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**1991 – Present**

**Superintendent, Dammasch State Hospital**

**1987 – 1991**

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I: I am going to start by asking you just what policy changes have you seen? Can you go back to the last ten years?

SH: Sure.

I: What do you think accounts for those policy changes?

SH: The last ten years will be basically through the nineties. Is that what we're talking about?

I: Yes. Maybe last eighties.

SH: And early nineties policy changes.

I: Policy changes.

SH: Some of them I don't think have been dramatic policy changes in the sense of clear cut delineation's such as here is a piece of paper that shows this happened but I think there has been a significant deemphasis on hospitalization for the general adult population and more of an emphasis on community services particularly in terms of residential options for people to be able to not live in the hospital which is more substantive than simply the deinstitutionalization that we talked about in the prior decades. At the same time there has been an increasing emphasis on forensic psychiatric services for people who have been adjudicated as guilty except for mental disease or defect in hospital.

I: In hospital. So the population has changed is that what you are suggesting?

SH: Yes. If you look at it just from the hospital angle itself, although for example when I started here in 1980 in a staff position, there were about six hundred or so beds at Oregon State Hospital. At the same time there were about 375 beds probably up at Dammasch. Now there are the same six hundred or so beds at OSH between here and Portland but there is not Dammasch. So the component that really removed out of that in that time frame was adult treatment services. We had six or seven adult wards here plus Dammasch at the time. We now run two general adult wards here and three at Dammasch. That has been a very positive switch for change or evolution or whatever you want to call it except for the fact that there aren't enough resources in my mind at least, on either end of the continuum for adults and a lot of that is just due to the population increases that have occurred particularly in the last five to ten years probably. At the same time there has been a bigger emphasis here on the forensic side of the house for adults. The other changes that I have seen occur in terms of treatment population and approaches would be actually before this decade but in the early eighties which is when the adult services in terms of hospitalization decreased. We looked at the populations we had and seeing the elderly population increase we began the geropsychiatric treatment services program in the hospital. Prior to that the adult services were general adult services with a couple of wards here called the geriatric wards. They were older folks or folks with certain kinds of medical complications. What we did in 1983 was to create a program which was specifically a geropsychiatric program. At that point the adult services were shifted. The plan in 1983 to 1984 was to shift all the adult services to Dammasch and to make, this was just from the hospital perspective to shift all the

adult services to Dammasch, and to make OSH a specialty program hospital. It never quite got there because of political forces. For example, 35B and C, two adult wards, were left here because Marion County didn't want to go to Dammasch for services for adults from these counties. Although there was a plan put on paper and some of it carried out it didn't all get there because of the political exigencies of the time. I think that is a big policy difference in terms of hospital and hospital operations.

I: Can I ask you a couple of questions to clarify?

SH: Yes.

I: You said there are not enough services at both ends. At the hospital end what would you like to see that is not there?

SH: I don't know that it has to be hospital specific, depending on how you define it, but there has to be an environment similar to this one for folks who need a little bit longer term than the acute care piece that we are able to provide and aren't able to manage in any of the kinds of community settings that we have now. There is just too much of a crunch in terms of the bed availability so it ends up leaving people in acute care too long or they're just not served in a way that is best or most efficient. Basically there needs to be, I think there is a tier that there is not enough of and that is around longer term hospital care or secure sort of residential care. That part has more people in it than we have the resources set up to handle. The other big policy change that came about, the governor's commission in 1989 was a key marker of change in our system, that is where we decided to move toward acute care on a more community based and regionalized set of principles and not everything at the state hospital. Prior to that time if it was hospital it was here or Dammasch.

I: What about Eastern Oregon?

SH: Or Eastern, yes that's right. Good point.

I: I just wanted to make sure.

SH: So it was either Eastern, here, or Dammasch prior to the governor's commission for adult services. After that we went to a regionalized, localized acute care piece, both in terms of triaging those folks getting them into services and hopefully being able to turn them around back into the community without getting stranded in the state hospital for a long period of time that wasn't necessary. That has worked very well. It has been a more humane and therapeutic way to deal with people. The intermediate and longer term care was still left at the state hospital with Eastern and OSH even when Dammasch closed. That's the piece where there aren't quite enough beds and there aren't quite enough beds in the community. It may be that there are enough intermediate and long term beds in the hospital and the real problem may be simply that there aren't enough resources in the community to keep the people flowing through the intermediate and long term hospital beds. That is an empirical question.

I: Explain that.

