

Don Bray, MD

Administrator, Mental Health Division

1971 -1979

Interview - April 8, 1999

I: This is an interview with Don Bray. It is April 8, 1999. We are going to start and progress through the time, 1962 to 1989. Do you want to start on just describing what was going on when you were a psyche resident in 1962 and you were at Oregon State Hospital?

DB: The hospital in Oregon in its original state, there was a large building that had long term patients in the old building that had been there for years and years and years. Then there was an acute treatment unit across the street, Center Street, where the new patients came but the practice in the past had been after long enough that chronicity was developing that they moved to long term care wards. Those wards were much harder to manage and more difficult. It often was trying to do good medical care there and making sure the medication was proper but there was very little treatment of other kinds going on.

I: In '62 what kinds of medication did you have?

DB: There were psychotropic medications, Thorazine and some of the Phenathizines were here. There were medications and there were ways to manage those problems in those ways. At that time Maxwell Jones was here and that is the reason I came originally because I knew he was on the faculty and teaching at this hospital. They were training the residents, Stanley Schwartz and other sociological and anthropological studies about institutions and particularly the nursing hierarchy and the various ways that things break down. The physician nurse interactions and the problems in the way the hospital structured. The point was to try to do a therapeutic community that engaged everybody in it. I am sure you are familiar with that era, that time. The state hospital went through a period, I felt fortunate to be here when it did because they started by having a pilot unit for what was to become a geographic decentralization of the state hospital. That unit was the Marion-Polk County unit and they picked the two counties that were here close. As a resident on that unit I got to first hand participate in the kinds of group meetings on the wards and decision making that involved the people that the decisions were being made about. Week ends family was encouraged to be here and that kind of thing. It was then, let me tell you one little anecdote because Max, early in my career here Max Jones came and wanted to watch me interview a patient to admit the patient to the hospital. So I did. I had done pretty well at Kansas University and at the clinic and I thought, I can do this, I can really cool this. I went through my usual interview and I thought I had it. Max said, that was pretty good but why don't you come back. Let's go have dinner and come back and then I will show you how to do it right. And he did because he brought in the whole family. He didn't just interview the patient. He got them engaged in things. He got them working through these issues together and that was a real lesson not just with how to manage patients but how to deal with large groups of people. Don't try to do it without everybody there who is involved, who has something to do in this case. That kind of thing was the sort of things that we were learning that the residents were learning. Of course Max had a way of telling the residents; you probably know less about this. Doctors don't know anything about this. What you do is hardly important. The residents would respond differently, some more than others. We had some pretty angry people. One other little anecdote. We lived on the hospital grounds and one day I looked out the window on the hospital grounds and there was Max dressed in overalls with a group of patients out there working on our lawn. He really liked to get into the people's shoes and see how it feels like and what is going on from different vantagepoints.

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I: He sounds like a real humanist.

DB: Yes, he was.

I: He was really the impetus for that change?

DB: I assume so. I think Dean Brooks brought him here and that predates my being here because this was all just beginning to happen. I think the thinking about it had been going on and obviously the powers that be at the state hospital had wanted to move in this direction or they wouldn't have brought Max. Unfortunately before I left, Max got into some difficulties around town here and he left rather abruptly. I think it was my second year. I seriously contemplated going back to Kansas where I came from because I wanted to make sure I got, but then I found Jeff Long, who was one of Max's students and who had been an analyst before, and who had come here in the therapeutic community thing. When I moved in as a unit director in my last year of my residency, Jeff supervised me and just helped me with working with and understanding all the ins and outs that were happening in that unit at the time.

I: That didn't stay forever did it? The idea of the therapeutic community?

DB: No. I don't think in some instances it didn't catch on as well as it did in others. I think some probably adopted it more than others. The unit I had was directing was the Klamath County-Lane County unit. We went full bore, I mean we had also gotten some help from a psychodrama person so I would just bring in the psyche aides to the initial interview and let them be the ones that doubled people in a psychodrama setting. When they walked down the ward with the person who had just been admitted they weren't afraid of them anymore. They didn't have to feel like it was. At first there was some resistance to that but once they realized they would come out of there with real feeling for this human being. It wouldn't be the patient aide dichotomy so much but would be a group of people trying. We did group meetings on the wards and decided most everything we could in those group meetings which took a long time and a lot of kind of strange things happening. It was very useful I think to the process.

I: People were symptomatic weren't they?

DB: Yes. We had people hallucinating and we had all sorts of things going on. It was something new for them. It was good to have them not be so frightened and to be getting engaged. Not all the psychiatrists liked it that well. I had taken rotations as part of our training at the medical school so I had gotten to know them well. The director up there would start rotating his residents through this unit so they could participate in it. I remember one who came who would just refuse. I finally had to say to him, ok just take histories and physicals and prescribe medication and do what it is you do as a psychiatrist. He was very uncomfortable with that.

I: These were the chronic patients?

DB: These were all the patients. We took all the patients. We were trying to keep the whole thing in one place and we had. Everybody from those counties was here and then we got off our

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hind legs and went down to those counties and over to Lane County. Then we invited them to come predischarge and get engaged in the meetings and see what we had done.

I: These are the community?

DB: The community people. So they could see where we were in the process with these people and could begin to understand how this had been managed. Basically, it was trying to make it as democratic a process as possible. There were times when you would. I remember when a patient in one of the wards threw a cup and hit a nurse in the head. I happened to be on the ward. I just lost it for a minute. I walked over to the telephone and I put my hand on it to pick it up to call the security unit and I thought now wait a minute. I stopped and said let's talk about this. The nurse was a little uneasy at first. We all just sat down, talked it through. I don't remember the specific dynamics of it. I do remember the consensus at the end was that the fellow ought to stay on the ward. That it hadn't been something that, including the nurse felt that way. So we didn't react by kicking him out of our family and sending him to the security unit. So the whole therapy community thing was a very exciting time.

