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I: Would you start by telling me the changes that you have seen over the years? How things were when they began.

GS: I think I was fortunate because I came in right at the tail end of the traditional state hospital system. The first year I was at the state hospital we had the old system of wardsthat were segregated by diagnosis or by behavior. You had the diabetic ward, the tuberculosis ward, the difficult girls' ward, the nice little old ladies' ward, and the workers' ward. Each ward in the hospital was either diagnostic or behaviorally designated except for the admission wards. The admission wards were where people first came in and stayed for thirty days or less. That wasn't a hard and fast rule. Some people stayed far less and got transferred to the chronic wards. Some stayed a little longer and never went to the chronic wards. As a resident I had both admission ward responsibilities and a long-term ward or two.

I: Who was on the long-term ward?

GS: Patients who stayed more than thirty days. There were a lot of patients there then that had been there for years. The second year I was there they desegregated geographically. That was kind of an interesting day because they put names tags on all the patients and numbers on the wards so they could get them all in the right place. When I got out in the ward the patients swapped tags so some of them didn't end up where we thought they were going.

I: I suppose it took a few days to figure it out?

GS: Yes. It eventually got all settled but there were snags. In those days the policy was that the public health department did the follow-up in the community so we used to go out and visit public health departments. They didn't have mental health in the community. If they had a patient that went out on medication they had to be followed by the public health officer. That changed gradually over the time right after the decentralization. They started to open mental health clinics in the community.

I: How did the health department work? Was it pretty effective?

GS: It depended on the interest. In the smaller communities I think it worked pretty well because they had the time and the interest. In the larger communities I'm not so sure. The clinics got started in a 50/50 match between the county and the state. They let the clinics pick from a list of what they would like to do. They had eight or nine different functions. We're going to follow chronically mentally ill. We're going to do this or that. Almost all of them would take care of children; it was one of their priorities. Very few of them initially picked the chronically mentally ill.

I: Let me ask you a question about the children. Were these the same people that had been involved in the child guidance clinics?

GS: Yes. Pretty much. At that time you didn't have a children and adolescent program at the state hospital. I think that came in about 1977 or so. The community level was the only place you had care and if a child ended up in the state hospital they were on the adult wards. I

remember an interesting story about a seven-year-old that ended up on the medical ward because he was diabetic in addition to being mentally disturbed. The reason he was put in the state hospital was he literally burned down five or six group homes where he had been placed in Klamath Falls. He set fire to them one after another and they couldn't tolerate that. The then Chief Medical Officer sent him to Sunday school because he thought every kid should go to Sunday school. The superintendent got a complaint about some state employee sending his child to Sunday school in a state car.

I: He let him out just for Sunday school?

GS: Yes. The thing that was good for me personally was that I went through this transition with the state I was in the middle of it all. It kind of helps you understand things better. Now if you walked in today and started in a hospital setting you would just see what is in front of you. You don't see the whole thing.

I: In the transition the clinics were not particularly interested in the chronically mentally ill?

GS: No. Most of them weren't. That was a low priority. As time went on that changed.

I: How did it change?

GS: I think state policy gradually changed the composition of the clinic and the other thing was that the funding changed. Communities put in less money and the state put in more.

I: So they had more say I would think?

GS: Yes, over time.

I: When the division occurred it was by county and some counties were grouped?

GS: Some were grouped initially.

I: How did that work?

GS: I think when they decentralized the state system and hooked up with the counties it worked a lot better. You had better follow up and better continuity than it did before when you just had the state hospital. Then you had to figure out what you were going to do for continuity because there was no system to it.

I: What about mixing all those patients?

GS: I thought that was beneficial in the long run. At the time I wondered about it.

I: You had people with tuberculosis?

GS: We did then.

I: Did you mix those?

GS: No. They still had segregation by that category until the TB drugs came along and kind of eliminated the problem.

I: Did you also have alcoholics?

GS: They used to have an alcohol program but they had closed that just before I got there.

I: So they just brought everybody together, the people who were long term patients?

GS: You always have a few alcoholics getting mixed in, or drug addicts. Now days probably a third of the people you admit have a problem with one or both in addition to their mental problems. But there is no special program in the state system for the alcoholics in the hospital setting.

I: At this time?

GS: At this time other than detox.

I: But there was, wasn't there?

GS: Yes. They used to have a long-term program. The problem was it always filled up on the winter and emptied in the summer.

I: Yes. Doctor Pati mentioned that. He thought that the open wards were a good thing because people who needed treatment could come in.

GS: Yes. I think when they started making an emphasis on voluntaries it helped a lot too. It used to be mostly court committed in the state hospital system. When they opened it up to voluntaries and let people who wanted treatment come in without having to go through court; it made a big difference.

I: When was that?

GS: It was in the early 60's.

I: In the mixed ward you had long term, children, new admissions, people who were physically ill?

GS: Occasionally. If you were physically ill enough to require hospitalization for that illness then you would be transferred to one of the medical wards or even to the medical hospitals depending on what it was.

I: Were the wards segregated by sex at this time?

GS: Yes. When they decentralized they starting mixing the sexes on the wards.

I: Was that problematic?

GS: Probably less than you would have thought. It still once in awhile has a problem but not as much as you would think.

I: What about children and adolescents?

GS: With children and adolescents when they segregated them out it made a difference. The kids agitate a ward. They are normally energetic. They normally run around. The ones that get into the state hospital are usually behavior problems or have a lot of behavior problems. So they tended to agitate the older patients. I think it was beneficial to split them off in that sense for the older patients. It was also beneficial to the kids because they didn't model then after chronic schizophrenics.

I: I think it was Doctor Pati who said that some of the older folks would look after the kids and the adolescents.

