Dr. Kristine Haertl
Anoka State Hospital Oral History Project
11 April 2014
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[Music playing]

Neal: Good morning.

Kristine: Good morning.

Neal: I am Neal Holtan. I am here with Dr. Kristine Haertle, and this is the Anoka County Historical Society's Oral History Project for Anoka State Hospital. And, this is April 11, 2014. Welcome.

Kristine: Thank you.

Neal: Thank you for coming in.

Kristine: Thank you.

Neal: So, tell us a little bit about yourself, where you grew up and where you went to school.

Kristine: Okay. I grew up in Golden Valley, Minnesota, and I went to school at Robbinsdale, was the last graduating class at the time, although it has reopened since then. And, went into my, though I have three degrees, my undergraduate was in occupational therapy at the University of Minnesota. And, at the time, when I went into occupational therapy I did not realize mental health was an area of potential practice. And, when I found out it was, it was something I was immediately interested in. My mother has schizophrenia, and my mother was in and out of hospitals when I group up. And, so mental health was an area that not only hit home for me, but one that I was interested in practicing professionally.

Neal: And, your other degrees.

Kristine: I have a degree in Health Service Administration through Cardinal Stritch University, and a PhD in a health psychology through Capella Harold Abel Psychology and typical the two really work together, because my psychology and my occupational therapy are a good fit for most of my practices in psychiatric or in working with people with developmental disabilities.

Neal: I will ask you more about that later…

Kristine: Okay.

Neal: …but, if we could focus on Anoka State Hospital to start with.

Kristine: Sure.

Neal: What years did you work at the hospital?

Kristine: I worked at the hospital, I came in 1988 and I left in '97 to become a professor at St. Catherine University. However, because I, besides being a full-time professor, I am a private

practitioner, I have on and off also consulted with the state hospitals, namely, mostly Anoka or St. Peter, those are the two that I have consulted mostly with.

Neal: And, what position do you have at Anoka?

Kristine: I started out as a line occupational therapist, a staff occupational therapist. I was the second one there. I was hired because they had been cited by joint commission on accreditation for not having an occupational therapy department per se. They had one individual, and so I was hired to help build an occupational therapy department, and through the years then I was promoted. I was in a more senior position later and then supervising services on three of the units out there for rehab and occupational therapy.

Neal: Prior to working at Anoka, did you have any knowledge of the facility?

Kristine: I did only because I worked in the community for mental health, organization called Tasks Unlimited, and interestingly, the founder, Dorothy Berger, who you have also interviewed before, started at Anoka and took her concept out into the community. And, I was working at Tasks at the time and knew of Anoka. I was recruited to Anoka and then interviewed and got the position. I am still involved with Tasks Unlimited on their executive board.

Neal: And, how did that recruitment happen?

Kristine: I had been called, they had had, they had opening. They were looking to find somebody to help them build a program. So, I still had to go through the state process. The state has very formal process, even if you are recruited or sought out, to go through an interviewing process and still go through the chains of command and the process that they have for interviewing.

Neal: Could you quickly describe what occupational therapy is?

Kristine: Sure. Occupational therapy is a rehabilitation profession, and occupation is the word that means basically how do we occupy our time. And, how we create meaningful lives with how we occupy our time, through purposeful activities. So, that would be work-related activities, that would be ADLs or self-care tasks, that would be play and leisure kinds of activities, spiritual activities. So, the activities in our life, and what we work with is activities or occupations to rehabilitate folks so that they can be either as independent or interdependent as possible, not only regaining function, but developing function. So, about a third of the therapists works in schools with children who have disabilities and teaching skills and rehabilitating skills. In a psychiatric situation, we often do things such as evaluate somebody's existing functional level, make recommendations or what types of supports the individual might need, where the person could or should live in accordance to what their wishes are as well. And, also teach skills, so, for instance, I oversaw several types of groups such as coping skills, living skills, cooking skills, money management, self-regulation or emotional regulation skills and those kinds of things to help prepare individuals to re-enter into the community.