I: Did you have children and adolescents on the ward at that time?

DB: No.

I: Just adults?

DB: Yes.

I: Does that pretty much describe your experiences as a psyche resident during that time?

DB: I think so. I think we had rotations in neurology, rotations and we had, but as far as this hospital is concerned, there is a lot more but I am trying to dig up the relevant stuff that is relevant to what began to happen subsequently.

I: Was there a change in funding that resulted from this or that precipitated it? The divisions into the counties.

DB: I wasn't going to the legislature then so I am not sure what happened in that part of it. The hospital I am sure somebody had to because the legislature in this state was very, required a lot of interaction which is not true in other states. I am finding that sometimes the directors of mental health hardly ever go to the legislatures let alone the superintendents of the hospitals. So this was a good place to do this kind of thing.

I: What happened next?

DB: In terms of the program changes, once the hospital's geographic area was centralized the community programs were developing. I was not as involved with them except for the two units that I went to. We were trying to draw people in from those counties to the hospital and vice

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versa so we would go down there and consult with them about what had been happening. We were learning a little bit about what was going on in the community programs as well.

I: There was money being infused into the community at that time wasn't there?

DB: Yes. But not to the degree that we got later.

I: Right, but it was becoming that because prior to that I remember reading the emphasis was mostly child guidance.

DB: Exactly. It had been pretty much child guidance. My next phase as assistant to the director administrator in the mental health division, was to be kind of given some opportunities to help in policy development in effect. To learn to get something. What reminded me of it was Ken Gaver sent me to go around and visit all of the facilities for children in the state and try to come up with, they were talking about building a new hospital for children right behind where the mental health division offices are now. The idea was couldn't we do that without hospitalizing all these youngsters. So we went out and visited a whole bunch of series of programs and came back with the idea that yes, we probably could begin to do something. There was a program at Edgefield in Portland that had a lot of very difficult to manage kids in it saying it was not a state hospital.

I: Edgefield Lodge.

DB: Right. So we kind of used that as a model and went to the legislature to get funding for some programs like that that could develop the capacity to deal with more severely disturbed youngsters. I think at that time Ken Gaver appointed a study group. I remember being down at the coast with a group of people, Al Borman who is a child psychiatrist at the medical school, a whole series of people discussing how to proceed with this. There were a lot of people engaged in this discussion. At that point we developed, and Ken will be able to describe this in more detail because I was just coming on board at this time and was sort of doing the leg work and getting it going, but the upshot was to fund that kind of programs around the state.

I: In the community?

DB: In the community.

I: By contract wasn't it?

DB: Yes. Actually the real focus on contracting came a little later.

I: So you must have funded it through the division?

DB: Right. I think so. We developed the contract approach somewhere in the '70's.

I: So what's next?

DB: I am trying to think of anything else that happened during that. Ken asked me to pull the superintendents together and get some kind of an idea about how to deal with people from corrections. We had hospital superintendents and prison superintendents meeting. I learned a lot of lessons in this one. We had the charge to kind of figure out how to deal appropriately with mentally ill people in the prison. I had, by the way, consulted out there for about three years when I was right out of my residency, just a day a week.

I: On cases?

DB: Yes. Seeing prisoners. It was an eye opener. I won't go off into that. I was conscious of what's going on in there and thought there ought to be a better way to do it. I really didn't outline it at first what was possible and what was not possible. I didn't set the parameters. I didn't do anything. I sort of made it seem like anything goes. What happened was that all the superintendents decided that they wanted to build a building. I should have known that when I started meeting with them.

I: But you were using the democratic process.

DB: That's right, I was. But always after that with task forces I always said, you have to understand at the outset it may not come out exactly like, this is a democratic process but it is an integration and it has to have some closure and it may not be exactly like what everybody wants. In this case there were some real angry people because we were proposing a mental health program in corrections that didn't involve a second building. Partly it involved the hospital taking up and helping run the mental health program in corrections which I think still exists today.

BK: Yes. It has changed a little bit.

DB: Subsequently we developed a unit within the hospital. We visited a whole bunch of facilities across the country actually. We all went different places and looked at things and came back with different ideas about it and thrashed it all out. The upshot was that we developed a correctional program within the correction system as well so that there could be some positive feeling in that area that this could be something other than punitive. I was hoping to get a female nurse in there early because that would be and I think they may have now, I don't know. They may have while I was still there and I wouldn't know but it did happen.

I: So there was a program both at the prison and at the state hospital?

DB: Yes. They still exist so that there were those possibilities. At that time in the same spirit of kind of like the therapeutic community, we decided to create a counsel of people to oversee these inter-related programs so that people could move between them as necessary and when they needed to. We had a group of superintendents of both the facilities on a permanent counsel that met each time and the director of, this part is happening after I was administrator. At any rate, I have to finish this. The head of corrections and I got together and said we would delegate to these people so they have got to work it out because there was a lot of disagreement about when they were going to transfer and what was going to happen. We formed this group and sat

with them. We would always go sit with them but not tell them how to do it. They took hold and really began to function as a good group. I don't know whether they still meet or not but it was kind of the operative counsel. We were trying to avoid the sort of mishaps that happened when conflict occurs between high level people and prisoners get hurt in the process.

I: Were most of the people in the hospital there because of not guilty by reason of insanity or were they actually there for treatment because they were very ill?