GS: Yes.

I: So that would have been nice.

GS: They did a study when I was a first year resident on who you got the most help from. They listed doctors, social workers, nurses, chaplains, student nurses, etc. You know who got the highest score?

I: Other patients.

GS: Other patients. I got more help from other patients than I did from the staff. They came out the highest.

I: What do you suppose that meant?

GS: I think it is like when you are a student, you usually learn more from your peers who are one year ahead of you than you do from anybody else. At least it was always that way for me. I think it was like that with the patients. They learned more from patients who had been there just a little bit longer many times than they did from the staff.

I: They probably got more ongoing support.

GS: Yes and a lot more contact. It is probably still that way.

I: I would think so.

GS: In 1973 they changed the commitment laws which I think was not good. I never have thought that was good. They made it so that you had to be dangerous as well as mentally ill in order to be committed, dangerous or helpless, one or the other.

I: Is that how they stated it?

GS: Well it is dangerous or unable to care for yourself. Some people would interpret that so literally that you could be floridly psychotic, eating out of garbage cans, and they would say you were able to take care of yourself and therefore you were not dangerous. If you wanted to live that way it was your right. I don't really think that is the way it ought to be. I think it has gone way to far that way.

I: That also serves to keep more people out of the hospital.

GS: Yes, it cuts the budget down. The way medicine is going in the last years is determined by budget, not just psychiatry, but medicine in general.

I: But you see it in psychiatry too?

GS: Yes. We are currently, in Marion County, going to a case rate system as of July in which cases will be split into three groups. The heavy users, the medium users, and the light users and you will get a flat fee for every case per month depending on the category. That is what you are going to live with whether you use it or don't use it.

I: Who determines who goes into which category?

GS: The patient's history. How many contacts they have had and how frequently. The problem with that is that you are depending on the budget analysis to give you what it is going to cost to do the work. Of course the budget people are always going to cut corners. They figure out how to save money and then they sell the budget based upon that. Like the decentralization was going to close the expensive hospitals and they were going to open up new programs in the community. The community programs never got funded like they should have but the hospital budget was cut. That is a tendency that government has is to make promises and then not really live up to them.

I: Based on that would you say that the quality of care has declined over time?

GS: Depends on whom you are talking about, for the chronically mentally ill, yes. I don't think they get as good a shake now. I'm talking about the chronic schizophrenics who are homeless and living under bridges and just not taken care of. I think the way the commitment laws were redesigned is as big a problem with that as anything. For what I would call the walking wounded, they probably get better care.

I: Do you think so?

GS: Yes. The outpatients, the people who are somewhat inpatient from time to time, probably get better care now than they did. I think they are better served in an outpatient setting like we have now. They are better served by the general hospital with the psychiatric ward. The ones who have been lost are the really chronic patients that tend to get excluded.

I: Because they don't meet the legal definition?

GS: They don't meet the legal definition and most of them are recalcitrant, they don't want treatment. They don't want to do anything except hang out under a bridge.

I: What about the services to those people in the middle? You said you think they have gotten better, in what way?

GS: They are more responsive. It's keeping things closer to home. People don't have to go away for treatment. They are more functional. A lot of them are able to work more than they used to. They have more freedom.

I: What percentage of those people do you think can work?

GS: Of the people who come through the clinic here?

I: Yes.

GS: Probably half or 60%. If not work, at least be in sheltered workshops.

I: You're talking about people who might be heavy and medium users?

GS: Yes. That is determined by the frequency of visits.

I: If you look at those two categories, would you still say 60% might be able to work?

GS: No. The more heavy you get the less work they are capable of.

I: But they are still able to maintain themselves in the community?

GS: Yes.

I: Is that through what?

GS: A lot of times it's through family. But that is a double sword too because sometimes the family really shouldn't be burdened with that patient.

I: So they can live at home. What other kinds of services do they have?

GS: Medications and counseling.

I: How often do they have counseling?

GS: It depends. It can be weekly or even biweekly. They also offer groups. Through this clinic we have programs for activities. Most of the county clinics have that as well, sheltered workshops and activities.

I: Like day treatment centers?

GS: Day treatment centers. You can tailor it a little more to the need of the individual.

I: Getting back to the hospital and the reorganization. You were saying that the number of the people in the hospital declined because of the definition, is that correct?

GS: No. It declined for a couple of reasons. One, the focused was placed on moving people back to the community by design. Plus we had the development of the psychotropic drugs which made it possible to do that so the two together helped shift the focus back toward the community and caused the hospitals to decline in population. We had a community mental health program that Kennedy started and there was quite an emphasis on that.

I: But Oregon had started their program before that time, right?

GS: Yes. I think several states had.

I: If we are looking at changes in practice over time, how would you summarize those changes in practice from 1960 to now?

GS: In the 60's you had just a few medical treatments available but you had some. You had, at least from my perspective, a lot higher percentage of chronically mentally ill or psychotic patients. Over time, we have gotten more and more medications available and more and more biochemical treatments. The mix of patients had been broadened to include other people that might not have been included before who are not so chronically mental ill. They are more neurotic or more depressed.

I: So these people have come into the system?

GS: Yes, I think so. There is more inclusion.

I: You were saying there is more inclusion so people who had probably not had access before were now using it.

GS: Yes because it is much more available. We used to have a rule of thumb. The sicker a person was the further they would travel for treatment which was used in reverse. If we knew if someone had come to the state hospital from Klamath Falls, they thought they were pretty sick as opposed to someone who came from downtown Salem. Usually that was true.

I: Interesting diagnostic.

GS: Yes. The other thing that has happened with treatment is that there has been more and more inclusion of other people rather than just the doctor and the nurse.

I: In the treatment providers?

