1973 — A TURNING POINT FOR MENTAL HEALTH PROGRAMS IN OREGON

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State of Oregon

MENTAL HEALTH DIVISION
Department of Human Resources

J. D. Bray, M.D.
Administrator

October 1, 1973

MENTAL HEALTH DIVISION

DEPARTMENT OF HUMAN RESOURCES

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To All Interested Persons:

1973--A TURNING POINT FOR MENTAL HEALTH PROGRAMS IN OREGON is a record of the activities involved in setting the stage for the most significant changes in Oregon mental health programs since the creation of the Mental Health Division in 1961.

A comprehensive community mental health program is being developed as the community mental health clinics, community mental retardation programs, alcohol and drug programs, hospitals for the mentally ill, and hospitals for the mentally retarded join forces on a regional basis.

High visibility and focus on program quality and excellence in comprehensive planning are being developed through Mental Health Division program offices for mental or emotional disturbances, mental retardation and developmental disabilities, and alcohol and drug problems. Significant growth is also occurring in all three areas.

This Comprehensive Community Mental Health Program was a part of the Mental Health Division biennial budget request for 1973-75 and was approved by the Oregon Legislative Assembly during the regular session in 1973. The reorganization of the Mental Health Division became operational on August 1 this year.

The first document in this compilation, "Oregon Mental Health Programs for the Future," is an excerpt from the Division's budget request. It brings together the extensive planning efforts of previous years into a document of direction for Oregon mental health programs for the future. It is purposefully not a detailed plan for county level mental health programs, as this planning is appropriately done at the county

level; but it does provide a structure for the growth and development of an effective comprehensive community mental health program. In a real sense, this document has many authors, since more than a hundred persons were intensively involved in the planning task forces where the basic thinking was accomplished.

"For your information...," the Division newsletter, summarizes highlights of legislative action on the Mental Health Division budget request for 1973-75, the largest in its twelve-year history.

The "Summary of Mental Health Legislation" includes major bills relating to mental health enacted by the Oregon Legislative Assembly in 1973. Significant to the new comprehensive program are Senate Bill 448 relating to community mental health programs, Senate Bill 510 relating to involuntary commitment of mentally ill persons, and Senate Bill 544 relating to drug abuse and dependence. Each bill is discussed briefly in this document.

Fourth in the compilation is "Mental Health Programs in Oregon Today" prepared in February 1973 for legislative committee hearings. It describes the extent of mental health problems in Oregon and the basic mental health delivery system at that time.

The mental health story will continue to unfold. These are, indeed, exciting times for mental health in Oregon.

J. D. Bray, M.D.
Administrator

OREGON MENTAL HEALTH PROGRAMS FOR THE FUTURE

Excerpt from

MENTAL HEALTH DIVISION
Biennial Budget Request for 1973-75

J. D. Bray, M.D.
Administrator

December 14, 1972

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MENTAL HEALTH DIVISION

BIENNIAL BUDGET REQUEST FOR 1973-75

INTRODUCTION

Mental health may be defined as a state of reality-oriented compatability with one's self, others, and the world, that results in a meaningful life and a sense of well-being. Mental health does not imply blind acceptance of all that is, or continual bliss. Instead, it implies mature self-determinism, accepting the fact that normal living often is accompanied by anxieties and depressions.

For many, mental health is best understood in terms of its opposite condition, in much the same way as one defines darkness as being the absence of light; or peace, the absence of strife. Viewed in this way, it can be said that mental health, like physical health, is the absence of disease, suffering, and defect. This concept of mental health takes on added meaning when one considers those who, to varying degrees, do not have it--the mentally ill, mentally retarded and developmentally disabled, alcoholics, and drug-dependent persons.

Mental health has a slightly different meaning for each person who reflects upon it. Each tends to view mental health in the light of his own value judgments, capabilities, and concepts of the essence of life itself. For this reason, the process of treatment and rehabilitation requires highly individualized objectives that are consistent with each person's intellectual and emotional capacity and value system.

Despite the many problems faced by society, the prospects for helping people achieve and maintain mental health are far brighter now than they were as recently as fifteen years ago. This optimistic view is justified by the new approaches to prevention, treatment, and restoration which have been developed and the rapidly changing attitudes of society toward mental illness, mental retardation and developmental disabilities, and alcohol and drug problems.