DB: Some of them were there, that was before the psychiatric security review board was established so they were placed and it used to puzzle me. When I was consulting at the prison on their psychiatric prisoners I would see somebody who looked really like fully schizophrenic, four star schizophrenic. I would have people on my unit at the state hospital that were just didn't look mentally ill to me. Then it came to me that the judges were deciding this on a county to county basis. It is not that controllable. That let us ultimately, and let me finish a little bit on the whole forensic thing. Ultimately in later years we tried to get pre-commitment screeners so that we could get help for these judges, give the judges some help understanding what they had. That really flowed out of what we were learning in that other context that people were going to the wrong place. The judges really just needed some consultation in how to do that. The whole pre-commitment screener idea came out of that so that they could begin to be better informed.

BK: Was that Senate Bill 510?

DB: I think it was.

I: Barry Kast has joined us.

DB: Pardon me if I am a little scattered. I have been away from this too long.

I: Go right ahead, I will put it all together.

DB: I think that was the forensic part. It kind of grew out of that original task force evolving a joint program between corrections and the mental health that was jointly managed and where we could begin to put people appropriately where they needed to be.

I: So prior to that time you said you had consulted with patients at the prison, there was no program, it was just individual?

DB: They just hired psychiatrists to come in and see people who were having problems.

I: Did they have a separate program or unit?

DB: They had a hospital and it was in the hospital. It just wasn't that well organized. They had a prisoner that was my receptionist and he would tell me how many cartons of cigarettes it cost to see me, that kind of thing. He finally opened up and began to tell me about what was really going on here. I couldn't fully understand why I was seeing who I was seeing and it was on the secure unit where they had the people locked up. The most gratifying thing there was

when they would come to me and say this man is insane and I would say, the reason he is is sensory deprivation. You have him locked in there. He is naked. He hasn't seen daylight. If you take him out of the cell he will get well. I could see them talking about this. They had old guys. Then I quickly learned that they would keep bringing them to me when they were about up to here they would bring them and I didn't have any control over it. You don't have much control over anything anyway but it was a matter of waiting for them to come and say, Well Doc maybe you ought to see him. Sensory deprivation has done amazing things to people. At any rate so that is what we came from.

DB: The other thing that I learned and this is more just a personal problem was that they were all reading my records. This receptionist also said that they can buy your records and it is getting them in trouble with so many cigarettes. He said, I'm not controlling that but there is somebody who can get those.

I: The patients would get them?

DB: Yes. So that whatever you had written in your chart about him. So I stopped writing. I just started writing these nonsensical charts. I would just write key little things in code to myself that I hopefully remembered.

I: But they could bargain with cigarettes?

DB: They could bargain with cigarettes and get that so that was what they did. After I was not working there anymore, then I started thinking, what if somebody ever sees my charts. They are going to think I am just a total. One night they had a riot over there and Jeff kept telling me that was going to happen. They are screwing them and they are just getting tighter and tighter and it will blow up and it did. The place was burning up.

I: Literally burning up.

DB: Literally burning up and there was the hospital unit that burned up. I thought one good thing; all my records are gone.

BK: Could you see the flames?

DB: Yes, I could just look out the back window and that is when it dawned on me. I hope nobody is in there and then I had this kind of devilish thought, at least my records are gone.

I: Something nobody has talked about, speaking of that. You lived on the grounds? Can you talk a little bit about that, what it was like and what your situation was like?

DB: Living on the hospital grounds was, at the time I came here I didn't realize you got to do it. When I arrived from Kansas with our four little kids and Roseanne and I we started looking for a house around town here. We got a motel and were trying to find a place to live. I talked to Dean Brooks and said Dean I just can't come to work tomorrow. I know I am supposed to but I haven't found a place for my family to live yet and I want to do that. He said, you have a house

here. There is a house reserved for you. It was some awful high fee like \$85 per month or something. I took my little family there and they walked into this huge house. They had never been in a house like that let alone live in one. Go up flights of stairs, three or four fireplaces, it was an old house. Just a wonderful old house. It had a big sunroom upstairs. My daughters thought I ruined them for life. They still think about that house. They are all grown and I have 16 grandchildren now but everybody always remembers that house. It was a nice house. It was old. It was an old superintendent's house.

I: So you were on call twenty four hours a day?

DB: Actually you took call every other weekend so somebody was always on call. You were on call during the week but then you got off every other weekend. It was much better than internship because I had been totally separated from my family during that. This meant we could buy camping equipment and get out and see Oregon. So that was a good time. I think that the problem with it is that it separates people from living in the community. Ken kind of encouraged me after I became his assistant administrator to think about moving. He was right. We then got to thinking about that and found a house with some trees in the back yard.

I: Was there every any sense of fear for your children or your wife living on the grounds?

DB: No. I think the kids quickly kind of befriended the patients that were walking around. The only time I can remember, my daughter and her friend were sitting on the front porch. One of them said, and I don't remember which one, somebody had exposed themselves to her. I sort of paused a moment to see if I needed to do anything and the other one said, lucky. I thought probably they don't need my help. But at any rate we had good fortune. At that time more people were locked up. That was before getting more open wards and more freedom for everybody.

I: So that was not an issue for your children?

DB: No.

I: Or for you? Was there any stigma for your kids at school because they lived on the grounds?

DB: Didn't seem to be. It was a different kind of thing to have everybody both living and working there. There were positive things about it. We got to know each other well, all of us who were at the state hospital.

I: It is really a community isn't it, or it was a real community?

DB: Yes. Before that, before I came here, it had been a farm. It had been a total world unto itself.

I: By the time you were here that was all done?

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DB: Yes.

I: Do you know anything about the psycho-surgery review board?

DB: Yes. That was a legislative bill and I am trying to remember the name of the legislator.

I: It is ORS 677. Before that it was my understanding that the superintendents had jurisdiction over whom would have surgery and who would not and made those kinds of decisions.