GS: Yes. In the 60's you didn't have much in the way of social work or psychology or counselors or that sort of thing. You had some but it has expanded quite a bit since. The same thing has happened in medicine. We didn't used to have physician's assistants and nurse practitioners, but now we do.

I: Do you think that has been helpful?

GS: It has provided more service accessibility.

I: Has that changed how treatment is provided, the kinds of things that are done?

GS: I think it has made it more available more than anything.

I: Part of my training was as a social worker so we're trained to look at the person in relation to their community which might be a different focus than a psychiatrist for example. Is that true?

GS: To a degree although psychiatrists should be looking at the other as well. I think it is an emphasis but it's not exclusive.

I: What other policy changes have you seen besides the commitment law and the reorganization?

GS: There has been an emphasis on closing hospitals, which I don't think, is good. I'm not in favor for example, of closing Fairview. I think that is a mistake.

I: Can you talk about why you think that is a mistake?

GS: I think it costs more to try and provide a lesser degree of care in the community for the people who are severely developmentally disabled or severely ill. I think it is the same thing we are doing with the chronically mentally ill. The really severely disabled are getting less of a share, which may be the economics of it.

I: What about the whole notion of sanctuary or a place to be that is safe?

GS: That is why I think you need the institutions for the severely ill. That and the protection of the family because sometimes the families will keep people that they probably shouldn't because they deprive other family members of their ability to really live their lives fully.

I: So the burden is so great?

GS: Yes. I think that gets forgotten at times.

I: I am sure the state is relieved that the families take that responsibility on.

GS: Sure. It is cheaper.

I: What other policy changes?

GS: I don't know if it is a policy change so much but it is a shift and that is because of the de-emphasis on institutionalization for the mentally ill, I think the number of mentally ill in jail has gone up considerably. I see a lot of people that I treat at Marion County Jail as much or more than I do at the Salem Hospital Psychiatric Medicine Center. They run afoul of the law and the law can't do anything with them except put them in jail. They used to be able to get them into a hospital.

I: What happens to them in jail?

GS: Time will cure some things. Removing them from the situation or taking away the substances they were abusing will cure some other things. Then there are fellas like me that come in and consult and prescribe medication and so that is available. What there isn't is the social services and the activity therapy, the kinds of physical involvement in groups that you would use normally, although jails are beginning to develop them. They are being forced into it.

I: For the psychiatric patients?

GS: Yes.

I: Would you say that most of them get the medication that they need?

GS: Most of them. The problem in a jail is that you can't force it so if they refuse it they don't get it. In the hospital you do have an override system so that if you have somebody who is in need of medication and not able to make an informed consent you can override it.

I: Are those people in the prisons or jails badly treated?

GS: I don't think so, not by the staff. Once again, the problem in a jail is you can't treat them softly. It is either harshly or not at all. There is not way to graduate it because you have to treat everybody the same. In a hospital setting if you have somebody who is upset you can assign a staff member to sit with them and talk to them and kind of calm them down. In a jail if they get so upset they upset everybody else you have to lock them up because they don't have the staff to sit down and talk to them.

I: Nor is that their mission?

GS: No. Jails depend on locks. Hospitals depend on staff.

I: You were the head of the forensic unit?

GS: Yes.

I: Was that a new unit or did you just move into it?

GS: They had a man called Chester Hedrick who was known in the newspapers as the fat man rapist from Portland. He committed a series of rapes. He pleaded insanity so they sent him to the state hospital. He broke out by charging a security screen and taking out the whole window, casement and all with his body. He was a great big guy. That lead to a big furor about why we didn't have a more secure treatment place for patients like that. The governor who was then Hatfield, said, develop a program. The mental health division responded and developed a program. Fortunately, I came out of the service right at that time and got asked to run it, probably because nobody else wanted it. At any rate, I liked it. It was an interesting program. It started off with ninety beds and has grown since then.

I: It started off with ninety beds?

GS: Yes.

I: So the idea was that there were probably ninety people in the system?

GS: There were at that time, ninety people in the hospital who were on court orders or had some reason to be in a security program.

I: Were they on the general wards at this time?

GS: Yes.

I: They were among all the other patients?

GS: Yes.

I: Was that a problem?

GS: From time to time. The security wards were staffed doubly compared to the others. They had more secure features like sally ports and locks and bars and things like that.

I: So there was some segregation because you talked about the security ward.

GS: Yes. There wasn't a specific program designed for it.

I: If you were disruptive you would go to that security ward or would you automatically go there if you were court referred?

GS: No, not before. They had a maximum-security ward but it was just a ward, that's all, there was no program or anything. You got in there if you were dangerous, that's all it amounted to. What we did was set up a program where it went from maximum to medium to minimum. As you were treated and your behavior improved, we would kind of progress you through. My thought was that you would have the same staff working with you all the way through. That was the way we did it then. It worked pretty well because people would calm down and you could move them along and kind of do things.

I: What were the program components? What did you provide to them?

GS: First of all, the three levels of security. Then we had activities that had not been included before such as a social etiquette course that was taught by one of the doctor's wives. This was to try and help people be more socially aware and able to cope better. A lot of people that come into a program like that have very limited social skills and feel very uncomfortable because of it. Then they act out because they are uncomfortable.

I: Give me an example of a social skill that you would teach.

GS: How to go to dinner. Which fork do you use? Basic manners, how to ask a girl for a date. Basic social skills that some people have never learned and because of that felt very uncomfortable and would act out. Not everybody needed that but we would try and provide it. We had groups on sex offending. We had a lot of people who committed sex offenses that were put in. We would talk about what was a socially appropriate sexual behavior. What you were able to do, not to do, and how to go about doing it properly. How you ask a girl for a date, some of them didn't know. At that time, we had a sex offender law in which people were sometimes committed to the hospital or prosecuted and it was up to the district attorney which way to go.