Neal: And, could you say specifically what you did, what your duties were at Anoka?

Kristine: Sure. Well, when I first started, and any time when you are going to develop a program, you really need to do a needs assessment. So, when I first started, we conducted needs assessments on all of the different, all the units. And, then what we did was identify and got approved for, we had at the time hired seven COTAs, which is a certified occupational therapy assistant, and then three OTRs, is what our staff was made of. And, on each unit, I helped them develop the groups and the plans for each unit, and how the services would work with the clients. Because, the clients on each unit had a little different need. We also had some groups and therapy services that were available to everybody, so all the units could access those services. I personally helped run some of the groups, but I also was probably half-time administrative, half-time clinical. I did also do quite extensive evaluations of clients, make recommendations for discharge, make recommendations for interventions or where or what types of things we could do with the clients, again, to prepare them to re-enter into the community.

Neal: Could you describe how there might have been special needs in certain areas?

Kristine: Yeah. For instance, the units were sectioned off, and I worked in the old State Hospital before they built the new one. So, for instance, on the Miller Building, the Miller Building had a unit for forensics. Forensics does not necessarily mean people posthumously. Forensics really pertains to the law and medicine. So, the forensics unit, typically we had persons who were considered a "mentally ill and dangerous." And, we also had individuals who were highly likely to either assault or commit suicide, and so it was more a locked-down type of situation. Then, we also had an entry unit, Miller North, which was more of a missions unit. Then we had a unit for psycho-geriatrics, typical had heavier medical needs and folks who had, might be older or have different care needs besides just the mental health needs. And, then there were some units, one unit specialized more with persons with chemical dependency. And, then there were about three units that probably, I would say, got a blend of different types of needs.

We once in a while would have persons with developmental disabilities. However, at the time, Brainerd was open and Cambridge was open. They later closed, although, now Medo [PH] is up at Cambridge. And, interestingly now, everything comes full circle, because Anoka again has a wing that now specializes in persons with developmental disabilities as well. Usually, those individuals have a co-existing psychiatric disorder.

So, there was quite a blend and there still is quite a blend, although I would say what has shifted, and we can talk later about it, is the lengths of stay are much shorter now. Although, I say that means more frequent, but individuals are really right away put on a trajectory toward discharge.

Neal: How did you get oriented to your position?

Kristine: Well, at the time, I cannot speak to their current orientation process, but at the time there was a very extensive orientation. I spent an entire week learning not only about their clientele, but about state regulations. We had what was called therapeutic intervention, so we would learn almost self-defense and safe take-down methods, especially because one of the units I worked with was a forensic unit. And, I would say the orientation process was very extensive, as was the educational opportunities that were available to me after that.

Neal: So, you had ongoing chances…

Kristine: Yes, every year. In fact, we were required. Not only externally did I partake in several educational opportunities, every year we had quite extensive training and many requirements.

Neal: Did you interact with people from the other state hospitals?

Kristine: Yes. I was actually in a group. I did quite a bit of training of other occupational therapists in other state hospitals, particularly in one area called sensory integration intervention. Because, we had done, with Dr. Judy Reisman, who I consider my mentor. We had done a research project at Anoka, and we had a, interestingly, it is, well, shortly after I got there, and we had a control group. And, we had a sensory integration group, and we had a craft group. And, we were told we could test them pre and post as long as they were still there, but we were told they all still be there, because they had all been there for ten years. And, interestingly, within the three months, over half the experimental group got good enough to be discharged. However, we no longer had a sufficient end to publish. But, at that point then we started a program, a specialized program in that area of practice, and did some training statewide of that, along with things like living skills training and those kinds of things.

Neal: Could you say more about that.

Kristine: About what specifically?

Neal: The sensory intervention.

