Bruce Olson
Anoka State Hospital Oral History Project
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Neil: Good morning.

Bruce: Good morning.

Neil: I am Neil Holton. I am here talking with Bruce Olson. Welcome, thanks for coming in.

Bruce: You are welcome.

Neil: I heard on the radio this is National Social Worker's Month. So, it is a fitting occasion. Could you tell us a little bit about yourself, where you grew up and about your family?

Bruce: I originate from Jasper, Southwestern Minnesota, grew up there until I went to college up at St. John's University at Collegeville. Graduated from there in 1963, went to graduate school in St. Louis University, St. Louis, Missouri, and got married on completion of graduate school. Moved to Anoka and have been there ever since, in the Anoka area ever since, living in Andover.

Neil: And, what brought you to Anoka?

Bruce: I had received the two-year stipend of fund graduate school from the State of Minnesota, and that had an obligation to return and work in a rural county upon completion of graduate school for an equal period of time, two years. And, Anoka was defined as a rural county at that time. We were excluded from working in St. Louis County, Ramsey County, or Hennepin County. And, came to Anoka figuring I might be there for a couple of years and move on to bigger and better things possibly. But, we continued there throughout my career and we very much liked the Anoka area.

Neil: And, could you say more about that, the program that you did the payback work? Was that part of a government program?

Bruce: I do not know how much federal funding was in that. It was definitely State of Minnesota money. They had two types of stipends, mental health stipends and child welfare stipends. And, I was tickled to get either, because I needed the funding to go to graduate school, and mine turned out to be child welfare. So, I went to work for Anoka County Welfare for two years, hired there by John Elfeldt [PH]. And, during that time, my wife, who also had a Master's in Social Work, she was recruited to work out at the state hospital and very much liked working there and learned a lot. And, when our first child came along, she left employment there after two years. And, my stipend at the welfare was ending, and I thought, "Gee, this is a place I'd like to go work and learn more about mental health." And, so I went there in the Fall of '67, that is how I got to the state hospital.

Neil: So, she had a very positive view toward it, huh?

Bruce: Yeah.

Neil: And, what kinds of, what was positive about it?

Bruce: Well, there are lot of top-notch professional people working there. I mean a full gamut of mental health people, psychologists, psychiatrists, physicians, social workers, psychiatric nurses, etc. And, everything about it she liked. So, I thought this looks good, and it was.

Neil: And, what was your exact position?

Bruce: I was one of 20-plus social workers, working on one of the mental health units. It was the Vale Building, is where I started, and I worked over the next few years in the Vale Building, the Burns Building, Cottage 8, two different places in the Burns Building. So, I worked probably in a third of the places initially.

Neil: Did you have an orientation when you first started, and what was that like?

Bruce: Yes. The orientation in many ways is to get to know the community. The social workers' job interfaces with the courts of commitment that direct people to come to the hospital, the mental health units, the hospitals, the county social workers, all the placement resources that we use on discharge. So, you spend all of the first year at a minimum probably just scrambling to get to know all these places and people, because you are communicating with them multiple times a day about the people coming into the hospital and those that are leaving. Certainly getting to know the staff at the hospital, the different units, but that falls into place quite smoothly. There are a lot of helpful people there to help to get to know the resources.

Neil: Could you describe the grounds of the old hospital, how that affected your work?

Bruce: Well, it is rather impressive when you first, when I first got there. It is almost a section of land, a square mile, the river on one side, the 7th Avenue on the other, the railroad to the south, and then farmland original the better part of a mile going north. There were originally ten cottages on the campus spread out around a circle of property that was probably a block across. They referred to them as cottages, but they were really three-story mammoth brick buildings that held probably at the time around 60 patients each. Some of these, when I arrived, Cottages 1, 2 and 5 had been torn down and Cottages 6 and 7 had been combined and modernized to be three separate units, one on each floor. And, there was a major food service building, there was a power plant, two big barns, well, off on the edge of the campus for the original farm land. Gymnasium, auditorium, the high school used the swimming pool for their meets, so it was a big operation.

Neil: Do you have any memories of the tunnel that connected all the building?

Bruce: Yeah. They were a plus, when it was ice-cold outside and/or pouring rain, that was a pretty good way to get around. There was, again, a circle that followed the cottages all the way around, and then straight ones that headed off for a block or two to other buildings. I am struck by your question, because I think people that live in the City of Anoka, for example, I remember some of my sons' high school friends that, they would say, "Gee, is true what you hear about those tunnels?" And, I never heard any factual story about the tunnels that was frightening or whatever.