DB: Have you talked to Dean Brooks yet? I believe so. I believe there was probably a deciding group within the hospital. They were not doing surgery when I came here.

I: It was over?

DB: Yes. I wasn't witness to any of it. I do think there was some group of people internally who were deciding, I think.

I: Yes the psycho surgery review board was established but prior to that the superintendents had had the jurisdiction, as I understood it.

DB: Yes. I remember when I was involved in that through the Oregon Psychiatric Association.

I: In the review board?

DB: I wasn't on the board but in helping put together that legislation.

I: Also along the same lines, the eugenics board was still in existence wasn't it when you came?

DB: I think so. I think Dean would know the answer to this too. It was not anything that I ever got involved with in any way so I don't remember. It wasn't presented as a problem or I was never aware of it as a problem.

I: In 1967 legislative funds for mental health services. Were you part of that or did that have a significant impact?

DB: The '67 funds, I am trying to remember. I am not sure. Each biennium we were getting funds for something but I am not sure what the year was.

I: In my understanding of it that is when mental health services really came to the attention of the legislature. Can you add anything to that?

BK: The '60's are for the most part a mystery to me. I do remember this. This is not germane particularly to this particular interview but when I got sent to county I found the 1966-67 budget

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for the mental health program. It was \$48,000. Pete Weirs and Ed Newman were on contract for \$12 an hour as psychiatrists. It was only 1976, ten years later; we were up around \$100 bucks an hour. What has changed? Something changed a lot.

DB: I should be able to answer your question. In 1967 I am trying to remember where I was. I think I was still at the state hospital at that point.

I: It was two years before the board of control was organized. Can you talk about that?

DB: Yes. The board of control was related to around a lot of issues and made a lot of those decisions for us so that part of the testifying would be at the board of control before it was abolished and replaced with the agencies assuming responsibility for those things.

I: And you were part of that agency?

DB: Right.

I: What happened next that was significant? I could ask you specific questions but I would like to hear if you can put it together.

DB: Let me look at the sheet I brought because I was trying to remember. Let me move on to '70. I came in '71 after Ken left and went back east. The big problem had been with the thing they had put together to propose the county mental health program. It was a state-operated program. That was the way it was in '71 and I think there was a lot of resistance to that all over. We went back to the drawing board after that and we called in literally hundreds of people it seemed like. At least 100 and divided them up into a whole series of task groups to look at how to approach developing a logical community mental health program that would interact with the state hospitals. That was a huge planning effort. It was kind of modeled a little bit with what we had done with the superintendents around the correction thing but this one was big because it literally involved the whole community mental health system as well as the superintendents. We were talking really about what should the whole system look like? We came out of that with a plan and went to the legislature in '73. That is when most of the stuff got passed.

I: That was the Turning Point?

DB: Yes. In basically establishing the local mental health authorities and establishing the capacity of the local group to manage its own affairs. Within the mental health division we organized to divide up into alcohol, drug, MRDD and DD, but we made those program offices so that they had the task of developing quality. There was a lot of conflict about this because the people who were going to be the heads of those felt they had lost all their power because they weren't in the line of control anymore. I am not sure it was then but we created three regions. I think we did that at the same time. We created three regions and the regions were the line of authority. The program officers were developing standards and defining what the service elements would be, what services we would provide. What we were trying to do was, and we were engaging subtask groups from the local people, in trying to figure out what is the optimal way to manage these problems that we have. Fortunately we had, who is the guy in Wisconsin

who did, Stein, and test. I got to know them. I'm getting a little ahead of myself because that came later but ultimately let me put that aside for just a minute. In this time we were trying to help the counties develop the capacity to manage these people. In '73 it was passed, it happened, literally eight community health program directors either quit, one of them had died of a heart attack. Were you?

BK: That was before my time.

DB: It was hellish. We tried to prepare people for it but somehow the timing of it was like the people who were there were clinicians primarily and not managers.

I: You mean in the task force?

DB: No, in the communities. We just didn't anticipate this problem well enough I guess because we shouldn't have had eight people have to quit at that point.

I: Did they feel they had been displaced and they had no authority, is that it?

DB: No, they had more authority than they wanted I think. They didn't know how to do it. We hadn't prepared these people adequately for, it was not like when Tom McCall hired me or us or a lot of people, and he brought in private industry. He gave us courses in management by objective. He gave us courses in getting participation. Tom really believed in educating his people and he sent people from private enterprise to sit with out management team.

I: This is with the creation of the division?

DB: Not with the creation of the division. The division was created in '61.

I: With reorganization?

DB: Yes. This was in '71. You need that as a little bit of background because in '71 I forgot about that. In '71 Tom McCall really gave us a lot of support. His managers a lot of support in learning how to manage and how to management by objectives and at that time it was very useful. Unfortunately we gave clinical training because clinical people would come up and say, that was very helpful. There used to be those programs over at Salishan. We brought in people from other states who were doing this community program. We hadn't defined exactly how we wanted to do it all. That was the other problem. If people were going to do child guidance and suddenly found themselves with adult psychotic people it became a little different kind of thing for some counties particularly. It was a time of turmoil. I wish I had a chance to read a little more before I got here because the timing of these things is important.

BK: My first memory of this whole Turning Point was the training that took place for the new civil commitment law.

DB: Right.

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BK: The one I went to was in the mootcourt over at the Northwest School of Law and it was fabulous training. You had attorneys and real judges, Lori what's her name that married Al Baxter, was the person who conducted them all. So there was an effort.

DB: There was an effort. Let me digress just a moment and stand back. We didn't do as bad as you guys. We actually had gotten engaged with the law schools back in the time when we had the third rate community running and we invited the law students to come. They got engaged and they wanted to come and understand about that.

I: About mental illness?

