Barry Kast, MSW

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1994 – Present

Interview - June 10, 1999

I: This is an interview with Barry Kast, June 10, 1999. Barry my first question is what policy changes have you noted?

BK: We're going right to the details.

I: We're going right to it.

BK: In what period?

I: Just give me an overview from 1975 if you would. Can you start back then?

BK: Yes. Actually I was in social work school. I graduated in '75 and the state was implementing what Don Bray called the "turning point" which created the local mental health system and also revised the civil commitment statutes. My first encounter with the public mental health system was training civil commitment investigators and examiners in the mock courtrooms of that Northwest College of Law which is Lewis and Clark College of Law. They were trying to teach people a new standard for mental health evaluations to help the judge decide whether someone met the criteria. It was very well done. I was very impressed with it. They had lawyers and doctors and real people in a mock up of a civil commitment hearing. I had never been to one before. My first encounter with the system was in a moment of really dramatic change when the state was trying to move away from a kind of a institution only environment to one of developing a community of services or rather a system of services in the community for people who had previously gone to state hospitals.

I: In 1975 mental health centers had been in existence because of the community mental health act so what about that?

BK: Are you saying that community mental health centers federally funded or are you talking about…?

I: Yes, federally funded.

BK: The only federally funded program in Oregon, actually there were two in the 70's. One was an Eastern Oregon project based in Pendleton where the state hospital was which actually was the foundation for community mental health in rural Oregon. The other was a small program in Eugene which focused on prevention, as I understand it. But most of the mental health activity in Oregon was state funded. In the 60's when, you've researched this and you know more about this than I do I am sure, they created the mental health division one of the purposes was to begin developing community services. These were not to a great extent services for people who were disabled by mental illness but clinics. They used to call them clinics in those days. I was not in Oregon during the 60's but they were programs that were built up. For example, my first job in mental health was in Benton County. The clinic there started in the mid 60's. It was created in the health department and I remember seeing the 1966 budget for the mental health clinic which was about $45,000 or something like that. There were a couple of psychiatrists who got paid an hourly wage of $12.50 for the hours that they worked. The director at that time who subsequently went to Clackamas, Bob King, had sort of ripped off a couple of

community nurses from the health department to do some work in the community with people who were having mental health crises and so forth. So that was it. It was a little bitty mental health clinic with a couple of social workers, a nurse, and a psychologist who did evaluations. They were based in a couple of old houses across from the courthouse. Life was slow. It was a college town. A sleepy little berg. That kind of thing.

I: So it was hardly a system?

BK: Hardly a system on the one hand. On the other hand the people knew each other and if the school administrator had a problem they knew who to call in the medical community which was much smaller. They had a nice little community hospital which is now a nursing home because they built a big modern medical center. But the little hospital knew that if they had a patient that was unusual or something they could call the mental health department. In some ways it worked quite well and it wasn't expensive.

I: The community touch.

BK: Right, but the other side of the coin is that if somebody was really sick they went to the state hospital in those days. In 1973 when the legislature said we are going to change the way we think about this, we're going to have the community mental health programs in each county and the county is going to be the authority. We are going to start giving the counties money on a matching basis but if they want to take people out of the state hospital they get 100% then you start to see some change in the way people think about the mental health program. More a split between the state's agenda and the local agenda and that starts to play itself out in the 70's. So you asked about the general change and if you begin there by the end of the 70's there were some alternatives to state hospitals. But there was a perception on the part of the state that the state's issues were not being addressed. That is that patients were not getting follow up care in the community and so forth. From the perspective of the counties, the harder they worked they did not reap all the rewards of their work. For example, Medicaid which started in 1965 as a federal matching program. The state began to exploit Medicaid more in the mid 70's encouraging the counties to bill Medicaid. It wasn't required. If the counties billed, the state would keep the state general fund share so for every dollar the counties billed they only kept sixty cents so it was a disincentive. Governor Atiyeh when he came in appointed a governor's task force on mental health headed by a nurse from Marion County who was also a legislator. Her name was Donna Zajong. I haven't heard anything about her in recent years but she had a great potential for leadership. She chaired this and after two years they presented their report to the 1981 legislature. I want to say parenthetically that the report would have had more impact if it hadn't been for the recession. I think the economy just tanked so seriously that there was no money. But what the legislature did do with that report was to end the matching fund relationship because the counties, when the recession hit particularly in Western Oregon counties that were dependent on federal timber revenues, were hard hit and they couldn't come up with the match. The state and legislature had to decide if we were going to insist on match or are we going to have a mental health system. They did away with the match. They also said in effect that if the counties billed Medicaid they would keep all of the money as long as it was spent on mental health. That task force also said that the state should be looking at reducing the state

hospital and reinvesting those dollars in the community programs. So 1981, if 1973 was the turning point, was really when the state got serious and said we are going to do this.

