Joseph Treleaven, MD

Administrator, Mental Health Division

1962 – 1966

Oregon State Hospital

Interview - March 9, 1999

JT: There was a small program for rehabilitation of the alcoholics under the liquor control commission. I am sure you know about that. I didn't have anything to do with that. There was in the Board of Health a program developed and operated by John Waterman, a child psychiatrist, who was developing a lot of the child guidance programs throughout the state with a lot of federal seed money. I forget what the name of that federal grant was. He sort of pioneered that and developed I think eleven places where they had a full time mental health worker. He would go, he and his wife who is a social worker, would go around and consult. One of my jobs when I came, he recruited me on my own time to be a psychiatric consultant, the first year down at Lane County. I was still in training and he taught me a lot of child psychiatry at that time. He was a good child psychiatrist. There was a movement in the early '50's to expand community mental health treatment, the National Mental Health Association. I forget the name of it. Anyway some national association was plugging it. Hatfield was a very progressive politician and he got elected in '59 and made mental health one of his programs. He created that task force to study mental health in Oregon and come up with a report. I used to have a copy of that. I don't know whether you have or not.

I: I'm not sure.

JT: It is a very important document because Dean Brooks was on that who was superintendent of the hospital for years and years.

I: I want to make sure I have it.

JT: I am sure it is in the state archives because it was an official document. I think that report came out in '59. It recommended the creation of the state mental health division to bring all the services together that involved mental health. They recommended alcohol treatment and child guidance program and the board of health and the state hospitals be combined together and then the division was given permission of developing a community mental health program through county government.

I: So originally the child guidance and alcohol were under the board of health.

JT: No. Child guidance was under the board of health. John Waterman worked for the board of health. Alcohol treatment was under the liquor control commission. At that time, when I first came on the scene as an administrator in state government they said there was 120 boards and commissions. It was only through later reorganization in the state government they developed a more competent system. The governor didn't have very much direct control over state government because there were all these commissions and they were advisory and most of the executives set the policy and had the final word on that agencies operation. The liquor control commission was one of them. So that was the deal. The governor's report recommended that the governors office or he had somebody I guess, draft legislation so there was a bill in the 1961 legislature for the development of the state mental health division. It was highly controversial. My understanding is that it passed by one vote. There was a politician in Portland called Gracie Peck. Gracie Peck was a grand old gal. A fireball if there ever was one. She was behind this. I know because when they swore me into office she was there to see that it was done. I think if it hadn't been for her it never would have happened. The Division was to start in July of '62 and

they hired me in March. The end of March or the first of April '62. The first job I had was to sit down and prepare a plan for the operation of the state mental health division. The state mental health division was under the Board of Control. Do you understand who they are?

I: Yes, I do.

JT: A little bit about my background. I was primarily interested in hospitals and the treatment of schizophrenics. We thought at that time you could treat schizophrenia with psychotherapy and it was an interesting and wonderful approach. I went to the hospital that specialized in that in Seattle. It was a very difficult year and I learned a lot, part of which was that some of those things didn't work very well. I still thought I wanted to take analytical training so I stayed up in that area and started analysis and started consulting up at the local child guidance ~~dentist~~ clinics in Tacoma and in Olympia. The first week I was on the job there, after I had finished my training, a guy called Gerald Kaplan came and gave us a one-week seminar. He was a profound teacher. Have you encountered that name?

I: I'm not sure that I have the right Kaplan.

JT: He was an English psychiatrist, trained as an analyst, who worked a lot in Israel and was a child psychiatrist but very interested in community mental health. He worked at Harvard as a professor there. He developed a theory of public mental health called the "Public Health Law." The idea being that you pick up the pieces all the time but how can you intervene earlier? In one week he sort of opened my whole eyes to conceptualize that there is something more to mental health than a one to one relationship with the patient who is ill. He got me interested in the community aspects of that. In my training at Topeka, the other leg of the stool was that the first thing they did when I went there, I spent a year and one half in Topeka, Kansas, they put out a sheaf of paper. It was written by a psychiatrist and a sociologist at a private mental hospital in Maryland. There they were focusing on the social aspects of the ward review and its affect on patient pathology, getting well or getting better or symptomotology and introduced again that social dimension instead of looking just at the person you are looking at the state that they are in. I was very interested in all of that. Those things led me into the community. When I came back here and ended up in this job, there was a reason why somebody with my background should be selected. I had worked in community mental health and I had worked in institutions and I could sort of tie the two together in my thinking. My job was to take a look at this law and write a proposal and submit it to the board for implementation. I think the state, at that time, was getting grants and a lot of money. They were giving grants to the county or whomever the county would appoint, or maybe that came later. I think it was to the counties to develop mental health services and they had a list of five or six services to develop that were in the law. We would match. So that is how it started. My job initially was to do a lot of going around public speaking. A local group would be interested in how do they implement this law, what do they do and the team from the board of health was moved into my division. The team that was working in alcohol prevention and treatment and the state hospitals were moved into my division which was all under the Board of Control.