DB: Yes. They would invite me to come down and talk at the law school to the law students so we engaged them. We also engaged the county people at that time by calling them into the unit. We were trying to do that. Somehow I felt badly that right after this happened we had all this exodus of people. They probably made good decisions, most of them. They said, I am a clinician; I don't know how to be in management. Get a manager.

BK: Karen and I have been working on a little time line from 1945 just to get a perspective on federal law and so forth. There were a whole lot of case law issues coming up around the civil rights for institutionalized persons and the constitutionality, right to refuse and all that. How much did that influence the Turning Point? Was the civil commitment rewritten partly from that or was it based primarily on the hospital and its operation?

DB: That was included in it because there were discussions of that and as you know when you go to the legislature you really need to be prepared to talk about all of the angles of the thing so that the statutes that were passed were important.

I: What are the events that led to the events that led to the events that happened everywhere when you are trying to get an understanding?

DB: This didn't happen in every state. That is why there was so much consultation to do a decade or two later. Things didn't happen the same across the country. Ideas changed and went through a big period of planning to try to change the way the expectations were of the local mental health programs.

BK: If you came in '71, were you interested in architecture at that time?

DB: No.

BK: I just had a feeling that you were going to be an architect. You came in '71 and then in '73 there was a redesign. Part of it must have had to do with the way you thought about the, how much of it was your anticipating and so forth versus this sort of tide on which everybody was surfing along?

DB: Certainly I believe that we should not have a state run local mental health system. I had believed that before. I had never really agreed with that. It seemed to me, in the concept of the

therapeutic community principals, what we are after here is all the counties to become, the goal is clear, we want them to all be highly competent in dealing with all these populations and the goal is that. The way to do that is to let them be responsible for it. We created these three regions as a kind of safety net because there was a lot of uncertainty. A lot of people in the central office would say, they can't do it, they don't know how, we can't just plunge into this.

I: So you put in another level of management?

DB: We put in another level of management. We had these program offices. We had a matrix organization. The matrix was the program planning, quality assurance and the program offices and then I taught Dan administration on the side of the matrix would have been three regional directors. The regional directors felt like they were the power people and the regular office people were whimpering all the time that they didn't have the power but then they found they really could make things happen. The program offices were not such a bad place to be.

I: Theoretically their ideas were fused into the districts?

DB: Right. But we were working with county commissioners. So the county commissioners or county, not just the commissioners, but other people. I would have county commissioners call me and say, this terrible thing is happening here. I would say, have you talked to your local mental health program director? They would say, well. I would be glad to come out and consult. We will come out here and try to unravel whatever the problem is and we tried to. But we were not running the system and that is really the way it should be. We took great care inside to organize in that way so that we had those three regions.

I: So the person who was in charge of the programs and the service delivery was really somebody at the county level? Was it the commissioner or was it the director of mental health?

DB: The director of mental health. The commissioners often didn't understand it. We would try to visit with them every time we would go out in the field and try to listen to them and deal with them. The commissioners often didn't know. One would just call up and say, what is going on out here?

I: So you would have the mental health director and the commissioner at the county level and then the district director and then the whole mental health division?

DB: Then they did something that nobody liked to see which was abolish the regions.

I: So you did that?

DB: Yes. I don't know how we decided this exactly. I had been uncomfortable with the regions in the first place but had become convinced we needed them as a transition. Ultimately, it became clear to me visiting the county mental health programs they had it together. So the next step is you don't keep spoon feeding your children when they can hold the spoon themselves. Of course our regional directors didn't like it and our regional offices didn't like it. It created a great turmoil in the middle of the mental health division. They had a lot of fun

poking fun at me about that. One lady would say it is kind of nice because it never gets boring around here. Wait a few years and the whole place will change. I kept saying, it has to change because the whole system is changing and we have to stay with it. But we did abolish our regions. A lot of states went to regions and then couldn't abolish them. I actually got on some consults where the topic was what to do about the regions because we did abolish ours.

I: So those people were basically out of work?

DB: No. We put them right back in and took them into the program offices. We did lose some, I think the mental health division has probably gotten smaller over the years.

BK: It certainly hasn't grown. It is pretty tiny.

DB: It was a matter of evolving through that. The executive councils and all, we didn't have the matrix in the same way anymore. We did establish a management council and I'm not sure what year we established that in. A program management council which included

BK: '81 or '82 I think. The regions when they were abolished were they replaced by the operating councils where the hospital people and the community people would meet together?

DB: Yes.

BK: That is when I came in. The regions were going away and the operating council, like for example, the first time I met was in Eugene and Doctor Pati was there and all the mental health directors from the whole Southwestern part of the state, I guess, and people from the central office. I don't think you were there but I can't remember who all worked for the division then.

I: This was called an operating council?

DB: Yes.

BK: Wasn't it supposed to bring the hospital and the community together directly?

DB: Yes.

I: So county representatives and hospital representatives. There was still the boundaries of the counties. The hospitals were still serving people by county at this time?

DB: Yes.

BK: The way I thought of it when I was in the community was the operating council and then there was the big system council.

DB: Yes. The system council had everybody sitting at the table that could either make this thing work or not work, that was the idea, and listen to them and try to go as much as possible where this groups thinks it ought to go as the decisions come along. Obviously there are always

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things to do. The system management, what was on that was the representatives from the county community mental health program council? They picked three or four to come and the hospital superintendents and the key players from the division and a family member and we usually had a consumer representative.

I: So how many operating councils did you have?

DB: I don't know how many.

BK: Three.

DB: Yes, you're right. We just replaced the regions with

I: With the operating councils?

DB: But this council, and I'm not sure I can't remember exactly when we established this council, it was I thought a very effective way of taking, and the thing you really had to do was bring the important issues there and not predecide them. Just bring them there.