Kristine: Oh, well, sensory integration intervention really is more heavily, and we have far more evidence with pediatric populations. And, so our idea was that it would be nice to have evidence, because we do there are sensory processing issues with persons with schizophrenia in particular, and so the experimental group, the control group and the craft group were all person with chronic schizophrenia at the time. Of course, the DSM-V has changed diagnostic categories a little bit. But, and so the idea being, it works with what we call proximal senses. The proprioceptors are receptors we have in our joints, in our bones, in our muscles to tell us where we are in space, the tactical, the touch system, and the vestibular system, your balance system. And, there are certain types of interventions we work with and, interestingly, we found some individuals, particularly with a history of catatonia almost seemed to come out of their shell, if I can use that term. And, we also had a couple of individuals in the experimental group that have been mute for quite some time that were no longer mute.

And, so, interestingly, even though we did not have a sufficient end at the end, it did get the state medical director's attention. And, so in particular right now, and I have done some consulting, they are using some sensory calming and alerting techniques down at St. Peter for some of the clients that they have that have high needs, definitely sensory processing issues and high agitation. And, so they, in particular at St. Peter, although Anoka has some of that, St. Peter, which, of course, the clients are much more long-term, because they are incarcerated, has taken on some of those types of methods.

Neal: Do you have any thoughts about why that works?

Kristine: Well, I can tell you, A. Jean Ayers, who is the theorist, who is no longer living, who was an educational psychologist and occupational therapist, her studies were really more with children. But, she studied very heavily the neurological systems and what she called neurological soft science at the brain stem level. And, we do know from EEG studies that individuals with schizophrenia have delayed processing, difficulties with dual processing and that kind of thing. And, the idea is that the intervention is supposed to enact on the neurological system. However, the question is when you are working with adults, we know that the brain is less plastic, and so we have far more evidence in working those types of therapies with adults. We need far more research with adults than we have with children. And, so, however, and I can say it is not a panacea, but nor is any of the medications that we use.

But, some of the, we all know, I mean, if most of us, if we had a massage, it would inherently calm us based on how it enacts into the neurological system and the brain. Most of us, if I went around and touched your neck with a feather would be alerted, based on the reticular activating system, again, in the brain and how it alerts the brain system. And, so because of that, I believe that we have some effect on the nervous system. However, with adults, again, it is unclear as to how much that is a lasting effect, and so just like with exercise, we typically with adults try to make sure people have meaningful sensory experiences every single day. And, we call that a sensory diet. Whereas, with children it is a little different. We know we can make pretty lasting impact in the brain early on, because the brain is so plastic in children.

Neal: We have talked with people who worked at the hospital before the drugs were available. Do you think that these techniques would have worked without the psychiatric drugs?

Kristine: I do not think they would have worked on delusions and hallucinations, of course, because the drugs are aimed at neurotransmitters such as dopamine and serotonin. And, so, no I do not think, I do think they would have helped other, maybe things like calming. You have somebody who is psychotic and jumping around and kicking walls and things like that. Certainly, I do think you can have a calming or alerting effect on the nerve system, but at the same time, we are not going to change hallucinations and delusions with that. And, interestingly, you think about the meds came in in 1950s, de-institutionalization came in in the 1960s. However, when I came, I was at that apex working with people from the old school in the ‘80s, who believed clients should live there. And, many of the clients did live there. Many of the clients I had worked with were there for over 25 years. However, you had another cohort of clients that typically were leaving within five, six months. And, so it is interesting to look at the history. Unfortunately, when we went into de-institutionalization, we did not have, and we do not still have adequate housing. And, so we have not fully fixed the housing factor for persons with serious mental illness.

Neal: How did you interact with the other professional staff?

Kristine: The team was integral, and it still is. One thing I very much appreciate and I know oftentimes the old asylums and state hospitals, there were serious concerns in human versus inhumane treatment. However, there was a lot of very good treatment that went on, at least when I

was there. I really saw a lot of good treatment, and part of that was because the staff worked very closely together. I was part of an interdisciplinary team, because I was working with and overseeing our services on multiple units. I would try to get to a team on each unit at least once every week or every other week. At times the assistant I was working with would also be a representative to the team. But, that was integral. When we started, and we developed the OT program, interestingly, no one had any clue what we were. Everybody thought we were rec therapists, and no one had any idea what occupational therapy meant, and that is probably not too dissimilar to today.