Neil: What kind of rumors were there?

Bruce: Oh, that people got lost down there, that was probably what you heard the most. There is signage down there, so, but I think the fear was maybe you would be down there and the power plant would go out or something, but that never happened.

Neil: You are a pretty tall guy. Was there plenty of head room?

Bruce: Not always.

Neil: You had to watch where you were going, huh?

Bruce: Yeah, yeah. Some of the old parts were probably, oh, 5'10", steam pipes and everything else going along the ceilings. But, many parts of it were very large, maybe 10 foot across and 10-foot ceilings.

Neil: Now, you mentioned there were 20 social workers at one time.

Bruce: Yes.

Neil: Was that consistent over the years?

Bruce: I would say, to the best of my knowledge, it was always in the high teens at least. Most of the state hospitals, by my recollection, probably peaked in the early '50s, possibly even as many as 2,000 patients each. And, around the time I got there in 1967, I am guessing there was roughly 700 patients. So, the population had dropped a lot and as it dropped over time, the number of staffings sometimes was dropping also.

Neil: How did you divide up the work among the social workers?

Bruce: Well, in most of the units that I referenced, there were probably a full-time or part-time physician. There would be a full-time psychologist. Usually, two social workers on each of those units, and that is basically how the work was divided up.

Neil: And, was there a supervisor for the social workers?

Bruce: Harriet Moon [PH] was the Director of Social Service pretty much the whole time that I was in the Social Service Department.

Neil: And, could you say anything about her?

Bruce: She was a pioneer in many ways. She, highly regarded at the University of Minnesota's School of Social Work, and among her colleagues in the Hennepin and Ramsey County, particularly. I felt it a privilege to work for her, top-notch lady.

Neil: Did you have meetings of your group?

Bruce: Oh, the Social Service Department, I am just trying to think here. I would say we almost had weekly meetings as a department.

Neil: And, what kind of topics would come up?

Bruce: Oh, there were changes going into place on the commitment law, announcements on resources in the community that were changing. I lose track of the details, but there were always announcements of change in staff personnel, planning that was going on in the hospital.

Neil: Could you say something about your average workday? What would that be like?

Bruce: Well, the staff were all housed on the unit, typically, a few exceptions, but most of the staff were housed right on the unit. There was also a morning report of what was happening on a given shift, new admissions, probably—it is hard to, I am guessing, we would probably average, I would as a social worker, a new admission coming in every week plus, maybe every two weeks. And, so you are immediately challenged with reaching out to family members, interviewing the patient, interacting with the other staff members, the county social workers and others coming out to the hospital. So, you were housed on the unit pretty much all day long, except for trips into the county to interview with issues there.

Neil: And, was there a treatment plan for each patient?

Bruce: Yeah, we had, we would have a treatment plan developed, I would, my recollection is probably within a week to ten days, pretty thorough treatment plan, with input from all the disciplines I mentioned. And, we would have by then had a sit-down meeting, almost in all cases there already was a Hennepin or Anoka, Ramsey County social worker already involved that knew the patient as well. And, we would have a sit-down with all those people and the patient to agree on what our tasks were to work toward a discharge plan.

Neil: I understand that in the earlier years, it was considered an asylum and not a treatment center. Sounds like that had changed by the time you got there, is that right?

Bruce: Yeah, I looked back in some of the history, and it is amazing how often the name changed. Consistent with what you said, it started out as the name asylum, then it became the State Hospital, then it became the Metro Treatment Center. And, those name changes were going on pretty consistently at all the state hospitals. They all were changing at the same, well, close to the same time.

Neil: And, do you think treatment modalities were changing? Did you see that?

Bruce: Oh, yes. When I look back through the data and recall, when the hospitals first started roughly in 1900, they were kind of a one-way placement when somebody came into a state hospital. And, it is my understanding that when Anoka first started, they sent about 100 psychiatric patients, mostly from St. Peter, if I remember right. And, they were sent there with the goal that they were permanent placements and would be the work force for the farm and support operation there that would support the hospital. It was a major farm, successful, hundreds of hogs and cows and pigs

and turkeys, and you name it. And, but, the hospital mainly was intended to serve women initially, and over time that changed. The major tranquilizers came into the picture, I want to say in the 1950s, I am not totally sure on that. But, and I saw in my time remarkable changes in medications. Some use of electroshock therapy. Some people thought that was very controversial and talked it down, but others to my knowledge thought that it was an effective treatment for some types of depression, for example, still used. But, the medication changes, I would say were clearly the most dramatic.

