Prasanna Pati, MD

Oregon State Hospital, 1958 – 1985

Interview April 2, 1999

PP: I am Doctor Prasanna Pati. I worked at the Oregon State Hospital as a psychiatrist from June of 1958 to December of 1985.

I: Could you start by describing the atmosphere at the hospital when you started and what kind of treatment you were providing?

PP: In 1958, when I came over from Michigan, there was very extensive voluntary commitment to the state hospital. That means a person would come in and he or she would say I want to check in for thirty days. There was very little formal assessment. The mandate was that you take them in so the majority of commitments were voluntary commitments. There were not enough doctors, not enough staff, like you have now. Despite that, the voluntary commitment was a good way of taking care of people, at least providing them with a place to stay, a place to interact, entertainment, three meals a day, plus medications. When they got the medications, it depended on the condition of the patient so it was very, very heavy work for all of the staff. No question about that. Staffing was very low in those days. But the general atmosphere was quite good when I came. We had a lot of electric convulsive therapy, occupational therapy; those were the two major. We didn't have the medications in 1958 as much as we have now. We had a few medications coming in like Thorazine and all that. But mostly it was talk therapy and group therapy and the medications what ever that was and we had a lot of emphasis on occupational therapy and some activities therapy.

I: When people left the hospital did they come back? I guess I have two questions. Were they appropriate to be there?

PP: Yes. The appropriateness that is a question of judgment. Appropriate means, I would say, that the legal criteria we have now, I call it legal criteria, has ruined the thing all over the country. The reason I am saying that is if you strictly apply the legal criteria, then many of the folks who need treatment are not able to come into a system. System means either the hospital or private hospital or private psychiatrist. In those days the door was wide open for all those people. We had inappropriate people coming too. Right now, because of the strict legal criteria in this country many of your folks are ending up in jails. In Multnomah County jail today, 30% are mentally ill. So there was an open door, some inappropriate, but the general teaching of the staff was quite positive, lot of investment in patient care because of very little paper work.

I: So you could spend your time with patients?

PP: Yes. Spend time with patients. Then Maxwell Jones came in about 1960 or so, therapeutic community, very controversial person, and he came in and stayed two or three years. He sort of introduced some ideas in terms of family therapy, therapy to community, big ward meetings, big group meetings, big family meetings. He introduced some of those things which were quite good I think. He was very controversial and very difficult to get along with but he had some tremendous ideas.

BK: Why was he here?

PP: Doctor Brooks got him. He came from England. He came as director of education to this place. There was a vacancy. The guy was in charge of director of residency training for the doctors. That was the main, official job. The rest of the job he visited the wards and trained the staff in this kind of things.

I: So we are up to 1960. What are the things that changed how you provided services?

PP: We had a lot of talk therapy. For example, myself, I did that and other doctors did that too. I said regardless of how much paper work I had to educate at least three patients every day in psychotherapy. That was my main training so I tried to do that. Sometimes I was not successful. Then with extensive family therapy, no family was there, and we had kids come in and parents come in and husband come in and wife come in and many of the units that we had we had extensive family interaction. We had group family individual counseling, one to one interaction because we did not have much medication in those days so we had a lot more time then.

I: What did you do with the violent patients?

PP: Violent patients were in Ward 84 which you do not have in the forensic program. Ward 84 is the maximum-security ward which is on the top floor of the forensic unit. That used to be called Ward 38 for male patients. That ward used to take the violent male patients. There was also another ward called Ward 81 for the female violent patients. So those kinds of patients ended up over there. Mostly we managed these patients in the long building you have for the admission, treatment building, on Center Street. Most of the patients were treated and could go home from there. The patients stayed a little longer in the so-called "long stay" wards. The very aggressive disturbed patients ended up in those two wards, but not to frequently. The forensic ward had a problem with enough beds at that time. This particular ward was for the violent male and female patients.

I: Did you have children and adolescents in the admission and treatment wards?

PP: No. That came way later. It was in the 70's. That building where we are now used to be the forty building and that was one of the regular psychiatric adult wards. Then it was closed and they opened the children's center and programs in the 70's but we didn't have that at that time.

I: You started using medication in the mid-60's?

PP: What happened was there was another important thing happened after Max Jones in 1962. Doctor Brooks can tell you more about that. Granger State Hospital in Iowa decentralized the entire facility. They were getting patients for so many counties. They said, we are a county unit so the people working in this particular Megan County elected a Megan County staff for Megan County welfare. In '62 Doctor Brooks got this idea from there. He thought we were the second hospital to decentralize along county lines so we divided the hospital into eight major areas. Six were county units, one was a medical-surgical unit which you still have, geriatrics, and the eighth was the forensic program which was a very minimum small program then. The

county division became for example, Lane and Douglas became one county. All the patients from those counties were housed in one building. We transferred the patients from various buildings. The forty building was the Marion-Polk unit. Of which I was in charge of this unit for a number of years, Marion-Polk, then Lane and Douglas, then we have the coastal counties, then we have another for Douglas, Jackson, Josephine, all those counties whose communities were one unit, so you add it up. We were left with another big unit called Unit 1, which were the patients who normally belonged to the area that was Multnomah, Clackamas, Washington, all those counties. Those patients did not get transferred to Dammasch; they stayed in our state hospital. That was our biggest unit. So we had the county units and we began to relate more intensely as part of the inner modality with the community mental health program. We would go down and talk to the public health nurses. In those days, public health nurses did home visits and we would relay it to the welfare people, we visited the foster homes before we placed these patients. So that began an interaction with the county people. That was the next significant event.