I: This was about in the early '60's?

JT: This was 1962 when this all started.

BK: I have spent some time talking with Senator Hatfield a few months ago at a ribbon cutting thing. Did he give you any specific direction of a vision for this or did he turn to you to build it? Did he have something in mind? A here is what I want you to do kind of message.

JT: I think he supported it. No. I don't think I ever had the governor work on a proposition.

I: So you were asked about whether it was your law or your implementation or at the governor's direction and you said

JT: I would submit a plan and they would approve or disapprove it. I don't think I got a lot of direction but the law was pretty specific anyway. It was my job to implement it and advocate for increased funding and report on what was going on.

I: So you advocated to the legislature for more funding?

JT: We used to have to go through the Board of Control and then each person would argue with you about it. There was a phenomenal growth in community mental health services for years.

I: The question I have about that is, do you feel that the people in the state hospital then got their full due or did the emphasis go to the community primarily?

JT: The state hospitals, when the mental health division started, were really a couple of feudal kingdoms and the superintendent reported directly to the board so I was in my offices and there between them which they somewhat resented. It took a lot of time before that relationship was worked out and resolved. The institutions represented about 85% if not 90% of the budget. The community stuff was important enough in coming that it was sort of a little bit of the whole balance. Institutions cost so much money and took so much management. Actually in the beginning the administration of the institutions was shared by the mental health division per se and the Board of Control. I didn't have to worry about a lot of the administrative details of running those institutions. Later on, that became the responsibility of the mental health division when the Board of Control disappeared.

I: At that point you were still overseeing them fundamentally?

JT: I was. It was a very interesting relationship between myself and the secretary of the board whether I worked for him or I didn't work for him. We sort of had the resolving of that to do.

I: Did you make decisions about the funding of the hospitals? After the superintendents did you make the decisions?

JT: It is like anybody else in the state administration. You make a recommendation to whoever is above you and then to the legislature. The legislature has the final decision. I would

make decisions and present them to the Board of Control and they would either approve or disapprove or tell me to come back with a different plan if they didn't like what I did. Then they would submit that to the governor's office for another review. It would often be changed because the governor would have to integrate that into all the other agencies and then it would go to the legislature.

I: To the Ways and Means Committee, right?

JT: Ways and Means Committee for review.

I: The hospitals would submit their initial budget to you? You were the first step in the process.

JT: Yes.

I: You had the authority to change or make other recommendations?

JT: Yes. They might argue with me and with the Board of Control, which could overrule me. I think in later years when I was back at the hospital I often did feel at first I was really trying to push these community health services because in my own heart I felt a tremendous need for them. I had served on the admission ward at the state hospital for 3 ½ years. We would take all the new admissions for one sex which would go through one admitting ward except for the ~~Ketchum~~ catchment area of Eastern Oregon until Dammasch came. There were no private practitioners in the communities. There were no local services. People would often come to the hospital that didn't need to be hospitalized but there was no other place. It was wonderful as a resident because I would see all these cases you wouldn't see in a mental hospital but it wasn't practical. It wasn't useful. We knew a lot of people were hanging around the mental hospitals that really didn't need to be there if you could give them something else. Also you knew you weren't dealing with all the other mental health problems that didn't result in hospitalization but were crippling people in society. It was part of a big national movement. Shortly after Hatfield and President Kennedy came up with the mental health bill, that impinged on what we were doing. It was a hot topic for awhile.

I: When it first began what were the barriers to implementing community mental health because it didn't seem to take hold right away?

JT: Part of the barriers was sort of inertia, an attitude and denial. People didn't like to deal with mental illness in themselves or their families. What happened with major mental illness is that the person would become psychotic and be very frightening and be very difficult to deal with. They would send them to the hospital with great upset in the family and great anguish but then they would get in the hospital and people would breathe a sigh of relief. At first they would maintain contact with somebody and after a period of time most families would loose interest and the community would sort of seal over and shut the door behind the person. If people weren't attended to, and they weren't, they were very badly neglected in the state institutions up until the last couple of decades and maybe even still to some extent, but terrible neglect. I studied the case histories of several people that were at Eastern Oregon who had been there for

twenty and thirty years and followed their progress. Often they had come to the hospital and they would go into remission but nobody would even talk to them. Nobody had seen them. Nobody would get them out. After a period of time they would loose their social skills and the community doesn't want them. One of the biggest fights I had in the first four years that I was administrator was with the welfare commission. There was some federal program that provided funds to place people in homes for the aged and nursing homes and state hospitals. I think it somehow impinged on the county welfare funding too. I forget just what the funding was.

I: Was that the initial social security where you had to be over 65?