I: Hospital or prison?

GS: Yes. That law since has been scrapped and they don't have that now. Now it is prison or nothing, prison or outpatient.

I: Did you do any behavior modification or anything like that?

GS: Not by that name. I am sure a lot of what we did could be called that.

I: You were trying to teach them new behaviors basically? Would you say that was the fundamental approach?

GS: That and medication and groups, activities. We used to take people on trips, recreational things. We tried to involve them more in the normal pattern of life. A lot of the people that came through the state system had been pretty deprived.

I: You were in some ways trying to parent them?

GS: In a lot of ways.

I: Teach them things they didn't learn. Was the staff supportive? Were they like coaches and friends? Did you feel that your program was pretty successful? Did you have a large readmission rate?

GS: I think we were really quite successful. I remember one time a fella that we treated in the 60's as a sex offender, he had been out for about twenty years, came back and I was talking to the district attorney that was prosecuting the case. He said something like, well he succeeded for twenty years, you did better than most. I was feeling guilty because he re-offended. The D.A. said, well he made it for twenty years, most of them don't. So I guess we did do something.

I: How long did that program last?

GS: It's still there. It's still evolving. It has grown now to a different level but it still has the same basic principles. There is a maximum area that you are admitted to and then you are moved to the treatment wards or the medium security wards. The minimum-security function is gone pretty much.

I: Is it out in the community now?

GS: It is out in the community now.

I: So there is a place for people to go if they are committed?

GS: They changed the law. In 1973 the laws changed to make it more difficult to commit. Interestingly in '77 they passed the not guilty by reason of insanity law which made it easier to keep people who had committed offenses. I think in part it was the reaction to the changes of the previous four years.

I: That not as many people had access?

GS: Yes.

I: So once they got them, they kept them?

GS: They wanted to get a way to keep repeat offenders off the streets. They were blaming the hospital for letting all these people out. So they wanted to set up a security review board so that the review board made the decision whether they left the hospital or not.

I: So that is the basis for the security review board?

GS: Yes. But in fact I think it was the law itself that made the big difference because you couldn't commit anymore.

I: I remember reading that when the security review board came in that those forensic wards really filled up because they didn't release anybody.

GS: That's right. At first they were very reluctant to release. It took awhile to kind of get comfortable with it. It also took awhile to get the communities to develop follow up programs. For example, in Marion County they assigned all the PSRB to one case manager and they limited his caseload to twenty patients. When he had twenty people to follow, that's all they would take.

I: And that is all they would release?

GS: So when the review board would say they had somebody ready to come out they would say they didn't have a place for them so nothing would happen. As time has gone on, the counties are a little more capable of dealing with the review board people. The review board is a little more comfortable with letting some people out. The nice feature in that system is that they can snatch you back if you start having problems.

I: Back to jail or back to the hospital?

GS: Back to the hospital.

I: The forensic unit at the hospital?

GS: Yes. If you call up and somebody is under the review board and you say, he has missed his last appointment and he is off his medication, they will issue a warrant. He will then be back in the hospital as soon as they can find him. There are some teeth to the follow up system. In the civil side on a commitment, if you are released, you are out, that is it. You can come back if you want or not, or you have to be re-committed.

I: Can you voluntarily admit yourself to the hospital now?

GS: Yes.

I: You can?

GS: Sometimes the PSRB people will come back voluntarily because they know they are falling apart. They don't want to be provoked because if they come in voluntarily they can get out easier.

I: So they are somewhat responsible in managing their situations?

GS: Some of them are. As far as voluntarily going into the state hospital now on the regular wards, no, they don't take voluntary.

I: That is what I meant.

GS: The regular wards are pretty severely disturbed people.

I: They would have to be a danger to themselves?

GS: A danger to themselves and others.

I: So they may not have committed an act so they are not part of the forensic program but there is the potential for it?

GS: Yes.

I: Where are the people who are guilty by reason of insanity? Are they in the forensic unit?

GS: Yes.

I: So they are separated?

GS: They are separated into the forensic unit but within the unit there are others than just not guilty by reason of insanity.

I: They would be criminal offenders?

GS: There are some there that are just civil commitments. Many of them were once not guilty by reason of insanity and their time ran out but they were too sick still to be released, or too dangerous.

I: Who makes that decision, is that the review board?

GS: If their time runs out under the review board then it falls to the hospital.

I: The superintendent?

GS: The superintendent and staff.

I: Was the eugenics board around when you were there?

GS: Yes.

I: How long did they function?

GS: The eugenics board went away around 1970, I think, I'm not positive on that.

I: I haven't been able to find a date on that.

GS: It was around in the 60's and I think it disappeared in the early 70's.

I: So what was happening with that board while you were working in the state system?

GS: If you wanted to be sterilized or if someone wanted to sterilize you, you had to go through the board and get their blessing before you could do it. That is another one that came about because some legislator's relative got sterilized against their will.

I: So they put the eugenics board in place?

GS: Yes.

I: I think they've been in existence, since I started doing this reading, in 1945. They've been around a long time.

GS: Yes.

I: Related to that, I remember reading that the superintendent was the person who had the right to make the decision about who would get electrotherapy?

GS: Yes.

I: Then wasn't that changed as well?

GS: Yes. The right to refuse treatment.

I: When did that happen? It had to be in the 60's some time as well.

GS: No. It got more and more restrictive in the sense that in the 60's, if you were voluntary, you had to consent. If you were court committed, the superintendent could order it.

I: If you were voluntary you had to consent?

GS: Yes. But if you were court committed, the superintendent had the power to order it.

