

Interview with Anonymous Staff Person [At AMHI from 1978 -1981]

September 8, 2003

Interviewer: Peter Devine

PD: What was your involvement with AMHI, when, and in what capacity?

ANON: In 1978 I began as a mental health worker on the admissions unit. I worked there through 1981. My job was to greet people and try to get them oriented if they hadn't been to AMHI before. Find out history. Find out as much as I could that would be helpful in their treatment. Sometimes people were in pretty non-communicative states when they arrived. Sometimes people had been in hospitals many times and pretty much knew what it was going to be like and sometimes we had people who had never been in a hospital before. Back in those days the admission unit typically had 25 to 26 people on it. It was in the old Stone Building at AMHI—Stone South Lower. People would come in, usually stay for 7 to 10 days, and then they would either be sent back into a community hospital setting, discharged to home if they had some supports, or if doctor decided and team decided they needed to stay in the hospital longer, they would go to one of the other units at AMHI—typically Stone South Upper. There were a few times when people would go to jail, or once in a while somebody would be eligible for...the veterans hospital and so they would be transported to Togus. The course of the day was interesting in that the dining room was on the unit. So people were expected to get up and go for breakfast and they spent a lot of time watching TV or just sort of hanging out. Then they would go to lunch, followed by some more hanging around. People would have team meetings from time to time and sometimes they would meet with their social workers. There were, I think, 4 social workers assigned to the admissions unit, and so sometimes they would meet with them...I think typically we had 5 staff on, and each of us were assigned 4 or 5 patients that we were supposed to be having communication with during the day and helping with whatever needs arose that we could help with. Then sometimes we would be taking people to clinics, like somebody might need an EEG done at the Augusta General, and so our job was to get them in the car and take them down there and wait around until it was done. Sometimes people had to go to court in places like Farmington, or whatever, and we would get a car and take them there. So it was an interesting—you didn't necessarily know how your day was going to go. You could sort of make some guesses, given who was on the unit and what their needs might be. Sometimes you would know a day or two in advance that you would be going to court, but you didn't necessarily know.

PD: How much of your time was spent out in the ward or unit?

ANON: Probably, I am going to say, about 80%, just out talking with people. At times we had pool tables and we would be out playing pool with people. After a few people starting throwing the pool balls at staff, that was removed, so we didn't have a pool table. So a lot of what was done was—we had back in those days...something called NAPI—Non- Abusive Physical Intervention training. Part of the philosophy was to stay in enough contact with the people so you would know before a crisis was actually occurring that something was likely to happen with someone. If you had a responsive nurse and a

responsive doctor, sometimes that would result in medication or decreased stimulation or whatever. Sometimes you had medical staff who appeared not to get concerned about that stuff early enough to make the difference.

We also had something called constant observation rooms where many people who were thought to be abusing the system by making many trips into the hospital when perhaps they could have stayed in the community...I think mostly to try to eliminate some of that, people were put in the constant observation room, a room about the size of this. For people who can't see my gesture, it's probably about 25 ft. long and maybe 15 or 20 ft. across and typically there were 3 men who were patients and one staff person in that room. On the other side of a dutch door there was the female constant observation [room] with 4 beds and 1 mental health worker. Sometimes it was absolutely boring because you would have one person in there and he would sleep for the entire shift and we would be in there an hour or two at a time, and we would have to write notes at 15 minute intervals –

PD: Sleeping?

ANON: Right, but sometimes you could have 3 people who were totally off their meds and were manic and just about to tear each other apart and wanting cigarettes every 30 seconds, and we were expected to sort of keep the peace with that...The cigarette thing was always, in one way or another, a problem. You had people who were chain smokers and we were supposed to limit their smoking because the state was buying the cigarettes and that was sometimes difficult to do. I received my worse assault during that time because of cigarettes. I was in the constant observation room. This guy wanted a cigarette. We had run out, and I was about to leave my time in the room. I said, "When I go out I will try to get some cigarettes so you can have some more." I never finished that sentence because I was in a fairly low chair. He came across the room and was going to punch me out for not getting the cigarette right then. I put my feet up to defend myself and he grabbed me by the ankles and thrashed me on the floor. I got a concussion, got my glasses broken, and he was put in seclusion room for a couple of days. He got some additional meds, and I went back to work after 4 days.

PD: How typical or how frequent was it to have assaults, restraints, people going into seclusion and that sort of thing?