I: That was in the early 60's?

PP: '62. Somebody wrote a huge paper on that but I don't know who has it. The person who chaired the extensive reorganization of the hospital, her name was Gertrude _____, she was the director of social service, the late. She chaired this extensive in one day we had to decentralize the whole hospital. Patient A, Patient B, all of that went to the county regardless of age although we still had male and female wards.

I: Do you think this was a step forward?

PP: This was a step forward in the way that Doctor Brooks was there. He said, I give you guy's autonomy. We don't want to run these various county units from the top unless I have to interfere. You guys run the unique programs and the therapeutic programs and that was kind of semi-autonomous in terms of power structure. That is one thing and number two they had to relate to the counties, we had to make trips to the counties. People who worked in the Douglas County unit here had to visit Roseburg at least once a month. They had to talk with the people there and get the feedback from the counties. They had to check on the patients who had been discharged. There were all kinds of stories around. For example, Douglas County told him don't send that woman to Roseburg she is an alcoholic patient not a county patient. They said, we have to many bosses here send her to Portland or something.

I: They didn't want her?

BK: No bars in Portland. Monmouth might had been a good choice, there are still no bars there.

I: Is that right?

BK: It is a dry town.

PP: It is a college town. There are many intellectuals in the county.

I: There were beginning to be services in the counties at that time?

PP: There were beginning to be services. Not as extensive as you have now.

I: What kind of service did they provide? I know it varied by county, but lets say your county.

PP: I was in charge of Marion-Polk County unit. They provided us with medication follow-up, medications, some groups, etc., and so did Polk County and Yamhill. I was in charge of Yamhill County too. Yamhill County was very strong, very well run program for a number of years. Doctor Joe Arnold still works there. Marion County has more complexities because they are right in this town. They have funding problems, etc. The emphasis shifted to the chronically mentally ill. They amended to take care of the chronically mentally ill.

or George Suchow

I: The community mental health centers.

PP: That is a two edged sword in the sense that there are people who could get better with some minimal kind of assistance, medications, anti-depressants. A number of people are depressed but they are not able to access the regular psychiatrist in private practice because of insurance and things. These people could get better and start functioning again. These people are not being treated in the mentally ill clinic. For example, I testified yesterday before the ALJ on a social security hearing in Eugene. This particular person has been followed by that county since 1983. Imagine the investment of money and the time and personnel.

I: In the community?

PP: In the community, plus hospitals. This person is not going to be able to function. It is not a question of putting blame on anything. The services provided to that person are so intensive and so much money and so much resource. Your regular people, who need something, maybe just psychotherapy for two or three months, some medication that could be provided in the mental health clinic are not able to access it. There is the dilemma that I think administration has to face. I would rather put a little bit more money in the people who will be able to function with families. They are going through crisis situations, anxiety, panic disorder, which do not meet the criteria of the world here at Oregon State Hospital. They are not dangerous. They have social phobias, panic disorder, very common, extremely common. They could respond to anti-depressant anti-anxiety medications, some group therapy, not many need regular therapy. These people are not given access. This is something that is happening all over the country tragically. I would rather put some more money and resources in the people who can be treated within a few months time and the tax money should go, some of it, to that particular portion.

BK: So the two edge sword is that by forcing a priority on the communities you excluded people who could well have gotten more productive and have poured a lot of resources into some people who may never.

PP: They pay taxes. They pay back to the society. They take care of if there is a housewife who takes care of two or three children she is stressed out, she is depressed, she is fighting with her husband, and they used to come in. A woman was depressed and fighting and they used to come on in. They have a look at her for thirty days. I have a lot of sympathy for them but to pour all of these resources and deprive other people who could be productive is something and to change their mind set in some way. Also I have a lot of compassion for the Fairview guys but how much money do you spend, $20,000 per month, $12,000 or $10,000?

I: Per person?

BK: About 27 right now. Of course it gets smaller and the fixed costs sort of ramp up the daily costs but we are spending about 40% of the budget on about 3% of the target.

PP: That is something that I see as a debate as to where the money goes. Many of these people are not being treated in the community by regular psychiatrists and they don't run to the other doctors social security system, SSI.

I: Would you still treat the people with the chronic mental illness in the hospitals?

