I: No, not for them. Edgefield Lodge comes into the discussion.

JB: Was that built for them? They built Dammasch.

I: But they built Dammasch for older people didn't they?

JB: They built it as a mental hospital.

I: Right. But for a lot of long term patients, not for kids.

JB: Not for kids, yes. Dammasch is probably the last adult facility they built which is pretty amazing.

I: It reflects the change.

JB: As I said, I don't think we will see them build anything else.

I: What about a return to some kind of state hospital?

JB: I think what we need, and again I am not close enough to say what the scope of it is, is some type of augmentation of the institutional beds that we have now. Again, whether people agree to that I don't know. Whether the state will help build it or if it would be some private enterprise that feels that they can make some sort of a return on an investment. That is what we are into now.

I: The state hospital certainly wasn't constructed to make a profit, was it?

JB: I trained in Boston and one of the famous old ones there, Danvers,

I: Yes, I am from Boston.

JB: was named the Paupers Palace. Do you remember seeing that place?

I: Yes.

JB: I did a research project there.