JT: There were a couple of programs. I can't remember. You can find them in the records that you could get people out. The Board of Control was very interested then. When I first came we were adding beds to the mental hospitals every year, 100 beds. It cost a lot of money to build new buildings and add new staff. There was this program that could get them out of the Board of Control system and into the community system if they were eligible and not too difficult to manage. There was this push to get some people out of the hospital and reduce the census. It was a good program. The welfare commission felt that the state was dumping the responsibility on the counties. It was part of that attitude that once you got to the state institution you were a state responsibility. When I was young and brash and didn't use good judgment, the head of the welfare commission said something to the press about the state dumping these people onto the county. I wrote a letter to the editor saying that they came from the county and they had as much right to county services as anybody else and we had a big brouhaha about that.

I: It seems like a legitimate discussion.

JT: It was. Andy Jurist, the head of the welfare commission, went to the Board of Control and said we were dumping all of these people and here are these cases and added a bunch of cases. I went and looked at it personally. I went around the state and looked at it. I found he didn't have his facts right. What I found was very educational for me because I talked to a lot of these people and I never found anybody that wanted to go back to the state mental hospital. I used that story many times on the Ways and Means Committee and it is one of the advantages of having been there.

I: Were they in homes, homes for the elderly or homes for?

JT: They were in homes for the aged and nursing homes.

I: You felt they got reasonably good care?

JT: Better care. It was spotty. Some places there was neglect, that was true. But a lot of the places there was sort of a homey atmosphere and most people felt better there. If they didn't like it they could always throw a few symptoms and be back. That was one of the barriers, an attitude. There was a lot of denial about mental illness and a lot of refusal to look at it. A lack of awareness about the nature of the problems, a conservative state. People didn't like to spend money on public programs. A little bit of resistance on the part of some of the professionals, the medical profession. I guess those were the main things I can think of.

twenty and thirty years and followed their progress. Often they had come to the hospital and they would go into remission but nobody would even talk to them. Nobody had seen them. Nobody would get them out. After a period of time they would loose their social skills and the community doesn't want them. One of the biggest fights I had in the first four years that I was administrator was with the welfare commission. There was some federal program that provided funds to place people in homes for the aged and nursing homes and state hospitals. I think it somehow impinged on the county welfare funding too. I forget just what the funding was.

I: Was that the initial social security where you had to be over 65?

JT: There were a couple of programs. I can't remember. You can find them in the records that you could get people out. The Board of Control was very interested then. When I first came we were adding beds to the mental hospitals every year, 100 beds. It cost a lot of money to build new buildings and add new staff. There was this program that could get them out of the Board of Control system and into the community system if they were eligible and not too difficult to manage. There was this push to get some people out of the hospital and reduce the census. It was a good program. The welfare commission felt that the state was dumping the responsibility on the counties. It was part of that attitude that once you got to the state institution you were a state responsibility. When I was young and brash and didn't use good judgment, the head of the welfare commission said something to the press about the state dumping these people onto the county. I wrote a letter to the editor saying that they came from the county and they had as much right to county services as anybody else and we had a big brouhaha about that.

I: It seems like a legitimate discussion.

JT: It was. Andy Jurist, the head of the welfare commission, went to the Board of Control and said we were dumping all of these people and here are these cases and added a bunch of cases. I went and looked at it personally. I went around the state and looked at it. I found he didn't have his facts right. What I found was very educational for me because I talked to a lot of these people and I never found anybody that wanted to go back to the state mental hospital. I used that story many times on the Ways and Means Committee and it is one of the advantages of having been there.

I: Were they in homes, homes for the elderly or homes for?

JT: They were in homes for the aged and nursing homes.

I: You felt they got reasonably good care?

JT: Better care. It was spotty. Some places there was neglect, that was true. But a lot of the places there was sort of a homey atmosphere and most people felt better there. If they didn't like it they could always throw a few symptoms and be back. That was one of the barriers, an attitude. There was a lot of denial about mental illness and a lot of refusal to look at it. A lack of awareness about the nature of the problems, a conservative state. People didn't like to spend money on public programs. A little bit of resistance on the part of some of the professionals, the medical profession. I guess those were the main things I can think of.

I: When I started working, one of my placements as a social work student was in a community mental health center and we didn't serve people with chronic mental illness at all. We wanted nothing to do with them.

JT: That was the later struggle we had in my second go around with the state. We didn't have the programs fairly well developed and we were spending a considerable amount of state funds or matching funds and grants and we were still having people leave the state hospital and not get the services they wanted. It became sort of a national awareness that the community mental health system was not taking care of the chronic mentally ill. The federal government came up with a program of community support. I remember when I was back at the mental health division in the MED program office in '77; I read about these grants that you could get.

I: Was it the CSP grant, community support program?

JT: Yes. I think we got a grant to study the thing. We got our foot in the door. It wasn't every state that had them. You had to apply. We did a local study about what was needed and what could be done. I remember going up to Vancouver, British Columbia, and looking at what they were doing there. We put together a program and went to the legislature. We had sort of a fight with the community programs because they, like anybody else, like I did as a state administrator, like to get the money from the federal government and now they have all these strings attached. We wanted to make sure that they looked after the people coming out of the state hospital. Also it seemed from the studies that were coming in all over the country that you need a certain set of services if you are going to be successful at keeping people in community placements.