I: Was there any recourse?

GS: Not unless you wanted to fuss to the newspapers or to an attorney or something like that. Basically, there wasn't. At that time, the superintendent could authorize surgery on court committed cases.

I: Lobotomies?

GS: Yes, but not on the voluntary. The board of eugenics went away, I think, in the early 70's or mid-70's.

I: Why did they go away?

GS: I think the times changed and they didn't really need it anymore.

I: They weren't doing lobotomies or sterilizations or anything quite so drastic?

GS: Yes.

I: You were around then when the board of control was dissolved?

GS: Yes.

I: How did that change things?

GS: It made it more difficult, I think, for the hospitals in the sense that it distanced them from the governor. It put more layers in between so you had to go through more bureaucracy and more bureaucratic process in order to get anything done.

I: To get anything done?

GS: Yes. With the board of control the superintendent went to the secretary of the board and said, this is what I need. The secretary of the board would say, there's how you're going to do it. That would be the end of it. Now you have to put in a budget and go through the mental health division. They go through the Dept. of Human Resources which goes step, step, step.

I: Do you know what the thinking was on that why they changed it?

GS: I have no idea except that all the states seemed to be doing it. I was once told that if California does it everybody else follows so it probably came from California.

I: But there is probably a lot of truth to it.

GS: Yes.

I: They are seen as a leader in a lot of ways.

GS: Yes.

I: What other changes have you seen over time? You went through some of the hospital closings, not this one, but you went to Dammasch.

GS: I went to Dammasch because the '73 legislature decided to move the forensic unit to Wilsonville. They also passed a law, the same legislature, that said that the state could no longer build anything without getting a building permit.

I: I remember the building permit fiasco.

GS: So guess what. The County of Clackamas decided they wouldn't let them build the forensic unit there. On the grounds of Dammasch Hospital there is about a million dollars worth of concrete

I: Three million, I think it is.

GS: Is it that much? Very carefully covered with dirt for some future historian to dig up and try and figure out what the hell happened here.

I: So they didn't move the forensic unit, or they did?

GS: No. It never moved.

I: But you went to Dammasch anyway?

GS: At that point, I figured the unit was going up there anyway. I might as well go up there as Chief Medical Officer instead of being just the director of the unit. Russell Guiss offered me the job and I took it.

I: There are some questions I have about Dammasch. One is that it seems like it was poorly designed.

GS: It was designed for the treatment of the time. By the time it was built, the treatment had changed. It was designed as a geriatric hospital for long stay patients who in the pre-drug days, pre-anti-psychotic days, didn't have a lot of turn over. They set it up in large wards so that the staff would be able to have visibility of all these chronic patients, most of whom would probably be in bed. When they finally got the thing built, they had started moving the chronic long-term elderly patients into nursing homes and didn't need a long-term geriatric hospital. They changed the function to the needs, which were acute care of psychiatric patients but the building was designed for geriatrics. Of course, it was built of stone and cement and brick, which meant you couldn't change it easily, so it was never really well designed for the purpose which it was eventually used for. There was nothing wrong with the building; it's like the Army fighting the last war.

I: It was also supposed to have the latest treatment methodologies, right?

GS: I don't know.

I: Let me tell you why I say that. What I have read is that it seemed like Dammasch was planned to have shorter stay people, that somehow the treatment would be more intensive and more effective so they could move people out more quickly.

GS: Yes, that was the idea, but that had nothing to do with the planning for the hospital itself.

I: Right. That was after.

GS: That was after the hospital was built. Yes, they did. The superintendent that got picked was a surgeon. He was picked because he was very good at organizing, I think. He organized a

system to try and move people rapidly. If the staff didn't do it, he would come in and push them until they did.

I: Use this new treatment?

GS: Yes. For short term, rapid turn over treatment rather than letting them stay as long as they wanted and waiting until a little more time had passed and then discharge them.

I: So it was, get them in and get them out?

GS: Yes.

I: Was there anything they did particularly to get them out quicker? By that time there were the medications, right?

GS: The medications and the community clinics were developing so they had more places to refer them.

I: Did they have any magic bullet that was the treatment?

GS: Nothing that wasn't available anywhere else.

I: Was it more of a philosophy?

GS: I think it was more of a philosophic approach.

I: Than actual implementation of a program or practice?

GS: Yes.

I: You were at Dammasch for a long time, seven years?

GS: Yes.

I: Any changes that you can think of that occurred during that time?

GS: The forensic program rose and fell.

I: At Dammasch?

GS: At Dammasch.

I: Along with a big tombstone.

GS: Yes. Then they developed an adolescent program at Dammasch which eventually transferred to the adolescent program in Salem. I think that happened after I left.

I: It transferred?

GS: Yes.

I: It was created when you were there?

GS: Yes.

I: How many people did you serve?

GS: At Dammasch?

I: How many adolescents?

GS: Probably thirty.

I: So they had their own ward?

GS: Yes.

I: Did you have a school for them at that time?

GS: We had teachers and classrooms, the same thing at the state hospital. The schools were not run by the hospital. The teachers were provided by the educational district and assigned to the hospital. All the hospital did was provide the space. If you graduated your degree didn't read Dammasch or Oregon State; it read North Salem or the local high school.

I: What kind of treatment did you use in the adolescent units?

GS: Basically the same things that you did in the adult, group activities, medications, with education, a bigger emphasis on education.

I: Were there any children's units at that time?

GS: Not at Dammasch. They started the one in Salem, which initially was kind of a day treatment program within the hospital.

I: So children would come there?

GS: From the other wards and then eventually it developed into a residential program. They differentiated it into a children's ward and a couple of adolescent wards. One was locked and one wasn't. I think it is still that way although they are probably both locked now.