I: This was at the central management?

DB: Right. When I was in South Carolina I started one of those there that is still functioning. They had the same system management council. It was a simple thing just get everybody at this table that can either make it work or not work and it generally will work.

I: That is separate from the mental health advisory committee?

DB: Yes.

I: Which was just an advisory committee?

DB: Right.

I: What was the function of that?

DB: It mainly would hear the issues discussed and give advice and bring other thoughts to the thing that might be other perspectives that might be different but right.

I: Did they have some influence?

DB: I think so.

I: I am on the mental health advisory committee and after one meeting I am not sure if they have any influence.

BK: You are on our mental health committee?

I: Yes.

BK: I better be careful what I say.

I: I don't think so.

BK: I think the advisory committee is like a keel on a boat or something, it doesn't move but it keeps things from tipping over. It is like if they ask a question and you don't want to look really stupid, you want to say, here is what we are doing. They say, why are you doing that? As opposed to the system council which actually voted on, said should we go that way or that way. They tried to avoid making those decisions. Don forced them and then I forced them to do that and they would actually make decisions and that is different because the advisory council isn't supposed to make decisions. It is supposed to reflect or something. Does that make sense? Often people on the council and the advisory board don't feel like they are doing anything and they want to do something. Just thinking is what they are supposed to do.

I: I like your analogy of the keel so if you go too far

DB: I think that is a good one. They can be very effective or not very effective. I've been on some advisory boards and sometimes I thought it was worth a lot. I guess you feel good if they take some ideas that you have had and put them into action which they do sometimes. But they don't always.

I: Getting back to this switch to the community and back to Barry's question about what precipitated the community mental health center movement here. Things were going on at the federal level at the same time weren't they? Their thinking was changing so those kinds of things went together did they not or did that precede Oregon. Did Oregon have an influence?

DB: We were required to make a plan, I am forgetting what the statute was

I: It was a big one.

DB: Yes.

I: 383. No that wasn't it. It resulted in all those planning documents that were necessary.

DB: Yes and I was involved in chairing their regional group from NIMH and co-chairing it with somebody from another state to discuss how to go with this. Basically, they were trying to get into a planning mode and it was subsequent to that that the state plans started coming in.

I: Did Oregon change prior to the development of those state plans or did that happen as a result of the requirement of NIMH to have this?

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DB: We had been planning and some of the other states had plans. In reviewing state plans for years they varied quite a bit in quality. We were planning prior to that. Some of our planning I think was better.

I: Can you talk about funding? For example, Medicaid changed things a great deal, right?

DB: Right. Before I get to Medicaid, actually there was a matching program initially with the counties, a 50-50 match. Then when we put money out after the '73 thing we put out some trial counties. We put funds out to counties to develop programs and sort of model counties and to develop pieces and parts of these programs, as they were needed. In MRDD and alcoholic and drug they had very specific operational definitions of the kinds of things they wanted. MED did not have those kinds of specific operational definitions. That was something I was always pushing to get more of that kind of same operational clarity that alcohol and drug and MRDD had. It was a time of moving with that whole idea.

I: You are saying that it started with 50-50 funding?

DB: Then we put 100% funding with these grants that were going out to develop

I: To develop the new mental health centers?

DB: Right.

BK: They were called alternatives to hospitalization.

I: Then where did that money come from? What was supporting all the mental health services at that time?

DB: We went to the legislature and we were getting it there from

I: So this is all general funds?

DB: Mostly. As the other funds became available we were trying to be creative with developing those funds and staying on top of where they were coming from.

I: NIMH funds primarily? When did Medicaid begin to have an influence on funding?

DB: I don't know when it was.

I: At some point, when I look at those pie budgets there is a piece to general funds, to federal funds, Medicaid funds and then eventually there is money coming from the health plan I believe so I am just trying to figure out when all those changes occurred?

DB: Right. It has to be documented someplace. By the time it was occurring, the Human Resources Department had become more a force in our operations and so we didn't need to attend to it as much because they were focused on the money and where it was coming from. In

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'71 when I first was administrator, the Human Resources Department was just created. It was in effect, I had been working directly for the governor before that and still was for awhile because they were a fledgling organization. I think at the time that happened the old welfare division was really the one that were boned up on that whole issue of those sources of funds. We didn't get into it as much.

I: Did you get into the closing of the institutions and the building of the new units and all of that?

DB: Yes. We closed a MR facility at the Dalles, Columbia Park Hospital. They said we could close Eastern and we did. We kept that one unit out there that is still there, I think.

I: You closed it because the population had decreased because of the deinstitutionalization and it was divided then. It became a MR facility and prison.

DB: Actually it is a mental hospital. The hospital for Eastern Oregon is still over there I assume. It is a small hospital and it was separate from the old hospital.

I: Posing as a mental health hospital?

DB: Yes. It relates to the county programs out there. That whole program out there had to be done a little differently. It was like we spent a lot of time out there about how to do it. Originally there was just a rambling couple people that went around the state out there and they didn't have local clinics anyplace. They had people who would show up periodically and it was pretty primitive.

BK: Who was the social worker who developed the living in the community thing out on the campus there? Do you remember a little guy with a mustache who? Link.

I: You mean that set up link?

BK: Have you found out about this?

I: Yes.

BK: I just can't remember his name.

I: Right.

BK: He was actually a famous guy for doing this in the '70's some time.

DB: Yes.

BK: We were taking people out of the hospital and putting them in a cottage. It was the fair weather type thing.

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DB: The Fair Weather Lodge. We got a lot of mileage out of the Fair Weather Lodge. I liked that Fair Weather Lodge model.

I: This was not fair weather though was it?

BK: It was sort of a hybrid.