ANON: I am trying to get an idea for that. Roughly in 3 years I was probably involved with maybe half a dozen incidents where we had to physically take someone to the seclusion room and hold them down while they were getting medication—getting shots. There were probably another, I am going to say, 4 or 5 incidents where people escalated, and if somebody hadn't been there to intervene by just talking with them or trying to get them diverted into an activity, there would have been some kind of assault. The only other time that I was assaulted was probably 3 months or so after the one that I just described when a person was hallucinating. He was down in the day room, and everybody was getting sort of afraid that he was going to hurt them, so my job was to go down and try to talk with him about coming down to the seclusion room for some time out. As I approached him—we had had a pretty good working relationship, so I wasn't expecting he was going to do anything to me—but I was ready because he was hallucinating. I wasn't sure where he was in terms of reality, and as I got close to him I

started talking with him about coming down. We had to walk from the day room down a long hallway, probably 60 ft. from the day room to where the seclusion room was and probably two-thirds of the way down, that walk he punched me straight on in the face. He just sort of swung around and [cluck noise] got me. It wasn't a hard punch. He didn't knock my glasses off. He didn't give me a bloody nose. I am not sure whether he realized at some point that he was swinging at me and decided he wanted to pull back or whether he just wasn't accurate, but anyway it really didn't hurt a lot. Well that happened, we needed to keep on walking because here was where he needed to be for a time and he went in with no struggle or anything.

PD: How often did that sort of thing happen? Or did people just voluntarily go into the seclusion room when they were told they needed time out?

ANON: I can't think of more than half a dozen incidents where that happened. There were some people who would start getting angry and start to escalate when asked to go there, but it didn't very often end up in an assault. So I think some people felt like they had to resist, sort of like it was their duty to resist, but they kind of knew that that was the better place for them and so they went.

PD: Can you describe the size and area?

ANON: The seclusion room was probably 10 ft. x 12 ft. It had a heavy steel door that was locked. It had a small observation window with safety glass, it had the glass with wires in it in the door, and it had a window with a safety screen, a high-pressure screen to the outside, so there was natural light as well as the safety light in the ceiling. There was a mattress in there, a plastic covered mattress. Sometimes, depending on the individual, there would be sheets and a pillow. Sometimes, because that wasn't felt safe with the individual, there was only the mattress, and the person only had the hospital gown.

PD: Was there a toilet in there?

ANON: No...We would usually have two mental health workers and a nurse, and... depending on the individual, probably about every 2 hours, someone would go and we would escort them to the bathroom to make sure they wouldn't be running off down the unit or doing something to...themselves...Plus, if someone said they needed to go to the bathroom, depending on the individual, sometimes they would be given a urinal and sometimes they would be escorted to the bathroom.

PD: It had walls, regular—drywall, not padding?

ANON: Drywall. They had rounded the corners. If there were inside corners, [these were] rounded with plastic or plaster when they did the actual building. Probably one of the most dangerous situations that I saw occurred around that. We had a pretty experienced nurse, but she, like all of us, made an error in judgment one day. We had a man who came in. He had been probably tripping on acid. I am not sure what other drugs he had been using, but he was pretty psychotic and he was in the seclusion room. He had been pretty quiet and peaceful for 3 or 4 hours, so she decided on her own to check on him. She had long hair pulled back in a braid, and as she got closer to check on him, he reached up and grabbed that braid and yanked her to the floor and it's a wonder it didn't break her back. Because of our NAPI training, we could use a pain release. So another

mental health worker and I went in there to get him to let go of her hair. The other mental health worker took his hand and used his knuckles, rocking back and forth on the patient's knuckles to get enough pain to get him to release. He wasn't releasing so he immobilized the hand, I pulled one finger at a time.

PD: The pain release is something that is different from that?

ANON: MANDT has no people who are taught not to do painful things, but NAPI still had that element of it back then.

PD: The release you did was consistent with NAPI. I am not sure the pain. In some circumstances might be helpful, but I think when someone is really pumped up, they probably not caring about pain.

ANON: I think he was not aware that anything painful was happening to him. Within 3 days the guy was doing okay, but at that particular time he certainly wasn't.

PD: Did you ever see people being restrained, put in seclusion, or chemically restrained inappropriately?

ANON: Yeah, I saw one mental health worker respond with excessive force. A supervisor from another unit was there and he said, "If you don't stop, I need to write you up. I will write you up if you're doing that." And the guy did back off. That person is someone who had worked there for probably 20 years. It was interesting to work there at the time that I did, because they—I referred to them as the lifers, people who had worked there for 20 to 25 years—the lifers had lots of stories about when there were huge wards with 50 or 60 patients to one mental health worker and sometimes 2 floors with 50 to 60 patients with one mental worker trying to cover both floors. So they had stories about pretty excessive force, but I didn't see a lot. But this one lifer was somebody I thought in that particular situation had reacted with excessive force. The guy was already down on the floor of the seclusion room and the mental health worker came in, got down on his knees, and was shoving really hard against the guy's side. The guy was already subdued so it wasn't necessary to do anything like that.

PD: That's one incident in the 3 years you were there. So something like that wasn't a typical or frequent?

ANON: On that unit I didn't see a lot of stuff from people. I saw more verbal stuff. I did not see a lot of physical stuff. I heard people respond very curtly in a sort of put-down way that I would not have wanted to be the recipient of. Lot of times people were sort of expecting the worse, and so they got the worse.

