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Roy Wright Memoir

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MENTAL HEALTH CARE PROJECT
Roy Wright, employee at Jacksonville State Hospital, discusses changing methods in patient care and treatment, changes in community attitudes toward mental illness, and changes in living conditions and staff in the hospital.

Interview by Rodger Streitmatter, 1972
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ROY WRIGHT MEMOIR

PREFACE

This manuscript is the product of a tape-recorded interview conducted by Rodger Streitmatter for the Oral History Office on October 6, 1972. Kay MacLean transcribed the tape; Ed McKinley and Kay MacLean edited the transcript.

Mr. Wright was born at Wrights, Illinois on September 3, 1913. He began his employment at Jacksonville State Hospital, Jacksonville, Illinois in 1935 as a ward attendant. Following military service from 1941 to 1944 Mr. Wright worked again as an attendant and then, for a short time, as an employee in the hospital's dietary department. From 1948 to 1951 he attended Our Saviors Hospital School of Nursing and then served on the staff of the Student Nurse Affiliate Program at Jacksonville State Hospital. He took educational leave again from 1954 to 1956 to work on the Bachelor of Science Degree in Nursing at Washington University and in 1957 he became first assistant chief nurse and then, in 1965, chief nurse at the State hospital. In 1968 he took an administrative position at the hospital.

During his more than thirty years employment in the mental health field, Mr. Wright witnessed changing methods in patient care, changes in community attitudes toward mental illness and changes in the physical conditions and staff composition within the hospital.

Readers of this oral history memoir should bear in mind that it is a transcript of the spoken word, and that the interviewer, narrator and editor sought to preserve the informal, conversational style that is inherent in such historical sources. Sangamon State University is not

responsible for the factual accuracy of the memoir, nor for views expressed therein; these are for the reader to judge.

TABLE OF CONTENTS

Roy Wright, October 6, 1972, Jacksonville, Illinois.
Rodger Streitmatter, Interviewer.

Q: Could you tell us about how you first came to Jacksonville State Hospital and about the different jobs that you have had here at the hospital?

A: Yes, given a little time. I entered state employment in mid-November of 1935 as what was known in those days as an attendant, which literally means an employee who works on the ward with patients. I maintained that position until I was inducted into the military service during World War II and thus, was absent from the hospital from 1941 to 1944. Upon my return from service in 1944, I reentered State service, again as an attendant, and after a short period of time in that position, I transferred to the dietary department for a period of a year or less.

By this time it had become readily apparent to me that I thoroughly enjoyed my association with the hospital, but if I were to ever be able to advance beyond that attendant level, it was going to be necessary for me to do something about my education. And, since I had not completed high school, that presented some difficulties. I was able to achieve high school graduation status by a GED Test, and was thus able to enter the Our Saviors Hospital School of Nursing in 1948. Those programs, of course, are for three years so I was absent from the hospital from 1948 to 1951.

Upon my return to service in 1951, I was on the staff of the Student Nurse Affiliate Program from 1951 to 1954. In 1954 I again took an educational leave from the hospital and enrolled in the nursing program at Washington University at St. Louis and achieved a Bachelor of Science in Nursing from the University in 1956. In 1957 I transferred from the Affiliate Nurse Program to the hospital nursing office with the title of Assistant Chief Nurse, a position which I held until 1965. In 1965, I became the Chief Nurse of the hospital and held that position until January, 1968, at which time I left the nursing department and transferred into Hospital Administration in essentially the same position that I currently hold.

Q: During the early years of your work here at the hospital, do you think there was much more of an emphasis on direct care of patients rather than their actual improvement or motivation toward moving out of the hospital?

A: Actually, from the period that I can speak to, 1935 to about 1954, for all practical purposes the word "discharge" was really not in our vocabulary. We simply accepted all persons who came to us, built more buildings and quickly filled them with people. We have used, and not too facetiously, the term "human warehousing". I really feel that was the business that we were in. Our staff was such that discharge was, even if the word had been in our vocabulary, pretty unattainable. Instead of concentrating on discharge, we simply met the physical needs of the individual and in a sense really functioned as a police officer. I use that in its kinder sense, in that the main job of the attendant on the ward at that time was to see that people didn't harm one another,

and that they were fed and bathed and clothed, after a fashion. But, really, there was no thought of treatment. Treatment, specifically, really hadn't come upon the scene at that time. The medicine cabinet on the ward in the 1930's and throughout most of the 1940's would have consisted of aspirin tablets, cough syrup, and laxatives; that was our drug supply.

Along the lines of treatment, the very first treatment that became popular was a form of shock treatments that was chemically induced rather than electrically induced. They used a drug called metrazol that was injected into the patient intravenously, which after a period of a very few seconds, put them into a deep convulsion. That was the earliest quote "treatment", other than hydro-therapy which we probably will get to a little later on.

Q: Could you recall the date that this type of shock therapy came into use?