I: Because?

GS: I think over time the hospitals have locked everything up pretty much because they have shrunk in size and concentrated more on the difficult more dangerous people. People who aren't that difficult or dangerous are treated in the communities.

I: So those that don't need to be in a locked ward are out in the communities basically?

GS: Yes. I read about the women's prison at Dammasch and think humorously of the forensic unit.

I: It's not going very well either is it?

GS: No.

I: In 1967, there were new funds for mental health services from the federal government, is that correct?

GS: Yes. The emphasis became more closing the hospitals and using community hospitals with psychiatric units. That is what happened when I retired. They closed the admission wards at the state hospital and transferred the function to Salem Hospital and Corvallis. The only problem with that is that they shrank the beds too much. You can't get anybody into the hospital now it is really difficult.

I: So what do you do?

GS: They end up in jails, in emergency rooms or going home and creating more fuss. For awhile they had diversion programs, they still do in some counties like the Lyle Center in Portland. Marion County had one that they closed which I think was unfortunate.

I: Why did they close it?

GS: I don't know. That provided a kind of a refuge that wasn't a hospital for people who really needed to get away from wherever they were and needed a place to stay temporarily or what have you but didn't actually have to be in a hospital setting.

I: Sort of like respite care?

GS: Yes. It gave you an alternative, I think, the more alternatives the better.

I: I have a question about the Scope staffing standards.

GS: It was a way of trying to develop a system that you could measure what people did and applying that sort of industrial engineering to human behavior and care. The problem with it was that the original studies were done in a setting where other things were provided, meaning housekeeping predominately. No housekeeping tasks were included because where these studies were done, housekeeping was done by a different department.

I: They overlooked that minor detail?

GS: Yes. The Scope studies always under funded you or under staffed you because in Oregon you had to do housekeeping too.

I: Your psychiatric aides did that?

GS: Yes. They were responsible for housekeeping and everything. It didn't work out that well here. It was an attempt to try and justify getting enough staff on the wards to do what was expected.

I: Prior to that you had used the AP standards, right?

GS: Yes.

I: Did that work?

GS: Not as well.

I: Not as well as the Scope.

GS: No.

I: When you started, patients were still doing some of the work?

GS: Patients were doing most of it. The staff directed it, but most of the work was done by patients. When I started, the hospital cost $6.00 a day.

I: This was in 1960?

GS: Yes.

I: What is it now? What was it when you left?

GS: When I left it was $3500 a month, I think.

I: So when you left which would be 1992, right?

GS: I think that's right. They had by then differentiated different levels of charge for different units like the geriatric unit cost a certain amount, the admission program was a different amount, the forensic program was another amount.

I: Were patients being charged for their visits at this time?

GS: They were charged based on their ability to pay. When I started out, if you had a family member, they would bill the family too. If you had a father, or in the case of a parent, a daughter

or son, they might get the bill. Then that changed over the years to the patients had to be responsible and eventually they said the patient had to consent to pay. A lot of people who were getting social security funds would refuse to pay their bills and would let the fund build up and would have it when they left. Then Reagan came along and said, when you are in an institution we are going to cut off your funds.

I: Nice guy that he was, so they got nothing?

GS: So then after that the institutions started getting the money. To me it doesn't make sense for the government to provide care and then not be able to bill for it.

I: True, but whom do they bill?

GS: If you have funds, they bill you.

I: Social security must have changed a lot of things at the hospital?

GS: Yes.

I: Can you talk a bit about that?

GS: It made a lot more money available for patients.

I: For the patients themselves?

GS: Yes. They were able to do more, buying things for themselves. In fact, to this day, you can go up there and see computers on the ward. People bring in laptop computers and things of that nature that when I started out you didn't even see radios.

I: Because they didn't have the money to spend?

GS: They just didn't have the money to do it.

I: They earned some money, didn't they?

GS: I don't think we had patient pay when I was first there. I don't recall that.

I: There was a law passed in the 70's.

GS: Yes. I think that is about when it came in. Then there was the big fuss about how do you figure out what they are worth because some patients were fully capable of working just like any staff member. Others could barely tie their shoes. But you had to pay them for whatever they did do. They had all sorts of studies and procedures developed to try to decide how you would pay.

I: Did that improve moral?

GS: Patient pay?

I: Yes.

GS: I think it probably did among the patients.

I: What about the staff?

GS: I don't think that the staff liked it much. Some did and some didn't but I think most of them looked upon it as kind of a rip off. At least there was that flavor to it.

I: Although the patients had performed a lot of the work?

GS: Yes. I think what the staff was seeing was that this patient is getting so much money for doing so little. If he wasn't being paid they didn't mind him doing so little.

I: That was the Fair Labor Standards Act.

GS: Yes.

I: What about the mental health advisory board? Did that affect you in any way?

GS: I will tell you a funny story. They decided that we were going to have advisory boards to the hospital. The advisory board came into the superintendent at Dammasch and they set up the procedures. A complaint came to the advisory board and they asked the superintendent to address a response on behalf of the board to the mental health division. The mental health division sent back a response to the superintendent who had to respond back to the division how he was going to solve the problem that he had already complained about. It really was kind of ridiculous in some ways.

I: What was the purpose?

GS: The purpose was to try and open up the hospitals more to the communities and get them more influenced by what was going on around them. It helped in that regard.

I: What about patient advocacy? That must have happened while you were there.

GS: Yes. Patient advocacy, I think, was actually beneficial. Not only to the patients but also to the staff because the advocates pretty quick caught on to who was chronically a squeaky wheel and would kind of divert it off and save you trouble in the long run. In a way, that has been good.

I: What did you enjoy most about what you did there?