Because of prevailing negative attitudes and lack of resources, the emphasis fifteen years ago was necessarily on the removal of mentally ill, mentally retarded, alcoholics, and drug-dependent persons from society to distant institutions or to jails. The emphasis in Oregon today is for a broad range of treatment, educational, and supportive

programs in the community, which build on all the strengths of the individual, his family, and his community.

In recent years, the Mental Health Division has been planning for an orderly transition of programs consistent with this emphasis. More attention is being given to the way in which all component programs within the Division relate to the whole.

An extensive planning effort was launched during the spring of 1972, involving 12 task forces of more than 100 persons from the Division central office and hospitals, community mental health clinics, advisory boards and committees, mental health-related agencies, professional organizations, state agencies, and other interested persons. Building on the results of previous years of planning, the effort in 1972 culminated in the proposed new Comprehensive Community Mental Health Program for Oregon.

This new approach is the central theme of the Mental Health Division biennial budget request for 1973-75. It will require:

1. Growth and evolution of the community mental health clinics which will provide the framework upon which the new programs will be built.

2. Development of community alternatives to care and treatment in state hospitals for the mentally ill and mentally retarded.

3. Growth in community mental retardation, developmental disabilities, and alcohol and drug programs, which will be integrated into the new Comprehensive Community Mental Health Program.

4. Strengthening of treatment staff in the state hospitals for the mentally ill and mentally retarded, to allow for strong support of the total mental health program in its transition and the development of appropriate new roles.

5. Construction of a psychiatric security unit at Dammasch State Hospital, which will serve the total mental health program through secure treatment of those persons who are dangerous to society.

6. Reorganization of the Mental Health Division central office program staff, to provide a structure for planned, orderly change and to assure program integration and quality.

7. Strengthening of central office administrative functions to assure sound management and fiscal accountability.

COMPREHENSIVE COMMUNITY MENTAL HEALTH PROGRAM

Mental health programs in Oregon have, in recent years, become more actively involved with the families and communities of the individuals served. There has been profit for everyone in this process. Mental illness, mental retardation and developmental disabilities, and alcohol and drug problems are better understood and dealt with by the public. When the problems of an individual are viewed in the context of his total environment, and when families and the broader community are actively involved in identifying and solving these problems, a positive change in attitude generally occurs. The professionals have learned a great deal about what causes problems but, more important, have realized that when, where, how, and by whom people are helped are at least as important as the extent of treatment resources available, the particular type of problem defined, or the specific treatment techniques and methods used.

The proposed Comprehensive Community Mental Health Program is designed to make appropriate help immediately available at the place of emergence of the problem and to relentlessly search for treatment effectiveness--the intervention that "works" by producing real results in the lives of people. The program will also seek to identify and support those positive forces in society which may, in the long run, prevent problems from developing.

This new approach was presented in detail to the Legislative Assembly in 1971. It was viewed favorably, and further planning was directed. The additional planning was accomplished and documented by the Mental Health Division Task Force on Program Delivery System and the Task Force on Resource Identification and Development in the spring of 1972. The accomplishments of these task forces were in the areas of (1) further development of the basic concepts, which are now included in the plan; (2) design of a new organization for the Mental Health Division central office program staff, which is incorporated into this 1973-75 biennial budget request; and (3) a study of funding mechanisms, which resulted in a recommendation for continuation of shared state-local funding for a portion of the program.

The recommendation on funding represents a significant change from the state-funded, state-operated program proposed in 1971. The majority of Oregon counties take pride in their mental health programs and have expressed concern that a state-funded and operated program would not be sensitive to local needs and priorities.

On the other hand, the state is concerned that program growth and development be consistent with a comprehensive plan, that the state's priorities are also met, and that program and fiscal accountability

are maintained. All agree that the level of local involvement and commitment which has occurred through shared funding is essential to an effective mental health program.

It is the position of the Mental Health Division that the objectives of both county and state government can be met through the differential funding mechanisms included in this budget request, and through clear definition of state and local authority, responsibility, and relationships.