PD: Whose expectations were they?

ANON: The mental health workers were expecting some kind of excessive demands, or manipulation or whatever on the part of the patients, and so they would respond curtly or negatively, beyond what the situation called for. Sort of a punitive approach, I guess, if I was thinking of it from a parent to child relationship, and...I would say that was bad parenting. You know, most of the time, the situation did not call for the degree of negativity that they were giving out.

PD: What about chemical restraint? Any excessive use of sedating meds, or anything like that or do you think that was all done pretty well proportionate to the need?

ANON: I think most of the time it was pretty proportionate. I think sometimes it was underdone. I think there were some people who were allowed to be more out of control than probably was good for them or the people around them, but, you know, it's pretty hard to second-guess that sort of thing.

PD: How supported did you feel by administrative people or persons in position of power? Were the front-line workers out there suffering unduly because of policy?

ANON: It depended upon who was in charge. We had layers of bureaucracy. We had the person who was the mental health worker III, who was sort of in charge of the shift, probably equivalent to a sergeant in the military setting. Then we had the charge nurse, who was kind of over her. Then we had the unit nurse, who was kind of over her. Then we had—what did we call her; I don't remember now—but she was also a nurse and she was over all of them. Then we had the doctor, whoever was there and probably for most of the time, that worked well.

Once in a while we would have a doctor, who would fill in on a weekend who wasn't necessarily a psychiatrist and they weren't as familiar with the meds as would have been helpful. Once in a while we would have somebody who didn't seem to care that so-and-so was about to blow in the constant observation room and really [needed to] have a seclusion room order and have some time out there. Once in a while we would have someone who didn't want to do anything with meds when it might have been helpful to get the person more under control with some more meds or medication sooner than...the order was written. There was kind of a struggle between the people who were running the thing and the lifers in that we were trying to make some changes. When I first went there, all the staff were hiding behind glass. The units were only painted.

PD: As opposed to?

ANON: A chair rail and wall paper that kind of stuff. I thought people are here for a while. We ought to make this a humanizing place. The lifers, I think, wanted to throw me out on the street, and so I sat in on some meetings to support the administrators who wanted to make the changes. One of things that we did was put an L-shaped desk in the end of what had been a sitting area. Sergeant sat in that area and we did, too, at times when we were working on charts and so forth. But people could come up and talk with us in that area, as opposed to a piece of glass. I am not sure it made a big difference, but it certainly made a lot of animosity with the lifers. They would say things like, "Yeah you're going to feel pretty good about that desk about the time some 6-footer comes over the top of it and pounds your head into the tile," and that kind of thing. I said, "Well that might happen, but I think that some of the good stuff that will happen will outweigh that." I was there for about 2 years after that structure was built, and as far as I know no one ever came over the top of it. I am not sure whether the lifers who were there before me and after me changed their mind about it at all, but I felt like it was a good thing to have pushed for.

PD: What portion of the staff were lifers and what portion were...like yourself...?

ANON: I would say on any given shift, probably about 50/50...Most of the action that happened in terms of people becoming assaulted and acting out tended to happen on the 3 to 11 shift. I am not sure whether that was because there weren't as many people coming and going. I mean, there were always doctors coming and going off the unit during the day. There were always social workers coming and going. If people had a need to call—like I need to call my wife right now, or I need to do this, whatever—there was somebody to take care of that in a relatively short period of time. On the 3 to 11 shift it was more like, calm down, settle down, we've got this night ahead, and I think you can't call your friendly neighbor or whoever on 3 to 11 because they have gone home for the day. So I think there was more need for people to wait, and some people weren't at a place where they could wait. I think a lot of this stuff that I saw happening in terms of people getting escalated was because of needs not being met in a timely manner that they thought was appropriate. I think, if I were in a hospital setting and I had to think about one or two things getting done and it's not getting done at the time when I think it ought to happen, I would get agitated, and I think that was what was happening with a lot of people. Because of the way the social workers and the doctor and the nurse would go into a conference room in the back of the unit for hours at a time to work on treatment plans, to have meetings with individual patients getting them ready to go out into the community, to set up services, or whatever, but Joe Schmoe who wanted to ask a question of his social worker at 10:00 might not be too happy to have to wait until 12:00 when they came out of that meeting to ask the question. So there was a lot of that adding to the agitation and discomfort of people.

PD: Was the workforce unionized when you were there?

ANON: AFSCME: Association of Federal, State and County Municipal Employees.

PD: Do you know when they unionized?

ANON: I don't know for sure. I was there in '78 and my feeling is that it probably was in '74 or '75, but I may not be accurate on that.

PD: I'm pretty sure and I had talked to someone who had been there in '73 and they were not...I'm curious...did the union have an affect, either positive or negative, on any of the working conditions for staff or even living conditions for patients?