And, so we had about probably three months of ongoing trainings, and then actually had a great day. One year they basically, it was probably two years in or even a year and a half in, we designated an entire day and representatives from every unit, including the M.D.s, came and we had, at the time, was called industrial therapy, which was vocational therapy, recreational therapy and occupational therapy. And, we had the staff, the doctors and the nurses and the social works go through our therapies. And, so we had them come in, we did some mock evaluations. We referred them to the types of groups, and so that way they had an experience of some of the differences. And, then we also developed pretty, I would say pretty detailed referral criteria so individuals had an idea who should go to recreational therapy, who should go to occupational therapy, who should go to work therapy and what kind of blend is right for this client. So, every client had his or her own schedule of those types of therapies.

But, it did take some time, because we were not, unfortunately, it is true, the person before me was called the Bingo lady, and we do not want any occupational therapist ever called the Bingo lady. So, we had to completely change things, change the culture, change the understanding and educate on what occupational therapy actually was.

Neal: Could you describe one of the routine team meetings?

Kristine: I would say the team meetings really were somewhat dependent on who the makeup was, and also the physician. Typically, in a team meeting, we would go in and we would go through either all or a subset of the clients very intensely. Some team meetings, the physician had a very hands-off kind of approach and everybody would talk and maybe recommendations. A couple of the team meetings we had I would call more authoritarian types of physicians, who really wanted to direct things. And, so the culture of those meetings were a little bit from unit to unit. But, in essence, we would talk about all or a subset of the clients. Sometimes we would have case managers or family come in, and in those instances, usually we would only get a subset. Because, the case manager might come in for 20, 25 minutes, and that is usually when there was some real concern with a client, or some questions where that individual would be going or what the future intervention would be. So, case managers did not routinely come in for every client. However, if there was some need for a shift or some need for planning, then the case manager would often come in.

Neal: Did you decide what treatments to give to the clients?

Kristine: I, as what they call OTR, a registered occupational therapist, yes, I did many of the evaluations and the assistants I worked with did as well, and some of the other rehab team. And, then I would make recommendations for the types of interventions. However, any good intervention

in mental health should be client-centered, so a key factor was what are the client's wishes as well. And, so not that everybody always wanted to be in every therapy, but we really did try to take into account the client's wishes, the client's goals, and to work with the client toward those common goals. And, the family, as well. If the family was involved, particularly, I mean, if you have somebody who has got chronic schizophrenia who has been in and out of institutions for ten years and says, "I want to go buy my own house," and does not have the financial means, nor the skill level necessary, there was some working together to come to some common, you know, you might say, "So, I hear you want to be more independent." And, kind of move that individual towards goals that would be more independent, but not, per se, have the individual go try to find a house and live in the house.

Neal: How did you interact with the rest of the administration?

Kristine: Because I was kind of in a split clinical/administrative role, I would have very regular contact with even the CEO or executives at the time. I was also in time the head of, the chair of what we called the long-term peer review, and also secretary for a while, I was recorder for that. And, those were a subset of clinicians that were selected to review the long-term clients and what is happening, are they improving, where should this individual go. So, that particular committee might have three or four individuals per meeting that we would make recommendations to the institution about. Because, by the end of the '90s, it was no longer acceptable for individuals to live there. And, so when I first came, there were individuals living there. By the end of the '90s, that was not acceptable, so if somebody had been there one or two years or more, it was highly likely they were going to end up being reviewed by that committee.

Neal: Was that considered a quality assurance kind of activity, or not?

Kristine: Yes, yes, but I was also on the QA/QI committee as well, and that committee, though the long-term peer review was I would say a quality assurance. And, of course, quality insurance and quality improvement are very close to one another. One is dealing with quality within the hospital, the other is dealing with quality as related to external agencies that are accrediting you. And, so we combined the two, and that committee, however, was also, we would look at things like goal attainment, which clients on which units are more likely to meet his or her goals, attendance levels of compliance versus compliance. So, we would look at very specific kinds of quality assurance, quality improvement markets, whereas a long-term peer review was I would say a subset of that.