The following description of the Comprehensive Community Mental Health Program is presented from the local vantage point and includes the essential elements and their relationships. These elements are: (1) clearly defined service areas, (2) mental health authorities, (3) local mental health directors and multidisciplinary teams, and (4) enough program growth and appropriate new programs to provide the necessary range of services.

Mental health service areas have been established, based on population, geographic considerations, and unique local needs. These areas will be comprised of either a county; or, where it is not feasible for one county to provide a full range of services, a group of counties. For each area, a comprehensive plan will be developed, a broad range of services provided, and a mental health director appointed.

The county commission or court will be the local mental health authority, as it is under present statutes. Individually, or with other counties, the authority may designate a public agency or a nonprofit corporation to plan and operate, with its approval, the comprehensive community mental health program for that service area. The advisory board or policy board of the designated agency will be strengthened. Membership of advisory or policy boards will be representative of the people of the area and will actively assist the mental health director and authority in planning, identifying needs, monitoring programs, recommending priorities, providing public education, and obtaining community support and involvement.

The local mental health director and his multidisciplinary team will have primary responsibility for identifying local needs and providing mental health services. They will also be responsible for local administration, public education, continuity of care, and coordination with other human services.

A multidisciplinary team that integrates the efforts of specialists in mental illness, mental retardation and developmental disabilities, and alcohol and drug problems is a basic element in the new program and is described in detail in the report of the Task Force on Program Delivery System. The team will make available a broad range of

services related to local needs. These services can be grouped as follows: (1) 24-hour emergency services and crisis intervention, (2) detoxification, (3) short-term inpatient treatment in local general hospitals, (4) outpatient treatment, and (5) partial support programs for those persons unable to remain independent, such as community living facilities, day treatment, and work activity centers.

The local mental health team will also have direct access to state-level services, such as psychiatric security and the Methadone Blockade Treatment Program.

This range of services will be developed on the basis that unique needs of the areas are not static and vary considerably from area to area and from time to time. The program will remain flexible in the development of appropriate new services, alteration of services as changing needs dictate, and discontinuance of services when outmoded.

The new organization of Mental Health Division central office program staff, which is essential to the development and administration of this program, is described in detail on pages 21-24. The program focus will be in three areas--programs for the mentally ill, programs for the mentally retarded and developmentally disabled, and programs for alcohol and drug problems. A brief discussion of each of these three areas follows. Each discussion includes a review of present programs in that particular area and an introduction to the program improvement proposals, which are described in more detail later in the budget presentation.

Programs for the Mentally Ill

There are few families that are not seriously affected by mental illness or emotional disturbances as manifested by depression or anxiety, psychosis, severe family conflict or disruption, behavior problems in children, alienation, poor self-image and self-esteem, mental confusion, or poor judgment. Approximately 10 percent of the state population, or a quarter of a million Oregonians, need professional help for major mental and emotional problems. Nearly one in ten will be hospitalized for mental illness in his lifetime. More than 55,000 Oregonians under 18 years of age are functionally imparied by emotional disorders; nearly 2,000 are severely emotionally disturbed.

The community mental health clinics served 22,633 persons in 1970-71, of whom 7,000 were children. New admissions to mental health clinics have been increasing at the rate of 700 per year. Many other persons receive mental health services through private mental health professionals, hospitals, and agencies.

Oregon Hospital has reorganized to integrate services with those of the community mental health program for Eastern Oregon and to provide intensive treatment on geographically-oriented wards.

Improvements in treatment staffing patterns, based on experience with SCOPE, are proposed for the three mental hospitals to improve the quality of treatment and to facilitate the transition of patients to the community. Oregon State Hospital proposes to establish a 24-hour residential treatment program for severely disturbed adolescents.

The Psychiatric Security Unit at Oregon State Hospital is facing increased crowding with more severely disturbed patients. Upon recommendations of a study by a special task force, construction of a new psychiatric security unit at Dammasch State Hospital is proposed to replace the unit at Oregon State Hospital.

The Comprehensive Community Mental Health Program will allow for greater and more effective utilization of federal money from a variety of sources, and utilization of private health insurance to augment state and county funding. Through differential state funding, it will ensure provision of high quality, high priority services at the local level, while retaining local involvement and responsibility. A significant allocation of General Fund moneys will be required to mount this program.