SH: For example, right now we have demand to admit people to OSH, Portland or here from the acute care facilities, acute care hospitals. We can't do it. We are full and we are full all the time. One hundred and thirty-three beds and they've had 133 people in them since we began this. It may not be that we need more of those kinds of beds but that we can't get enough of those people out quick enough to free up the beds. If I were to be taking a direction at this point what I would do would be to put additional resources into community options and see if that doesn't relieve the pressure off of the hospital beds before I go out and say we absolutely need more hospital beds.

I: So you would move people through faster?

SH: Right. Exactly.

I: So there would be a better place to receive them?

SH: So there would be a place for them to live in the community which is the ultimate goal anyway in this whole business. The idea would be to have places out there that they could be discharged to from here once they are ready to go.

I: But didn't you say they're not moving out of here as quickly? Is it because they don't have a place to go?

SH: Yes. I think that is probably one of the primary reasons.

I: So the treatment may be finished in terms of what your treatment goals are.

SH: Yes. We have taken it as far as we need to and if they're at a functional level sufficient to be able to be served in the community but there aren't those options for them. Those options, for a number of the people we have to get them out of there would have to be pretty intensive services.

I: Who comes into your hospital?

SH: Among the general adult population?

I: Right.

SH: Generally they come from the acute care facilities. They have been civilly committed. They have not reconstituted sufficiently after a round of about thirty days at max in acute care facilities to be able to be discharged back to a community setting so they come here for further treatment until they have reconstituted enough to be able to do that.

I: So the people you have are really the sickest?

SH: They are pretty ill. The majority have, I think the statistics show, that about half are schizophrenia and then the next biggest is bi-polar, some sort of affective disorder, major depression and a scattering of other diagnostic categories.

I: How long do people generally stay? Is it thirty days max?

SH: That is the plan in the acute care side. For us the intermediate piece, which is what Portland is all about, is supposed to be not more than 180 days. Salem is the longer term beyond 180 days. We have folks beyond 180 days at Portland now as well.

I: When you say Portland do you mean Dammasch?

SH: No. We run sixty-eight beds in Portland. The way it happened, we closed Dammasch and we leased space from Legacy Health Care Corporation at the old Holiday Park Hospital near the Rose Garden. We run four floors there and we run 68 beds of adult services up there.

I: So that is an extension basically of this hospital?

SH: That is correct. It is all Oregon State Hospital on two campuses.

I: You have that population and then you have the forensic population?

SH: Right.

I: They are housed here?

SH: That's correct. All the forensic hospitalized folks are here.

I: What kind of interventions do you use with them?

SH: It's the same sort of with the general, the general population. Medication is a big player in that, psychosocial rehabilitation, education, group and individual are targeted on whatever the particular treatment plan is and then medical concerns as they are on the treatment plan. That population but for conduct that is considered criminal from a mental health side isn't much different than the adult general population. In fact, you see folks there that at one time were in the general adult population but something has gone wrong or been more seriously problematic for them.

I: Are those all locked wards?

SH: Yes. In fact, all of our wards are locked wards.

I: They are?

SH: Yes. There are no unlocked wards anymore.

I: If someone was eligible for an unlocked ward they would probably be moved out of the hospital?

SH: Yes. Absolutely. If there were a place to go to. The difference though with the forensic population is that it is behind what we call a secure perimeter. For the general adult population it is truly just a lock on the door. For the forensic it is a lock on the door and then a sally port and a fence with wire and cameras and all that kind of stuff.

I: Do you want to go back to the policies?

SH: I think from the angle of who we treat and how and where we provide services those are sort of the big changes that took place. I think the governor's commission is really the lynch pin in all of that. The point of significant change.

I: That changed the funding as well did it not? The governor's commission. Didn't they make some recommendations about funding or did that not occur?

SH: There was discussion of funding but I don't know that there were any big changes as a result of that.

I: If someone comes into your hospital now are they funded primarily by the health plan?

SH: It depends on who you are and where you come in basically. General adult services tend to be primarily by and large general fund directly from the legislature. For kids and gero, for the Medicaid and Medicare group of people, that money for kids in particular goes through the health plan and back to us so a lot of that is federal money but it shows to us as other funds. Forensic is primarily a general fund operation so that is directly allocated from the legislature. I just learned yesterday that due to some twists and turns we are going to have a big chunk of other funds in forensics too because the state has figured out other ways to bill the feds for some services within DHR. We are going to be the repository of the other funds part of that. The funding mix depends where you are but basically I still think of it in terms of the simplest explanation is that those who are eligible for federal funds in those programs, we have about \$1.00 of state money to \$2.00 of federal money. In the non-federally eligible patient population we have pretty much all general funds. There are some other funds in terms of private insurance and so forth but it is pretty negligible. In terms of the funding for the state hospital I don't know that there were really huge substantive changes from the commission though given that the health plan has come on board since then and so forth the actual dollars that pay the bill take a different and more circuitous route than they used to.