A: The very late 1930's; 1937, 1938, 1939, some place along there. I can only arrive at these dates by certain milestones in my own life, I know it was before I left the hospital to go into military service in 1941. This was by present day standards a very cruel, inhumane sort of thing. It had to be done on a hyperextension frame, which means that the person is literally bent backwards. We did this to keep from having compression fractures of the vertebrae, due to the intense contraction of the action of the metrazol. And, since this was rather risky, it was only widely used for a very short number of years.

The next treatment to come in vogue was insulin. We're all familiar with using insulin in the control of diabetes, but there was a time that we felt that by giving massive doses, putting this person into a hypoglycemic shock, we could somehow alter his electrical brain waves and thus achieve some amenability to recovery. It, too, was a dangerous sort of thing because whenever you alter the body metabolism to the point where you put a person into hypoglycemic shock, there is a point beyond which you cannot go and then reverse the process. So, that was a very, very touchy thing that was very carefully controlled and fortunately, our mortality rate was practically nil on that. But, had it not been very carefully done, with the unit heavily staffed, we could have hurt many, many people.

Q: Were many of the patients vehemently against any kind of treatment like this or were they more docile and willing to do most anything you asked them to?

A: We had both. We had people who literally, to all practically purposes, couldn't have cared less what we did to them, and I emphasize the word "to", because in those days we did things to people rather than with them, or not necessarily for them. Others literally had to be bodily carried into this treatment situation. It was a traumatic experience and there were some memories carried over from it. Most people would go fairly willingly the first time, but insulin, for example, was given every second day, and after one or two treatments, some of our people had unpleasant memories; bad enough that they literally were bodily carried in and restrained and subjected to the particular treatment.

Q: Were the families of the patients accepting this type of treatment pretty well? Did they accept whatever the hospital thought was best for them?

A: In most cases, upon admission, a consent for treatment form was usually obtained by the responsible relative. In the cases where this was not possible, where the person was literally brought and dropped by the sheriff, which I might also add, was our major way of acquiring people, the superintendent could, under the laws at that time, authorize treatment for those individuals. I really can't go beyond those statements on consent, family participation and/or intervention, because, remember at that time I was literally a peasant in this operation and was really not too aware of what was going on up at a higher level. However, in looking back at the changes in the Mental Health Codes and the legal changes that have taken place since that time, I have a strong feeling that we really were not paying too much attention to the wishes of the family and/or the patient.

Q: You briefly mentioned hydro-therapy. What are your recollections of this type of treatment?

A: Hydro-therapy is probably, well, it just <u>is</u>, the oldest form of quote "treatment". Very possibly if that were used absolutely properly, there could be some positive effects. Hydro-therapy basically consists, or consisted, of two forms of treatment. One was what was called, at least in this hospital, a neutral tub. That consisted of an immensely large bathtub that was filled with water—water constantly entering and leaving. The person was put on a canvas hammock in that tub and a

cover was put over the top. The water was at about the same temperature as the body and with this constant flowing of water at what would constitute a neutral temperature, was supposed to have had a very calming effect on the individual. I would underscore the word supposed, because in my own mind there really is some question.

The other was a procedure called the pack. A neutral pack consists of enveloping a body in sheets that have been wrung from icewater and spread across the bed in a very peculiar fashion. The body is then placed upon those sheets and they are enveloped about him in a very strange fashion which completely immobilizes the individual. He resembles at that stage the pictures that we see of the old Egyptian mummy. He can only move from his neck up. He can shake his head but that is really the only part of his body that he can move. Then, this wet sheet cocoon that he was wrapped in was wrapped in two wool blankets and he was restrained to keep him from thrashing and rolling off the bed. This was done on a pack bed or pack table which was about the height of what we think of as a hospital bed today. It was not done on a low frame but rather on a high one. This produced different stages, and as I've indicated before, the sheets were wrung from icewater so they created quite a sensation. You'd agree if you've ever tried lying down on a bunch of ice cold wet sheets. But, as soon as the wool blankets were applied, and since this was all very tightly wrapped, the person's body heat began to counteract the cold and then we really literally built up heat. It was our responsibility to put cold towels about that person's neck--remember just his neck and face are exposed--to keep him from becoming overheated. The theory behind that was that the sudden change from body temperature to

cold and then the gradual build-up of heat somehow stimulated circulation which in those days was supposed to have had some kind of effect. Again, I would underscore the supposed. But, that was the theory, really, behind the whole thing.

Q: Could you hazard a guess as to the last time that you recall the neutral tub or the neutral pack being used?

A: Their use started to decline as I would recall, in the late 1950's and our last piece of equipment to do these things was physically removed in the early 1960's.

Q: As these types of treatment disappeared, what treatments replaced them? Was there more emphasis on chemotherapy after this time?