Programs for the Mentally Retarded and Developmentally Disabled

Mental retardation is the most handicapping of all childhood disorders. National studies indicate that approximately 3 percent of the population will at some time during their life be identified as mentally retarded. It is estimated that there are approximately 37,000 mentally retarded persons in Oregon who could benefit from services. Only 35 percent, or 13,150, are receiving some kind of service through various agencies.

The Mental Health Division now provides direct services to 8,909 mentally retarded persons. Of this number, 2,670 were residents in state hospitals for the mentally retarded on June 30, 1972, a decline of 216 from the 1971 population; 665 were in the community on trial placement from state facilities; and 5,574 were receiving services through community programs administered by the Division. These figures dramatize the effect on hospital populations and the population-at-risk that can be achieved by expansion of community-based services for the mentally retarded.

There are also approximately 16,000 persons in Oregon with a developmental disability--defined as a disability which is attributable to

mental retardation, cerebral palsy, or epilepsy, or other neurological conditions requiring treatment similar to that required for mentally retarded individuals. A wide range of services is available to them under the provisions of Public Law 91-517, the Developmental Disabilities Services and Facilities Construction Amendments of 1970.

Present Programs for the Mentally Retarded and Developmentally Disabled

To fulfill its statutory responsibility and to accomplish the objectives of meeting the needs of the mentally retarded and developmentally disabled, the Mental Health Division is developing a range of services organized in a sequential manner to provide a continuum of care, treatment, and training. The program objectives are to (1) help maintain the family unit; (2) promote the maximum health and social, intellectual, and vocational adjustment; (3) protect the mentally retarded and developmentally disabled from exploitation and abuse; (4) establish standards that promote enlightened care and treatment; and (5) promote a family and community approach toward meeting the needs of the mentally retarded and developmentally disabled.

Implementation of the Division goals and objectives for treatment and habilitation is accomplished through a system of diagnosis and evaluation to determine eligibility for these services, community programs, and three hospitals for the mentally retarded to meet specific needs when alternate programs are not available.

The Diagnosis and Evaluation Section has a statewide responsibility to (1) determine eligibility of applicants for hospital and community-based services and develop preliminary treatment-training plans; (2) provide comprehensive diagnosis and evaluation, when necessary for the completion of a treatment-training plan; (3) provide treatment, counseling, and other services where local resources do not exist; and (4) promote the development of local resources to accomplish all or part of these functions through training and supervision.

The Section maintains liaison with, and provides consultative services to, community mental health clinics and other agencies that offer services to the mentally retarded and developmentally disabled.

The three hospitals for the mentally retarded are organized to operate collaboratively as a single component in the total range of services to serve those whose needs cannot now be met in the community. The hospitals coordinate services to meet each individual's need for care, treatment, training and habilitation; periodically evaluate progress and current status of individual residents; and organize resources to provide programs necessary for the sequential development of each individual. Each hospital utilizes a uniform resident classification

and reporting system to conform to a bed utilization plan which is designed to maximize the use of each facility and provide easy access to and from the community.

The Community Mental Retardation Section is responsible for developing and maintaining services in the community. Classroom services for the trainable mentally retarded are provided under ORS 430.760 to 430.820 enacted by the Legislative Assembly in 1969 (House Bill 1217). The growth in classroom services is illustrated as follows:

School Year	Number of Children Served	State Grant-In-Aid	Local Share or Contribution
1969-70	483	$ 400,000**	$ 420,000
1970-71	630 (52%*)		
1971-72	916 (44%*)	1,080,000**	1,200,000
1972-73	1,110 (projected) (21%*)		

*Increase over previous year
**Biennial appropriation

Each year approximately 150 such students become too old for classroom services, which are available to trainable mentally retarded between the ages of 4 and 21. If these persons are to remain in the community, they can best be served in community living facilities or work activity centers. At present, there is no state support for either type of facility. The few in operation derive their resources from local or federal funds, or a combination of both.

Through parent education services, parents are trained in teaching skills. A partnership between school and home is fostered, and the training process is improved. The parents of 600 trainable mentally retarded children are now enrolled in these parent education classes.