PP: We had lots of chronically mentally ill people when we came in and many of these patients were placed in care homes, etc., with some medication management which is still happening. They were provided with medication and activities and they stayed in the hospital. Some of them stayed too long. It is a philosophical question whether they are better off or not. Whether they are better off in a group home in down town Salem on 14th Street or whether they are better off in the hospital. Many of the patients were right they thought they were better off in the hospital. We had lots of long stay patients then but we placed them out when you decentralized and mental health division came in and the expectation of hospital projection as if you were going down every year. The patients were placed outside.

I: So you saw the population go way down?

PP: Yes. Population went down all over the country because many of the long stay patients were placed outside in care homes. Many times most inappropriately, including by myself, because we did not have the follow up which we thought we were doing the right thing. They would go there and there would be some follow up by public health. That didn't happen with the mentally ill patient. These people were not given follow up in many cases. All over the country there was this so-called decentralization.

I: Your job must have changed a great deal over time?

PP: How do you mean?

I: Instead of having the open door and all the patients coming in it sounds like you could do pretty much what you wanted.

PP: The hospital changed. In 1970 because of how many mental patients we had, we started a lot of intensive treatment work, LIT we used to call it in the building upstairs. I was in charge of that for a couple of years, the most difficult mental patients. We had one or two admissions a day of the police sort or something, plus transfers from other wards and we managed that for two, three, four years. We had a little bit heavier staffing there. We went through that phase and then the regular committed patients numbers became smaller and smaller. Then the forensic program became bigger and bigger.

BK: Why was the LIT ward transferred to Dammasch?

PP: LIT ward was closed. LIT Ward, Jim Pomeroy, was assistant superintendent of building services, he had trouble and it was a real big mistake. Tom McCall was gone by then. The Ward was pretty successful until the mental health division came in and I can't remember the reason, Doctor Brooks might know, they decided to close it. Later on it was reopened in the Dammasch facility.

BK: Ward A for the most challenging, high security?

PP: Yes. LIT ward in the Oregon State Hospital it was a regular civil commitment. It was not the forensic patients, court committed and a coed ward too. That was another story, coed.

I: Can you talk about that? They separated patients primarily?

PP: 1967 we coed beginning from the _____ Unit, of which I was in charge. We had a Doctor David Clark, Superintendent of a mental hospital in England for thirty some years. He used to visit us and give us a little training and insight. We asked him one day I said, can we coed the ward. What prevents you? Good question, and we did it. We coed the Ward in the forty building. We had four wards there, two females, two males; we made all four male-female. We didn't have any problem. Only one person came and he was the husband of one of the patients and he was very angry. He thought his wife was going to be raped or something like that and he pulled her out of the voluntary commitment. His wife did not want to leave but he pulled her out. That is the only incident I remember when we coed the ward. What was in the coed situation was inappropriate interactions like happens in the community but not a big problem. From then on all the other inmates started coed too and the geriatric program was coed in the late 70's, like 1977. The forensic program coed the female ward we used to have.

I: Does that mean that they all slept on the same ward?

PP: Same ward, different rooms but they interacted with the same staff and the same kind of group therapy meetings. We didn't have to many problems as far as that rather significant event in coed.

I: What other changes did you see in treatment as you went through?

PP: The major part of treatment that is not happening nowadays is the outdoor programs. We had the outdoor programs, adventure programs and we had a lot of emphasis on interacting

outside. We took them to picnics, the coast and various kinds of places. We would literally close the whole ward and all the staff, including the doctors, would go. We had a big adventure program like white water and also went to the mountains. We were written up in Life Magazine in 1973. So there was a lot of emphasis on outdoors and adventure and these kind of programs. That was a lot of emphasis on activity therapy as we used to call it.

I: Did you think that was helpful?

PP: Yes. Because first of all in mental ill and so many different things it is not a question of medication. Some housewife comes in and she is depressed and I give an antidepressant in two or three weeks I expect some results. If she comes to counseling I am going to ask her how she spent her time yesterday. I am not saying you must do this or do that. She has to respond and says I didn't do anything. Did you change the diapers, did you feed the child, did you do the laundry, I am trying to interact on that level of psychotherapy saying that now you start relating to what life is. If a patient who is locked up in the hospital it is better to work in the grounds, kitchen, dining room, and laundry. They used to work all over the place.

I: That must have been a huge change in the hospital when you had to pay patients.

PP: Pay for patients came in from the State of Indiana. Some patients started a lawsuit, Souda versus Indiana. The judge decided it was an exploitation of the patient. Then they started paying the patient minimum but that was not the answer. That became a bigger and bigger problem. The whole thing is not operating now. I think very few patients in the hospital work outside as far as I know. We had a huge number of patients getting out of the ward includes the supervisor and does some meaningful things. Cleaning up the grounds or working in the dining room.

I: Didn't they do a lot of the cleaning?

PP: Yes. They did some cleaning too. The staffing was so poor there the patient help was a significant factor. Somebody could say it was exploitation but it depends on how you look at it. If I had a patient I asked to go out and work in the grounds or do something outside and we expected anybody on status to go out to activity or industrial therapy.

I: Which was work?