Neal: Was there a feedback loop that the findings went back?

Kristine: Yes, absolutely, and they would go, it really depended on with we were—for instance, the clients considered mentally ill and dangerous, typically we would get from at the time, Moose Lake or from St. Peter, and those individuals has to also go through a three-judge panel. And, so we would make recommendations to the unit, to the doc, physician, to the CEO and at times external it might go to DHS, it might have gone to the three-judge panel, the case manager for certain. So, it really depended on the case and the reason we were reviewing the case.

Neal: And, why were patients transferred from other hospitals to Anoka?

Kristine: Well, and, it is a little bit different now. However, that is not that that does not happen. We were considered a transition toward the community. So, let's say somebody had a felony and had been at St. Peter and had a label of mentally ill and dangerous, and had completed his or her time at St. Peter. Often, that individual might be transferred up to Anoka to help continue bridging that transition into the community, and so that person might have less security at Anoka, a little bit more freedom, a little different profile of interventions. One of the other things that I had to work quite a bit with was reintegration with the other sex. At St. Peter, you have heavily segregated units. That is not true at the state hospitals. And, so somebody who has been in a forensic unit for eight years only with their same gender, there is definitely an adjustment of socialization when all of a sudden you are introduced into a co-ed environment. And, so, as an occupational therapist, one of the areas we would work with was socialization and boundaries and things like that in trying to re-acclimate people into the community.

Neal: Did you feel safe and secure on the job?

Kristine: I did. I certainly had seen, I saw one of my friends have his jaw broken. I certainly had, I was threatened with scissors at one point. However, it sounds unusual, you have to understand that that is going to go along with the territory, and I will be honest with you. I used to feel like I was really lucky that I only was assaulted twice in the decade I was there. Because, one time, and both times a person really did not know what he or she was doing. Sometimes, usually the therapist, occupational therapists were not assault, because clients liked what we did. They enjoyed coming to therapy. It was the nurses or other individuals that had a higher risk. But, one time, I was assaulted was an individual with traumatic brain injury, who I should have known better. If you, brain injury goes through a series of recovery and in one, you have the agitated client, and I was working with an agitated client and was just way to close to him. And, he was actually hospitalized because he would spontaneously and unknowingly just sucker punch people. And, I got too close to him and I got sucker punched.

And, the other individual who is no longer living, I had a very good relationship. He had very severe schizophrenia, but he also had muscular dystrophy. And, unfortunately, and we worked very closely together, I was with him the day he could no longer stand up. And, he got psychotic and panicked. And, he did not hurt me, because he really make too much contact, but he really panicked. And, I did not know at the time he was not going to be able to stand up. And, even when I tried there, and so he had lost his muscular ability to stand, and it was just too much for him. And, so a psychosis took over and he got combative. But, he was easily calmed down and we were able to work with him.

Neal: Do you know anything about the surrounding community here, how they viewed the hospital?

Kristine: Well, I live in Anoka County. We actually moved within, near Bunker Hills. I would say it shifted over the years. When I first started, it was this mysterious place that somebody escaped from Anoka and even in the earlier '80s, you would hear somebody escaped from Anoka. And, it was also interesting, because there was this persona or question, well, what does that even mean. You know, if somebody escapes from Anoka. Because, to be honest with you, when I was

there, we had people go AWOL all the time. And, so I am sure the community did not know. I think with time, that has gotten better and is not really, I think it has actually developed its own place in the community. It is very different now. I worked in the old hospital with cottages in the very original buildings with the tunnel system underneath it.