I: Still it is a certain proportion of federal versus state. Is there any county funding in here?

SH: No.

I: What happens to people if they don't get into the hospital and they need to come?

SH: I don't know statistically what happens because it is sort of the class that doesn't get studied but I guess I don't know the answer to that in any systematic way. What happens to those that need to come in and don't in some way.

I: Would they be staying in one of the acute units or treatment centers?

SH: I understood you to mean somebody who gets nobody services.

I: I assume there's not too many people like that.

SH: I would hope not but there are a lot of homeless folks and folks incarcerated that may not be getting any services and are in need of them. In terms if somebody is in the acute care facility and there is not a bed here, what happens is they stay in the acute care facility. Then the bill runs up because there is only so many contracted beds that the division has available and that gets outside the amount of money allocated to pay for it. In this biennium we have had to go to the emergency board twice to get money to pay that bill but they wait there until there is a bed available in the state hospital if that is what they need or if in that period of time they reconstitute well enough to be discharged into the community, they are discharged directly to the community then.

I: Do you see the legislature increasing the number of beds?

SH: Why? The legislature did add a ward here in November, a forensic ward. We had a request for thirty adult secure residential facility beds in the community in a package before Ways and Means that was nixed and turned down. If you go by reality, the answer is no. They have basically said no they are not going to increase the number of beds that are available. Again, I consider it as a continuum from acute care to community living and so anywhere along the line helps the problem if there are resources added and they said no to that proposal.

I: So that is that?

SH: Yes. That is the answer.

I: Do you see any other policy changes that you can comment on in the last ten years? More and more money goes into forensics, right?

SH: Yes. The program has certainly grown over the years.

I: Is that because of the increased population or is it because people are more inclined to get those folks off the streets?

SH: One is the increase in population. I think that is pretty empirically verifiable. In terms of the hospital there are fewer options in the community for PSRB folks, folks under the jurisdiction of the PSRB. There is certainly right now in this session a political movement against being able to cite group homes or facilities for PSRB clients in neighborhoods. There has been a big ruckus about that. It is tougher to get people out and we have people at any given



time that, the number varies, but we have had people that need to be discharged and there wasn't a place for them. A year ago April, the emergency board gave us about twenty-five or thirty additional community slots. We got a big group of those people out. The problem is in forensic there are two major populations. One is the PSRB or Psychiatric Security Review Board group that have been adjudicated guilty except for insanity. There is another group that fall under ORS 161370 and become referred to as 370 patients. Those are folks who have been adjudicated unable to aid and assist in their own defense so they are sent here for treatment. That number has increased very dramatically over the last five to ten years.

I: Why do you think that number has increased?

SH: I don't know that any of us have an answer to that. Part of it is the population increase. Part of it is the way courts approach these kinds of defendants. Part of it is the way defense attorneys are meeting their obligations to their clients.

I: Are they using that not guilty by reason of insanity more?

SH: No. This is the 370 group. They haven't been adjudicated yet.

I: They are not able to stand in their own defense.

SH: Yes. That is the thinking and I think that the judges are very careful to be sure that if there is a question of a persons competency to defend himself that they want to make sure they are competent to defend themselves so they don't get overturned in anything that they do.

I: Are these folks able to go back to court fairly often or not?

SH: Again, there is sort of a bimodal distribution in terms of length of stay. There is a group that stays up to three months and then there is another group out here five, six months and longer that just never seem to be able to have it pulled back together enough to go back. There are requirements under the law for evaluations we have to do and so forth to keep the court informed. A person who comes here in that way can never be held by the court longer than the time they would have served if they were convicted of a crime. That is sort of a safety valve otherwise it wouldn't be very fair.

I: What I am reading is one day to the rest of their lives that's crime in the sixties. That obviously has changed.

SH: Yes.

I: Is it the maximum sentence?

SH: Right. The maximum sentence they would have received. Let's say it was a minor crime of some sort of trespass. The maximum you would have gotten was a year if you were convicted. A year in jail. Let's say that after a year you haven't reconstituted yet. The charges go away and then we have a decision to make. Do we look to discharge the person or are they



still so out of contact or unable to take care of themselves or a danger that they need to be recommitted. In this case we would put a hospital hold on them and then go to court to see if they would be civilly committed and then move to the adult side out of forensics.