PP: It was work. Even Freud said that, work is therapy. The fact that some people say we treat them with medications. The bottom line is intensive staff investment. If it is not that it is a lot of staff investment.

I: I found the same in my work. If there is somebody that really believes in the person and encourages them it seems to get them started.

PP: Yes. You need those ingredients in helping, especially a mentally ill patient, because there is no science to it yet. Although there are a little bit more medications there are no science to it. You have to make a tremendous investment and build a doctor and work in a team. A team

of social worker, nurse, and all that and the doctor as the team leader he will see it is together sometimes the staff will come up with their work. So the team approach to treatment with investment we did all those kinds of things as much as we could depending on the time. For example, I remember a husband and wife were on the verge of divorce, both schoolteachers around here, and in those days we had sensitivity training. I went to training in California in the 1960's. Long sessions. I said one of my aides, he and I, we work with this couple and there is no time limit. We will start at 1pm and go as long as it takes to help them resolve. They were brilliant people, both teachers. It was summer time and we sat on the lawn, the four of us. We sat on the lawn and just had a little break to go to the bathroom. We met with them for four or five hours. This kind of investment and the patient can figure it out pretty fast.

I: Were you still able to do that toward the end of your tenure?

PP: No. I became more and more popular in the administrative structure. I became clinical director in the regular adult psychiatric program and then the forensic program. Half administration and half clinical. I always did clinical work. Regardless of how busy if was in administration but most of my experience was clinical rather than administration.

I: Do you remember any events or laws or policies that changed the hospital and how you provided services? Anything in particular that sticks out in your mind?

PP: I think the changes in commitment laws. The changes in commitment and the criteria became so strict. JCH came in and demanded certain standards. You guys fight all the time and JCH is not easy to maintain and that drains the resources to only a few patients. In order to get the money you have to maintain so many this, so many that, so much paper work, so much documentation. All those things came in the late 70's and 80's. That had impacted. Legal criteria has impacted the control and the governor, secretary of state and treasurer running all the institutions until the mental health division came. There is only one psychiatrist on the board of control. There is a direct between the governor and the institutions. When Hatfield was governor he used to visit the hospital quite a bit and check on us.

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I: Did you think that the dissolution of the board of control was a positive thing?

PP: Dissolution of the board of control was a direct channel between the governor and the institution and was much better.

I: I know Barry is sitting here.

PP: He is just getting views, he didn't create the mental health division. Mark Hatfield used to visit. Bob Straub used to visit. Tom McCall also but Vic Atiyeh didn't visit. He was gone for eight years.

I: You think that affected how policy was made and how much funding was given to the hospital?

PP: It created a big mental health division plus the Department of Human Resources came in with good intentions and it became a vast bureaucracy. The whole DHR and I am not saying it is happening only in Oregon it is just that you cannot even talk with them without getting their voice mail. What is happening is that the bureaucracy is propitious. I think the resources of the state, what the legislature gives you guys, how much is going to the direct patient care is the bottom line. Bottom line is direct patient care and are we getting the result. Somebody has the money and mental health division has the money. What kind of a job they are doing. Are you getting your money's worth as far as the patient care is concerned, and not anything else?

I: Did you have any evaluation methods that you used?

PP: In those days?

I: Right.

PP: We didn't have any certain department. We had somebody survey how many patients got better. If a patient got better we would send them home and follow and study like that. There was no clear; we didn't have the resources to do real research. The goal in those days was to put maximum amount of energy and investment and time on patient care. If you didn't do that most of our time was spent on that. So we began to neglect paperwork too and that was not good.

BK: You started your work at the hospital when it was at its maximum number of patients?

PP: I think we started declining in 1957. I came shortly after that.

BK: In the next 20 years the hospital became a third or even less of the number of patients. Was there an effort to reduce the number of patients or did you respond with changes that occurred and that is what happened?

PP: Both. There was an effort to reduce. The mental health division also had a mandate that you are going to decline and your budgets will go down. There was an expectation from the mental health division as well as the expectation of ourselves. Both factors were there. I think one of those days, Doctor _____ who read in the newspapers, Oregon State Hospital closed, it was on the front page.

I: He said it was going to close?

PP: Yes. It was front page. He will tell you if you ask him. The expectation of the administration of the mental health division was to go to all community programs. People would be taken care of in the communities. The big state hospitals are not good. That was the system. institutionalized, etc. The direction went too far. People were wandering in the streets.

BK: Were you here when the state closed the tuberculosis hospitals?

PP: Yes.

BK: Jim Pomeroy came from there didn't he?

PP: Oregon State Hospital had a TB ward there. Not a ward but a whole building called G or something like that. When I came there was a full ward which was near that Quonset hut side on the South side. That was the mentally ill people who also had TB.

BK: Is that building gone now?

PP: That building they erased it in 1960 or '61. The TB hospital was closed. Yes. I was here. Pomeroy was superintendent of Fairview.

I: You also served a lot of people with drug and alcohol problems, didn't you?