The service coordinator functions as a fixed point of referral in the community to assure that the various local and state programs are available to the mentally retarded and developmentally disabled at the time when the services will be the most effective. The service coordinator is also responsible for eliminating duplication and filling

with local program resources, they will facilitate meaningful program planning to meet individual needs. Program improvements requested for 1973-75 are designed to further the implementation of this decentralized concept.

Program improvements requested for hospitals for the mentally retarded will assist in the development of self-help skills among the younger residents and accelerate the development of vocational skills among adolescents and young adult residents. Both are aimed at earlier placement of these residents into community facilities that will further integrate them into a relatively normal life in the community.

Additional staff is needed at Eastern Oregon Hospital and Training Center and Columbia Park Hospital and Training Center to provide resources for developmental programs to serve a broader mix of individuals, who require language and speech development, education, recreation, and vocational training. Improvements requested for Fairview Hospital and Training Center are primarily aimed at providing developmental programs for a greater number of residents with specific handicapping conditions, such as blindness, deafness, and other physical and emotional problems.

Improvement requests for community programs reflect a strengthening of present programs by expansion into areas where services have not been available, as well as introduction of additional services to fill gaps. Expansion of classroom services for the trainable mentally retarded is requested to meet a projected 17 percent increase in enrollment. Included in the alternatives to state hospitalization are Service Coordinators, Community Case Development Specialists, community living facilities, work activity centers, parent counseling and education, and preschool programs.

Each mentally retarded and developmentally disabled individual has the same basic rights, dignity, and responsibilities as any other citizen; and he should be helped to have a meaningful life as close to normal as possible. It is, therefore, essential to provide him with those opportunities and experiences that will enable him to develop his physical, intellectual, and social capabilities to the fullest extent.

Programs for Alcohol and Drug Problems

Current estimates indicate that there are 55,000 alcoholics in Oregon. Eleven percent of mental health clinic patients seen during 1971 had alcohol-related problems. During that same year, 21.8 percent of admissions to the three state hospitals for the mentally ill were diagnosed as alcoholics or problem drinkers. Approximately half of

In many communities, local mental health clinic staff have played major roles in the development of alcohol and drug projects, and in providing consultation and treatment within these programs.

Emergency Stations, commonly known as detoxification centers, have been established in Portland, Grants Pass, Medford, Klamath Falls, Baker, Eugene, and Roseburg, and are funded through a combination of local and federal money, without state support.

Halfway houses for alcoholics are maintained through state grant-in-aid in Portland, Eugene, and Grants Pass. Another halfway house in Pendleton has been funded directly by the Division.

The Outside-In Sociomedical Aid Station in Portland and White Bird Sociomedical Aid Station in Eugene provide services to drug-abusing, alienated youth under subcontracts through state grant-in-aid. The Division is also assisting other communities to develop "store front" clinics, without state funding.

Alcohol and drug programs in Oregon were strongly influenced during the 1971-73 biennium by state and federal legislation. The implementation of Enrolled Senate Bill 431 (1971 Regular Session), which declares alcoholism to be an illness and which makes provision for the handling of publicly intoxicated persons through treatment facilities rather than jails, is resulting in a major shift in the local management of alcoholics. Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972, require a state alcohol and state drug plan, respectively, and provide federal formula and project grant moneys for the development of alcoholism or drug abuse prevention, treatment, and rehabilitation services. A State Alcoholism Plan has been completed and submitted to comply with Public Law 91-616, and $288,598 in formula grant money will be available to Oregon for alcohol programs in 1971-73. A State Drug Abuse Plan is being developed in compliance with Public Law 92-255.

Proposed Programs for Alcohol and Drug Problems

The overall plan for services to alcoholics and drug abusers is to place alcohol and drug specialists within each local mental health team over the next several years, develop community-based emergency detoxification services, provide additional residential services in the community, and improve the quality and integration of alcohol and drug programs within the state hospitals, mental health clinics, and local alternatives to hospitalization. As a part of the latter program, greater utilization of local general hospitals and day treatment programs is also projected for alcoholics and drug abusers.

Approximately $600,000 in formula grant moneys is anticipated for Oregon during 1973-75 under the two Federal Acts already described. Priority will be given to the employment of alcohol and drug specialists at the local level to develop programs and to provide education, information, and referral services and direct treatment.