I: Then would they be moved out of the adult ward as other folks are after thirty days?

SH: No. The thirty-day piece is the acute care piece. They would come to us directly. They would just stay here.

I: They would just stay here as regular hospital patients?

SH: Right. They would go onto the adult side of the house here.

I: I'm missing something. If I am just a person the street and I become mentally ill and I'm in the hospital I can stay here if I continue to be ill for as long as I need to?

SH: Yes.

I: I can. So when you bring the person over and they are not reconstituted they can stay for quite awhile.

SH: It depends. Until they are able to be discharged. The goal being discharge.

I: How long would your longest staying patient be here?

SH: In all of our programs?

I: Yes.

SH: In gero we have some folks who have been here for a number of years.

I: What about the adult program? Do you have a sense?

SH: I don't know what our greatest length of stay is right now but there are some folks that have been here for a number of years in adult services.

I: Really. Still?

SH: Right. Some folks that are just really in dire straights and nothing seems to touch them in terms of medication or supportive therapies or what have you unfortunately.

I: What percentage of your population is like that?

SH: I don't know. I wouldn't even guess. I would be glad to look it up for you and get some numbers. We can do that through medical records.

I: I'm just curious to see what percentage of the folks simply do not budge. It sounds like it's not a great percentage.

SH: It's a smaller percentage but it represents some pretty long lengths of stay.

I: Right. Some of those could be criminal forensic patients?

SH: On the forensic side we have folks that have been here for years and years and years. One pops to mind right now. He's been here twenty-five years that I know of and he has another seventeen or sixteen on his PSRB time and he would have to be doing a lot better than he is doing now to be able to go outside of the hospital. He's in maximum security. He's been in maximum security the whole time he's been here. We have some of those folks. The discharge of forensic folks is not our decision. That's the board's decision. There the primary responsibility is public safety so in forensics there are some even greater lengths of stay.

I: Has the treatment changed in the last ten years?

SH: Certainly in terms of pharmacology there have been new medications come out, particularly in the last five to seven years, that have made some enormous differences in the lives of people. It just seems that research and development is continuing positively. They are pretty expensive agents but Clozaril was one of the first that really made a difference. There are any number of others now. There have been some pretty big quantum leaps in terms of chemical interventions and ones that don't have nearly the severity of side effects that the older ones had. That has been a big difference. I think that the whole emphasis on psycho-social rehabilitation rather than treatment to a cure has been a positive change. Taking off some of the old voc-rehab kind of ideologies and philosophies that used to be around. The idea that mental illness is a disability. We are not at the point of being able to eliminate it but we are at the point of being able, through psycho-educational formats and so forth to be able to work with people to understand their disability, behave within the limits of it, recognize signs and symptoms of relapses or going back to less productive ways of living and so forth, and they can get better and function in the community in that way. It isn't sort of traditional model where it used to be sort of like you are ill and you are this way forever or you're going to get cured. Getting rid of some of the black and white of that has been helpful. We have looked at the nineties as the decade of the brain and brain research. This has made a huge difference in understanding mental illness particularly in the population at large; more understanding as a neurological or chemically based problem. It isn't somebody's fault and in that research on violence and dangerousness has shown that just because you have a mental illness doesn't mean you are going to be an ax murderer. I think that is a stereotype of movies and Hollywood and society at large. I think some of those things have been very positive changes that have occurred in the last ten years, maybe a little bit more than ten years. Those are the huge improvements giving people a better opportunity to get through their illness and be able to manage it so that they can live more normal lives.

I: Do you have time to do rehabilitation for the people who come into the hospital or would you define what you do as primarily treatment?

SH: I think we do, in adult services where the turn around is quicker and there is always somebody at the front door needing to get in, I consider rehabilitation to be treatment. It is just sort of different levels and different modalities. In terms of treatment as psychopharmacology then that is more in that sort of a program. In forensics where we have people for longer periods of time because the board isn't going to release them until they are very sure of their safety, that we do a lot more psycho-social rehabilitation and educational kinds of things. We help people work on their if they don't have a high school diploma we help them get that. Education has become a huge part of the program that wasn't here fifteen or twenty years ago. We have kind of an auto-tutorial computer assisted learning program where people can sit down at a PC and not know how to read and come up through that program all the way to a GED. Also things like how to manage one's money, how to prepare a budget, how to prepare and plan meals and those kinds of things, all different than we used to do.

I: Do you still do therapy?

SH: That is therapy. Therapy to me is some intervention you provide to somebody that is going to make their circumstance better and helps participate with them in getting there.