ANON: I'm not sure. I know there was a fair amount of discussion about...[what] we probably should file a grievance about for and this situation is something I want you to talk about when you have your union meeting and that kind of thing. But I am not sure whether it was new enough that people were still trying to figure out what the capabilities of the union were for changing things...I am trying to remember where we were fiscally in those years, whether that was a depression era or a recession era or whether the economy was doing fairly well.

PD: '78, would that have been Carter...

ANON: Yeah, I think people were not getting enough money...and I think the state was telling us, "We ain't got it, so you ain't gonna get it."

PD: Beyond pay, is there any way in which working conditions were affected by union as far as number of staff?...Issues of ratio?

ANON: ...If they were it never trickled down to us. We saw no increase staffing during that time. We didn't see any taken away, but we didn't see any increases. Sometimes there was really thin coverage, especially on weekends, especially on Saturday mornings. Saturday morning usually was the time that the van from Cumberland County Sheriff's Office would arrive. We would have four or five people who were essentially detoxing. Because there would be two of us on, sometimes that got to be a little precarious and sometimes we would have to ask for help from another unit to get someone to the seclusion room or that sort of thing. Typically, on Saturday mornings, there would be a STAT call from another unit and we would go racing across the hospital, climb the stairs and helping somebody get somebody into seclusion in another part of the hospital. I don't know if it's because it's the weekend and people feel duty-bound to cut loose or what, but that was when that kind of thing most likely happen. Usually we felt it more because we knew that if we were leaving our unit...that meant two people left on our unit. One of them was probably trying to get meds ready and the other one was trying to man the phone. So you had 25 or 26 people, who could sort of cut loose over there, so we didn't like to be off the unit too long. *[end of side A of tape]*

PD: Did you observe any changes...?

ANON: *[beginning of side B of tape]*...I am not sure whether...it was because of personnel or what, but it seemed to me that the lifers...were a little less abrupt and curt and thinking a little bit more about individual needs. I am not sure whether I like to think that or it really did happen. But I think that some of the people who worked there were trying very hard to do a good job with the patients. One woman is still there as a nurse, so I think she has had some really hard times over the years, but she is still working there. She is someone I would call a lifer now. She had been there now 2 or 3 years when I started working there. But still to this day when I was working for Tri-County as a hospital liaison, I would go for treatment planning meetings and she still was asking the kinds of questions that made me feel that she was really try to do a good job with the people.

PD: For example, just give me an example.

ANON: Well, if she goes home this weekend, who is going to be there, and if she goes home this weekend is she going to be taking her meds, or if she does this how she is going to get food for the next few days? Those are the kind of questions she would ask, so I felt pretty confident that even though she is now a lifer, she has maintained that level of trying to make sure that people have supports in place or a way to take care of themselves if they do leave the hospital. She is somebody that I remember way back in those days. If somebody was having a hard time in constant observation room, and she was the person on duty in there, she would try to find ways to make that be a better time. Maybe making sure that she did get to go to the bathroom when she needed to, or maybe making sure that she did get to call her kids and that kind of stuff.

PD: Tell me about the kinds of interactions both between or among the patients and also between staff. You were talking about the curtness of some of the lifers. What kinds of things and how did people interact and what were relations like?

ANON: There were some patients who had been there for 20 or 25 years and had had 16 or 18 admissions. They were well known to staff and vice versa... Their patterns were fairly well known so that the staff knew that here is somebody that is probably going to be loud and menacing for a day or two, but after they get some meds on board, they are going to be okay, so we don't have to be as concerned about them. So if they came up and started some loud talk, they could say, "You are really way louder than you need to be here right now," and try to put some controls on that. Maybe [they could say] "Here let's go get a cup of coffee", or "Let's go down here and play checkers for a little while", because they knew they could handle that.

There were other people who were new to the system and new to the staff. [The staff] didn't really know what to expect from them and were pretty guarded. [They might say] "We can do this, but it's going to be for this long and it's going to be over here. Let's set some parameters around what the interaction is going to be like." There were other people who were sort of—their whole MO is to try to mooch off somebody else the cigarettes or the money or whatever. Sometimes staff had to intervene with that and say, "Hey, you know, you're causing a problem for yourself and for this other person. There are other ways we can do this." They used to handle—I can't remember now what the number of cigarettes for the day the desk sergeant used to hand out cigarettes. [They might say] "This is your ration for the day and here's what you get."

PD: Did they give them a whole bunch of cigarettes for days or months, or did they pass them out hourly? How did that work?

ANON: Usually they got the day's worth, whether it was 10 or whatever. Once in a while, we would have somebody who could come up and get one hourly... We had one woman who was a lifer, and she did things with a sense of humor. Most of the time if somebody came up after they had had their ration and they smoked them all in 2 hours, they would come up and try to get more from her. She usually would handle it in a joking way, but they knew the message there. "You came and you got what you could get, and that's it for the day." There were other people who very rigidly, forcefully, curtly said, "It's up to you to – blah, blah," in a cut and dry sort of way. It varied by individual styles.