I: No. The man you are trying to

BK: I just can't remember his name.

I: OK. I am sure I have it some where.

DB: The other thing I loved was when we got interested in something they would send me around the country and let me look at all the Fair Weather Lodges. That was perfect. There was one in Denver and Arkansas. You walk in and you realize that these people are family and they care about each other. You can see what is going on and it is so much better than the group homes. It is just hands down wonderful. We came back and said, let's do it.

I: Did you do it?

DB: Yes. I think we did.

I: Very extensively?

DB: Not everybody did it. We made it available. At that point we were I think not, at least in the MED programs, we didn't have the level of quality assurance over the, not in the '70's. That was kind of when I got into the program office in the '80's, this is something I had been pushing for. I remember Trelevan telling me; OK you want this done, now you can do it. He was right. That was a little different level of doing something.

BK: My contribution on this would be the CSP program that Don was talking about earlier that he said, we will get to that because he got us CSP credit. I was hired on a contract to go out and visit all the group homes in the state to define what their technical assistance needs were.

I: That was your first job?

BK: No. I was working in Benton County but we had a pretty good little group home, Janus House. We went around the state and the turn over was so high and the program was so bad that some of them were just homes for the aged that had been converted. They divided the pie. I think you never did like them.

DB: I hated group homes. I would walk into a group home and think there had to be a better way.

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BK: I hated to go out and look at them. We said, don't train these people, get rid of them. It was just awful looking at the salaries and stuff.

DB: Comparing these to the Fair Weather Lodge as I walked around and looked at the ones in Denver and Arkansas and other places and New York. Those people really had a decent lodge. We just moved in that direction and tried to get it in as many places as we could.

I: As the assistant administrator for ten years, what were your primary duties?

DB: I was responsible for the quality assurance of the community mental health programs. I set out to start to define what kind of a program would be right. Gary Field was there. Gary Field had been with Stein and Test in Wisconsin. I liked that model and I had read about it. He and I sat down and wrote a paper about how we could help counties begin to do that model which was sort of an outreach of case management and a much different model than the usual welfare case manager and a decent place to live. Just simple elements of living that were lined out in that program. We modified it a bit in this paper and then we began to discuss it with people around. We had some more meetings with a lot of people and then we took that to the legislature. We tried to define how many people we could serve and get it down so that we wouldn't do what we did with all the rest of them and that is overload it with people. Because one of the things that I had learned looking at these other places, if you under staff or if you put too much it won't work and it is just a mess. I remember arguing with a woman at the legislature. She said, we will give you this money but you have to serve more than this number of people in each one of these that you are talking to. I said, we can't do it, it's just not right. We have seen these in other states and it's just not possible. They were trying us saying we can't promise you that, we may not give it to you. But they did. That was a great evolution. Then we began to define in the program office the service elements of the inpatient capacity. We had started in '73 trying to develop the local capacity in the hospitals and helping develop psychiatric units in the local hospitals. We were just trying to promote that to happen and it did begin to happen.

I: That was part of the community mental health movement?

DB: Right.

I: So people would stay and get served in their communities?

DB: The idea was that for a short episode they could get that treated and get back into the environment. Then we developed a critical mass.

BK: How much money would it take?

DB: To do this and do it right.

I: Case management?

DB: To provide these kinds and this array of services that we had lined out and began to try to get realistic about what was happening. The other thing that was happening then was computers were coming in. Who was the young man in my office because I got so excited I could hardly stand it when I saw my first spreadsheet and he worked

BK: Dave Edwards?

DB: Yes, Dave Edwards. He started bringing me this data and I thought I had never seen anything like this. I just got excited. He could do stuff with that spreadsheet and we began to know where the local programs were. How many people they had and then is when we started trying to conceptualize what this would be. We had some good help. We had psychiatric residents coming in from the medical school and they were also doing studies. That is another thing that happened that I left out and that was that in the early '70's I had been engaged pretty heavily at the medical school when Saslow was the director there. He and I kept running into each other at meetings, APA meetings, and saying we have to do something together. Then we finally decided we would do something together. We decided to create a training program. I said I thought it should be multi disciplinary. We should get as many disciplines in this as we can. That was my old therapeutic community days coming back.

I: You were right.

DB: We tried to get nursing, psychology and psychiatric social work, every profession that we could conceive of involved in it. The psychologists wouldn't come. I remember going down to Lane at the University of Oregon and trying to talk to those people down there about coming in and it was not just trying to sell it. They just never did come aboard. We finally did get a fair number of people engaged in this. We started public academic collaboration around training. The point was that people would be trained appropriately to work in our system. That was one of our big problems. We didn't have people who knew what to do when they came. They behaved like they were in their private office. They really needed to be on a team, working with a group of other people, taking as well as giving. It required some different skills than most of our trainees were coming up with. That was fun and it worked. The medical school was placing people out in Eastern Oregon. Then they really opened up. I went with the Dean of the Medical School to the legislature that time. The legislature was kind of agog at this. A staffer came up to me and said, who has the control over here? Are you giving them and higher ed this control over? Don't you want it so you can get it? I said, no I don't think so. I think it should be equal. We are going to just sit with them on this. We don't want it that way. I remember that happening and thinking there is always someone that wants to make it not work. He thought he was going to make it work. The legislature was pleased with them because they were very down on higher ed and they thought it was a very good example of higher ed getting down to practical work and doing stuff. The net effect for us was though that where we used to get psychiatrists coming into our system that didn't know anything we now got psychiatrists coming into our system that had already worked in our system, were trained in our system and knew it. We got research coming out of the medical school because we would bring people down and engage them in things. We had a big task force that changed the civil commitment law.

BK: In '87.