And, now, of course, it has got the new, it has got the central courtyard and a mall, and it is a very, much more modern facility, and it has got a different persona to it. Interestingly, they have always tried to close all of the state hospitals, but there is a subset of us who thought that we need a state hospital, it does serve a purpose. It does, I believe, has some very good therapy and some individuals get to a point where it is very difficult. Because, I do personal private practice and it is very difficult for some individuals at certain times to be living say with, especially the DDMI, those who have dual diagnosis, to living in a four-bed group home if that person is constantly assaultive. And, so right now and always it seems like there is a waiting list to get into Anoka, and interestingly, they are talking about reopening more state hospital beds again, because of the need. And, part of that is because we do not have enough housing options for persons with mental illness. And, we have some things we can continue to work on, I think.

Neal: And, what are you opinions about release into the community?

Kristine: Well, my research area, in fact, you had already interviewed both Pat Pelto [PH] and Dorothy Berger who worked at Tasks. My research area is in peer-supported housing. I believe there is not one type of housing that is perfect for everybody, just as there is, you know, and the same with all of us. And, I have written on this quite a bit, but if you were to look at the research on where we all live, I bet everybody in this room, I bet that less than half of us live alone. However, there was a time where the idea was that everybody wants to get to his or her own apartment, or everybody should be in his or her own apartment when that is not even what is happening in America. And, so peer-supported housing, I do think has value for some individuals. So, I am on the executive board of one institution, or I should say, not at institution, an organization that has 24 houses. And, we teach people to live in as peer-support, which is interdependent, which truly, we are all interdependent. We are not all independent, most of us rely on each other for living, and that is no different with persons with mental illness.

I do believe there are some individuals who need longer term placement. I do not think we have, we do not have any more enough housing options where individuals can go and stay in a supportive environment for long term. And, that does not mean it has to be big, a big institution. We have a lot of programs that try to get individuals in 90 days out to their own apartments, and that is not perfect for everybody. Not everybody can do that well, and not everybody should do that. So, I believe that we need, and we need to continue to develop a variety of housing options, just like we have with the general public, that suit the needs of persons with serious mental illness.

Neal: Could you say something about what led you to leave the hospital?

Kristine: I was again recruited. I actually, I mean, I guess I can be honest with you. I was being heavily recruited to St. Kate's. I was called three times. I said no three times. I had planned to leave, or stay at Anoka. I was going to be a lifer. I had the perfect job; I loved the job. At the same time, they were going to increase our evenings, and I had a seven-year-old, and so I went and I

interviewed and I said no. And, they called me again and I said no again. And, then I started praying about it and I figured out exactly how much money—I am the primary wage earner. My husband worked, when my daughter was born, my husband quit his full-time job and went part-time and had an idea in mind, well, if I ever considered it, this is how much they have to pay me. Because, I knew I would take a hit in pay, although that has certainly since been made up over the years of promotions. But, and they called me the next day and offered me almost the exact amount that I figured I needed. And, so then I started thinking, well, maybe I am meant to move on. But, I never lost my love for working at Anoka, and I have consulted with them since then. And, I love it. It was one of the most difficult decisions of my life to leave Anoka. Probably one of the best, because being professor has really afforded opportunities for teaching and research, and also practice. But, I did love working there. I really did.

Neal: And, how about your current position?

Kristine: I am a full professor, tenured at St. Catherine University. I teach in graduate occupational therapy program, and the doctoral program. We have a doctoral program as well. And, then I do do research. I just finished a book, also, and I also have, teach aerobics at 5:45 in the morning for lifetime fitness, and I also have a private practice with persons with developmental and intellectual disabilities. But, my full-time and then some job is being a professor. So, I am busy, but I love being busy.