I: As a result of that report?

BK: As a result of that report and as a result, as in education or any other enterprise, if the state pays the whole bill the state is going to decide what gets done and the legislature insisted on that. So the 80's were a time of struggling with the fact that there was ambitious goals and not very much money. The big casualty there was kids mental health. The state had done some significant things in the 70's creating a program at Oregon State Hospital and day treatment programs for kids around the state. Of course the community mental health centers in the counties were built upon child guidance clinics. Then along comes the recession and the mission of helping the state manage the state hospitals and there is no money left over and suddenly kids mental health was almost wiped out in the state. It wasn't revived until 85.

I: What revived it?

BK: The senate human resources committee was heavily lobbied by advocates in the community led by Muriel Goldman who is still around and still advocating for kids. Joe Havil was the council to that committee or the administrator. I have forgotten who the legislators were but we can certainly find out. I was in Benton County at the time. They put a couple million bucks into the budget as the state was recovering, there was some money available, dedicated to kids mental health. The state took that money and put it where the counties were most under funded. It turned out to be Deschutes, Lincoln, Benton and a couple of others got more than an average amount. Everybody got something.

Jim Havel

I: So the 80's the state felt the recession very deeply?

BK: Right.

I: And then?

BK: In addition to the rebuilding of kids mental health the other dominant theme in the 80's was maximizing federal revenue which was available through Medicaid for mental health services. The state started pushing goals to get the counties to put more effort into billing for people who were eligible. In those days, before the health plan, the way you became eligible for Medicaid was if you were receiving some categorical assistance. For example, you weren't eligible based on your income primarily but if your income was low and you got the supplemental insurance program that the federal government paid or that the state paid to people on SSI then the states participation in that made the person eligible for Medicaid. So most of the people who were seriously mentally ill could be made eligible for Medicaid. When Reagan came in, this going a little bit afield, he thought there were too many people on disability whose disability was rehabilitated or something so they slashed the SSI and within a couple of years this was an outrage and it was rebuilt. Howard Goldman did an interesting study of this whole thing published in the Millbank and you can read it if you are interested. It was a deliberate public policy to try to reduce SSI.

I: I remember that so well.

BK: It was horrible. Anyway the counties could bill for them and the state set targets first at fifteen percent of the budget and then twenty-five and into the 80's it was up around thirty-five or forty percent. That was one theme, maximizing federal revenues. Another was the crowding that was occurring in the state hospitals. The big deinstitutionalization, as people call it, had happened between, in Oregon at least, 58 and 78 where the hospital went down by about 75-80% from over 5,000 to about 1,200 patients and the number of admissions went up. The graph of this thing was pretty consistent across the country. Suddenly you had more patients coming into the state hospital and fewer beds to serve them. Then we began to focus our attention on who were the most difficult to place out of the state hospital, what kinds of programs they needed. In 1986 Dammasch was decertified because it didn't meet federal criteria and the state had little incentive to get it certified. Since Dammasch was for adults and adults in state hospitals weren't eligible for Medicaid funding it would cost more to get the hospital re-certified than the federal resources that it would produce so Dammasch was allowed to slide. It became more crowded and at its very worst had a budget for 330 patients and there were over 400 patients in the hospital. You can't explain what happened next without understanding that during the 80's on the development disability side there was a huge federal push. Geraldo Rivera did an expose' on a developmental center on Staten Island called Willow Brook where they actually went in with hidden cameras and exposed the awful conditions. The federal government went after the states on their programs for people with retardation. The feds came in and were attacking Fairview here in Oregon. When Governor Goldschmidt came in he wanted to be sure that we weren't vulnerable in the state hospitals as well as the training center. He set up a commission appointed by the governor to look into the quality of care in the state hospital. That was the first time that had happened since, the Governor's task force by Atiyeh was focused on the financing system, but Governor Hatfield in the late 50's had a group that advised him on the quality of care and improving state hospitals so it had been twenty or twenty five years. I guess more than twenty years, twenty-five, maybe even close to thirty years. I should just say in terms of truth in packaging here that Goldschmidt didn't kind of think this up on his own. We were advising him that he needed to do that and he agreed with us and he appointed this commission. He had several commissions going at once. One was on the cost of health care and how to get more people insured. Interestingly that was staffed by a guy named Mike McCracken who, until recently and may still be the lobbyist for the mental health directors, but it is just an irony of history. He had a couple of other commissions. I think one on juvenile justice or something. He told me later that the governor's commission on psychiatric inpatient services was the best he had seen because they had a plan and it was really a blueprint for change and said exactly what to do. The commission found that the hospitals were in bad shape, they were crowded, their mission wasn't clear and things like that. It was a pretty lengthy report about it. Based on that in the 1989 session, there was some more money put into the budget to do some things to reduce crowding. We started thinking about developing acute care programs in the communities. Targeting the group homes for people who had been living in the state hospitals. Reducing the number of kids who came in on police officer holds and things like that. There is a whole set of recommendations in there and that is pretty much what we spent our time doing on the adult side for the next eight or nine years.