An expansion in the Alcohol and Drug Education program is requested to meet increasing demands for educational materials, public education, and professional training to prevent alcoholism and other drug abuse. The present field services offices will become an integral part of the interdisciplinary teams in the Division regional offices.

Additional staff are requested for the Alcoholism Treatment and Training Center in Portland to meet the increasing workload of this Center, including patients referred from the Alcohol Safety Action Project, when the current treatment grant expires.

It is proposed that several proven elements of the Alcohol Safety Action Project be continued and expanded to two additional areas of the state with partial state funding. The current federal grant will expire June 30, 1973.

A substantial increase in caseload is anticipated by the Methadone Blockade Treatment Program in 1973-75 with improved law enforcement and increasing referrals to the program from the criminal justice system. Emergency Employment Act and Law Enforcement Assistance Administration funds will not be available to finance the basic program, which will therefore require total funding by the state. Additional federal funds from the IMPACT law enforcement program in Portland and the Office of Economic Opportunity are being sought to improve program quality and to expand the size of the program.

The Narcotic Addict Rehabilitation Act Program expects to grow substantially during 1973-75, principally due to greater law enforcement activity and Public Law 92-293, which allows courts to require that narcotic-dependent persons participate in this type of drug-free treatment program as a condition of parole or probation. This program will continue to be 100 percent federally funded.

State funds will be requested to continue the Drug Treatment and Training Project in Portland, with certain improvements related to program effectiveness, increased caseload, and training needs. Federal funding of this project will end on May 31, 1973.

Additional group living centers are proposed for alcoholics and drug-dependent persons.

Many communities have had difficulty implementing the provisions of Enrolled Senate Bill 431 (ORS 426.450 to 426.470 and ORS 430.305 to 430.335), which calls for treatment of publicly intoxicated persons. There are no state funds directly appropriated for detoxification centers, and continued federal funding is uncertain in several of them. Additional facilities are urgently needed, and state funds are requested to assist local programs in establishing and maintaining emergency stations (detoxification centers) and to serve as matching (most commonly 25 percent) money for federal grants.

PRESENT ORGANIZATION OF MENTAL HEALTH DIVISION

The Mental Health Division was established by action of the Fifty-first Legislative Assembly in 1961 and became operational on July 1, 1962, as an agency of the Oregon State Board of Control. By legislative action, it became a separate agency of state government under the Office of the Governor on July 1, 1969. All duties, functions, and powers of the Board of Control relating to mental health were transferred to the Division.

Subsequent reorganization of state government resulted in the creation of a Department of Human Resources. Since July 1, 1971, mental health services are being provided through the Mental Health Division of that Department.

Programs of the Mental Health Division are now administered through two assistant administrators as illustrated in the chart on page 20. The hospitals for the mentally ill, the Alcohol and Drug Section, and Community Mental Health Section report to the Assistant Administrator for Mental Health Services. The hospitals for the mentally retarded, the Community Mental Retardation Section, and Diagnosis and Evaluation Section report to the Assistant Administrator for Mental Retardation Services.

The other components of the Division central office are the Office of the Administrator, which includes the specialized functions of public information, Medicaid coordination, and manpower development, and the Administrative Services Section that provides personnel, budget planning, business management, and management services.

Three boards or committees are authorized by statute to advise the Mental Health Division.

Mental Health Advisory Board

This advisory board, authorized by ORS 430.050, is comprised of thirteen members. It meets quarterly to consider all Mental Health Division policies and programs and make recommendations for their development.

Oregon Alcohol and Drug Education Committee (Council)

Authorized by ORS 430.100, this committee has met bimonthly to participate in the planning and review of alcohol and drug education and rehabilitation programs. It became the Oregon Alcohol and Drug Education Council on July 1, 1972, in accordance with section 5, chapter 622, Oregon Laws 1971 (Enrolled Senate Bill 431). The Council

is being divided into two groups--the State Alcoholism Advisory Council and the State Drug Problems Advisory Council. This course of action is reflected in the State Alcoholism Plan, which has been prepared under the provisions of Public Law 91-616, and will be reflected also in the State Drug Abuse Plan now being developed.