Neal: And, how did the transition go? Was it a big…

Kristine: It was difficult. It was interesting. I would love to study, although I do not have time to study any more. I have enough research I am looking at. I would love to study institutionalization and the effects not only on the clients, but on the people who work there. I really realize I had been institutionalized. And, so for instance, working for the state, bound by heavy, heavy rules, hourly, you know, you are writing in and out how many, you know, if you are gone a half hour early or come in a half hour late or work a half hour extra, very, very rule-bound. And, so for instance, the first Christmas I was a professor, I told the head of our department at the time I was going to go to Florida for a week, and she looked at me and said, "Oh, should I tell somebody?" And, I thought, wait a minute, don't I have to sign my life away or anything like that. And, there really is no sick or vacation leave. You have to do your job as a professor, which is a very different paradigm. So, I realized it probably took me a year to de-institutionalize myself. I mean, it really was a change, and I would not say it was easy. I loved Anoka, I enjoyed learning about being a professor. But, the culture is so different in working for an institution and a state. And, I did love it there, then working for a private university where it is a college and academia. And, it is being a professor, and you probably understand this as well, is not like a job, it is more like a lifestyle. So, I mean I can go home early, but that might mean I am grading 20 papers at night. So, there is a much different flexibility with time and so, I would say there was a transition, that is for sure.

Neal: So, you are implying that you might have taken on some of the characteristics of either the institution or your clients?

Kristine: I do not know that it would be the characteristics of them. I would say the process of working in an institution that has its own culture, and you are with the same people day in and day

out leads you to get used to that environment. And, when released to a different environment where you are on your own to manage your time, you are on your own to seek out your research opportunities, to plan your classes, it is a different culture. And, I know I mentioned this, too, this earlier, Anoka changed quite a bit while I was there, because I came in in the old school, when people lived there. And, we had psychologists who believed that people should be in therapy for 20 years straight and talk therapy. And, then as the '90s came along, the psycho, you know, we had all of a sudden the psychosocial rehabilitation movement and Bill Anthony and Lieberman and the focus was, "No, we need to be doing skill training, and in the skill training, we need to help people get out of an institution." And, there was some pressure, because there was the cohort from the old school who believed, "No, we should have them forever." And, then we had the new school who believed more in rehabilitation.

Neal: Can you think of an example or two of how your time at Anoka informed what you did, what you do at St. Catherine's?

Kristine: Yeah. Well, I had seen both spectrums, because I have been involved in Tasks, which is community mental health, and then I worked with individuals who had very difficult illnesses. And, so that compassion and, I call myself a rogerian [PH] Girl Scout. This idea of therapeutic use of self, this idea of conscious use of self, unconditional positive regard, there was not one client I could, even if somebody had committed heinous crimes, there was not one client I could not find something I liked about them. And, certainly, that is true when I work with students. In fact, I have even written a journal article on the therapeutic use of self in the classroom. Because, I think compassion starts building. Now, I probably had that as a child of a mother who had schizophrenia, but not in the same way. And, so compassion for, it is not easy to be going from institution to institution. It is not easy to be homeless or not have resources. It is not easy to be told you have to spend down $5,000 so you qualify for insurance. Those things really hit home as to the reality of what it is like for persons who do not have resources maybe. And, yet there are some with very high, high skills and talents and we have to see those talents. We have to see those skills. We have to empower individuals to use those skills, because too often, we are in the medical model of focusing on disability versus ability. And, so I think I brought that to the classroom, plus I teach many, many psychiatric, psychological classes, and actually within those, in fact even yesterday, my students role play clients and they role play the interventions. And, so I am hoping that leads to flexibility of thinking, and then we process after, I mean, we actually do intervention groups and process how did that go, what would you do different, what would it be like in a real situation.

Neal: Do you consider yourself an advocate for mentally ill?

Kristine: Oh, absolutely, especially, well, in fact, some of my research actually changed mental health law in Minnesota for evidence-based practice. Absolutely. I think, unfortunately, and we, you know, we have many good things about our political system and we have some challenges. And, one is that oftentimes we have legislators who are making decisions based on areas that they are not educated in. And, that is how our system works and every system works. And, so, we have to help educate as to what does this really mean, and what are we talking about. At Tasks, where I am on the executive board, we have often had our clients testify, because that is the face of what we are talking about. And, so I think that is really very important to be an advocate. And, also to teach individuals, which the psychosocial rehabilitation emphasizes, to be their own advocates, too. And,

so that it is not this power differential, but let's, how can we work together to advocate for the mental health needs of all. Because, any given person, I tell the students, one out of every two of them are either going to personally have a mental health issue or a family member or close friend. And, so it is not a mystery, I say, it is not a mystery if there is mental illness or abuse or a neglect or those kinds of things. Those are issues we need to help work with to empower and remediate in the best ways we can.