We had this little charge nurse on the 3 to 11 shift. She was an amazing person. She did everything very cut and dry and nobody messed with her at all. I don't care if somebody was 6' 5" and weighed 300 pounds. She would go in and read them the riot act, and they usually cooled their jets. I have no idea whatever became of her. She was not a lifer, but she had been there for probably 5 or 6 years by the time that I came on board. I feel like she was probably the personality that was needed for that 3 to 11 shift. There were fewer problems the days that she was on duty than the days when somebody who was less straightforward about things was on duty.

I think there is a way to be straightforward and positive and there is a way to be straightforward and negative. Some people could pull off the straightforward positive

thing—people knew where they stood. They didn't have to guess, but they also didn't feel put down in the process. There were other people who were trying to be straightforward and would do it in a way that would make people feel put down...

There was a doctor there who developed this attitudinal scale—how to deal with such-and-such a personality and what you do. One of his basic tenets was 'kind firmness', and that was the thing that he was trying to make happen. Some of the lifers kind of understood it and could do it, and some of them didn't seem to be able to.

PD: Was that doctor there long?

ANON: Yeah, he was there for quite a long time. I think he is still practicing within the state, but he is in private practice. I don't know how long he was at AMHI after I left...He tried to get some attitudinal stuff to happen. He probably did more about it indirectly than was helpful. I think [it would have been helpful] if he had sat down with some people and had conversations about...this is what I mean when and this is how you do it, and come by a day later and catch somebody in the act of doing [it] and say, "Hey that's it exactly!" But he was a pretty busy guy, so he didn't have time to do that; but I think he was at least making some attempts around that...

I think some people who were in positions to reinforce either didn't see that as their role or didn't buy into his thing; I am not sure which. I don't remember ever hearing someone say to another person, like the desk sergeant for example, saying to another person, "That's exactly what he needs" or "Yep, that happened; that's why." That kind of thing. That sort of coaching aspect from administrators wasn't necessarily there and it could have been helpful to bring staff along faster.

I think some of that has happened over the years when I went back. My latest connection with AMHI was while I was doing the Tri-County job and I did that from 1999 to 2001, just before I came here. I saw more of those elements in place. I still saw some people being curt and abrupt when I felt like it wasn't necessarily helpful. I saw more people I thought doing the 'kind firmness' thing. You can use the phone, but these are the times when it is available. Or you can make a call, but this person has requested that you not call them and we have to abide by that. You know, whatever rules have been set up. I think sometimes when I worked there, it seemed like some of the rules didn't necessarily [fit]. They probably fit somebody sometime, but they didn't necessarily fit the situation when I was there. I think because people had lived under a certain kind of system for a long time they would enforce those rules, even though they didn't necessarily fit the situation. I don't know if you were there when another former worker was talking about the guy in the boat who would come up...

PD: Yeah.

ANON: I could not imagine that happening during the time I was there. I think that whoever would have allowed that to happen would have been dismissed. I am just amazed that worker was able to keep a job, because she was there even a little earlier than I was.

PD: That was a patient going off for weekends, being taken by a non-patient for the weekend by boat to Hallowell. Did you see any incidents of people doing things that were positive like that, where it was violation of what the actual rules were, but seemed human or appropriate?

ANON: I am trying to think of an example of that. (Long Pause.) I can't really. Probably some people got extra food or somebody might have gotten extra cigarettes, but I don't think something happened on a large scale. I mean I would consider the boat thing a large scale incident, but I can't think of anything while I was there that happened that would have come even close to that.

PD: What about positive things between patients, demonstrating a supportive culture. You mentioned the mooching and various things. Do you have any recollection of anything positive?

ANON: Yeah. I think I saw people who were really feeling pretty down and desperate, and I saw people going up and having a conversation with them to sort of help them through those times. I think that probably happened. I didn't work the 3 to 11 shift, but my guess is that's what happened. You hear stuff in the intershift reports. We would come on at 7 am and we would hear the shift report from the shift before. We would hear the 11 to 7 report and the 3 to 11 report and we would hear about so-and-so patient talking with so-an-so patient. Sometimes people got concerned because they thought that was a manipulative thing. Or sometimes people got concerned because they thought this person is really wallowing in self-pity and this is a way to help them wallow, but once in a while you would hear about a positive one where people didn't have those concerns, so I do think that happened. I am trying to think about other contexts or other ways... We did have people who were trying to do some things with art therapy and so forth. I think there were some people who could give positive feedback for making attempts at artwork. I think that happened. I am not aware of times when somebody said, "Wow you really cleaned up your room" or things like that or "Hey, if you give me a hand with this, I will help you with yours." I don't remember that. I think most of the people that we had were probably ill enough that a lot of their focus was only on themselves. I don't think they had much energy to really think about other people. I think that was how we were probably different on some of the longer term units where people were in better control and had more needs met by the time they went to those other units. But I think [in] the admissions unit, people were fragile enough that they didn't take too many risks in doing stuff with other people.