A: Chemotherapy was beginning to come in on a rather experimental and certainly very limited basis. But, if we could sort of put tags on these various treatment eras, the next major era that we should consider was electric shock. As I mentioned earlier, the insulin treatment was so hazardous, and was such a very cumbersome process, that eventually the electric shock treatment became popular. It had a good many advantages from the mechanical standpoint, at least, over either the old metrazol that we talked about earlier or the insulin. Number one, it was rather easily administered, rather quickly administered. There was not the danger of compression fractures that we had from metrazol, and this was widely used in the late, the middle to late 1950's. And, at that time, our population was high. I might add here that our population peaked out in 1954 at about 3,600. And, during those years of an enormous population, we were literally using shock treatment on hundreds of

people throughout the hospital. I'm not talking about an occasional treatment, or literally a little nickle and dime operation. It was really mass production, literally. And, we had a good many of the same feelings existing that we had had with the previous forms of treatment. Some people came into it very willingly as though they were just walking across the room, others literally had to be carried in and put on the bed or table that we might be using, each and every time. This did alter the behavior of some people. I can't say that any of these were without benefit, but they certainly were not without hazard. And they certainly produced changes. I'm not sure we know today what harm we could conceivably have done to people with electric shock or any of the other mechanisms that produced convulsions. There are still debates raging in the medical community about brain damage and that sort of thing, so I don't know when or if some of these questions will really be answered.

But, as chemotherapy gained a foothold and then really became quite widespread, even electric shock declined rather rapidly. And, to the best of my knowledge, had not been used for, well, seven or eight years and for the last few years that it was used, it was only on a very limited basis and by that time, they had developed some quite sophisticated pieces of machinery. Some of our first shock machines were, by later standards, very crude affairs. But, like in every other technological situation, as time went along, every year every company would come out with a more sophisticated piece of machinery, so it did become less of a traumatic experience, due to some of the refinements in the machine itself.

Q: Do you recall any of those early mechanisms well enough to describe them?

A: Well, to the layman, all of the machines looked very similar. They were simply the little black box. The differences were technical and were built in and really wouldn't be that visible. The biggest thing that the layman would notice was that the early machine was rather a cumbersome affair that weighed forty or fifty pounds and was quite difficult to move around. The very last machine that we used around here was about a fourth that size. But, other than the actual physical appearance, the differences were largely in the wiring, the way the amount of electrical current was delivered, and that sort of thing. It was all done by electrodes, one attached to the left temple and one to the right. And, what shock treatment really consists of is passing a certain measured amount of electricity from one of those electrodes which was positively charged over through the frontal part of the brain and over to the other electrode which was negatively charged. That's the basic principle of any electric shock treatment.

Q: Would a doctor or a registered nurse normally be on hand when electric shock was administered?

A: Oh, yes, they were always administered by a physician; at least in our hospital, it was always a physician who pressed the button on the machine. The treatment team consisted of a physician, at least one registered nurse, and however many aides or attendants it took to physically do the job.

Q: Did chemotherapy become strong in the late 1950's?

A: It came in in the late 1950's and has really been our major source of treatment, other than verbal communication, since that time, as I recall.

Q: Have you been involved in any kind of occupational therapy in which a patient could be urged to learn some type of vocation, and establish some sort of a goal for himself?

A: I've been involved, but our occupational therapy department was really never geared to establishing vocational skills for an individual. It was done more on the premise of occupying that person's time, than really teaching him anything constructive. It was exercise, entertainment, diversion, that sort of thing. Only since about 1966 have we really done anything about vocational skills and that is done through our sheltered workshop program. That has been a very effective program for a lot of people, but we are now getting to the point where most of our people who we would feel at this point could benefit from it, have achieved benefits from it and have left the hospital and are functioning either independently, marginally, or in a supported manner in the community.

Our workshop operation is not nearly--well it couldn't be as large now as when we had a larger population--but our workshop operation consists of doing subcontract work for private industry on a pay scale that is set up according to the Fair Labor Standards Act and various and sundry other pieces of Federal legislation with which

I'm not really all that familiar. But, I do know that we have to adhere to certain acts of the Fair Labor Standards Act in order to contract with private industry and also to provide monetary incentive to get people to work. And, our patients do not differ that much from the general population; they are motivated by the buck so we do have all those things.

Q: We've mentioned, at different times, the population and how it has changed. What is approximately the patient population of Jacksonville State Hospital today?

A: We are slightly under 600. Really, 600 in round numbers, today. One big thing that accounts for this, as I mentioned earlier, in the mid 1950's we were 3,600. But, at that time we were only really becoming aware of the word discharge, and then started looking at our people and wondering why some of them couldn't function outside the hospital walls. And, as that process has gone on, it has been intensified largely through moving people who really were here inappropriately. We're now down to our present population.

Q: Do you feel that public acceptance of former patients has improved over the last 20 years?

A: Oh, yes. The public is becoming much, much more aware and is accepting the person from the mental hospital. I don't want to mislead you or anyone else into thinking that it is a utopian situation. It isn't. But, there has been a many-pronged attack—I hate to use the word attack—but there has been a diversified effort made to

acquaint the community with the fact that people who had been in a state hospital didn't necessarily have to go out and harm the people they came in contact with in the community and all of this.