I: I am thinking more of the traditional fifty minute hour talking therapy.

SH: There's not nearly the kind of emphasis on that but there never has been in this setting. If you have a significant thought disorder that is not something that we've ever gone after with sort of inside oriented talk therapy. That has never really been a primary mode of treatment. When you are to that point you are really to the point of not having to be here and you can move on. There is individual work with folks. It is very behavioral problem associated. It is very much tied into the patient's rehabilitation goals and those kinds of things rather than inside oriented therapy or resolve inner conflicts. Given that these are brain disorders, more to the point is the process by which you want to learn to manage that disorder and develop adaptive life styles around it so that you can still be in a normal circumstance in the community.

I: Makes sense to me. What does a patient's day look like here?

SH: It varies a lot because of the different programs. We have a child and adolescent program so you have kids that get up and wash up and eat breakfast and go to school and that is a big part of their day.

I: At the institution?

SH: Yes. The Willamette Education Service District for Marion County is on contract to do the schooling. For the adult and forensic population it can be getting up in the morning. Let me just backtrack a second, in terms of interventions that are used which is how I think of it now in terms rather than what are treatments or therapies or rehab, what are the interventions we use to help patients be able to better manage their circumstance and grow and develop positively. A huge part of it that we do now that wasn't here in the past is work and vocational kinds of things. That has been a big thrust or emphasis of mine because in this society we define who we are by our work. To leave folks with a mental illness without the ability to work is to automatically

leave them out of the main stream of what's going on. At the same time, it can be very difficult for somebody who is particularly disordered to work. We have developed, particularly in forensics which is our biggest program and somewhat in adults though the turnaround can be so quick that it is difficult to get them in and out of that program in a meaningful way, differing levels of vocational services. We have a prevoc program which is some basic woodworking and assembling and so forth. We have a pretty extensive benchwork program which is everything from collating materials for county health programs to putting together circuitry for PC's. We run a wood shop. We do some of our janitorial; warehouse and automotive work that the hospital has to get done in grounds work with patient pay work. We pay patients for doing that kind of work, having that kind of job. They work in the kitchen as well in terms of food service which is a pretty good exposure to what for a lot of folks, if they don't have a lot of job skills, is pretty routine entry level work nowadays in terms of fast food and all that. In fact, we are putting up a brand new \$180,000 building out back here to house more of a benchwork program to expand our voc services. In terms of forensics it is sort of getting up in the morning and getting organized and going off to work and working in that supported environment with occupational therapists where they work on what are the skills necessary to go to work. You have to get up on time. You have to wash your face and brush your teeth and comb your hair. You have to have clean clothes on. You have to get to work. You have to not argue with your co-workers. If you are hearing voices you have to manage that yourself and not start talking to them on the assembly line because if you did that in a factory the other people aren't going to like it. If you get angry at something you go away from that to deal with your anger or manage it in some way. Then you come back and you take the money that you have earned and you spend it in some responsible way, first looking after whatever necessities you may feel you have and then treats like candy or cigarettes or whatever. The occupational therapy is built around the voc services to get people into that area of work that is a lot more mainstream. Then there are after that groups and classes around some of things that I have talked about before, managing a household and a budget and all that. Substance abuse is a big piece of the program. I would think that forty to fifty percent, at a minimum, of our folks have those problems to a significant degree. It is a lot higher than that given certain age groups. For substance abuse work we have folks come in from the community in the evenings and provide AA and NA classes for folks who want to participate.

I: In some ways I would think that is a mute point because there is not drug and alcohol access is there?

SH: That's right, but the day they get out, there is and they've got to get ready for that. You could say that we have no substance abuse when people are here but they've got to get ready in some way to be able to deal with that. It is a lot tougher to help people deal with it when it isn't a problem.

I: In the abstract?

SH: That's right. It's very tough. Particularly if you are wrestling with a thought disorder on top of it. Those kinds of things go on. Classes. In this ed lab they can sort of come and go, as they need to. There is a big recreational program in terms of physical exercise although we have a lot more people that need to do that as with the population at large than actually can be pushed

to do it. Nutrition and learning about good nutrition and so forth. Then the leisure time things we have some social things that folks do. Movies, videocassettes like all the rest of us rent to watch on weekends when we don't want to go to the movie house. Some outdoor activities that people go to as part of the program in terms of their shopping needs to go to the mall with staff and do some shopping.

I: So they get out of the hospital?

SH: Yes. Not so much the forensic people but the other folks certainly do. Gero, kids and adult services.

I: Does the state provide their clothes?