Neil: What percent of the patients do you think took medication?

Bruce: Among the mentally ill, 90-plus percent, I would say almost all of them.

Neil: Did they also have psychotherapy or…

Bruce: Yeah, yes. When I was in graduate school, Freud was one of the recognized experts. And, I thought that, boy, got to get people therapy and they will all be well. And, those thoughts changed considerable on my part. By my way of thinking, major mental illness is in some ways like diabetes. It is a chronic illness that you manage and treat, but it does not really go away, seldom. And, for those people, getting them on appropriate medications is effective in minimizing their symptoms. Granted, there are some people, and I recall some, I helped one fellow in the early ‘70s, late ‘60s. I remember getting him into a Lithium program at the University of Minnesota, manic depressive engineer. And, he was, boy, he was, he grabbed me by my tie one time, pulled me all the way across my desk. That got my attention. But, he, when we got him successful into the Lithium program at the U, it was just dramatic, the change. I mean, he literally showed no symptoms at all. So, it impressed me, medications were very effective. The challenge oftentimes is getting people to continue on their meds. Oftentimes when they are feeling better, they want to quit taking them.

Neil: Did you do psychotherapy as a social worker?

Bruce: I am glad you—I got off the subject, obviously. You know, psychotherapy, there were some patients that were getting significant psychotherapy in the sense they were meeting with a psychologist or a social worker, typically, maybe once or twice a week during their treatment. But, that in depth psychotherapy was clearly an exception. Most of the people were in different types of group therapy.

Neil: How long did people stay?

Bruce: Some were there for, well, typically, I would say they were there for a couple of months. There were some that got out in a month, would probably be the shortest. Some were there for years, but over time there were fewer and fewer of those. In fact, I think around the time I left Anoka that you would be hard-pressed to find anybody that had been there a year.

Neil: Did you have any role in post-discharge care?

Bruce: Very much so. I would say that that was a major role of the social worker, was, many of these people needed to go to a place that would supervise their meds. It was an exception,

somebody that had a family to go live with, so typically the last thing you wanted to do was just discharge them to the street and wish them well, because that was a plan for disaster. So, you are trying to get them into preferably a board and care sort of place, where their meds were handed out two or three times a day or once a day, whatever it was they needed. And, there was some degree of med supervision and some activities and a safe, supportive environment. So, for many, we would be working at trying to get them placed in one of the many resources in their home county, hooked up with a mental health center for medication follow-up. And, whatever other resources, I mean, whether it might be vocational or social, to fill out their day with them.

Neil: Did they ever return to the hospital?

Bruce: Yes. I have not mentioned that the patients, 90% of them, came in under a civil commitment. And, so they typically went out on what was called a provisional discharge, and that was a very detailed after-care plan, spelled out their meds, their doctor, their family contacts, social/legal situation. And, would itemize a discharge agreement that they and us were, and the county social worker, case manager he or she was often referred to, it would spell out the plan. And, the patient was held to that. And, if they did not follow through with it, the county could revoke the provisional discharge and have them brought back to the hospital. And, that would happen, oh, I am hard-pressed to make a guess, but 25, 30% of the time. And, the court then would review the—because, the commitment had to be reviewed at least yearly. And, that would happen and the court might extend the commitment. So, yes, they came back on occasion.

Neil: Could you say something about the front end of this commitment process? How did that play out usually?

Bruce: Well, to get, say a family could initiate a commitment action by contacting the, typically, that would be through the county social service department, and each county had slightly different contact resources. But, they would sign a petition, there would have to be a medical support statement by a physician supporting the necessity of that. And, then there would be, they called it a pre-petition screening, and a commitment hearing would be set up, my recollection is within a week probably, there would be a commitment hearing. And, the people that had opinions on that would be there to express those to the judge, and the judge would make a decision. And, it might be to stay a commitment if the potential patient could be, they could negotiate with the patient some plan that the patient was willing to follow through with, fine, the judge would stay the commitment. But, our staff were not, only by exception were we involved in that process. That all happened prior to the patient arriving at the hospital.