At the other end of the scale, we have spent a lot of time and effort and a certain amount of money in encouraging the communities to take care of some of their own problems rather than after the least bit of deviant behavior, grabbing a person up and literally dumping him into the state hospital. And, we've had a great deal of success in all of those areas really. Our admission rate isn't nearly as high as it used to be. This is especially true with the elderly individual. We, at one time, operated the equivalent of today's nursing home on a massive basis here. We had literally hundreds of elderly, helpless people here, simply because they were old and confused and this was just a nice convenient spot to put that person. Then the family could go merrily on their way and forget that Uncle John or Aunt Susie existed. We seemed to have a tacit agreement, although there was never anything written, that whenever a family brought a member to us, there was just sort of a gentleman's agreement that existed that we would keep that person until he or she might die. There was no pressure put on the family to say, "Hey, Uncle John has leveled off and there is no reason why he should be here. Why can't you come and get him, why can't we work out something else?" This just wasn't thought of. This was literally the end of the line for the person who came in, pretty universally, whether they be young or old. Just recently, to really strengthen that statement, we placed an elderly lady in a nursing home who had been hospitalized continuously since

1905. From 1905 to 1913 she was at the Elgin State Hospital and from 1913 to 1971 she was in Jacksonville. So, regardless of the age of the individual, we were just sort of expected to keep that person.

Q: How has the patient-staff ratio varied over the years, and has the staff become more professional?

A: Oh, yes. It has changed tremendously, in any aspect that we might discuss. Going back to the time when I was on a ward as an aide, our wards were quite large, with an average of 75 to 80 persons on a ward. Except in what were known then as our disturbed or violent wards, one person on duty per shift constituted the staff. There were perhaps six wards within the hospital, out of a total of at that time, I believe 72 wards, where there was more than one aide on duty at any given time. So, I think that would make it very apparent that treatment was not even considered. It was simply keeping people from harming one another and seeing that they were sent to their meals on time, seeing that they were clothed, and I use that term rather loosely--seeing that they were not nude--they were draped with cloth, but that's another area where we have improved tremendously. We at that time made all of our own clothing. It was made with patient labor and most of it resembled bags rather than any form of really identifiable garment that we think of today.

Our professional staff at that time consisted of one social worker in the entire hospital and that was at a time when our population was about 3,000. And, that social worker had a blind stenographer who did all of the correspondence for the social service department. Now, I

am not saying that to imply that a blind person can't be employed, and gainfully; this person happened to be very proficient. But for one person who was sightless to be able to keep up with all of the correspondence and the intake histories as they were done in those days for a large hospital is, by today's standards, pretty unbelievable.

Q: Do you think there were many patients who were, if I can use the term, "warehoused" who could be helped significantly now?

A: Most of those people have been helped and have been discharged. We now have a group of approximately 200 out of that 3,600 that for one reason or another we have not been able to remove from the hospital at this point. But, we're still working on that. And, some of those really are quite capable of living in a structured setting outside the hospital, but strangely enough, we have some families who are resisting us violently when we talk to them about moving their relative out into a community facility. That is a problem that we have not been able to resolve. They develop a very comfortable feeling as long as that person is safely locked up in the state hospital, and they become very, very uncomfortable and quite belligerent sometimes, if we make noises about putting this person in a nursing home or shelter care home.

And, with our legal setup, some of these people have a situation where some member of his family may be a court appointed conservator so he has whatever little estate this person might have and can make it terribly difficult for us. If he is controlling the estate and if

it is above the Public Aid minimum which is $400 and refuses to part with it, we're pretty effectively blocked. Right now we have a number of cases where we have finally appealed to the court to either replace this conservator on the basis that he is not acting on the best interest of his ward, as the court calls the persons that he is responsible for. We're attempting that. But, it's, as any legal process is, quite slow. And, being a public facility, we have to be careful that we do not create too unfavorable a public image. Not that I back off from a fight, if that be the appropriate term, if I think it in the best interest of an individual. But, it has to be done at least fairly carefully. We can't legally, and we couldn't afford to, go out and literally throw our weight around. It has to be a thing with a great deal of negotiation over a long period of time; that's more desirable than going out and literally putting the hammer on a family member.

Q: At one time the hospital could almost have been considered a nursing home. Did some of the staff live on the grounds of the hospital in those days?