I: How did the CSP program integrate with the existing community mental health centers?

JT: As I recall, we would get grants to provide these services. You get the money to see that they have a place to live and that they have consultation and they have medication control.

I: Regular health services. They would contract for those and incorporate those into their existing services? Did that improve the services?

JT: I thought it did. There were two or three years when I thought it was very promising. I thought it was a real step in the right direction. I don't think we ever got all the funding that we needed to do the job thoroughly.

I: Are there any memorable events or policies or whatever that stand out in your mind during the time that you were working for the state? Any particular controversies?

JT: One of the initial controversies was what knowledge do we have to develop community mental health services. One was to let it develop out of the institutions. Oregon State Hospital in the '60's went through a regionalization program in which they would each divide the hospital in units to serve regions. One of the ideas was you could extend the hospital service into the community with branch offices and run an integrated program that way. That was not a model

that fit in with the way the state operated or California or many other places. There was some success in England although I never went to see it. It was a model some people were thinking about but it never got very far here with other controversies. There was a big controversy about Dammasch before it was even created. Somebody wanted to develop it as a nursing home and it was headed in that direction and then they decided to change it so it was controversial from the very beginning. I remember Hatfield said to me when he first appointed me and this was just a year after Dammasch opened its doors, he said, I wish I had that money that we spent on Dammasch to give you for this community program.

I: What were the pressures that were brought to bear so that Dammasch was constructed?

JT: Beds. Bursting at the seams at the state hospital. They had 3500 patients and stacked up like cord word. Eighty on a ward and no place to put people. Also the population center was up there and people had to run back and forth between here and there. All these people wanted to have something local and have a new facility locally located that could provide better services. Actually I think they needed the hospital because I don't think the community programs could have gotten up fast enough to take care of those people at that time.

I: Were you around when they started building the new building without the permits?

JT: I was at the meeting. I was on the committee planning that thing. I remember saying; don't you need a permit? No, we don't need a permit; the state has eminent domain. I was just one of the committee members. It wasn't my concern with that at that time. I thought they were getting in hot water but they thought they could get away with it.

I: Were you around also when they abolished the Board of Control?

JT: I had gone back to the hospital by then. I think Ken Gaver was the administrator. I followed a little bit in the paper but it didn't affect me directly very much. Although the way it happened I didn't think was a good way around the state system.

I: Why is that?

JT: You had this board and the governor didn't have control over it and he could be outvoted two to one, it complicated the politics of the whole thing tremendously. Also these boards and commissions, the welfare people off in this direction, and mental health in this direction, and the board of health in a different direction and the governor didn't have any authority to coordinate all that. I thought it was not an efficient way to run a state government. I thought the administrator should report directly to the governor and not have another body between him and the governor.

I: Were you around when the fair labor practices act was implemented? Were you working in the hospital at that time? I think that was in '74.

JT: When we had to pay patients?

I: Right. Can you talk about that?

JT: I always had ambivalent feelings about it because it was right that patients should be paid and they didn't get paid enough before. It also imposed so many restrictions it was much more difficult to provide work opportunities for patients. There had been an initiative in the hospital, we had a program that put people to work and gave them some small pay. I thought it was very effective in rehabilitating people. The pay for patients was in many respects a step in the right direction because it made it more legitimate and a little fairer from the patient point of view. I can't even remember now too clearly why I feel negative about it but it seemed it made it difficult to get patients to do some sort of things. They would sit around because you couldn't get them to do something because you didn't have the money I guess to pay them to do it.

I: Or they knew what their rights were and said you can't make me work?

JT: I don't think that was a big issue because most patients wanted to work.

I: It also created a lot of staffing problems because they could no longer do the work, right?

JT: Yes. It was true the patients were exploited and badly exploited by the system before so I guess on the whole I felt it was a step in the right direction.

I: Did you have anything to do with eugenics?

JT: Yes. When I first came to the hospital, they used to use sterilization a lot to prevent passing along the genes of mental retardation and mental illness and also to treat sex offenders. When I first came there we had a staff meeting with the physicians every Tuesday and so much of the time was spent presenting cases for sterilization that we used to call it tube-tie Tuesday.

I: Who made the decisions? It was the hospital administrator at that time, right?

JT: I made the decision at the hospital but it still had to be presented to the Eugenics Board. There was an in-house decision that yes this patient should be sterilized and the final say was the superintendent that was the basis of that meeting. That is where a person had to present their case to the superintendent for his approval. Then it was taken to the Eugenics Board.

I: What was a situation where you might vote for sterilization?

JT: It was females that I would recall cases where they would have repeated psychotic episodes. I think at Fairview where the head mental retardation was it was to prevent the passing on defective genes to offspring. Some people thought that it reduced the incidence of recidivism in sex offenders but that was never my opinion. The younger psychiatrists didn't believe that but some of the old timers did. Sometimes I think it was really a punitive measure disguised as prevention.