PD: How long did they tend to be in that unit?

ANON: About 7 to 10 days. Some of the people who had been there many times, kind of knew the system and how things were going to go. [They] were helpful in teaching to some people about how...you've been down here now and you are going to going upstairs and this guy is going to take you over to the busy station pretty soon, or whatever. I think some of that happened.

PD: How do you feel now about the work that you did at AMHI? What is your perspective looking back on it?

ANON: It's a thing that I am glad that I have had as an experience. I think that whatever I have done in my life that has helped me to learn more about myself as a person and how I want to deal with other people. At the time, there were days when I was very very stressed with too many things to do and too many places to go all within a framework. Sometimes I got very frustrated with what seemed to me long delays between a person asking to make a phone call and actually being able to make the phone call. Certainly I don't like getting punched out, and I did feel unsafe probably more after that than I did before. I didn't think of myself as invincible. I had lived long enough to know that. I did feel more concerned than I had before that incident about what's that guy going to do to me and how will I respond if he does. Talk about life's ironies, when I worked at Motivational Services, before I went to Tri-County—I think I worked at Moco from 1997 through 1999—that person who had punched me out was one of my clients during that time. I was a financial mentor, and I was supposed to help him out with his budgeting and he had no recollection of me at all. He had done enough drugs over the years that he didn't have a very intact memory and probably three or four months after I started working with him he had a cerebral hemorrhage. The last I knew he was in a place for people with brain injuries. It was interesting for me to have that whole other way of dealing with him. That incident had happened 20 years before and I remembered it well. I could still set that aside, and I think that was a good kind of personal growth for me to have. I guess I probably have a healthier skepticism about institutions and medication, and doctors and the whole thing than I would have had otherwise. I saw people who were very badly out of control get better within a reasonably short amount of time, and I felt that the medication was probably helpful for them for that reason, but I still want to know maybe more than I would have. What is this really going to do for somebody and what should I really be watching for in terms of side effects? Should we be looking at other ways to help the situation, instead of just relying on meds?

PD: What were the primary modes of treatments? What were the meds of the day?

ANON: Back in those days people were getting Thorazine but less than they had been only few years before that. Haldol was a biggy. Lots and lots of people were on Haldol. Some people were getting Mellaril [and] Navane which sort of came and went—and that is what really heightened my skepticism. I had not see the pharmaceutical industry operate very much until I had the Navane salesman come in one day with his big bucket of Kentucky Fried and pass out the pans of the chicken. Three days later, everybody started getting Navane. Whoa, there's salesmanship. There's capitalism at work. So that made me more skeptical than I had been up to that point. I did see people having dystonic reactions from Haldol, and I could see that Cogentin could help that. It sort of made me wonder why somebody had to have a dystonic reaction before they would up the doses of Cogentin, given that was likely to occur with that drug. I am not sure whether that was caution on the part of the psychiatrist or lack of attention on the part of the psychiatrist... I still have skepticism about use of medications.

PD: What other treatments were they having at that time? Was ECT being used?

ANON: There were some people who were getting ECT. They would go to the Augusta General and get their anesthesia and so when they did have ECT, it wasn't like the old days with the broken bones and massive seizures and so forth. There were still periods of

memory loss and we were supposed to be there observing the person as they came up from under the anesthesia and get them reoriented as quickly as possible and make sure they weren't having any kind of discomfort. Did I see it being effective for some people? I never saw long term enough results. Usually if somebody were going to stick around they would go to another unit, so I didn't get to see them two or three weeks down the road or whatever to see if that was really effective. I heard reports from people that yeah it helped and they didn't like the memory loss stuff, but they weren't as depressed.

PD: Was memory loss long-term?

ANON: Some people felt like it was long term, but I don't know what their ability was like before the treatment. Most people reported short-term memory loss. Within a couple of days they were kind of back to where they had been before. I don't know how accurate those reporting and recollections were.

PD: Were any other treatment modalities being used at that point?

ANON: Once in a while someone would run a group, but it didn't seem to be anything that was sustained for long periods of time. But again, we were dealing with people who did not function particularly well in a group setting...

PD: No one-on-one counseling?

ANON: The one-on-one counseling is what we as mental health workers were doing. We would talk to people about pretty basic stuff like you know where are you going to live when you leave here, who takes care of things when you are in here, and that kind of thing, and try to get people's day-to-day needs met. We didn't get into too many things like did your mother beat up your grandfather...or...historical things other than what people would tell us when we are doing the initial interviews. Much of the initial interviews were pretty much what was going on 24-hours before you got in here, not 10 years ago or whatever.

PD: No cognitive therapy?

ANON: Not while I was there and not with those people. It may have happened when they went to another unit. There were psychologists there that were running some groups, but most of the psychologists on our units were there for assessments, not for therapy or counseling.