SH: If they don't have any, yes, we do.

I: If you are here for twenty-three years does the state buy your clothes? Do you get to pick them out or how does that work?

SH: Yes, depending if you have resources and decide to spend them on that and some folks do have resources or they have family that set up trusts for them or family that buy them things that they would like.

I: The families no longer play any part

SH: There seems to be a way to get the needs met and we will try to do that if we can. Certainly clothing is the highest priority to be sure everybody is properly clothed.

I: Do they look pretty good?

SH: I think so. There is variability again and some people don't understand, due to their illness, the issue of clean clothes and what goes together and all of that but we work with them on those things.

I: So it's not like the old days where there were clothes in the closet in a box and you went and picked something out?

SH: We have a clothing shop that we buy things for the clothing shop that are sort of the necessities that aren't donated or otherwise like tennis shoes and those things. We get donations from clothing and shoe manufacturers and people donate clothes here to the hospital and everything that is in good shape is washed and pressed and put on racks and it's like a department store or a consignment shop or second hand store in some ways. Patients are allowed to go over and pick out of that what they want but it's a lot of stuff. They can pick out what they want or buy what they need to if it's from a store outside the hospital.

I: There is no standard uniform?

SH: There is no standard issue uniform or anything like that.

I: Not like Arizona where they have pink uniforms.

SH: No, in fact, I will speak for myself, I would be pretty opposed to that.

I: So would I. I'm not into humiliation.

SH: Yes.

I: How much do you pay the patients?

SH: They get paid based on productivity relative to the same classification in state service. If, for example, on a janitorial crew, if the patient can perform at the level that would be expected of a janitor in state service to perform they would get that much pay. Otherwise it is a percentage of that. Generally, we don't have a lot of folks that are able to work full time, forty hours a week. The stress of that is far more than can be tolerated for the vast majority of our folks. So three or four hours a day.

I: They must make a fair amount of money.

SH: Yes, they can make some money and we of course run trust accounts for patients which is the same as a bank that assigns interest to the accounts and so forth. When working they can certainly meet all their incidental needs.

I: And also I would think, they don't pay any board and room.

SH: They are billed. We don't do the billing. The billing and collections part of the operation is with the mental health division. Patients are billed for their cost of care and under Oregon Statute it is based on their ability to pay. Some frankly flat out refuse to pay anything. Others pay some percentage every month.

I: You don't bill families anymore do you?

SH: I don't believe that the division does but they can bill against any assets that the patient has and it is all under the ability to pay. The division is very good and our social workers are the liaison here between billings and collections and the patients. Everyone is aware of the fact that if you were to bill and collect everything a person had there would be little motivation for them to leave and very little chance for success once they did leave. That is all kept in mind in this ability to pay condition.

I: Do you have a food or cooking facility? Where does your food come from?

SH: Yes, we prepare it here. We have a central kitchen that we prepare from.

I: So you feed everybody?



SH: Yes.

I: I have just been reading about the old hospitals and looking at the pictures so these are interesting questions.

SH: Yes.

I: Back when they raised all the food.

SH: Yes, in fact, the patients from here in the late fifties used to work on the state farm out here. They would be bused out on a daily basis and back and forth. The hospital produced a lot, the patients in the hospital, produced a lot of it's own food in a sense. But now we buy from regular food vendors, I think Sysco is our big contractor for food. Some of it is prepared and some of it is the raw stuff and then our staff put it together. Some patients work in food service.

I: So those are all in a sense a manifestation of the practice of how you provide services and we've talked about funding I think. I haven't seen this facility. Has it been remodeled at all?

SH: Parts of it have been. This is an old decrepit facility. There is just no questions about that and we are always behind the eight ball on deferred maintenance issues. Roofs leak, security isn't all state of the art. In terms of communication, we are only now have a toehold on a land system in terms of PC's throughout the place and we're still needing to expand that to get into sort of today's world. Only one of our buildings is centrally air conditioned and heated in terms of an enclosed HVAC system. We have patients in buildings of varying ages. Nothing built more recently on this campus than the 1950's as I recall. The facilities part, that is one part of the governor's commission where some things have been done but that is probably the biggest lag, the investment in facilities. It is most starkly apparent in going to the leased space that we use in Portland from the old Holiday Park Hospital to our maximum security space here. There are big differences. Up there, there are two person rooms, each with it's own bathroom, shower, stool and sink. Here, except in maximum security, they are referred to as two floor, six person bedrooms, but it still has a dormitory flavor. For example, in all of our adult wards the bathrooms are centrally located on the wards and they are to be used by everybody. There are no bathrooms located in the rooms. There are very few private rooms. Privacy has always been an issue, accessibility of the bathroom and the shower and those sorts of things which is a bit of a trade off too. In a psychiatric facility where you are very concerned with people's potential for harming themselves, the more rooms you have the more difficult it is to supervise people. At the same time, we want as normalized and environment as possible with as much privacy as any of us would expect in our day to day living. That is always a tension that exists that you have to be careful about. The best way would be some time to visit Portland and see a couple of wards here and see that comparison. For the most part our patient living areas within the limitations of the building and the style that they were constructed in, our physical staff looks after them well in terms of cleanliness, repairs inside, painting, those kinds of things. It is a stretch to get it all done. It certainly takes more money than we have available.