I: What kinds of treatments were they using in the hospital at that time?

JT: When I first came there the only treatments that they had were electric shock treatment, coma-insulin treatment and hydrotherapy which included hot tub and wet sheet packs to calm down the extremely excited people.

I: Can you talk about the hydrotherapy?

JT: When I started psychiatry they didn't have the anti-psychotic drugs. Patients would get so excited they would exhaust themselves. If you didn't watch them very closely they would die. One of the ways of calming the person down without actually restraining them was to put them in a wet sheet pack or in a hydrotherapy tub. It did have a calming effect and it was useful in that regard. In conjunction with and it was an alternative to electric shock. My favorite story in clinical psychiatry in all these years is of a girl who came to the hospital when she was 18. She had an extreme agitated psychosis her first attack. She had been a college student. I was responsible for her care but I wasn't doing shock treatment, the guy next door was. I had to have him give her ECT two or three times a day to keep her alive because she was exhausting herself from hyperactivity. There wasn't anything else we could do. If I didn't do that she would dehydrate, develop a fever, wasn't eating, wasn't sleeping. We finally got her calmed down. I kept her around for about 1-½ years. She finally left. I got one report a little bit later that she was doing all right and then three years later I think it was, I got a call from the federal aviation commission or a letter wanting to know about her illness because she was learning to fly an airplane. I got a little bit of her history. She had never had another attack of mental illness. She completed her college education. She had worked as a PE teacher in high school for years, raised a family and now as a grandmother was learning to fly an airplane.

I: That is amazing. So she was cured?

JT: She got over the attack and didn't have another one. Remission was spontaneous. All we did was keep her alive until she recovered.

I: Did you have a lot of cases like that?

JT: No. More typical, one time I came on the ward, my admission warden and I found acute young schizophrenic ladies in their twenties and I remember seeing those people around the system for years and years. We used to always say, and the literature seems to support it, two thirds of acute schizophrenics would recover and go out, one third would have recurrent attacks. It is really a terrible illness.

I: You also spent a lot of time in the forensic unit. Can you talk about that? Were you part of the development of that?

JT: Yes. We had a notorious escape called the fat boy. I forget what he did. Whether he was a sex offender or some other heinous crime but anyway he was just on the regular wards. He kicked out a window or something and left. So they developed one ward up there, Ward 18 I think or 31 or something, that had bars on the window. That went on for awhile and we began to have more of these people that were dangerous. The people in the prison said the Board of Control told me to develop a plan for a forensic unit. This must have '64 or '65. I met with the

superintendents. We looked at all the facilities and it didn't look like there was anyplace that would fit the remodel. I said we just don't have anything fit. We have to build a building. The rest of the wards are junk and not worth putting money into. They didn't want to come up with the money for a building. They said find a place so we bought that unit where the forensic unit was originally in the old J building, just remodeled the wards the best we could and had a forty-unit ward there that was temporary. Doctor, next year we will go to the legislature and we'll get you a building. I guess eventually, it might have been two or three biennium's later they got the money to dig the hole up at Dammasch that had to be filled in so that didn't get off the ground. We are still making do there at the state hospital.

I: What about wards for adolescents or children?

JT: That was a long, long battle.

I: Can you talk about it? When you started there were the child guidance clinics. That was basically taking care of the children and the adolescents I would assume.

JT: It was one of the glaring lacks that we had and it was recognized right from the first when we started the mental health division. I think I hired a guy called Gene Taylor, a psychiatrist who studied the whole thing and came up with a plan. I think I went to the legislature with a plan for adolescent treatment. I think it got dropped. That is the best of my memory. Several years later when the space shuttle blew up and the astronauts were killed, just before the moon launch either late '68 or early '69, I was on my way to the legislative committee in Washington (state) to look at that unit. Don Bray was the administrator then. I know we were planning for a children's unit at that time. I can't remember just what happened to that plan.

BK: Were children mixed with adults in the hospital before?

JT: Yes. That was a big step.

BK: How young?

JT: We had some six, seven and eight. I will always remember a little girl called Lavonia. Lavonia came to the hospital and she had a history of being drunk on the streets in one of our towns in Oregon and involved in prostitution. She was eight. She smoked like a chimney and she was always bumming cigarettes. Smoke would be coming up from behind the piano or through the door. We tried to keep her off cigarettes. I don't know whatever became of her but she was on the ward. Some people around the hospital said they get a lot of care from the older adult patients. You put them on a ward where you don't have enough staffing and they are just going to be a bunch of kids and they will be more deprived. A lot of people said, that's terrible these mental patients looking after children and abusing them. I guess the truth was somewhere in between but I think the consensus was that we needed a children's unit. Why we didn't get one I don't know. I don't remember that. I just remember it was a long, long struggle and finally we got one in the '70's.