I: Implementing those recommendations?

BK: Right. To expand community care, reduce the dependence on the state institutions and normalize the pathway or the trajectory of a mental health career in the mental health system. I mean career of the patient not the staff. That same session in 1989 is when Kitzhaber, as President of the Senate, got the Oregon Health Plan approved and mental health wasn't in there at first. They created a committee to look into it and in 93 the committee brought forward a recommendation to include mental health in the health plan. The middle 90's were a period of looking at financing again and how mental health could be covered in the mainstream. Let me go back for a moment to 1983 because the legislature passed a law in 1983 that for the first time set minimum coverage levels for people covered by group health insurance for mental health benefits.

I: Private companies?

BK: Yes. This was not Medicaid this was benefit. There is a whole set of statutes, I have forgotten the chapter number, but 752 or 762 or something that talks about what insurance companies have to do to do business in Oregon. This set minimum coverage levels. It did not include, as I recall, self-insured entities and it didn't include HMO's. There were some exemptions in federal law for certain kinds of insurance but for a group policy like the state would buy for state employees or that I might buy on my own, those levels were minimum levels. Minimums became maximums so that became the benefit that the companies would pay. When the Oregon Health Plan came along we had a few years of experience in managing private benefits. The legislature also said that no health clinics publicly funded community mental health centers could not be discriminated against in terms of insurance reimbursement. If somebody was treated in a public clinic they couldn't say well that is a mental health clinic and the state pays for that. The insurance had to treat them like any other vendor. The Oregon Health Plan came along so in addition to community care for the seriously disable person, we were also looking at how Medicaid eligible people could be covered under a better benefit program. That has been a major theme of the 90's, benefits management, thinking differently about Medicaid. This wouldn't have happened save for two phenomena. One is the state pushed federal revenue maximization and Medicaid became a very large source of revenue. The amount of Medicaid paid out was growing at a very rapid rate all across the country and Oregon as well. There was a need to contain costs.

I: From the feds point of view?

BK: From the feds point of view. At the same time, there was an effort within the state to try to get more people insured.

I: Private insurance?

BK: No, covered. This wasn't just here. When Clinton was elected he talked about health reform and so forth. Why are there so many Oregonians who don't have health insurance? About 18-19% of the population. In places like Oregon when you look at that, since Medicare covers the elderly and the poor are covered by Medicaid, we are really talking about young

adults and their families who often don't have much income. They are not insured because they work at marginal jobs where the employer doesn't cover them. They don't have the money to buy insurance on their own. They think it is a decent risk to go bare without health insurance. Of course, when they get sick where do they go for care? They go to the emergency room. They go to the doctor and they don't pay their bills and pretty soon that gets shifted back onto those who do pay, Medicaid, Blue Cross and so forth. The goal across the country was to get everybody covered somehow. It is very hard to do without having some kind of national health insurance program, a single payer, or something like Canada has. Health reform here was partly, if you say we are going to fix Medicaid so instead of having a categorical eligibility like I explained earlier, eligible based on being poor, that makes another 100,000 people immediately eligible for Medicaid. Then we will also have mandatory employer coverage called the employer mandate and we will have a high-risk pool for people who can't get insurance under any circumstances. The state will cover them and set a rate for them. Those three programs were the Oregon Health Plan. The employer mandate ran up against the ARISA exemptions in federal law and the state couldn't do that. We needed an ARISA exemption. ARISA was a 1972 law that came during the Nixon administration. Most people don't know but Nixon had a very good plan for national health coverage and was rejected. Nixon is a highly underrated president.

I: Smart man.

BK: Yes, just had a few little flaws. A little paranoia there that undid him.

I: And sort of unpleasant.