A: Yes, up to fairly recent years, fairly large numbers of the hospital staff lived on the hospital grounds. Going all the way back, it was really expected that as a condition of employment that you live on the grounds. Your room, board, and laundry were an integral part of the very meager salary that was offered at that time, and if you did not live on the grounds and utilize that, it was extremely difficult to be reimbursed for the part of your salary that you didn't use up in room, board and laundry. I have never lived on

the grounds, and even under optimum conditions I was only able to be reimbursed for one meal. I forfeited the rest of the part of the salary that would have been attributed, or would have been allocated, for the other two meals and my room and board. And, this reimbursement was possible simply because my family lived here in town and on the basis that my father was dead and I was really the support of the family, I was finally able to sell the idea that it was really necessary that I live at home with my mother and younger brothers. And, I was reimbursed for one meal. But, you were really expected to live here.

Q: Well, what would happen to a staff member who was married and had a family? Would they reside on the grounds also?

A: They were really excepted from this, but again, they suffered financially for it.

Q: They still did not receive any kind of reimbursement?

A: Yes, in fact, unless you were at the top of the heap or certainly in the upper echelon, you couldn't have your family living on the grounds. This also opened the door to another subject that I've always found intensely interesting. We operated under a full caste system, up to not too many years ago. The lower level people ate in one dining room, for example, the intermediate level people ate in another dining room, the medical staff ate in still another dining room, and the superintendent, of course, had his own private quarters and his own private dining room. And, the patients were even lower than the low level employees. The same sort of system applied to living quarters on the grounds. A childless couple, if they were both em-

ployed at any level, could live here. But, a couple with a family with children, unless they were in the very high echelons, could not live here. But, if they were high enough on the pole and could live here, it was for all practical purposes, free. It was a fairly lucrative situation for the "officers" who could have an apartment for himself and his family with room, board and laundry provided for all family members. Early, this was done for a fantastically low price; a few dollars a month, and by a few I mean $10 to $12 a month, could get a family complete maintenance.

Q: Do you recall any early salaries that you might have earned, or that you might recall other people earning?

A: I came on the payroll at $50 a month. That was the induction rate for an attendant in 1935.

Q: That's changed considerably. Would you say that in those days the living conditions of the individual patient were much, much lower than they are today?

A: Unbelievably. In the first place, the Old Main Building was literally crammed with patients from the bottom to the fourth floor. Never, in my time here at least, did patients live higher than on the fourth floor. I might also add that at one time the employees lived on the fifth floor in the attic of the Main Building. But, at first four floors of the Main were literally jammed with people and the Old Annex Building, which thankfully has been demolished and hauled away, was crammed with people. It was a three story building, containing fourteen separate wards.

Q: Do you recall any kind of disaster in which the patients were endangered because of these multi-story buildings, or did that ever occur?

A: Thank Heaven it didn't. Those of us who really had a conscience, I'm sure, were very, very concerned that this might happen. And, we lived in constant fear that it would happen, but the Man Upstairs seemed to be watching over us, because there has not been a major fire in a patient area here, to my recollection. There was a fairly serious fire here just before I came on the staff, but it was limited to the administrative core of the Main Building. It caused the evacuation of large numbers of patients and perhaps there was slight water or smoke damage but no real conflagration. In the event of a major conflagration, our death toll would have literally been in the hundreds, or perhaps in the thousands.

We were discussing a moment ago the Annex Building which thankfully has been hauled away. That was a 1,400 foot long three story building housing fourteen separate patient units. On the night shift it was standard operating procedure to have ten staff members in that entire building. It doesn't take a vivid imagination to figure out what would have happened had a fire erupted in that building, especially on the night shift. It would have been tragic at any time, but especially at night. The Main Building would have been almost as bad, except there were more provisions there for horizontal movement and then eventual evacuation. But, even the Main, which appears to be a masonry building but is a masonry shell with a wooden interior which has been there for more than a hundred years and of course

is thoroughly dried out, would go like a paper fire if it were ever to become ignited. But, again, thankfully, this has not happened. We have had waste basket fires and little things like that, but that's really the extent of our fire occurrence and I think we should all, even at this point, be very grateful that this has been the situation.

Q: Are there any patients residing on upper floors, or is everyone on the first floor?

A: Our tallest building that has patients in it has two stories. And, that building--well, it is really two. One was constructed in the very late 1930's and one was built immediately following World War II, which would put it in the mid-1940's. Now, those buildings are solid masonry construction. That doesn't rule out death from smoke inhalation and that sort of thing, but it does rule out the possibility of an entire building being enveloped in massive fast-moving flames. We are not occuping any buildings with wodden interiors that are more than one story tall. So the fire hazard has been greatly reduced and every building we have is tied into our fire station by an automatic alarm system which is a fairly recent addition to our hospital.

Q: Were bars placed on all the windows of patient buildings at one time?

A: Yes.

Q: Have the bars disappeared in most cases?

A: Bars, per se, have disappeared completely from any building that is occupied. The Old Main Building still has the bars on the windows but there are no people living there. We, in our two story building, do have a window arrangement that is of small panes of glass set in a metal frame that swings out in awning fashion which would make exit through that window very difficult. Now, I do not say impossible, because it has happened; but for all practical purposes, it was not exclusively designed as a barred structure. Our buildings here in this unit where everything is one story, do not even have what is accepted now as a security screen. The screen on our windows here is exactly as one would have in the home.