I: Yes. It was interesting to me that obviously it was a problem that everybody recognized. There was nothing unusual or it just seems it would be common sense to have one and there is no indication of why one didn't come into being.

JT: I think maybe it was sort of shunted off to develop residential community facilities. There was that program at Fairview. I think there was a little competition between some of the community providers and they wanted the action and not the state. That might have been a little of it but most of it was in the budget area.

BK: Common sense.

I: Don't you think?

BK: Well it is a question of about thirty seconds.

I: Go right ahead.

BK: I was thinking that if you started in 1953, that was only a few years after all those patients died from rat poisoning. Did you hear about that?

JT: Yes. Dean Brooks brought this up. It was in 1947, I think. I have seen the newspaper articles.

I: Yes. He has them. Maybe Doctor Pati has them. I just saw them recently.

BK: Really. The point was that when you look back you say well why did they do that but then when you look forward you can't anticipate all the things that will change. My kids were looking at some book and there was a picture of two water fountains. One said white, one said colored. They couldn't believe it. There are a lot of things that don't make sense but you kind of accommodate them or something. Those ladies said I don't know how we could have kept kids on those wards.

I: It is like child labor. I am sure it is the same. We just view children differently now and I like your idea of them getting care from the older patients. That is what Dr. Pati said as well.

JT: I never saw with my own eyes evidence of serious abuse of children in the adult wards. I never was comfortable with the idea either. I think they needed special care. I think they needed a special team. It wasn't good enough just to leave them on those wards. I don't know if anybody has pointed it out before but the state hospital system started as a reform movement because of the lousy care that people were getting in the facilities. I think the conclusion in my mind is that you can neglect the mentally ill anywhere. It is not a pretty picture wherever you do it. I have often felt when the hospital sort of disappeared or shrunk to the current size that there was a role in the mental hospital for asylum. That is what they used to be called. Some patients made, that were very handicapped, made a life for themselves there that it was difficult for them to have in other places. If you don't have decent community facilities they can end up in jail, get abused and neglected and be worse off.

I: Live on the streets. I would like to hear just stories.

JT: I am sure I have lots in my brain. I need to stimulate them.

I: My questions have to do with different things that were established at different times and I have kind of gone through those. I don't know what your stories are so I don't know how to even ask you questions. Were you involved in the training of the psychiatrists?

JT: Yes, for years and years.

I: Do you want to talk about how that developed?

JT: When mental health became a big thing, I guess Dean Brooks is really responsible for getting a psychiatric training program. There were federal funds going back even before community mental health for training psychiatrists. I think that came out after the war. World War II led to the realization there were an awful lot of psychiatric disability in the population that was being ignored. There was a big push on to get more people trained in this country. I guess there were some funds available for training psychiatrists. Dean had the initiative to get some residency training programs at the hospital as part of the way to recruit people to come to the hospital so they could get staffed. They were very hard to get staffed because they didn't care very much and there wasn't much prestige connected with it. That is how it got to the state hospital. To me, I thought it was a job. I never thought it was training because there wasn't any, or very little. I was broke and I had to leave the training program so I came here to work. In fact they gave me some credit for it but I never thought in my own mind that it was a real credible training so that was why I went for a fourth year somewhere else although it wasn't required. The training program gradually became more significant and there were federal funds that would pay pretty large stipends so you could attract people. After a few years it came to my attention that there was something bad connected with that program. I know several cases where they would encourage a physician to leave general practice in a rural community that was having trouble recruiting people. They would bring them to the state hospital at public expense for three years to train them as a psychiatrist when they needed general practitioners more than they needed psychiatrists. I think it served the state well. I think it provided a lot of manpower in our system and attracted a lot of people to our state. It certainly was good for the institution because a learning center is always a better place to go if you are a patient than someplace where people are not on the cutting edge or not really interested in expanding their knowledge. It was a very rich opportunity for clinical material. I think of all the jobs I did in psychiatry and all the places I've been, I learned the most, and what was most rewarding, was the 3 ½ years I worked on the admission ward at Oregon State Hospital. I had enough training by the time I got here that I could use the clinical material that was passing before me and it gave me a chance to see a great variety of different political syndromes. The system was loose enough that I could do what I wanted pretty well. I always kept a few patients long term on this admission ward really to get acquainted with them and follow the course of their illness. In some cases to do psychotherapy to see what I could do and what I could learn. I certainly felt that it stood me in good stead as a clinician because I had seen patients both in large numbers and in depth. It was a very interesting place, Oregon State Hospital, in those years. Dean was a good superintendent and he

always brought a lot of different people there that were known in the field and talked about staff and stimulated development. There was a real enthusiasm and impetus to try things that was always very exciting.

I: Did you find that psychotherapy worked with the people you were seeing?

JT: Sometimes yes, sometimes no.

I: What would make the difference?