Drug Addiction Advisory Committee

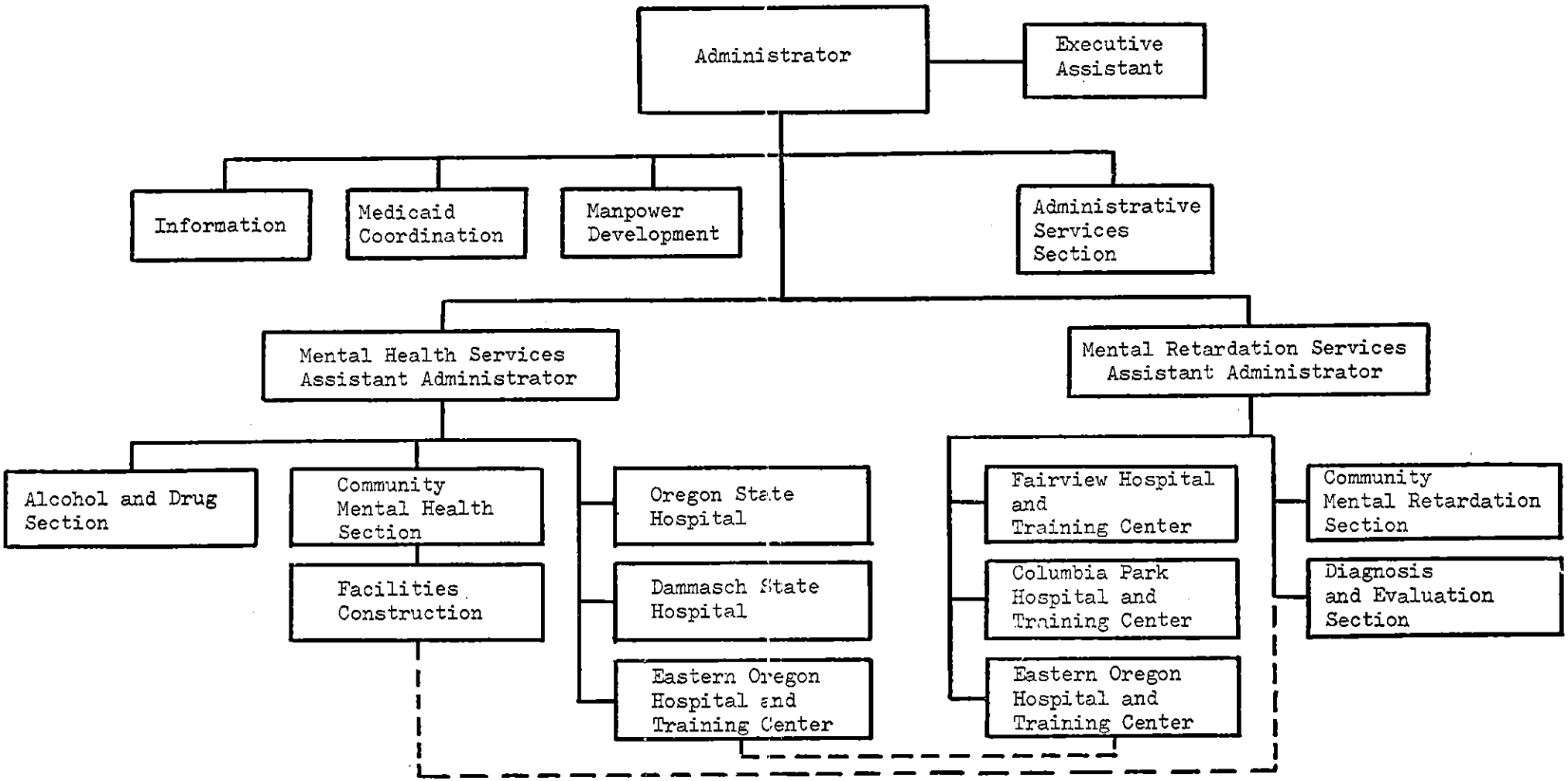
This committee, known as the Methadone Advisory Committee, was established under authority of ORS 430.107 (chapter 442, Oregon Laws 1969) to advise the Division on the administration of the synthetic narcotic (Methadone) maintenance program.

There is one other major advisory group.

Oregon Commission on Staffing Standards

The Staffing Commission was established by the Mental Health Division in December 1969 to fulfill legislative intent relative to implementation of the SCOPE staffing methodology. It met monthly until June 1970, and has convened on an ad hoc basis since that time.