BK: Yes, he could be unpleasant. He probably drank too much or something but he was very popular. He won an overwhelming victory and he still couldn't use it to do what he probably could have done. He started the block grants for example. He did a lot of good stuff. Anyway back to ARISA. It was something that was part of this effort that was national reform in the early 70's. The legislature here wasn't ready to move to the employer mandate and said unless the congress exempts Oregon, it's not going to happen. Then of course congress didn't exempt Oregon because congress had become much more conservative during the 80's and the Reagan years and so forth. So what we have now basically is the high-risk pool and the Medicaid form to which has more recently been added the health insurance subsidy for the working poor. That is people who are above the Medicaid limit but don't get insurance from their employers and get some subsidy from the state and the CIP program which is the Children's Insurance Program which Oregon has said will be done through the Oregon Health Plan. It makes more kids eligible. The mental health division instead of just thinking about certain targeted population started thinking about the whole Medicaid population. I think that pretty much takes us up to the present. We are now in the kind of the post health reform area where we are thinking about where are we going next. Through this whole period we haven't done a whole lot on employment. It has really been a faltering policy and it is probably going to receive attention over the next few years, certainly at the federal level. I think the governor would like to get something through the maze of the legislature.

I: Did you include education in there?

BK: I hadn't included education until you came into our state and I was thinking about it. I hadn't thought about it at all. I thought about it as training as opposed to education. The other big inhibiting factor is housing which has become really, really unaffordable for poor people. This is a major barrier. There you have it. My synopsis.

I: How has practice changed? What we do with people.

BK: Enormous changes. In the mid 70's there was still a model of admission and discharge to programs. It was based on the assumption that with intervention, with treatment or whatever people would move out of the service and back to a nonsupported life. There was a great deal of interest in family therapy. The models for that were coming out of structural family therapy, communications theory, Gregory Batesman and the idea that schizophrenia was caused by some defective communication between mother and child. All of these things seem very passé now but that was very current.

I: And very revolutionary.

BK: Yes, and we were using paradoxical techniques and all kinds of interesting psychotherapies. Along comes a federally supported study out of NIMH about community support. I think it was published in 76 or 77. There had been some work done in Wisconsin where they were trying to move patients out of Mendoza State Hospital. The federal government got interested in the idea that perhaps what was needed wasn't an admission and discharge philosophy but a continuing support. In 1977 Oregon became one of the first states to get a grant to study community support. I was in a day treatment program at the time. We thought of our program in terms of admission and discharge. Very quickly we perceived that what we really needed to do was just define the caseload and manage people at whatever level of support they needed.

I: A revolutionary idea.

BK: It was a revolutionary idea, it really was. It isn't so much how many people you serve but what kinds of outcomes you are getting. Are they staying out of the hospital? Are they living in the community? Are they getting arrested? Are they on assistance? Do they have some source of income? What kind of housing are they in? Very revolutionary. The opportunity was delayed some to really implement those programs by the recession I mentioned earlier. By the late 80's that ethic or philosophy of converting day treatment to community support programs had pretty much happened across the state. There are still, even today, people who are thinking in terms of doing psychotherapy. A lot of people got into this field because they wanted to change agents to cure mental illness. I think by and large people understand mental illness as a chronic disease for many people. In terms of practice the reimbursement law I mentioned earlier wasn't until 1983. In the 70's social workers weren't really getting reimbursed. If you were in private practice you were probably on a fee for service basis from the client. Reimbursement for outpatient services in general was very poor but because the insurance industry thought of ambulatory versus hospital care, hospitalization was reimbursed. So there was a tremendous growth of inpatients in psychiatry in that period. For example, Holiday Park Hospital in Portland, during the 80's, became incorporated into first Interlink and

then Legacy. It became almost completely a psychiatric hospital with a couple hundred beds. The era of managed care which came in following this explosive cost increase in health care, psychiatric beds were one of the first things to get managed better. I don't need to go into the whole history of what happened in health services but very quickly the insurers perceived that there was a lot of inpatient psychiatry being delivered because it was the only form of reimbursement that they were sponsoring so they decided to manage it. They began to bring management techniques. First, prior authorization and utilization review and then later benchmarking the kinds of risk based strategies that are pretty common place now. That was also accompanied by the fact that psychiatrists were joined by social workers, psychologists and licensed counselors as groups that could be reimbursed and were mandated to be reimbursed.

I: In the community?

BK: In the community so there has been during this time a kind of containment of inpatient care or even a shrinking of inpatient care which is now reserved only for the most ill and an explosion in outpatient treatment in the private sector and public sector. Practice has changed quite a bit in the public sector for the chronic illness management side of it we are looking more at supportive methodologies. On the less ill we are looking at managed outpatient with briefer therapies and more use of medication and less use of the hospital. All of that was a very useful background so when the Oregon Health Plan came in there was a kind of technology of managed care and a distinction between chronic disease management and acute care were brief rehabilitation.