JT: I had a very strange experience. In all I know about psychiatry today and what has happened it is very hard to assess it. I was very interested in the psychotherapy of schizophrenia. I had this young patient come in and she had been a teacher and had three or four acute psychotic episodes. I was going to send her on to insulin, which was a treatment, I never liked very much but it was all we had. The EKG indicated she had some cardiac problem and they were afraid to touch her because the mortality rate there was significant.

I: With the insulin therapy?

JT: Yes. We didn't have medication and I wanted to see if I could treat somebody with psychotherapy so I started to work with her. I reviewed all the psychiatric literature on the therapy of schizophrenics. I spent fifteen minutes a day with her when I was on duty and then half an hour. To make a long story short, I saw her become non-psychotic in front of me. It seemed what was going on between her and I had something to do with it. One day she came in to me and she said, Doctor I have been telling you all these things all these months and I just want to know if you believe some things. I was trying to maintain a relationship. My strategy was just trying to get along with her and try not to get into conflict but I felt I had to be honest. I swallowed hard and said, you are entitled to your opinion but that is not the way I see it. She got mad at me. She wanted another doctor. She jumped up and down. She said, if I were a man I'd beat you and turn you into a grease spot. She didn't want to have anything to do with me for about two or three weeks. At that point she stopped being delusional. She got well, got a job, got married, lived in town. I would run into her once in awhile. She did very well for fifteen years but the sad part of the story is she had another psychotic episode. She took on two young children, adopted them, and it was just more than she could handle.

I: So you think that may have caused the second episode?

JT: I think so. It was interesting. I think my conclusion is that it is of some help but psychotic people may need the medications and you can't do anything about it.

I: What was involved in the insulin therapy, I am not really familiar with that?

JT: Somebody observed that some psychotic people that had diabetes, when they went into coma would go into remission. They developed an idea that if you could give people periods of coma by insulin injections it would reduce their symptoms. This became an established treatment and they would try and shoot for sixty hours in a coma. It would take about two

months. We would give people insulin and they would be in a coma. We would have to watch them very closely and when their blood sugar dropped down to far they would either give them oral sugar to get the blood sugar up or an injection. The first residency I had, I helped out on the coma insulin ward. We would stick tubes of juice in them to bring them out of it. People would get very overweight, very sluggish.

I: They would do this over a six-week period of time?

JT: Two months.

I: Did you see results?

JT: I was never impressed with the results. I don't think the studies were really well done at the time. I don't think it was ever documented scientifically if it was effective. It was a brutal treatment. People would have seizures. People would die.

BK: Did the same think happen in ECT?

JT: I never thought it was as damaging to the body as a course of coma insulin.

I: What kind of treatment did you provide to the forensic patients?

JT: If they were psychotic, it was medication. It was supervision attempt to teach the patients to assume responsibility to control their anti-social impulses. A graduate set of privileges were increasing responsibility to see how they would handle it in counseling.

I: So you did it with a lot of medication basically. Did you see positive results with that?

JT: I think so. I don't know whether the treatment did it or some people straightened out. Some people would look like they were doing well and then screw up again. It certainly wasn't a very high recovery rate. When you are dealing with anti-social behavior it is very hard to change. Some people would be just plain psychotic and hard to handle and their recovery rate was the same as other people with psychosis.

BK: I have a question I would like to ask if you are done with that one.

I: Yes, I am.

BK: I think you were the administrator when the United States Department of Justice first showed up at Fairview in '83 maybe. It seems to me every day we are talking about lawsuits, constitutionality and violation of some federal statute or other and how we are vulnerable to litigation. Was that the case in the '60's and early '70's? I have often wondered if the Civil Rights Movement with all the landmark cases that were moving through the courts in those days influenced how people thought.

JT: Definitely because it wasn't an issue when I first came on the scene. I don't think it was until the '70's that it came on the horizon. It didn't really heat up until the '80's. It sure changed the whole practice of caring for mentally ill people. Some for the better and some for the worse.

I: You are talking about all the civil rights legislation?

JT: I don't know how many times when I came to the state I thought I was a flaming liberal about patient rights and what not, a crusader. After awhile, the whole crusade was taken over by the lawyers and I thought it became an abomination. They could only see the legal side of the thing and the fact that people needed protection from themselves. Many a battle over the test for commitment and confinement, use of medication. The system before was lousy because it was autocratic. The institutions had far too much control. The patients had no rights or very few rights and they weren't respected and that needed to happen. So any time you put a cure for abuse in the system you can go to far the other way but it had to be done and I think on the whole things are better. They were pretty abominable in many ways.

I: When you started? Did they have a lot of nurses on the ward at that time?

JT: We had few nurses.

I: Who took care of the patients?

JT: Psychiatric aides with almost no training.

I: Any social workers?

JT: There were three I think when I came to the hospital for 3600 patients.

I: So it was you and the aides?

JT: I think I had 160 chronic patients and half of all the female admissions to the hospital.

I: That is what you were in charge of?

JT: When I first came, yes.

I: Then the aides took care of the twenty-four hours?