DB: Yes. That was the same thing. They staffed the committee. Joe, who now is Dean of the school, agreed that he would just bring staff to it.

BK: You have to keep in mind, they get something out of this too. These guys get access to huge databases. We have one of the biggest databases on mental health in the country.

I: Is that right?

BK: I don't know when you started all that stuff.

DB: That was when Dave Edwards came and said, we have to define stuff. MRDD and alcohol and drug just jumped in there and defined all this stuff because they saw the wisdom of it. Dave Isam was pleading for a personal computer and that was after I was

BK: Isam was the head of DD before

DB: It was wonderful.

I: When you said define stuff, what was the define stuff? Counting things? How many people served? The definition of the program? Is that what you were talking about?

DB: Yes. You are right. That is why I said I didn't read all my old stuff. I really need to get at it because that was where basically we were trying to get data that we could see and move with and make decisions with. What kind of people with issues? What we were really after was how many severely, that's why the definition of, the operational definitions, what is a severely and chronically mentally ill person? How many of those people do you have? What is the critical mass that it would take to serve all those local people in your community? Then we can go to the legislature and say, Mr. Legislator, you have this many people in your community and it would take this much money to really give them an optimal, by standards that we know now, service that people could live decent lives in their home community.

BK: You can't have data without definitions.

I: No. I was tried to get out what definitions.

BK: I remember when I was working, he starts this community CPMS, whatever that stands for. Process Monitoring System. If somebody comes in you have to enroll them in the system. It is only one piece of paper but you have to say if they meet this definition they are chronically mentally ill or they are some other crisis case or they're a child with a severe emotional disturbance. That all goes into the data system. Then there is this other data system in the state hospital. Pretty soon you can say, how many times did somebody go in and out of the service in the community. That was unbelievably powerful stuff. People complained about it but all the systems started in the '70's still have continuity.

DB: There were times when it wasn't as accurate as it is now but it was because it took a long time before people were able to adopt these definitions and for us all to digest it and get it within. That is the data basically that then we were able to go to the legislature with critical mass. What it would take to serve all its people and where they all are and what we need initially by serving them? These are the kinds of services we provide. Then we went on site visits on a regular basis. I loved those. We would go to the county and go out and visit those places. It didn't feel like walking through a group home anymore. It felt better. It felt like it really was much better. It was at some of the site visits that people at the medical school and the other schools were welcome too. Sometimes some nursing schools were involved and they were able to participate not to the extent of the psychiatric unit. The community psychiatry thing was the most.

BK: It is still growing.

DB: It was the first one in the nation. That is basically what South Carolina wanted initially from me was to develop a public academic relationship and there all the disciplines came in. We formed a consortium. You don't need to know about that but it was the same.

BK: You get it started

I: In the '70's did the creation of the community mental health clinics affect treatment of the chronically mentally ill positively or negatively?

DB: Both. I am sorry to say that I think sometimes in the transition before all the skills developed perhaps people were not managed as well. I take that back though because disasters happen in the state hospitals. There were murders. I remember a murder in the state hospital. I remember a patient walking out on the railroad tracks. It is a difficult task. I would say by far the more would be the positive side. More people have more of their own freedom and self-determinism and are engaged as a part of the team themselves, the people with the problem. That is the kind of test of it. Sometimes even when it looks like it has had a disastrous outcome I am not so sure it may have but I think sometimes you have to let a human being to have some freedom to move in directions that don't always agree with what you would do.

I: One of the things I was thinking about is as the resources went into the community, the communities often seemed to respond to the pressures in that community and it wasn't always to work with the people with the mental illness but rather with children and families and so on. If people were discharged did they get the services that they needed?

DB: Early on they didn't but when we developed this more finite way of contracting, performance contracting, and that started in the '70's. When we began the performance contracts with the local mental health programs and did the site visits and actually go out and see the people in service and we could count how many were being reported, short of fraud, we were sure that's where that money was going because we had made the definitions and put the money there and were getting some idea of the cost effectiveness of that by how many of those people were living lives that kept them out of the state hospital and in a more normal setting and actually providing for some of their own support.

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I: And you think the mental health clinics were able to do this?

DB: Yes. They were. I think very well. Even in Eastern Oregon they developed a rural mental health program that was superior to any rural mental health program.

BK: It is very good. Better in some places than others but that is part of life.

I: Let me ask you a closing question.

BK: I have to go because I have to be somewhere.

I: Yes. I have to go because I have to be somewhere too.

BK: I love doing this. I would like to get together with you some more. Do you want to go on a site visit?

DB: Yes. I used to enjoy site visits.

BK: How is your wife?

I: One final question? What are you most proud of in terms of the years that you worked with the Department of Mental Health?

DB: That is a hard question. I guess I would have to say the planning effort and the results of the planning effort between '71 and '73 and the successful beginnings of this program. Before that it had been kind of single efforts of mental health and corrections and clinical programs for children and adolescents after that. It was building that thing. That was the beginnings of it and the involving of all those people and getting them committed to this thing was very rewarding.

I: And that laid the groundwork for the normal work that subsequently happened.

DB: Yes. I thought at the time, this is a Turning Point, this is a change, this is different than anything that we have, because I had been around since almost the beginning of the mental health division, I came in '62 and it was established in '61. I was aware of it in listening to presentations from the people there as it evolved. It seemed to me that just getting all those people together and coming up with a consensus about a way to proceed was

I: So that was crystallized in the Turning Point and you wrote that?

DB: I didn't write it for any purpose other than to document it. I had an excellent person, secretary, who had worked at the legislature and who was always involved. I don't know what I would have done without her either. There have been several people in all this but she goes for precision and goes for getting it right and was well informed about what it takes to make things happen legislatively and kind of documentation.

I: That really helps me put things together.