I: But there is a third one in there and that is the follow along support. Is that covered in the Oregon Health Plan?

BK: Yes.

I: As what? What is it called?

BK: It isn't called anything. The Oregon Health Plan is based on diagnosis and treatment pairs and the rates for each diagnosis vary with the kinds of technologies that are required to treat it. If you think of this in terms of physical medicine, myocardial infarction is probably one of the diagnoses and that may, in the rates for treatment of myocardial infarction, be everything from cardiac intensive care to coronary bypass graft.

I: To rehabilitation.

BK: To rehabilitation. In terms of psychiatry, two people may have exactly the same kind of symptoms. One goes into the hospital, comes out and on medicine does well on monthly outpatient visits for medication management. Another requires support rehabilitation, assistance with housing and lots of case management. Those are all built into the rates. All those monies get paid out to the managed health care organization that is responsible for mental health. They put the program together and we watch them, advise them and monitor them carefully.

I: So are you an oversight group?

BK: Primarily.

I: In your role you provide leadership and oversight?

BK: And we operate the state hospitals.

I: But all the mental health centers are there as well?

BK: Not under me. The statute is pretty clear. The county and the state are, the common term these days is partner. We have an intergovernmental agreement that allows both of us to fulfill our obligations. The county is the local mental health authority and the state is the mental health authority to assist the counties and fund the programs, set standards and so forth. There is a lot of local discretion which means there is a lot of variation both in terms of program design, practice patterns and quality.

I: So you can't mandate a particular kind of service? Let's say you decide that the PAC program is the very best.

BK: That is correct. We don't mandate services. We don't have a line item that says electro convulsive therapy, which we pay for. I wouldn't want to do that. I think that the more the state tries to tell the practitioner how to treat an illness, the closer we get to a uniform level of mediocrity and lots of mistakes. It is not how the health care system works. Mental health has long done that by putting all the services into institutions. When we went to a community based system we began thinking about integrating mental health into the health care system more fully. There is this tension that has been there all along which is that because the state hospitals did more than just health care, they also provided shelter, nutrition, socialization, care in all of its respects, when you being to integrate the psychiatric or health care parts of care in the community into prepaid health, as we are doing these days, it opens the question of what about housing, what about employment, what about case management, what about legal status to termination and all these other factors. There has been some fragmentation that has taken place. That is the next challenge to try to bring those things together in a way that gets the job done but it is not by the state telling everyone how to treat the patient. The treatment part can be done by the practitioner. It is the state helping merge streams of funding and get an integrated service delivery system or a system of care organized at the local level. Help them do that. That is very hard to do.

I: Would you have the money go to the person who needs the help? How are you approaching it?

BK: I don't know about the money. I think the benefit needs to go to the person. The money can go in a variety of different places. For example, we have managed mental health organizations that have the health care dollars for mental health. They need to work closely, if it is a child, with the juvenile justice system and child welfare system. The money in those systems may be going to other providers or other entities. The art of integration is local; it's not state. We need to hold people to a standard that says if a kid, for example, requires three or four

different kinds of things that the health care provider is obliged to participate. To try and tell them what kind of medicine to use or what kind of treatment to use would be a fairly destructive message. We don't really know the patients.

I: This collaboration or whatever it is going to be called is being directed by the state but occurring at the local level. Is that fair to say where there are directives by the state to do this, that they must do this? Is there funding tied to that?

BK: To the collaboration?

I: Right.

BK: The money for mental health is either going to the mental health organization under the health plan or to the county authority or its designee. There are some places where a private nonprofit is designated by the county. All the mental health money is available at the local level. I think it is more tricky when you start to talk about, for example, employment. Vocational rehabilitation operates the branch offices at the State Department of Human Resources. The employment division is outside the Department of Human Resources. Mental health has limited employment money so it is intriguing to think about how you might think about work in an integrated environment. The Department of Human Resources, since about 1995, has been working on integration. There are a number of experiments going on experimenting with co-location of services, specialized financial arrangements, community based strategies which bring all services together in a common administrative structure. Jackson County is experimenting with that. Not exactly our neighborhood but West Medford, White City and so forth. There are different ways to approach it but that is where we are learning right now. How to reintegrate things that used to be all provided at the state hospital or all done by the public welfare agency or all managed at the poor farm or wherever it happened to be.

I: I read, I don't remember who, said that the systems exist for the state and for the county, not for the patient. What would you say about that?