PD: You talked a little bit about the satisfying aspects of your work. Are there any other positives?

ANON: Yeah. I guess I saw it as positive that it was basically a safe place for people who, if they were out on the street, probably would have been killed or would have died from exposure or something. I am thinking of one guy who came in. It took us 3 days to get down to his skin because he was so filthy. He had been living in a decrepit trailer. His mother had died sometime in February or so, and he was not sure what to do about that because he thought he would be blamed for her death and we never did find out whether he should have been blamed for her death or not. Anyway, some time after the spring thaw, the neighbors smelled the decomposing body, because he had just stuffed her in a utility closet. The sheriff came and brought him to AMHI. They had to burn the trailer

because it was so bad that no one could do anything with it. We had to clean him up and gets some meds and within probably three or four weeks, he could function on the unit. I don't know what happened to him after he left our unit, but he was at least able to have conversations with people and take care of his own daily needs. I think he is somebody who probably, if he had been left out in the community, would have died. So we had people like that I think AMHI probably saved. I think we had other people who, for a time at least, AMHI may have made their lives worse, such as severing connections or making it more difficult for them to have connections with people who might have been important.

PD: That ties into another half of that question. What was the most unsatisfying or difficult [aspect of your work]?

ANON: I guess for me personally it was never knowing the rest of the story. I would always see somebody come in, and I would see them move along a path that looked like they were probably getting better, but because they would always move on, I never knew the rest of the story. I always have felt good in intervening years like when I was working for Moco at a group home. I went for my interview and this guy hopped up and said, "Mr. L....., it's July 4, 1981." Yeah, so this guy had an awesome memory, and there was another person there who did a similar thing, because I had known both of them on the admissions unit. I said, "You guys are awesome. Have you ever played Trivial Pursuit?" And they said, "Yep. We've even made it to double jeopardy before." So...I remembered how those guys were when they came in and even though they were living in a group home, it was a much higher level of functioning than what they had been doing. I knew that something had happened to make their lives more reasonable than what might have been otherwise.

PD: We talked about this a little bit. What activities or treatments at AMHI were the most helpful for patients and what were the least helpful? Anything you want to add to what you said already?

ANON: I think for most people the meds were helpful. I think the long delays, the lack of many things to do when people felt they could be doing something were not helpful. I don't know if hanging out and watching TV and smoking are the best ways to use one's time. I think a lot of that was a factor of the poor economy. They couldn't hire or didn't use the money to hire enough recreational people or OTs, or other people who would have been helpful in getting people to do more things. The lifers used to talk about the days of the gardens and the day of the greenhouse and so on. We didn't have that. That was all gone by the time I worked there because of the stuff with exploitation, and that was probably correct judgment. Some people were probably exploited, but on the other hand it gave people something to do and helped people learn skills. I think that there should have been a more balanced approach of instead of get rid of it—think about how can we make a change and still keep some of that intact. I think even though some of the people were there seven to ten days, there were a few people who were there for a month or two and some of them certainly could have gone to work in the garden or work in the greenhouse or done other things off the unit.

PD: Were there any...alternative therapies happening informally—massage, foot rubs? Any things like that?

ANON: If it happened, I don't remember many people doing that. Perhaps once in a while somebody would give somebody's back a rub, but I think often that was looked upon as, "Heh, what do they got going?" I don't know if that was considered any part of any kind of therapy per se. It certainly wasn't part of any institutionalized or official therapy.

[second tape, side A] On our unit I wasn't aware of anything that was even rumored about in terms of unequal power being used against anybody, sexual exploitation or that kind of stuff. I had not heard about that stuff on our unit. As I think about the people that I knew on the unit, they were—except for the excessive force thing—seemed to be pretty intact people. I don't think there were people there that I would be wow, gotta watch that one, kind of situation.

PD: So some of it sounds a bit more subtle then, maybe verbal put downs, but not a lot of physical abuse, not a lot of excessive use of chemical restraint? But maybe a kind of dehumanizing interaction –

ANON: Right...I think some of that may have happened on other units, I think because of the long-term nature of stays. When you have some people on units for three or four or five years, maybe that can happen more. But on our unit we had the rapid turnover kind of thing.

PD: What are the major lessons that you learned from your time at AMHI and what implications might these have for the new facility?

ANON: I guess the thing that I had talked a little bit about before is learning about myself...I had worked at Pineland Hospital back in the summer of 1966, and one of my big learnings from that was not to make assumptions, and the AMHI thing just kind of reinforced that even more. The Pineland thing was about a guy who used to spend the entire summer pretending he was playing guitar and he would say the weather today is going to be partly cloudy and it's going to be sunny tomorrow and that is all I heard out of him for an entire summer. Five years later, my wife and I were chaperoning at the Special Olympics and the guy walks up, grabs my hand and says, "Mr. L..... when are you coming back to Gloucester Hall?" I had no idea that he had any other kind of language. So I learned from that, don't make assumptions and that stood me in good stead at AMHI. I would ask people questions. Sometimes they would not want to answer and that would be fine, but I tended to ask more questions I think than I would have otherwise. I guess that is part of my life-long learning.