PP: Yes. Anybody with an alcohol problem any of these guys would come voluntary some would call it commitment. That building which is now SRF, Salem Rehab Facility, on Center Street, that building was where the special alcohol program was before they decentralized. We used to have four alcohol wards including AA and group therapy and all that kind of thing.

I: These were not people who were mentally ill necessarily they were just people who had alcohol and drug problems?

PP: Possibly as I look back now because there are so much drug diagnosis now days. In those days we thought purely of substance abuse rather than drug. Right now I think we have a lot more drug diagnosis like schizophrenia. We had that program for a number of years. It was not bad. The question is if you have to have JCH standards to finance that would be very expensive. In those days it was not that expensive.

I: So you are suggesting that without those standards you may have been able to provide more care because more energy would have gone into it?

PP: Yes. What is happened is that the PSI came in 1978? I was clinical director then in the forensic program. For the first few years indiscriminate commitment from all over the State came in. Defense attorneys thought it was best for their client to get out of the penitentiary and go to the state hospital. Hundreds of patients came here much less none. We didn't have the beds sometime we just put patients on the floor. Right now the admission rate has come down. When I was there it was very high. That has drained so much resource. I objected to it vigorously. I said look this is crazy. This person will be five or ten years under tight security of PSI. 30% of these patients belonged in the penitentiary. It would have been less expensive. I have compassion for these people but money wise these people belong there. The whole hospital has become forensicization. That is the word I heard from somebody. The whole thing has become forensic because most of the money in the state hospital now is going to the forensic program.

I: I understand that the board did not necessarily want to release people because of the community.

PP: The board became very strict with their mandates and after care. That takes money from the community and other programs. Then the attorneys in the state found out after so many years that it was better for the guy to go to the penitentiary because the board was so strict. So it dropped off. No state has adopted this law.

BK: Just Connecticut.

I: What the review board?

PP: They are so strict. So much resource going to these people and general health is not good. We were talking about this fellow who had escaped. To visualize that he has improved enough to be a good citizen is difficult with such a strong area. We are putting how much money on that? The penitentiary would be less costly naturally considering money wise. So all the resources is going to those people and not to the kind of people I was talking about before. The people who would get back working in the work force and continue in society or take care of a family. There has to be a shifting of this. PSI came in and became so powerful and so strong and the superintendent is totally helpless. What can he do? He has to take all the patients who come in and you created another ward recently and it is an expensive business.

I: Barry do you have some questions?

BK: I am going to leave in about two minutes.

I: I enjoy hearing you talk about how things were. It seems like it was a kinder, gentler kind of treatment in the hospital.

PP: Yes.

I: Yet a lot of the changes came about because of the abuse, because of the institutionalization idea.

PP: The idea was we go back to the history of the mentally ill in the United States. The mentally ill people were mostly in the county poor houses in the early part of the nineteenth century. Dorthea Dix ut of Massachusetts _____in Cambridge, Massachusetts. I went to visit her grave last October. She was a schoolteacher and started this movement of building mental hospitals. After Massachusetts she went to _____. She even came to Oregon. These big mental hospitals were started as a part of what they used to call the moral treatment. The concept came from England. That worked fairly good. In the early part of the twentieth century these became sort of warehouses, these big mental hospitals, without any treatment and things started going down hill until World War II. After World War II they started a little bit more funding and a little more money and a little bit more staffing so things started going up. So things sort of opened up. The concept of insane asylum is not a bad one. The pioneers started that concept. Some people need the asylum, they cannot maintain. The humane thing to do is to put them in some kind of asylum where they can survive. If you think deeply about this concept, it is not a bad thing. When we used to get these voluntary people, like an asylum. They abused our lack of

funding in the early part of this century. So things were very different. It became overcrowded; minimum treatment and minimum care kind of things, that is what happened. President John Kennedy's committee of mental health coming in and funding from the congress things seemed to be more focused on the community treatment rather than warehousing these people.

I: And you sort of threw out the baby with the bath water.

PP: I think that society needs an asylum concept. The chronically mentally ill cannot survive outside. They are street people or in some group homes. It is better to have some kind of an asylum with minimum expenses but not neglecting them. Not JCH standards lets not call it a hospital, let's call it something else. As long as you call it a hospital you have to have more funding. Then it would be more accessible to people who want to come in. There is already the stigma about mentally ill but this way people can come in and have some help. With all the medications we have now the prognosis is much better.

I: But it sounds like, and I am trying to figure this out. What brought about the changes? It sounds like there were abuses to the system and then there was legislation passed and then the legislation created standards and the standards needed a bureaucracy to manage it. Do you think that?

PP: It is a combination of legislation and the state criteria of admission and commitment and massive funding for the PSRB people which is a very few number. Those took a lot of funding to the point that they became priority and the rest of the people who didn't belong to the legal criteria and could not accept the system outside sort of

I: It is almost as if the people that you could treat no longer have access?