BK: I would say that to a very great extent, human services in the past generation or two have disempowered people enormously and only in the last ten to fifteen years have we started to talk about consumers, clients, survivors, whatever label we use, controlling the resources that are available to them and directing their own services and supports. It's a pretty ambitious philosophical undertaking but it is odd to me that in a place in this particular society where the market seems to be the model for most of what we do, in this one important domain of human existence, that is, welfare, mental health, disability policy, the market is so completely untapped. When I think of the market, I think of the relationship between a consumer and a marketer or a vendor. A person is buying something; a person is selling something. That nexus is the model of the market. In mental health we have excluded marketplace principles. We have had a very much public welfare model. We have a state hospital. We decided how it was run and who staffed it and who went where right down to which bed people slept in. A lot of those techniques used in the hospitals were involuntary and not much choice there. We started responding to the fact that we wanted consumers to have a better life in the community. We started building group homes. It wasn't until the late 80's that somebody actually asked people in group homes what

they wanted. None of them said they wanted to live in a group home. We started looking at other kinds of housing models, supported apartments for example, independent living. Where else do we say to people, you have a mental illness, you probably want to live in a group of people who are mentally ill. That may be a choice some mentally ill people make but most people want their own place and they want to have a job and make a living and indulge their obsessions like the rest of us do. Whether that is collecting stamps or carousing or whatever it happens to be. But not us, we have said no, we will decide what your interests are and what is at stake. The idea in the market of competition and choice has not been developed well in the mental health marketplace. I think we are starting to see that. There is tremendous resistance because if you are running a welfare system with contract based community care; the people who potentially get hurt by those choices are the providers that we have depended on to care for people. It is a slow process of change. The question you asked is probably the heart of our debate right now. I got an e-mail message from a consumer today actually saying that I never put the consumer first when I talk about who our partners are. Actually I made a conscious choice in a recent speech that I gave to put the consumer last because it is sort of a rhetorical technique of building from the least to the most important. The consumers conceive that as being put at the back of the bus. We are now putting consumers in everything we do. We fund advocacy and technical assistance organization and we don't make any decisions without putting representatives of the consumer community at the table. That is a big step forward but it is not the same as each consumer making those decisions. In the DD system, which has always been a few years ahead of mental health in this respect, we are now implementing something called, "self determined supports" or SDS, not to be confused with Senior Disabled Services. It is unfortunate that the letters are the same. Self directed supports means that instead of contracting with the provider, the agency which has case management responsibility has a pool of resources and the consumer and/or the consumer's family will make some decisions about what kinds of service plans will be used and then the funding will follow the client. We've been talking about the funding following the client for years but we've haven't really made good on it in mental health. I think we are on the verge of that with things like the health plan where consumers can choose which program they enroll in and things like that.

I: Do you have anything else you want to say about the practice?

BK: No.

I: My questions is, what do people do? It sounds like they basically provide social services, that is support services, housing, finance, is there treatment in the community?

BK: Yes.

I: Treatment how?

BK: You were talking about psychoanalytic methods earlier which are, at its worst and most costly form, five days a week. That isn't really done anymore but there is a lot of counseling that goes on. The research is pretty clear that in treating depression or psychosis that medicine is the most effective thing but it is more effective in conjunction with psychotherapy. Psychotherapy meaning helping people manage their feelings, anticipate their needs. We were talking about the

fact that there is psychotherapy happening but it's not psychotherapy a la twenty-five, thirty years ago. I remember in those day's people used to say, well Karen I would like to see you twice a week for the first couple of years and then. That's not the model. The model is a very problem focused model of therapy that uses more cognitive techniques. In fact there are some techniques that weren't available then for intervening with people with personality disorders which were long regarded as intractable. When I was first learning, personality disorders were like an exoskeleton, which couldn't be

I: It was the personality after all that was the problem.

BK: Right, but when we are dealing with behavior there is a complex of thoughts and feelings and action and you can change that complex by changing the way people think or by helping them manage their feelings better or by making better decisions about what to do. Even people with fairly serious personality issues can look better and make better decisions.

I: Who pays for that?

BK: In the case of the Oregon Health Plan, the state and the federal government do. In the case of certain insurance programs, the private sector. For many people they don't have any coverage and it's going to be the public mental health clinic. My wife is a psychotherapist and she has a private practice and she likes brief therapy. You don't have to think about every aspect. It's almost like containing what your goals are and managing better. For example, I go to my doctor and he says, well your cholesterol is up and we're going to treat that and you've got a hangnail and we've got to lance a boil and give you an antibiotic. But he doesn't have to take responsibility for my whole physical. I've got some responsibility there too. It's conceivable that we are entering an era where people go into mental health care and use it the way they use any other kind of health care, as needed, and only to the extent that it is useful in achieving the goals that are appropriate to the problem.