GS: It was totally varied. It was never the same. You think you have seen it all and something else happens. It was enjoyable and fun to work there.

I: Why was that?

GS: Part of it was the atmosphere that was created by Dean Brooks and to some degree at Russell Guiss's institution as well. He was sort of part of the same thing. If you have a good superintendent in that kind of a system, which was the last relic of the feudal system.

I: What did he do that made it special?

GS: Brooks tried to make it a good place to work. He tried to back you up. It didn't feel like you had to micromanage. He would give you a task and say, this is what I would like you to do, these are the resources you have, tell me how you are going to do and then go do it. If you ran into problems he would be kind of helpful to you. I remember calling up one time to say that we had a problem on the ward. One of the patients was making an allegation that a staff member had beaten him up and I was going to kind of fill in Dean Brooks with this and I got Mrs. Brooks because he wasn't available at the moment. I asked her to pass it on. She said, by the way, what does the staff member look like? It was that type of an atmosphere that you always looked at the whole picture. You didn't just jump off and run. You weren't scared. You weren't worried about you were going to get picked on. They would take the time to listen to you and see what was going on. I'll tell you another funny story. Hatfield used to sneak into the hospital when he was governor. I don't know if Brooks told you this or not.

I: No.

GS: One night one of the famous Hatfield tours occurred about midnight. He got onto one of the female wards without the ward staff knowing because the ward next door had let him in. The aide in charge saw a man on the ward and said, what are you doing here? He said, I'm the governor. The aide said, sure you are. She wouldn't let him off the ward until she had called Brooks. Brooks had to say, Governor is that you? Hatfield said, yes, it's me. Brooks told the aide to let him off the ward.

I: I assume the ward was not fired or anything. It was probably a big joke.

GS: No. It was a big joke. One Christmas we had a party on the ward for the patients. This was when I was running the forensic unit. It was on the minimum-security ward. We cocktails because we had turkeys. We had a dinner, the staff and the patients all together. One of the patients, later in court in Jefferson County about three months later, said we introduced him to alcohol and that was the reason he was in court again. There was a big furor because the legislature was in session and Brooks called and said, what did happen? I told him. He said, did you have soda pop there? I said, yes, we did. Did you serve minors? No, we didn't. That was the last I heard of it. He went down and talked to the legislature and said this is what happened. I think Betty Roberts was in charge of the committee that he was testifying in front of and said something to the effect that, it sounds like a tempest in a teapot. That was the end of it. It was

that kind of back up. Other places people would come in and say, you've embarrassed me. They would fire you on the spot or something like that.

I: It sounds like he really believed in his people.

GS: Yes. On the other hand, he also could, if you were screwing up, fire you. I've seen people get canned. I never saw anybody that got fired that didn't deserve it.

I: That is a high compliment. Did you live on the grounds?

GS: I lived on the grounds for a year as a resident. Then again for a year in the 70's on the staff, this was at Salem. When I was at Dammasch I lived on the grounds the whole time.

I: What was that like?

GS: At Dammasch you were sort of isolated. There were only four houses there. You were out in the country and it was nice if you liked country living, but you didn't have any neighbors or anything. Here in the Salem hospital you are just in the middle of downtown. The nicest thing about it was you didn't have to do any of the repairs.

I: No repairs. Call the state.

GS: Call up the engineers and say, the kids next door broke my window. They would come and fix it so it spoiled you a little bit.

I: What do you think was your greatest contribution?

GS: Running and developing the first forensic program, getting it going. Having the confidence to do it which may have been stupidity.

I: You were just right out of school practically weren't you?

GS: Yes. Ignorance is probably a better word. At any rate, when I knew I was going to run it, I was still in the Army at Ft. Lewis. I went into Madison and looked up everything I could through the Army libraries on treatments of psychopaths. I decided that the biggest thing I had to do was to slow down things in the way of manipulation and to try and organize it so that people couldn't go around you because that is what psychopaths do. They avoid, evade.

I: Just keep them accountable?

GS: Keep them accountable. So that is how I set it up.

I: That in itself is treatment?

GS: Yes.

I: Important treatment.

GS: I think so. Then when we finished the program, the last few years I was there I ran the admission wards in which we had sixty or seventy percent of the admissions but only ten-percent of the staff. In a hospital setting, admissions and discharges are the biggest areas of work as opposed to ongoing treatment or day to day treatment. You had to really try and organize it efficiently and get everything done without a lot of fuss and bother. The way I did that was just simply to wherever possible, delegate and wherever possible, organize and eliminate anything that wasn't time effective. To give you an example, we organized group meetings for treatment teams in which we would have patients come in and meet with the whole staff at once. We had other staff outside having patients ready to come in as soon as the one was finished so we didn't have a delay while we went to find somebody. Then we could see everybody on the ward at least twice a week as a group and made a point of doing that. I think it made it much more efficient than trying to deal with people on an individual basis, having to go look for them when you wanted to talk to them or having them trying to find a staff member they wanted to. They had an organized time with the staff at least twice a week.

I: How much time?

GS: Anywhere from five minutes to thirty minutes depending on the individual and what was happening. If they had relatives we would get them in. We would tell them we were going to meet with their husband on Tuesday morning around nine o'clock and if we knew they were coming we would wait until they were there and then fit them in. We also included the community staff in that. I did the same thing at the Salem hospital. We would go through everybody, one after another, and get the nursing staff to do your running finding the patients and bring them to you. Then I would sit down with the charts and the staff and go through them one after another.

I: So everybody got looked at twice a week and everybody had a chance too.

GS: At least. In the Salem hospital with ten patients instead of thirty or forty, they all got looked at every day. You took whatever time you needed per patient. Once in awhile you would have somebody in seclusion or was physically unable and you would have to get up and go see them separate. Most of the time you could organize it.