PD: [What about] implications for the new facility?

ANON: I think about the safety concerns. I think if I were ever a patient at AMHI, I would have been more concerned about my personal safety. I think I am somebody who would be a target for moochers, or a target for people who want to take advantage of a quiet person in anyway that they could. Unless you have staff who can be pretty aware, then I think that risk still exists.

I know I was a patient at [a] hospital about 7 years ago. I was in a group therapy session, and I had revealed something that had occurred to get me into the hospital. This other patient just started hammering on that and the social worker who was running the group meeting [rescued me]. I am not sure, at the time it felt good to have been rescued a bit by this social worker. For the long-term result for me, I don't think it was best that I was rescued or [I wonder] if it [would] had been better if I had defended myself. But I didn't at the time and he stepped in. I didn't feel the same way towards that patient than I did before. I felt like I had to watch my back a little bit more around this guy, and I think there is probably at least that and stronger feelings...at the new Riverview and present AMHI. I know there are people who stay in their room because they do not feel safe around other patients. I think part of that has to do with the layout of AMHI—those long corridors. Somebody could be down in a location and hurt somebody before staff would ever know about it. When I was a staff person, I tried to be aware of those places and used to keep an eye on people and say who's doing what and know what was going on. I am not sure if other staff people do that. That's something that I would certainly want staff at Riverview to be trained very well about...

PD: It isn't the same physical set up so there won't be those corridors. I heard that described as a possible downside because long corridors allowed covert activity that might be positive, although we can certainly think of covert activity that would be negative.

ANON: Right, anyhow I guess the predatory situations always exist and you sort of have to be as a staff person and as a patient watching for that to happen. It is part of personal safety.

PD: Do you think having consumers in some positions of power in running the institution would be helpful?

ANON: Probably. I felt like as a consumer I was doing some pretty decent stuff when I worked at Moco and Tri-County and I think probably the experience of hearing the door lock behind one makes you more aware of what that means to other people than just being the one who locks the door.

PD: Okay, time runs out. What is your vision of the ideal mental health system? In 25 words or less (laughter.)

ANON: It's a system that assesses very carefully people's needs and then finds ways to meet them, whether it be related to employment; therapy; ongoing therapy; ways to reconnect if people have become disconnected; skill development, whether that be further formal education or...enhancing skills people already have developed but need to go even further with; [and] ways of self expression and creativity. Putting it all in a way that is accessible.

PD: As far as medical insurance accessible or --?

ANON: That's part of it, but even physically accessible...If I live in Lewiston should I have to go to Portland to take a class? Or if I live in Skowhegan should I have to go through Farmington to meet a therapist? All of the things that happen living in a rural setting. We can think of other ways to provide services. I think the interactive television

seems very promising. I have been pushing that for a very long time. Way back in 1974 I went to a series of seminars back when I used to do Speech and Language therapy and they were done at Purdue because Indiana was trying to do stuff in the 70s with interactive TV and having seen video tapes of what happened with their interactive TVs, I thought “Yeah, we can do that in Maine.” And I still keep pushing. It is happening.

PD: What about recovery? What is your sense of it and what is your sense of how much the mental health system fosters it.

ANON: Recovery happens, and it bothers me that it is still sort of a new concept. It bothered me that it wasn't addressed in the surveys we were doing last year and that is why I raised it a couple of times. Let's at least use the terminology. People like P.... D....., for example. She is a person who is in recovery...I was running a group when I worked at Tri-County, a recovery group, and we tried to get very much into the whole thinking about recovery and how you may need some interventions along the way, but it doesn't necessarily need to be a total life style. You can get out in the world and...you don't have to be hiding because something happened with your brain. You can find ways to live with it and learn to live with it, and try to learn early enough about yourself so that if things aren't going well you can get some help. Going back to the ideal system—that help would be available when people needed it, not when someone thought they could afford it. You shouldn't have to be living on a street, if you don't want to be living on a street, until somebody says, “Heh, we can do this.” I think...there are many other ways to get people connected with services than we seem to be doing.

PD: The last thing is whether you have any other comments you would like to share? Is there anything we haven't talked about that we should have?

ANON: I will probably think of something a day or two from now, but right now I feel like we have pretty well covered the bases. It's all an individual trip. Each of us makes our own journey in the world. Some people do it with more ways of thinking about it than other people do. Some people just haven't had very many experiences with how to live in the world and don't necessarily see that as something they can make choices about... Part of what I do as a case manager is help people to think about options and choices. Okay you try this. That was the choice you made at that time, but given the situation would you make the same choice today? And if not, what else might be there for you to make choices about. Some people are in situation where they don't feel they have many choices available to them. I try to get people to think about that.