I: One of the things that I was fascinated by was they had an undertaking service and all of that. You must have patients that die while they are here.

SH: Yes.

I: What happens under those circumstances?

SH: Particularly with the gero-psychiatric program, we have some folks who are quite elderly that haven't been able to maintain in a nursing home and so come to us. To backtrack, in the years when this place first existed, it was almost a city to itself. It raised it's own food and people were born here to mothers who were here, worked here, lived here and died here. There was a mortuary here and so forth. In fact, we have the urns of many a person who had died here whose body was cremated and to whom there was nobody to return the remains. In years and decades past it was a pretty seriously negative social stigma to have somebody in the house who had a mental illness. I remember, just by way of an anecdote, a couple of years ago a lady phoned me and she was searching for the remains of her mom. She had only recently found out that she had been here and died here. To give you an idea of stigma, as it turns out, her mother was born and raised in the Philippines. Her father met her mother in the Philippines toward the end of the Second World War, married her, and brought her back to the United States. They settled in Southern Oregon and had some kids. After the birth of one of the children, she went into a very severe depression. It sounded like a post-partum depression, very severe. The husband decided that something had to be done about this and he didn't understand it and I think there were some cultural differences too that weren't understood. This was all exacerbated by the fact that by then she was pretty homesick to return to the Philippines. She came up here and was admitted to the hospital and spent some time here, developed pneumonia and died here and was cremated. The father never told the kids where the mother had gone but that she had left. The kids, when older, got more out of the father as they were adults and tracked it all down and came here and sure enough we had her remains in an urn here and turned them back over to the daughter who wanted them to return them to the Philippines because she felt that is where the mother really wanted to be laid to rest.

I: That is a tragic story, isn't it?

SH: It is. It really speaks to the issue of stigma and social ostracizing that went on as a result of having a mental illness. This place in its earlier years was kind of the public welfare system of the State of Oregon. In the late 1800's the Oregon State Hospital budget or the money spent, on the Hawthorne Hospital up there and then here was fully half of the state's budget. The rest was police and fire in the counties and a few roads. This in a sense was, as it was termed in those times, an insane asylum. It was also the poor farm and the public welfare system.

I: And the tuberculosis hospital.

SH: And the tuberculosis hospital.

I: And the alcoholic's hospital.

SH: So eventually people would end up here and not be necessarily claimed back. Nowadays what happens, and we average about twelve to twenty deaths a year, virtually all of them in our gero-psychiatric service who die here. Virtually all of the remains are claimed by the family. In the majority of them the family is here when the person dies, in fact, just as they would be at the general hospital if their relative died. A lot of the folks that we serve here of course are way down the ladder in terms of socio-economic status and so we, on behalf of the state, will pay for the funeral and the mortuary expenses and that. We do it the way the family believes they want to do it so that we take care of that. It used to be that it was the states responsibility. The state had a rule book. The person would be cremated and the remains stored. We've changed all that in recent years so that we work with the family on how to do it. If the family can't afford it or says you know really it should be the person who died and they don't have an estate, then we will. We rotate through the local funeral homes in town on contract and take care of those expenses.

I: That must be a considerable expense in some cases.

SH: Actually the funeral homes are very good in that way too. They as a public service work with us on what the price should be. I think the prices are reasonable. From my personal experience they are certainly a lot less.

I: What else do I want to know?

SH: I don't know what more there is I know.

I: We've talked about policy. We've talked about the buildings. We've talked about some of your customs. The practice is really psychosocial rehab.

SH: Yes. That is by and large the emphasis.

I: I think that takes care of it.

SH: I can't emphasis how much we believe work is a key part of getting things back together and on one's feet. Not just from the angle of do you make enough money to support yourself because that would be more pressure than some of the folks we serve could ever handle. It is more to the idea that work is the way we characteristically define ourselves in this society. It is interesting how often we meet folks and one of the first things we want to know is what they do. I sort of balk at that at times. I say it is more important who I am.