PP: Yes. You can put it that way. People in this country now, unless they have some psychiatrist, unless they have some good insurance policy, and a lot of people don't have that, what are you going to do? I mean hospitalization and outpatients are quite different. Hospitalization you go away from what is going on at home and stress. So brief hospitalization is quite good. But not like what is happening in the Salem hospital for like six and seven days. Massive doses of medication. I am not blaming them but some of the patients would be better out. We didn't do that. We used to keep them longer. We used to expose them to group therapy, family therapy.

I: Suppose someone came in who may have been working but had a breakdown or had to come in quite often. Did you help them go back to work? It seems like one of the things the longer stay did was it disconnected people.

PP: Yes. The people who got better got out fast. The people who stayed for many years the chronically mentally ill, the chronic schizophrenic patients, they stayed a long time. The acute patients who came in got better fairly fast and they got out and back to their home and job.

I: How long do you think?

PP: An average was thirty days. Thirty days minimum. Nobody told us to discharge anybody. Nobody said you have to discharge this people by so many days or something like that. It depends on what happened and how far we went and whether the family was ready or not. It took all those factors. Not only that, we had the families involved when we discharged many too. Lots of families used to come and relate to the staff.

I: What percentages of the people had their families involved?

PP: When I was in charge of the Marion-Polk area, for example, in 1962 I was director because we were right here. Polk being on the other side of the river and we are really so close. We used to have at least 30-40% of the patients, that is a guess, of the families were involved. Sometimes we would call them. In those days the social worker would have to take a history from the family which is a part of the total assessment. In addition to that, many of the patients had relatives who liked to get involved. For example, we used to have a huge family group together for years, Thursday evenings, 7-9pm. We would give them coffee and cookies in Building 40. We used to have 50-60 patients. Sort of a support group we called it. Also discussed some psychodynamics' of family illness. How the family can cope because you know how difficult it is for the family to cope with all these things. The other side of the coin. For example, we had a woman. She was so angry. She came from Polk County. She was so angry at our staff one day she says nobody talks to me. Her husband is a patient, depressed and both in their fifties. She was just so angry. I said, come on, just sit down and talk with me a little bit and find out what is wrong. She said, your nurses are ignoring me, your aides are ignoring me, nobody talks to me and my husband doesn't talk to me. Of course she is so aggressive herself. She is so passive-aggressive. She puts him down so much. So we got her into the group therapy and we talk with her. She came to the group for at least a year and a half. She came regularly every week to the group therapy to understand. So that was the relation on our part and the husband got better and they continued to come and participate in this kind of family interaction and learning? The hospital provided these opportunities to people to participate and learn from each other how to cope with these kind of things.

I: What did the psychiatric aides do in the hospital?

PP: Psychiatric aides gave medications, clean linens and see the patients are dressed. Also interact. They are really the main people who interact with the patients. When we decentralized the hospital we had a limited amount in our power structure and the doctors and the nurses as well participated in those meetings equally. The Doctor in the psychotherapy, we all participated in the therapy activities so psychiatric aides had multiple duties.

I: What about the nurses?

PP: Nurses were more trained for the psychiatric nursing part of it. They were more responsible to give special medications and all that kind of thing.

I: Did they do therapy?

PP: Yes. They are the boss. They are in charge of the psychiatric aides. In the power structure the aides reported to the nursing staff. They participated in therapy.

I: Did you have social workers on the board?

PP: Yes. Social workers participated in the group process, team process and main relationship with the family members. Main contact with the family members and all the community agencies, all the placement and money situations, all those outside things, the social worker has the expertise to deal with those things. We didn't have.

I: What about the psychiatrists or psychologists. Did you have psychologists then?

PP: Psychologists mostly were testing at that time. I think their roles expanded to some extent. I think right now they are probably more part of the treatment.

I: When somebody came in what would happen to them?

PP: In those days or now?

I: Let's go with those days.

PP: They were assigned to a doctor and the doctor would do a physical exam even if they were trained in psychiatry they would still do a physical exam because right now the regular family physician does a physical exam. So they did a physical exam and they did a mental exam and a psychiatric history. You have to dictate within a couple of weeks. Then the team teaching process started in the 1960's rather than in the 50's. The team got together to review the patient, interview the patient got the assessment to write a treatment plan. Then every week you reviewed the progress of this patient.

I: Of each patient?

PP: Of each patient. There might be thirty or forty patients and the team would get together at least once a week to review. We called it the card-x review. Each patient had a little card. Now it is more elaborate. We reviewed the progress and what needed to be done and asked ourselves if the direction we were going was right for this patient. So there was the team teaching review process and then we began to assign each patient to a particular psychiatric case, one to one with a doctor who didn't have that much time. Then there were a lot of family groups.

I: Was there any kind of rehabilitation? Vocational rehabilitation?

PP: We had occupational therapy which was not great. We had some patients going to occupational therapy. There was a department of occupational therapy where they do the crafts and stuff like that. There is not a lot of vocational kind of therapies. There are a lot of activities therapies. Patients are assigned work when they get better either in the ward or in the building or out with a therapy supervisor on the grounds.