Neal: Would you say that attitudes in general are changing over time toward mentally ill persons?

Kristine: I think it waivers. I think we are better. I think there is more awareness. However, it is important, yeah, concerning it is, I do believe that media coverage of things like mass shootings from people with mental illness lead people to believe that person with mental illness are inherently more dangerous, when if you look at the statistics, people with mental illness have no more dangerousness than the general population, unless drugs or alcohol are involved, which is true for the general population, if drugs or alcohol are involved. However, we do have some individuals who definitely need medication to try to avert those kinds of things. And, I think early detection, even as a professor, we are doing more to train other professors on early detection. Because, the average onset of major mental illness is 18 to 24. And, because of that, it is often in late high school or in a college setting that we start then detecting a mental illness that we may or may not have known was there prior. And, so we have to help individuals get into intervention as soon as we can if that is the situation.

Neal: So, what have forgotten to cover?

Kristine: Oh, that is an interesting question. I think you have actually done a really nice job. I guess, again, I just would like to reiterate that not only is there a stigma about persons with mental illness, there is a stigma toward the institutions that service people with mental illness. And, I am not sure that stigma is fair. I do believe there are concerns for humane versus inhumane intervention. I also believe we need to understand the complexity of that, what we are talking about. So, for instance, if individuals are working at St. Peter with individuals who have high assaultiveness and high dangerousness, it is difficult, because there has to be a self-protection as well. And, so what we have to do is embrace how can we support those with mental health issues and those working with those with mental health issues to have healthy environments. And, I do think for the most part, in my experience, we had pretty darn good treatment, and people really did care. Of course, you would have outliers and you would hear about the outliers, and you would have incidents and you would hear about the incidents. But, the day-to-day operations in the mental health system, I really believe, for the most part, are people who genuinely wish to do the best they can, both the clients, who genuinely are trying as hard as they can, and the staff, who genuinely are trying as hard as we can. And, to think about how can we embrace supporting those individuals in the process, rather than condemning or criticizing. I think how can we embrace and put this together to improve the mental health for all, including the staff.

Neal: Persons with mental illness have shorter lifespans. What do you think is going on with that?

Kristine: Well, it is interesting you ask, because at Tasks Unlimited, we are now finding our clients are living the same length as other clients. But, we have housing, they had, we have a

retirement job now. They have adequate food, nutrition, they have, we have a wellness program with Tai Chi, we have a wellness program with exercise. We have opportunities, they have gone to Europe multiple times, they have gone to multiple states, they have gone to Canada, they have gone to Hawaii. They have done volunteer jobs. I think some of the issues we are seeing in longevity have to do with what is going on with the lifestyle and the resources available and the medical interventions available for medical conditions. Because, and I would love to have this studied, because we are finding in this organization that services about 300 people a year, that many of our individuals are living to the average lifespan. And, my mother, I believe, will as well, and so having proper supports in place. Now, of course, we are going to have to look at what long-term use of neuroleptics does, so certainly we have got an effect on the body. But, I believe in part, part of that is, is this individual afforded the things that he or she needs to have a healthy quality of life. And, if so, I suspect, just as we have found in developmental disabilities, we are going to see people live longer. Because, those external supports are so important.

Neal: Any final thoughts?

Kristine: No, I think you have had some very interesting questions, and it has been interesting to reminisce and think back to this time of my life and my trajectory. It has been very interesting.

Neal: Well, thank you for coming in.

Kristine: You are welcome.

Neal: And, sharing your thoughts.

Kristine: Sure.

Neal: It has been interesting to hear about the trajectory of your career.

Kristine: Well, thank you. I appreciate it.

Neal: And, thank you for all the service.

Kristine: Well, thank you, and thank you for this project. It is a wonderful project. I was so excited to hear you were doing it. So, thank you.

Neal: You are welcome.

Kristine: Great.

[Music playing]

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