Neil: And, were most of the patients okay with that or upset by it, or what?

Bruce: Well, they were not pleased. I mean, because if they were, they would not need to be committed. You know, wish them well and there would be no problem getting them admitted voluntarily. But, no, they usually did not agree with the decision.

Neil: Did they change their minds over time?

Bruce: Oh, yeah, frequently. Oftentimes, a patient within two weeks of admission would agree that yes, there was need to do something. Now, they might be a little more convinced than we were that it was time to go. But, they oftentimes saw the differences in themselves.

Neil: You were working around the time of the change to the new facility, is that right?

Bruce: The new hospital was in the planning stage for a few years, and that was near completion—I left Anoka in October of '98, and my recollection is that the new facility was occupied in April of '99. I have been in parts of it, very, very much an improvement. I would guess, I do not know this first-hand, but I would guess that it is probably as good a physical plant for psychiatric as there is in most of the United States.

Neil: Were you involved in the planning for the new facility?

Bruce: No, no, I was not, no. I had occasion earlier in my career, in 1980, a new building was built for the treatment of the chemically dependent, the Cronin [PH] Building, and I was in the center of the planning for that with a number of key people.

Neil: And, did you switch over to caring for alcohol and drug-addicted people?

Bruce: Yeah, in 1970, the alcohol and drug programs throughout all the state hospitals were really, were taking off in terms of there were only a few that prior to that had alcohol and drug treatment programs. And, Dr. Gordon Olson was involved in getting them started at Anoka. And, I thought, gee, that sounds interesting. And, so I volunteered for a position in the alcohol and drug programs, transferred over to them and worked there for oh, up until '92, '71 to '92. And, from, let's see, from '92 to, no, it might be too long here. Let's see, '71, in '78 to '92 I was the alcohol and drug program director.

Neil: And, how was that different from working with the other patients?

Bruce: Oh, from the mentally ill?

Neil: Yes.

Bruce: Oh, it was major differences. First of all, officially, probably only 10% came in committed, instead of 90%. But, they were not committed because there were all sorts of other levers usually available. When you got a DWI and the judge offers you a 90-days in jail or volunteering for treatment at Anoka, Anoka looks pretty good. Or, the wife says, "You either get treatment or we're done," or the employer says that. So, it is the ones that there is no levers left that end up getting committed. And, they, which was pleasing to see, oftentimes came to a recognition within a matter of a week or two, that, gee, I really needed to do something different. And, so they cooperated with treatment and did reasonably well on discharge.

Neil: And, what did the treatment entail?

Bruce: Well, a lot of group therapy, patients were in group at least twice a day. Again, a multi-disciplinary staff. Minnesota is well-known for what is called the Minnesota model. It came out of the Wilmer State Hospital in Hazelton. Other places helped shape it. Certainly, a reliance on Alcoholics Anonymous as part of the after-care planning. These people oftentimes were referred to halfway houses on discharge. We had probably averaged about 90 patients on an average day in the Anoka State Hospital.

Neil: Did you run any of the group therapy?

Bruce: No, not during the time I was program director. Prior to then, I was involved in groups, yes, but I did not do it as program director, no.

Neil: As program director, what, how was that different from your usual duties as a social worker?

Bruce: Well, I, that is a good question. I orchestrated other people helping them. I mean, there were probably six social workers, eight counselors, couple of psychologists, one or two physicians, psychiatrists, I mean, chaplains. And, we had a pretty intense program, but my hands-on stuff was working with the staff. Does that answer your question?

Neil: Yes, yeah. Did you enjoy that?

Bruce: Yes, yes, I did. I could see that through the benefit of the State of Minnesota has good retirement programs. By the time you meet the rule of 90, age and your years of service, that looks pretty good. And, I knew that I was in a position that that was available to me. And, so I decided prior to my eligibility to go back and be a social worker in the psychiatric programs. The alcohol and drug programs statewide, nationally actually, were downsizing. The inpatient treatment model was giving away to much more reliance on outpatient treatment. And, I mean, the dollar drives many decisions, and the money funding alcohol and drug treatment was going directly to the countries much more. And, so they had a good thing going when they were using the state hospitals prior to that, because they were paying probably ten cents on the dollar for hospital treatment. And, once they were getting all the money but having to fund all the treatment that changed things. And, outpatient treatment looked very appealing. I am not complaining about any of that, that is reality. And, so there was a lot of downsizing going on, and I had hired probably over half of the 40 employees that were in the alcohol and drug program, and that was not fun having to lay a good number of them off. So, I went back to being a clinical social worker.