I: My background is a lot of rehabilitation. It sounds like your approach was more; you come in for asylum because you are in lets say an acute phase. Our job is to sort of be there to hold you. To almost keep you from not losing anything because we want to interact with you and look at what your problem is. Then when you are better, when the acute phase is over, we think that you can go back and resume your life basically. Right? It is a period of holding during that crisis that also is looking at that.

PP: We did have a lot of that. I understand what you are talking about.

I: I don't mean to take away from treatment but part of the treatment is holding people and making sure they are involved and caring about them. So did they get better because time passed and they were in this?

PP: The treatment is a process. The beginning of treatment and the end of treatment is not quite clear in psychiatry. For example, I cared for a patient over there for two or three years and that treatment was never ended. There is nothing in my mind saying I ended her treatment. I said, schizophrenic lady, after she got out of the hospital, you see me once a month. Neither she nor I thought we would end in December of 1999 or something like that because I wanted her to comply with medication. There was a prescription that came from me. Number two, I checked on her. Number three, I have a relationship with her that she knows and I know that I can provide the support and assistance to this lady who is traveling by herself with the schizophrenia. She knows that and I know that we have a good therapeutic relationship regardless of her paranoia. Her paranoia was fantastic. It is an accomplished person. She used to work in a department store for female garments and nobody could look at her and tell she was schizophrenic. But she had so many delusions. I cared for her over two years. She said I am not going to take your medicine, not anymore. I said she could say whatever she wanted to but she knew that I cared for her. I said, why don't you take it for another month and then we will talk somemore. She said, only for you I will take it for one more month. So the idea is to provide compliance with medications on the basis of the therapy to the relationship. And rely on the relationship for the patient's benefit. Those kinds of things we worked on. The basic thing is a therapeutic relationship in psychiatry as you might have heard. That takes times to build a relationship it doesn't just come like that.

I: Would you say the relationship is the most important thing or what you do when you interact?

PP: Yes. We in psychiatry talk but the relationship is extremely important in psychotherapy. Now the doctors training in psychiatry are getting away from there and they rely on medications. The doctors are not doing psychotherapy. In the days I grew up we did psychotherapy ourselves. In Michigan we might see the same patient three times a week, three hours. Can you imagine how long that is? Plus you cannot supervise the psychoanalyst; he is going to treat you.

I: Do you think that worked? The psychoanalysis with the patient?

PP: We thought that was the best thing at that time. We were trained like that. We learned the sense of psychotherapy that way which is listen. In fact one of my psychoanalyst supervisors told me, you really couldn't know the patient until after three months. We spent a lot of time, three hours a week for three months. He said it takes three hours a week for three months at least and he was a psychoanalyst. Actually he was analyzed by Freud himself. He was originally from Greece and he was analyzed by Freud. He was a very good teacher and I respected him. He just died two or three years' back. That is what he told me. It takes three months to understand and know the patient. Not only that he said, then you begin to go beyond the diagnosis, you see the total personality, the total person.

I: Then you have a relationship with that person?

PP: Yes. With the person and start working on the basis of the relationship toward some kind of an improvement.

I: Was the person to sick to have a relationship with you? Did that occur?

PP: Actually what happened was Freud taught that the schizophrenic patients are not able to establish a relationship. Which I don't agree. I think you can establish a relationship with the schizophrenic patients too. Freud started that thinking. Many of us went along. That is not true. True schizophrenic patients each of them are quite different. Though they are the same diagnosis and the medication might be the same. Anybody who works with these patients will know that each patient gets individualized and try to establish a relationship. You cannot do that if you are in a hurry. It takes time. Sometimes it is difficult to.

I: It sounds like what you offered as the doctor was, first of all you were an important person in the hospital and you showed regard for this person who was the patient. I think that would, it says, I am important enough to have a relationship with this important person among other things, and they care about me.

PP: Doctor Brooks used to say, the patient is the VIP. Of course, this is the medical thinking. You treat the patient as VIP. There is a business relationship. Other than that you should not think you are better or this and that. You are a doctor in care of your patient. This is a business relationship and you must think the patient is equal. You use your authority as a doctor to guide the patient at the same time one must be introspective of one's self as a doctor or psychologist or whatever. You must be very introspective because trust, counter trust, problems that can enter the picture, which Freud thought of, and which is true. Then you get into those kinds of problems then you deal with those like in intensive psychotherapy that happens more. You utilize the relationship for the patient's benefit.

I: I think that is the key phrase. You utilize the relationship for the patient's benefit.

PP: Yes. Then do not take credit for the patient. We were talking one time just before we started this; we had Doctor Camila Anderson who was director of outpatient in Oregon State Hospital up to 1961. She told us, she was very good teaching in fact she wrote several books on psychiatry, one is called "Beyond Freud" and the other is called "Saints, Seniors and

Psychiatry." She is 97 or so now. She used to say, do not take credit if the patient gets better or the next time somebody is not going to get better and god will cut off your necks. Don't take credit. The complex process of operating that will make the patient better or worse neither of these are yourself which you tend to do. But the patients are getting better so we try to do the best on that kind of basis of attitude and relationship.