JT: When you made rounds you would go in the chronic ward and say, how are things today? They would say, fine doctor. You would breathe a sigh of relief and go on and do your own duties. It was not good.

I: What changed all that? I know in my reading there was a lot of discussion about meeting APA standards for staffing and that didn't seem realistic so they eventually went to the Scope standards. Do you remember about that?

JT: I was an administrator then but I was aware of it. It was sort of a way to I guess put some sort of accounting practice into what was needed to take care of patients to settle the argument that you would always get when you went to the legislature saying, I need more staff. Every superintendent and every administrator always went and said we need more staff. The budget analyst of the legislature would say why? Show me. I guess that was an attempt to document in some way the need for staffing.

I: One of the things that I don't quite understand is that in all the documents that I read like the biennium reports or any of the other special reports, there are these goals of the mental health division. They are very lofty. Yet, there doesn't seem to be the money to put those into practice like you are talking about. We can't have more staff because we don't have the money even though we need more staff to fulfill these goals that we all supposedly agree with.

JT: When I first realized this the first time I was an administrator I felt like with all these lofty goals it wouldn't take very much money to do it. However, when you look at the state budget process and you look at every human need that the legislature or congress has to address and how human needs can grow with geometric proportions there never enough money to meet all those needs. If you took all your gross national product it wouldn't meet all the human needs. Inevitably there is going to have to be limitations. It is a question of where those are and who gets the goodies and how the pie is divided up. How much of the pie do you want to spend? I guess that is what politics is all about.

I: Right. What you want to spend where and with whom. Who are your priority populations? Mental health gets a good portion of the budget don't they?

BK: The fourth largest agency in the general fund, $550 million dollars.

I: We still have people who don't get services.

JT: The other things I came to realize is that by and large these decisions aren't made on a rational basis. The last time I was administrator I had some people who were pretty good at program evaluation. I was all hot to do some real evaluation of programs and as scientifically as we could present the facts to the legislature and let them make decisions on a factual basis. When I presented that to the governor and the Ways and Means Committee, oh yes, it was wonderful, great. The first thing that gets cut in the budget when things get tight is the money to do it. The second thing is you go present it and this pressure group come in and says we want this and that pressure group says that we want that and when push comes to shove usually the decision is made on a political basis of where the pressure is. That doesn't mean that you shouldn't do that. I felt that I had a role to try and push the process to the extent that you could to make at least what I thought was a reasonable decision. Somebody else might have a different opinion on that.

I: Did you feel that they made reasonable decisions for the most part?

JT: I thought the process was pretty good when I was there. I thought by and large the legislators were very responsible people and the process sort of got it out on the table. I don't

know how they do it now but I remember the Ways and Means Committee would hear our budget and hear our pitch and then they would have a couple of days, at least the subcommittee would, for the public to come in and they could have at us and present their side of the thing. I would have to go up and give the rebuttal. It was a pretty open process and I think a pretty fair process. I think they made pretty good decisions. I don't know about now. I have my doubts. I think the whole political system has gone down hill but maybe that just because I am an old guy.

BK: I think it has gone down hill.

JT: We used to have some really I think excellent legislators on both sides of the political fence. They weren't career politicians, they were people who were concerned citizens who were able to take a little time and work in the legislature. I think the term limits is not good for the legislature. It destroys that experience where the old timers could keep the young turks in line and keep them from doing foolish things with their newfound power. Same applies to administrators.

I: Did you enjoy your career in actually working for the state mental health?

JT: Yes. I always felt very fortunate that I had those opportunities that sort of came at the right time. I really did enjoy it.

I: What do you think is your most important legacy or contribution?

JT: I don't feel I left a legacy. I think the last time I was an administrator I did a good job at it. The first time I was a little rough and I didn't know what I was doing most of the time. I was glad to at least play a part in the development of community services and the support of the hospitals. That was a worth while program. I enjoyed the people I worked with. There were some very fine people in the mental health division and the community programs. I missed them a little bit when I retired but I would hate to have to go back to that regimentation in my life just to see them.

I: Maybe a party is called for.

JT: Yes.

JT: I happened to have a long haul and I was studying for my boards in psychiatry which included a heavy dose of neurology that you had to master. This lady walked down the hall in front of me and I noticed just the slightest drag of her toe. It was so slight it was barely noticeable but it just stuck in my mind. About half way through the interview I kept thinking about this and I got out my reflex hammer and tested her reflex. Sure enough one side was diminished. I said, she better go see a neurologist I think she has something in her brain. Sure enough she has a meningioma which whether it was causing her depression anyway when they removed the meningioma she wasn't depressed anymore. That is a rare example but I think there is a role for somebody to be thinking about that aspect and whether it is in the background. I always felt it was a very heavy responsibility as a psychiatrist to always be on the look out for

that case that you can miss who has got some serious general physical pathology that is presenting as a mental problem.

I: Right. I did a literature search on that and found in some cases, some authors said it was as high as 50% that the physical was causing the mental problem.