Neil: Before we wrap up, could we talk a little about how, about your perceptions of the hospital as viewed from outside? Did you interact with other state hospitals?

Bruce: Yes, mainly in my years as the chemical dependency program director. I mean, I visited all of the hospitals, particularly the ones that had the alcohol and drug treatment programs, knew all of the, well, knew many of the staff. You are asking how were they perceived? Can you restate the question?

Neil: Well, I guess I was wondering about how much interaction you had with the other, your peers in the other hospitals.

Bruce: Oh, at least weekly, so quite a bit.

Neil: Did you have annual meetings or anything like that?

Bruce: Well, we had at least monthly meetings and phone calls and conferences and quite a bit of interaction.

Neil: And, how about Anoka and the area around here, how do you think people view the hospital?

Bruce: Well, I think it is evolving all the time. I think the new hospital, I do not hear as much about it in the news or in the community as I did the "old hospital" because, I mean, that was a much less secure place. People could come and go very much so. That is not the case with the new hospital. The new hospital is rather unique in that it, again, it is a big circle of a building, but it has got a full park in the middle of it. I mean, open to the sky and it is just the perimeter of the building becomes the containment. I think over the last 15-plus years, the State of Minnesota has moved to a number of small, almost house-type psychiatric settings. And, they are falling way short of meeting the volume of the need, to my knowledge, from what I read in the paper. I mean, the jails and the hospitals are full of mental health patients that need treatment. And, I think there is a shortage and I do not know how that is going to end up.

Neil: At the old hospital, were there incidents of patients going into town…

Bruce; Oh, yeah.

Neil: …and having negative experiences?

Bruce: Yeah, yeah, that was a frequent event. I think of one example. There used to be, right on 7th Avenue, where you come out of Anoka High School, there was a Kemp's [PH] grocery story and liquor store. And, some patients kind of liked to go over there without permission. I mean, it was only a two-block walk. And, then the city realized that they had an ordinance that said you could not have a liquor store within such and such distance of the high school, and this was clearly in violation of that, as well as was a problem for the State Hospital. So, the liquor store closed. But, patients would walk into town, many of them without causing a problem. But, I mean, it was always a concern to us. I mean, we did our best to get them back as quick as possible. But, it was a problem.

Neil: And, who would bring them back?

Bruce: Well, we employees might bring them back. I did it a few times. But, if that was a problem, then it was the police or community resources, family.

Neil: So, maybe a broader topic. What would you advise to advocates for mentally ill people?

Bruce: Well. Well, I would advocate, I mean, there has got to be funding. These things do not happen without funding, and that is always a challenge. If somebody—I am off on a tangent now—but, I mean, if somebody is eligible for medical assistance, they probably can get access to some mental health services. But, if they do not have any funding, it is hard to get it. I would be an advocate for the families to get involved in some of the support groups and learn about the resources. You need advocates to help make it happen.

Neil: Do you overall attitudes toward mentally ill people are changing?

Bruce: Yes, yeah, I do. It is slow, but I think people are understanding that these people are not possessed, they are, they have a major illness. And, I personally am of the leaning that there is a strong biochemical factor to this that we do not, in some cases, fully understand, well, we clearly do not fully understand. But, and the medications help. They do have side effects and some of them are very serious side effects. But, I mean, I know a number of people that are on anti-depressants that they help considerably. I know manic depressive people that are on mood stabilizers that help considerably. And, there were a number around the time I retired, so I am not current on this, but a number of new major tranquilizers that were coming on the scene that had a dramatic impact on symptoms, very encouraging. So, there are medicate—as I say, I have a biochemical leaning to this versus in-depth psychiatric counseling. So, there is hope.

Neil: Is there any area or topic that we have not covered that you think is important?

Bruce: No, we have touched on most of it. I do think that the, I mean, I and the people that I worked with, I think almost consistently have a sense of pride in what happened there. And, I do not think the public really had a chance to see much of that. But, there are a lot of dedicated people that did a lot of good work.

Neil: Well, thank you for coming in today, and for all your years of service to the patients.

Bruce: You are welcome. Glad to do it.

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