I: I saw you look at your notes. Did you have some points that

PP: One Flew Over the Cuckoo's Nest. I had some notes on that.

I: Ok. Do you want to talk about that?

PP: There is a lot of feeling among people that I heard a couple of weeks back that some people said this sort of took the mental health movement backward. You know that movie of this and that and this and that. It also took the hospital backward which is not true. Because I am in the movie, just a small part. Basically I was a guest of the movie when this thing started. Doctor Brooks wanted this movie. Without him it would not be done because the people in the mental health division were against it but Doctor Brooks wanted it. Doctor Brooks was for it. A couple of us were against it because it would take time away from the doctor's time, the staff time, like a circus. Anyway I got into the movie one way or another. I don't think that the movie has hurt the mental health movement. In fact, anybody who has seen the movie enjoyed it. It is a great movie. Only people who didn't care for the movie were the psychiatrists in this country. Psychiatrists became very concrete. They thought it was a documentary. It was not a documentary it was a power struggle. It was about what happens in any society family structure if there is a struggle for power. A struggle for authority. That is what it was all about. It was symbolic.

I: The setting happened to be in a hospital.

PP: Just happened to be in the hospital because it was so dramatic and mental illness touches almost every family in this country. This is the kind of thing that happens in our structure. I don't think it set the mental health movement backward or anything like it.

I: From what Doctor Brooks said it sounded like it was sort of a fun thing for everybody to be involved in.

PP: Yes. The people were very nice. The movie people were very nice to the patients and to the staff. They stayed two and one half months and saw the groups operating and other things and it was quite an experience for them. That was a significant event in the history of the state hospital.

I: You have answered my questions.

PP: There is nothing more I can think of but I am speaking not as a citizen but as a doctor. The changes that have happened throughout the country and the State of Oregon but this process operate like that. I give you some examples. I put much more resource on treating the patients

who can improve. We as professional people like to see people improve. Without that feedback it is difficult for us to operate and in the forensic unit it isn't there. You don't see people getting that much better and getting out. They are just going through the process of the routine sort of work so that emphasis should be established in the mental health program and not just dealing the complimentary and something has to be different. If a housewife in Corvallis says that I am depressed, I don't have anybody to go to, she should be able to come to the mental health clinic and have the psychiatrist, social worker and psychologist assess her and start her on treatment and medications. She shouldn't be rejected because she is not chronic. No questions should be asked about those kinds of things as long as we know that she cannot afford something private or something like that. There should be other kinds of priorities which need to be established. The substance abuse program there is no reason why the State of Oregon should not establish some kind of a special substance abuse program. It is a big problem. If it is sort of a special program for the State of Oregon. I don't know but those are the kinds of things. Spending so much money on so few people just doesn't make sense. They aren't going to listen to me. The bureaucracy has become so big and so fat and so much money is being drained to the bureaucracy they need to keep for patient care. Another thing that should be monitored very carefully is the level of training and expertise, credentials of the staff working in the mental health programs in the communities. I'm not going to point out any particular community but I think talking about trust and counter trust, I have seen some bizarre notes from staff in some mental health programs. Some do a very good job like Yamhill. Anyway those are some of the things but overall the picture is not very good. Especially where people are in the streets or in the jails with mental illness.

I: Why do you think that is? What do you think happened?

PP: Because of misdirected and misguided thinking by some people at the State of Oregon who thought that everything could be done on a community basis. There are some powerful people in the State of Oregon who are misguided in their thinking that if you put your money there and this and that and this and that and resources are diluted and that is what happens, misguided thinking.

I: So you think it really is putting all the resources into supposedly serving the people in the community?

PP: Yes. A lot of resources went over there and the hospital resources became confined to the long stay patients. Actually the major part of the programs are with the adult psychiatric unit. We still have many wards. Some of those kinds of patients come in on a voluntary basis. Open it up and tell the legislature we are going to do this because there is a need here, which we think, is a problem not the PSI patient, they are long stay. Of course they are dangerous and the community would like them to be locked up but what about other people? So I think various people in the State of Oregon are misguided in their thinking like that. That idealistic views which are not there. We are almost back to ____in 1940's. People wandering the streets, Portland, Eugene, Salem, San Francisco, you would see them.

I: That is interesting isn't it.

PP: Yes. We might be back to the same days and the compassion level is much less. Either the patient is going to get better if there is a tremendous amount of emotional investment on the part of the treatment staff, nurses and the doctors and if the doctor is burnt out then it is time to say goodbye to psychiatry, you cannot do that. You can do all the paperwork beautifully. You can dictate all the notes nicely. You can do all the routine things very nicely without the emotional investment and that is a part of the burn out syndrome and you will not, I don't know for sure, you would be amazed how many people are in the same frame in the Oregon State Hospital. But when the superficial paperwork, documentation, very nicely so nobody can fix them. In other words, writing a note is far more important than visiting the patient or something like that.