I: Even if people were in seclusion you saw them?

GS: Sure.

I: Sounds like a good system.

GS: I think it was. Unfortunately it is not the usual medical system. The usual medical system is to make rounds bed by bed and you do the running instead of having somebody else run for you and it is far less efficient.

I: Plus there is something about going to your own treatment team. It seems like you would feel more like you were participating or in charge or had something to do with it as opposed to being so passive. Is there anything else that you want to add?

GS: I'll tell you a funny story on Brooks again. This is the kind of thing that made it fun to work at the hospital. We had a patient, his first name was Ray, who decided he wanted a drink so he went out to the hospital fire truck and got in it. He drove it downtown and parked it in front of the tavern. The local chief of police called up Dean Brooks and said, Doctor Brooks are you missing a fire engine? Brooks said, I don't think so. He called the engineer and said, go see if the fire engine is there. It wasn't. He said, yes, we are. He said, it's down here in front of so and so's tavern. They went down there and looked in the tavern. There is the patient sitting there happy as a clam. Most people don't know that the fire engine has a key ring on it with a key to every single lock in the hospital practically.

I: Of course, it would have to, wouldn't it?

GS: Yes. So it was a little bit of a security breach but nothing happened with that either.

I: A big security breach. That is funny. Any other good stories?

GS: The other one I like is the day that the census was off. Suddenly one day, they had one extra patient. They couldn't figure out where this person was. It turns out that there was a patient in the hospital who had been there for years who had an unusual name. Brooks was called up one day and asked if this patient was one of his. He said, yes, so they brought him out to the hospital. About a week later they figured out they had two people by the same name. I don't know why it took so long but it did. Brooks went up to the one who was brought to the hospital and said, how do you like the place? The guy said, I think it is fine. The food is good. Brooks said, you forgot to sign the admission register and handed him a volunteer. When I was at Dammasch, we had an admission clerk who came in one day and said, Dr. Suckow I just admitted a patient and they are using my social security number. Another one that I think is funny, although it wasn't at the time; I used to have to review the driver license recommendations. There was a law at that time that everybody who was discharged had to have a recommendation, should they or should they not drive. To keep some sort of continuity, one of the jobs of the chief medical officer is to review that. We had this patient at Dammasch, another one with an unusual name, and I looked at it and said, no he shouldn't drive. He was mentally retarded and he was mentally ill and had seizures and any number of reasons he shouldn't drive. So I signed it and sent it in. About a week later I get a call from a lady who said, why did you pull my husband's license? I said, your husband's license? Who is your husband? She told me and I said, where do you live? I live in Gresham. Her husband had the same name and what is worse, the same birth-date as the patient who had come from Hillsboro so I had to get on the horn to Salem and say, you guys pulled the wrong license. My patient had never had a license but her husband had.

I: Did have.

GS: So you ran into some very interesting things like that that you would never run into anywhere else that I can think of.

I: Especially the fire truck. Anything else?

GS: We took a group of patients from the forensic unit steelhead fishing on the Nestucca. One of the social workers from Yamhill County was down there. I didn't happen to be with the group. He was complaining about this group from the state hospital was catching fish and he couldn't. I don't know if you have run across this one before but Oregon used to have a law that said all the state institutions had to be in Marion County.

I: All?

GS: That is why almost every state institution is in Marion County. It took a vote of the people in 1915 to locate Eastern Hospital where it is. It took another vote of the people to locate Dammasch where it was. It took a second vote to change the purpose of Dammasch from being a geriatric hospital to a general psychiatric hospital which delayed things.

I: By the people? Like a referendum?

GS: It was in the constitution that every state institution had to be in Marion County. The long-term effect of that was that all the institutions being here all knew each other. I don't know of any other state where, as a director of the forensic program, I would be on a first name basis with the Warden of the prison and the Warden of the correctional institution and the head of the juvenile facilities. We all knew each other and it made it very simple to resolve institutional differences in a lot of ways. You could call up somebody and say, I have this patient of yours and this is the problem we're having and what can we do about it? Other states you would send forms and talk through the bureaucracy and it's not that way.

I: There was a fire in the prison. Wasn't there a riot during your tenure?

GS: Yes. 1969. The Warden that was there, Gladdin, was retained by the legislature because he was so good. He got cancer at the age of 75 and became kind of infirm and was failing. Gladdin was replaced by a Warden who was very liberal, and he had been very firm and strict. He wasn't cruel or anything like that but it was just a stick is a stick and a stone is a stone and you will not throw them. The Warden that came in was a lot more liberal in the sense that he wanted to rehabilitate and he wasn't in the business of punishment. That led to a riot.

I: When the prison was burned and locked up there was no laundry facility for the state hospitals.

GS: Yes. That created a problem because the prison wasn't providing the laundry service. Because we were all in the same area, a lot of the institutions had inter-dependencies of that nature. The state hospital used to run a farm. I'll tell you another funny story. Brooks was touring the warehouse and walked into a room. He said, what are all these horseshoes? We haven't had horses around here in ten years. The warehouseman said, every week we get two

more pairs, they come automatic. They had a standing order for horseshoes that no one had canceled.

I: In ten years no one had canceled?

GS: No one knew it. The administration is here and the warehouse is way out there. Somehow the information didn't get back and forth.

I: They also processed a lot of food from the farm didn't they?

GS: Yes. The hospital used to grow its own. That's why it only cost $6.00 per day, among other things.

I: I read a story where they brought a bunch of patients out to the orchards to pick cherries but they brought them at the wrong time so they picked all the green cherries.

GS: Yes, that sounds to me like what would have happened. We're here to pick; we're going to pick.

I: Yes. Nobody tells us what kind.