Q: Could you give me any kind of a date when this elimination of bars began?

A: Well, we would have to say that it began with the construction of the first parts of this unit, which was in the early 1920's. I find it rather unbelievable that we were that enlightened in that period, but half of this complex that we're in right now was built immediately following World War I. And, it was never built with bars or really any other restraining device on the windows. The most that was ever done there was a block arrangement so that the window could only be opened to a certain height. But that, so far as preventing people from going through the window, was pretty ineffective because it was easily removed. So, we would have to say that our bars as such, started disappearing at that time. Now, in the building where they were installed many years ago only a small portion were ever removed, but rather we removed the people from that area.

Q: Have very many abuse cases occurred while you worked here at the hospital?

A: Unfortunately, yes. Many were not necessarily cases of staff-patient abuse, although I'm sorry to say some were. There was a good deal of patient-patient abuse, which one would have to expect when large numbers of people were confined continuously in very crowded quarters. We have had and still have an occasional incident where staff, for one reason or another, become abusive toward a patient. I regret that this is true, but human nature being what it is, it will occur. We all have a point beyond which we can't be pushed, so far as frustration and irritation, that sort of thing, is concerned, and if a person really works at it hard enough, you know he can get any of us fired up to one degree or another. We show that--some of us show it--by becoming verbally aggressive. Unfortunately, some of us show it by becoming physically aggressive.

But, the rate of incidents on that is really very, very low. We have, oh, perhaps, one alleged case per month at the present time. And, I emphasize alleged there, because probably a good percentage of those are allegations. Again, we get back to human beings, and if there has been a minor disagreement between a patient and a staff member, it is entirely reasonable that the patient will manufacture some kind of story because that is the one way that he has learned through his experience here that he can conceivably "get even" with somebody who wouldn't or could't let him do something that he would have liked to have done. But, there are some cases where it is true and we are able to establish it. That is dealt with very severely, and it should

be. We actually have to go through a certain procedure as a matter of protection, but ordinarily any kind of abuse that is significant at all results in the discharge of the perpetrator.

Q: Would you say that there were many dehumanizing conditions for patients a few years ago?

A: Well, a few years ago we had some and today we still have some, but again, going back a good many years, we could literally be accused of being in the dehumanizing business. I can't think of anything that would be much more dehumanizing than to take a large group of people and literally dump them into a closely confined area, let them live under marginal, or by today's standards, sub-standard conditions, feed them very poorly, clothe them very poorly, literally pay no attention to them, to where they just become another blob of flesh that we had to feed, bathe, and hopefully provide some care for.

There was absolutely no way that one person working on a ward with 70 or 80 people could ever really do more than just go in and say good morning to the entire group. Regardless of how conscientious or how interested the person was, there was no opportunity for him to ever consider a person as an individual.

Q: At one time the patients worked on the grounds here. Was there a farm here at one time?

A: Oh, yes (laughs). To be quite honest about it, up to fairly recently we exploited the patient population as slave labor. We had departments in the hospital that could not have functioned without

patient help. For example, when our population was at its maximum, in the 3,400, 3,500, 3,600 range, we probably had as few as 35 or 40 employees in the dietary department who were responsible for cooking and preparing the food and getting it to all that vast number of patients, and at that time we were also feeding on the grounds approximately 1,000 employees. If something had happened and no patients showed up for work in the kitchen or dining room, those facilities would have had to have closed. During my very short stint in the dietary department, my responsibility was the manufacture of the ice cream for the place. But, that plant was located in one corner of the kitchen. We were cooking in that particular kitchen for 800 patients at that time and it wasn't uncommon at all to have only one employee cooking for 800 and the rest of the help was patients.

The laundry was another area. When we were doing laundry for all of that group plus Braille and Sight Saving--or as it was known in those days, the Blind School and the Deaf, which we have done laundry for for many, many years, a very small handful of employees and 150 to 200 patients operated that laundry facility.

Our farming, lawn and garden operation was equally patient dependent, if not more so. At one time we had a herd of 100 dairy cows here. We provided all of our own milk. We raised hogs and cattle and we provided all of our own meat, which also was processed here. We farmed extensively, both on state-owned and state-leased land. And, one employee would take anywhere from 35 to 50 patients out and work on the lawns, gardens, farms, barns, whatever. So, it was almost exclusively patient labor. And, it was really sort of expected that

if a person were physically able-bodied, that he would work. I think we always went through the motions, at least, of saying that that was therapeutic but really there was a lot more emphasis on productivity than there was on therapy.

Q: Was there any payment for the patients?

A: There was not and is not and there cannot be under existing laws. Even in this enlightened year of 1972, we are expressly forbidden to pay a mental patient. An inmate in a penitentiary under corrections can be paid, sure, pennies a day, and the people in our sheltered workshop, which we mentioned earlier can be paid, but other patients are not and cannot be under even today's legislation. Of course, a few years ago there was no thought, there was not even any consideration given toward paying those people. We have tried many times to find some kind of mechanism whereby at least a token salary could be paid to the very few people who perform real work at this point.