I: If I go into the hospital because I have an acute psychotic episode and I stay five days or ten days or whatever and go out into the community, then I would expect to receive some kind of psychotherapy for as long as I might need it to kind of get myself back to work and back to whatever it is that I am doing.

BK: It would be very different if it were your first hospitalization or your tenth because it depends on how much you know about yourself and how much your physician and your therapist and your case manager know about you. The goal might be to get you back into as normal a life as possible as quickly as possible and back to work.

I: But therapy would be available. If I had more of a chronic condition it would be more social services that would be provided as opposed to counseling?

BK: It depends on how resilient you are and what your needs are. That is also true for medical and surgical procedures. I was an athlete when I was a kid. I'm pretty strong and I've got a good heart and everything. If I ever have a heart attack, my rehabilitation is going to be a lot faster than for people who have had a lot of smoking and no exercise and so forth. Similarly,

if I have an orthopedic procedure, you take one of these football players and they're back on the field in six weeks as opposed to somebody else who is going to need six months of going to a physical therapist and working on their knee or whatever it is, it just depends on the individual person.

I: But you think that is available?

BK: It's not available as it should be but it's there.

I: Theoretically.

BK: Not just theoretically, it's there in practice. In some places it's more available than it was ten years ago. In some places it's less available.

I: By County?

BK: Depending on a lot of factors, most of which have to do with the way in which we financed the system for so many years. It got very lopsided. It's getting harder in Portland and Eugene. It's getting better in Baker City and Medford.

I: Why is that?

BK: In the old days when we were maximizing Medicaid, some places were more aggressive about billing than others so that their budgets were more and more built on Medicaid. When we went to the health plan, the rates were based on the average practice. The rates were set partly on what had been happening but also on what's the right thing to do. Places that were billing more than the average have experienced some shortages. Places that were kind of slow to pick up on this where they weren't generating much Medicaid, saw the Medicaid rates as being for growth. It's been different in each place.

I: The other is facilities and you mentioned that one of the problems with facilities is that there really aren't a lot of places for people to live, right?

BK: Right.

I: What else can you say about facilities? Do you still have group homes?

BK: I don't think of them as facilities. I think of it as housing.

I: But housing has replaced facilities, is that correct?

BK: Housing has replaced institutions in terms of residency. The state hospital was a place to live. There were 5,000 people in the state hospital in 1958. The state population has doubled since then so you can imagine that there may have been 10,000 people off the housing market because they lived in an institution, crowded in a dormitory, eighty patients to a ward or whatever. That's a lot of people.

I: It is a lot of people. What else can you say about facilities? What has changed over the last ten years?

BK: The commission in 1988, looked at the quality of the physical plants at the state hospitals. It was very discouraging because there was so much work that needed to be done. We are sort of piecemeal improving the quality of our institutions. They don't match anything in the private sector. You wouldn't go to a hospital that looked like these hospitals if you were a private patient. Slowly we are making some improvements. There are a few wards at Oregon State Hospital that actually look modern and contemporary. When we have an opportunity we will do that. I've been talking with this current legislative assembly about bringing forward a plan to the next session about how we would do a face lift on the state hospitals and improve the quality of our physical plants, make them more modern, and take care of the deferred problems. Sometimes you look at a building and say it looks nice but if you go in and look at the pipes, it's kind of like somebody with heart disease. The infrastructure is not good. That is the case with Oregon State Hospital. We do have one modern plant up in Portland that we lease from Legacy. It's kind of like the best physical plant we've got and it's up to the standard that would meet the private sector. Eastern Oregon Psyche Center needs improvement but it is sound. We're are going to be able to operate there but the nurses stations are old fashioned, the interior needs a fixing up. In the community we are relying more and more on the kinds of community based housing that we have been able to build with partnerships with banks and housing authorities and counties and all kinds of housing resources. Some of them are pretty nice.

I: Are they group homes or apartments?

BK: All different kinds, duplexes, five bed group homes, and sixteen bed group homes. We have some fifteen unit supported apartments where there is an extra unit for an apartment manager who is also a caseworker in the mental health system. All kinds of places. Hotels that have been converted in a sense to a mental health hotel like the Taft or the Royal Palm.

I: Are those here in Salem or is that in Portland?

BK: The ones I named are in Portland but there are a couple places in Salem. They are all over the state. My favorite is the Pioneer Guest House. Have you been there? It's the old hotel in Enterprise, Oregon, which is an old western town right on the Community Square. It's this large group home for people with mental illness. It is a very, very nice place and one of the backbones of the community. Every year they have a big party for the family members so these people can come visit them. We have all kinds of places you see.