I: Yes. Who you are is.

SH: Exactly. That is exactly how people understand your value system, where you are coming from and so forth.

I: And your education and your socio-economic status and all those things.

SH: Right. All those things come together in the work place for adults in this society. The other component I shouldn't leave out because we have this interdisciplinary treatment team approach where we have physician, nurse, psychologist, social worker, OT, recreation therapy coming together to work on the treatment plan for patients. There is also the religious side that the state provides.

I: Please talk about that.

SH: We have a clinical pastoral education training program where people who are ministers or want to be ministers come here and enroll in the program and get experience working with folks who have mental illness. We provide religious services for whatever denominations are represented in the population here at any given time. We have one full time pastoral position on board. The denomination varies with whoever is filling the job. We contract on a regular and on-going basis for Catholic services and for Jewish services and for Muslim services.

I: Protestant?

SH: Protestant is generally, the pastoral full time position, is filled by one of the major Protestant denominations. We had a fellow who was a Baptist clergyman for a long while and I forget what Roy is now. Then we have folks from Mt. Angel come down as part of their seminary training and so forth so that provides another emphasis on things. We do that, one because again it is a normal part of life; it is required by statute that the superintendent looks after the moral education or spirituality of the patients. But also because some folks that have mental illness have some difficulty integrating religion in with their view of the world and what their illness means in ways in which to deal with it. There are some religious groups of course that preach that medication is evil, it's artificial, shouldn't be done, and you just need to pray to god and you get past all this stuff. With all deference to people's faith systems, I haven't seen that work very often. You have to work with people to understand those kinds of things. It can be very, very difficult so having this pastoral education piece on board is very helpful to the staff in working with patients on those issues.

I: You also have medical doctors here, do you not?

SH: Right. We employ overall about thirty physicians, I believe. The vast majority of those are psychiatrists. A lot of those are board-certified psychiatrists. We also have some folks that are internists and general practice folks to handle medical problems. We have a medical clinic that the psychiatrists can refer to so that the internists and general practice folks can look at a person and see what is going on either physically or medically. We have 35B which is operated kind of like an infirmary within a psychiatric hospital. Anything very significant or requiring very sophisticated technology we have arrangements with Salem Memorial to transfer the person down there and do that immediately when it is necessary. In Portland, we have an arrangement with Emanuel Hospital to do the same. Depending on the security needs of the person we send the staff down to help supervise them while they are down there. For example, last weekend on Saturday, I got a call that we had a fellow on maximum security who is diabetic and they were having a lot of difficulty getting his insulin in balance and he was not doing well. So he had to go down to Salem Memorial and he just came back today so he was there Saturday, Sunday,

Monday, Tuesday, Wednesday. We've had three staff down there with him that entire time because he is a significant escape risk and he had murdered somebody so he is seen as a threat to public safety.

I: So twenty-four hour coverage by three people?

SH: That's right. So you can see what that does to our personnel calls. We're at the margin anyway in terms of adequacy of staffing. We're adequate. We're \_\_\_ certified in the distinct part where the entire hospital is JCHO credited in all of its programs but there is not a lot of play or slack in the staffing and particularly when we have cases like that or we have patients that are on constant behavioral or suicide watch. The fortunate side to it is, one we got a new ward which helped us with our census problems and the Ways and Means subcommittee just approved thirty new positions for this hospital in terms of registered nurses, physical therapy positions and mental health therapy tech positions to help with weekend and evening activities for patients. That was a two million dollar plus package so the legislature does, and the governor certainly, DHR and the division, understand what our needs are.

I: It sounds like it very much is what I would call treatment, what you would call a lot of interventions. People do not come here and sit.

SH: Yes, absolutely not. We would all like to offer more and that is a labor intensive issue but yes, the idea that people would come here and sit and not be a problem, then they shouldn't be here and they shouldn't be using the state's resources in that way.

I: So this is a pretty vigorous intervention.

SH: That is the hope. Again, there is variability. It varies somewhat by treatment teams. There are some patients whose illness is so debilitating that it is very difficult to motivate them out of bed. There is variability. I would not want to paint a picture that everybody is sort of well dressed, hair combed, working in the shop all day.

I: It is a state hospital.

SH: Yes, exactly. The people are here for some pretty serious reasons. We have a very good staff as I have seen state hospitals. By and large are very dedicated to try and be of help, to intervene in a positive way. I think that gets done a lot here.

I: That is a nice note to end on.