I should also make very plain that this situation that we've been talking about does not exist today. Number one, we've been out of the dairy cattle business for many, many years. We've been out of the farming business for several, and we're completely out of all the agricultural, gardening and farming business, the whole bit, at the present time. And most of our lawn care is provided by staff members and power equipment. The only vestige of that old situation that remains is that we have approximately 12 patients who are assigned to the lawn to trim around the trees and shrubs with a hand mower. But,

all of the 160 acres that was not in garden was mowed by hand by patients up to not too many years ago. Of course, about half of this 160 acres was in gardens at the time I came here.

Q: Was there also a greenhouse on the grounds or was that part of the farm?

A: There was a greenhouse on the grounds. I honestly don't know administratively whether that was a part of the farm or a part of the grounds, but we had a rather elaborate structure, Victorian in style, with a round dome on the front tier of it in which grew a banana tree or plant that we maintained until the old greenhouse literally fell apart and had to be dismantled. But, we had quite an active functioning greenhouse. In fact, in my early days here, twice a year our greenhouse sent flowers to the Governor's mansion.

Q: Were other fruits grown in the greenhouse?

A: The greenhouse was largely flowers. In the spring when we were in the wholesale gardening business, sure, the cabbage plants and the tomato plants and celery were our big crops. Our celery plants were produced there. But, at other times of the year, well, the major function was really flowers. We had a large number of very elaborate and very well-groomed flower beds scattered about the grounds. All of the plants for them and all of the flowers that we had were produced in our own greenhouse.

Q: Were most of the products in the greenhouse and the farm used right here at the hospital or were they sold elsewhere?

A: Oh, no. There has never, to my knowledge, been any provision for--well, the state cannot sell anything to anybody. Recently there has been a system developed whereby obsolete surplus property can be turned over to general services and then auctioned off, but so far as taking a bushel of tomatoes downtown and peddling them goes, no. It was for our consumption, or we traded it to some other hospital. That was not only possible but it was really encouraged. Anna State Hospital, for example, being in the heart of the fruit belt of Southern Illinois, canned peaches, literally by the thousands and thousands of gallons. Well, we would trade them green beans or peas or something like that for peaches. We also had our own canning factory. All of this garden produce, literally tons of it, that wasn't needed while it was fresh, was canned for winter. We raised potatoes by the 40-acre field and we had at one time three enormous root cellars here where we stored potatoes and cabbages and beets; the type of vegetables that will keep.

Q: It sounds as though at one time the hospital was almost an independent city.

A: We were practically self-sustaining. We really were.

Q: The clothing was prepared here and all types, or nearly all types, of food products were produced here.

A: Right, our diet at that time, especially the patients' diet, was a very, very simple one. So our food purchase--I was again not in the position to really be aware of that, but my guess would be that

the cost of purchased food per person per meal would be pennies. Because, the meat was produced here, the vegetables were produced here, all of that. It was literally the old staples, flour--we never did have a flour mill--we always bought things like flour, sugar and that sort of thing, but other than that we raised what we ate and conversely, we ate what we raised, whether we liked it or not. If it were a bumper year for carrots, you better believe we had lots of carrots.

Q: Today, of course, staff members work approximately eight hours a day. Do you recall if this was always the case?

A: It has been since I've been here. I'm told by people that were here when I first came that the ten hour day had only fairly recently been done away with in 1935. The change that has occured since I've been here is that we've gone from a 48 hour week to a 40 hour week. I worked six days a week instead of five for many, many years.

Q: Could you possibly put a date on that, when it changed?

A: Yes, again by relating it to other things that have happened to me personally. Strangely enough the first group of persons who were given the 40 hour week here were the registered nurses. And, that was in the early 1950's. It was brand new when I left the staff to go to St. Louis in 1954; that's the way I can pinpoint that. And, when I came back in 1956, it had spread across the board, so in approximately 1955 we changed from 48 to 40 hours as a standard work week.

Q: As the various administrations of the State, as well as the Department of Mental Health, have changed, have you seen quite a number of changes in policy?

A: Yes, many. Personally I think the most significant and probably the most beneficial, is our being removed from the patronage system, which was really, to my knowledge, the only way of entry into state service in 1935. I am not in a position, and have really never been, to be that intimately aware of the Department structure. I can only see the end result as it gets down to the hospital level. And that has been really a pretty constant improvement. We aren't as threatened by the Department. We aren't as intimidated by the Department as we once were. I can recall, a number of years ago I believe, hearing that the Department this, and the Department won't let us, and that sort of thing. I really don't see any evidence of that now. I can't verify that we were intimidated but I know that that was the general feeling that we were very tightly controlled. We literally asked the Department permission for everything, even in little insignificant matters.