I: What about funding?

BK: I think I mentioned that the state investment in mental health has gone down relative to the total state budget although the budgets have continued to increase. Medicaid has become a dominant portion of the budget.

I: Is it that the federal government is picking up more or is it that we are doing less?

BK: We are doing more. The demand has increased more than the increase in what we're doing so there is a perception that we are falling behind. My metaphor for that is like trying to chase a train that's moving away from you faster. No matter how fast you run you're not going to catch up to it. It doesn't mean we're not doing a good job it's just very hard. This is a messy area and it's hard to do it all. The federal government is picking up a greater share of the bill, no question about that.

I: Why is that?

BK: There are several reasons. As with Mount Everest, it's because it's there. The state has an obligation to balance the budget; the federal government does not. I think the recession changed the way we thought about financing.

I: The recession at the state level?

BK: Yes, in the 80's. We really shifted a great deal of the budget to Medicaid. This is not in itself a bad thing except that some of the services we provide are not Medicaid services and a lot of people still aren't eligible for Medicaid who need help. The amount that's available, that's flexible, that isn't tied to eligibility for Medicaid is fairly limited. It's a very tight market out there. In some ways, in that respect, there's more money but it's like having a lavishly appointed closet. People feel cramped here even though there's lots of money being spent and it's very difficult for people to understand why, with all this spending, there isn't flexibility. I think the reason is because we are so tied to federal funds. The flexibility that the state had was always in the general funds; those are a very small portion of the budget. Let me give you an example of that. We are going to spend in Medicaid, about $350,000,000 or $370,000,000 dollars in the coming biennium. We are going to spend probably in the neighborhood of $20,000,000 on treatment in the flexible general funded area. We've got $350,000,000 for Medicaid eligible and $20,000,000 for everything else and that is not good.

I: Do you see that changing?

BK: I don't think so. One of the ways in which we ramped up community spending in the 80's and 90's has been through closing state hospital wards and we're not going to be closing anymore hospital wards. I don't think there is anyplace to go but to the legislature for more funds. They've rejected the things we've put on the table this time around and the governor didn't put an increase in for community mental health programs. I guess I would have to say I'm not optimistic at this point. It may be that there will be a crisis of some kind and it will lead to more investment but I'm just very cautious right now.

I: Is that because the mental health funding is being rejected because of the emphasis on education and there is money being pulled or allocated for that that might otherwise got to mental health improvements or is it again not that simple?

BK: It's not that simple. If you go to the budget and look at how much general fund is spent on mental health, it's very large.

I: The dollar amount?

BK: Right, but it's matching Medicaid. It's matching the federal money. If you're a budgeteer at the highest levels, and you look over the budget and say, where has the money been going? It's going over there to mental health. From the mental health director's point of view at the community level, they don't have the flexibility, so they say, we need more. The budget people can't understand, we've given you so much more over the past ten years. How come you need more? Right now we have a problem with education. We're going to fund that so be patient. Do you follow me? It's like there are different perspectives on this and both of them are correct.

I: Right.

BK: So we've got funding and we've got practice and facilities, what else is there?

I: I think we've covered it. Do you see the hospitals increasing in size anytime?

BK: Yes, I do. You mean the state hospital?

I: Yes.

BK: We just opened a ward this year. That must have been confusing for people.

I: You have more people who need hospitalization with the greater population, right?

BK: Right, but since 1990 or so we've been closing hospital wards here and not opening them. Suddenly we opened one and for people who are paying attention, that must have been a signal that the trend has changed. I think we will open more wards in the coming years.

I: Who will go there?

BK: As the community care system has increased in its capacity to deal with people's problems, the one population that remains state responsibility and institutionally oriented is the forensic population. These are people who have committed crimes. They are guilty but they're not responsible because of their mental illness in some important way and that is growing. It's growing in two ways. People have been convicted and sent to us and people who are unable to assist in their own trial and their own defense. They come to us for treatment and treat until they are fit to proceed. We have a number of those patients. That is probably the fastest growing area right now.

I: Was that the ward that opened up?

BK: Yes.

I: Do you see the hospital serving some of the mentally ill homeless? Serving more of them in the future?

BK: No. If the legislature said, you've got homeless people, we want to give you some money, would you like to spend it on housing or the hospital, I would put it into housing. Homelessness is not a clinical condition it's something else.

I: That brings us full circle doesn't it.

BK: It does.

I: Do you have anything else you want to add?

BK: I should add some colorful stories like those other guys did.

I: Do you want to?

BK: No, they didn't come up with many. I'm too intellectual or something. I'd like to have at least one story as good as the fat man.