But, generally speaking, the whole thing has improved. Certainly the salaries have. The care that the patient gets really should be our prime consideration; that's why we're here and really what it's all about. That has improved constantly, in many, many ways. In fact, anything we'd want to mention; diet, clothing, living conditions, treatment, you name it and it's certainly more in keeping with the general public, the general population than it was years ago.

Q: Would you consider the salaries of professional people like registered nurses and psychologists to be comparable with the salaries they would receive outside of the Department of Mental Health?

A: Yes, my opinion is that dollar-wise we're highly competitive with the "outside" job. Plus, I personally feel that when you take into consideration our fringe benefits, we have really tremendous leverage over almost any non-DMH or non-state facility. Now, I'm sure there are people here who would disagree, but that certainly is my opinion and I tried to keep up with especially nursing salaries because that's one area, being a nurse, I can feel comfortable in watching. We're highly competitive dollar-wise, and then when you take into consideration the fringe benefits here versus the fringe benefits at the private hospitals in this immediate community, or in Central Illinois, we're very, very competitive. And, as aware as I am of salaries for other disciplines, I feel that the same must be true [in those jobs] because I do not think that they would have singled out the nursing profession and, you know, given them proportionately more than any other profession. And, so far as the ward staff is concerned, the "lower level" positions, when we take into consideration our educational requirements and that sort of thing, we are quite competitive, with the possible exception of perhaps the first year or two of employment. Our induction salary might possibly be a little bit low to compete with a factory job, [the kind of job] that person would be looking for elsewhere. But, after he has been here one year, or at the most two, with our rather automatic increment system, by the

end of the second year I feel that again dollar-wise, he's just as well off here, and the fringe benefits here are at least twice what they are in comparable jobs in this particular community. Now, what other communities might offer, I'm really not that aware of, but I expect industry is pretty darn standardized. Their holidays in industry would be fairly consistent whether it's in Central Illinois or in any other part [of the state].

Q: You mentioned quite a while ago that you were involved in the military during World War II. Were there any changes in the operation of the hospital because of the war effort?

A: Yes, we really learned several things there. Men were simply not available. The only men on the staff around here were extremely elderly; they were much too old for military service and were too old to even work in the ammunition plants and the war-effort associated industries, so we learned then that we could work women on men's wards and do it safely. When I left here in 1941, we were just really beginning to feel that pinch and there was a tremendous apprehension because, remember, we didn't have all the tranquilizing drugs that we have now. Some of our wards were literally screaming, noisy pieces of a building. And, there was a great deal of feeling about bringing women into that situation. But, to the best of my knowledge, we had no--we certainly had no one killed. To the best of my knowledge, we didn't have people even seriously hurt from it, and the apprehension has died down. We never reverted back to this thing, of nothing but men working on men's wards and that sort of thing. We have maintained women working on practically every men's ward in the hospital since that time.

Which I think is good. Conversely though, we have not put men on women's wards. I'm not saying that's good or bad, and I don't think it's really done in too many other areas, but we haven't done that except in a very few isolated, very carefully controlled situations.

Q: Male and female patients live in different wards. Are these wards in the same building?

A: Yes, this was done deliberately and I will take credit or blame for bringing a lot of that about. This was accomplished in 1966. Prior to that time, a building, or a portion of a building, would be delegated to men. For example, the Old Main Building, from the central administrative core east, was all men. West was all women. For other reasons in 1966 we had to relocated large numbers of people. And, at that time I was in the nursing office and was involved in that; I really kind of had to set it up--plan it and do it. So, I deliberately broke that tradition and put men on one ward, women on the next, men on the next. Again, all sorts of dire things were predicted, but there were no untoward events at all. Now, it is totally acceptable. We would have men and women living on the same wards if our physical plant would permit. Now, we deliberately arrange it so that the men from one ward and the women from the adjacent ward can come together in a common recreation room or some kind of facility immediately adjacent. Our reason for not having them living on the same ward--except in one, we have one situation where we have both sexes on the same ward--is that when our physical plant was built, there was only one set of sanitary facilities in each ward and that is the deterring factor. It is not for, well

literally, for any other reason. We have this one building and I couldn't tell you why, but they built it with two bathrooms and two sets of toilets and in that area we do have men and women living. It lends itself beautifully. The sleeping quarters are separated by the living quarters and we have had absolutely no difficulty with it. I feel sure we wouldn't in the other areas if we could just overcome the sanitary facility bit, which hopefully we will over a period of years as these facilities become obsolete and have to be modernized. I feel that anytime they are modernized they will be arranged differently.

Q: Well, that pretty much covers my questioning. Do you have anything you'd like to add? Are there areas that we haven't covered that you would feel comfortable speaking about?

A: I've rambled on here on so many subjects for such a period of time that I really don't think of anything at the moment.

Q: Okay, then thank you very much for your details.

A: You're very welcome.

END OF TAPE.