PRESENT ORGANIZATION OF MENTAL HEALTH DIVISION



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PROPOSED ORGANIZATION OF MENTAL HEALTH DIVISION

The proposed Comprehensive Community Mental Health Program calls for the building of a true system from a group of complex hospital and community services which serve the mentally ill, the mentally retarded and developmentally disabled, and those with alcohol and drug problems. The new program also calls for a relentless search for treatment effectiveness--the intervention that "works" by producing real results in the lives of people--and for the development of comprehensive plans which will result in an appropriate range of services in each mental health service area. Finally, the program calls for clear program and fiscal accountability.

Strengthening and reorganization of the Mental Health Division central office program staff as proposed by the Task Force on Program Delivery System is essential to this new program.

Barriers now tend to exist: between hospital and community programs on one hand; and mental health, mental retardation and developmental disabilities, and alcohol and drug problems on the other. The integration of these major areas is a prime objective of the proposed organization.

Another objective is to improve program quality and planning consistent with the goals of the Mental Health Division. In the past, responsibility for program operation, planning, and quality have resided in the same organizational units. Because of the immediacy of day-to-day problems, program operation has been given first priority; and the functions of planning, development, and quality have not consistently been afforded high priority. Today programs are rapidly becoming more diverse and complex--a fact which makes the assurance of quality programs and effective planning increasingly difficult.

To achieve the goals and to resolve the problems, the Division proposes an organization which has, as its primary features, the integration of program administration and service delivery on a regional and local basis and the separation of responsibility for planning and quality from day-to-day functions. Through this means, an optimum level of coordinated and integrated program delivery, planning and development, and program quality can be attained.

This organization also has the benefit of clearly delineating the line of accountability and responsibility from the community level through the regional directors to the Administrator of the Mental Health Division. Integration of services would be effected at the regional level in both program areas, i.e., mental health, mental retardation and developmental disabilities, alcohol and drug abuse; and method of

delivery, i.e., community-based services and state hospitals. A state-local partnership for community services would be retained to ensure that community needs are incorporated into state plans. At the same time, the Division would be able to ensure that plans are developed and carried out in an integrated manner.

The proposed organization of the Mental Health Division provides for the performance of statewide functions through three program directors specializing in the areas of mental illness, mental retardation and developmental disabilities, and alcohol and drug problems. These program directors would be responsible for planning, standard setting, monitoring, and evaluation for all mental health programs in the state. They would have no direct responsibility for provision of services. Other statewide functions would continue to be performed through the Office of the Administrator of the Division and the Administrative Services Section.

Three regional directors would be responsible for all mental health services in their respective regions, whether provided directly or through contract. They would implement the programs developed by the program directors in accordance with standards set by them and express the needs of local areas and the results of local planning. Fiscal management, supervision of service programs, regional policy making, community organization, local public information, and assurance of continuity of care among the system components would also be the responsibility of the regional directors.

Geographically, the regions are contiguous with the catchment areas of the three hospitals for the mentally ill. All state hospitals for the mentally ill and mentally retarded would report to the director of the region in which they are located. The community clinics, alcohol and drug services, community services for the mentally retarded and developmentally disabled, and community mental health centers, whether state-operated or contractual agencies, would also report to the regional directors. It would be their responsibility to assure coordination of services and continuity of care between state hospitals and the various community programs within the region.

The proposed organization, illustrated in the chart on page 24, assumes a participative management style. Key decisions would be discussed in regularly scheduled meetings of the Executive Council comprised of the Mental Health Division Administrator, three Program Directors, three Regional Directors, and the Director of Administrative Services. The ultimate responsibility for all decisions would remain with the Division Administrator.

In order to fix responsibility and maintain an unbroken line of authority and accountability, the integrated service concept would be

extended to local mental health service areas. The local mental health authority (county Commission or court) would designate the local mental health director in consultation with the Mental Health Division and in conformity with its regulations. In most areas, the local mental health director would be the director of a community mental health clinic. All contracts and federal grant application approvals and endorsements for local programs would be negotiated by and through the local mental health authority. If the local authority were unable to provide a service, the state could provide it directly.

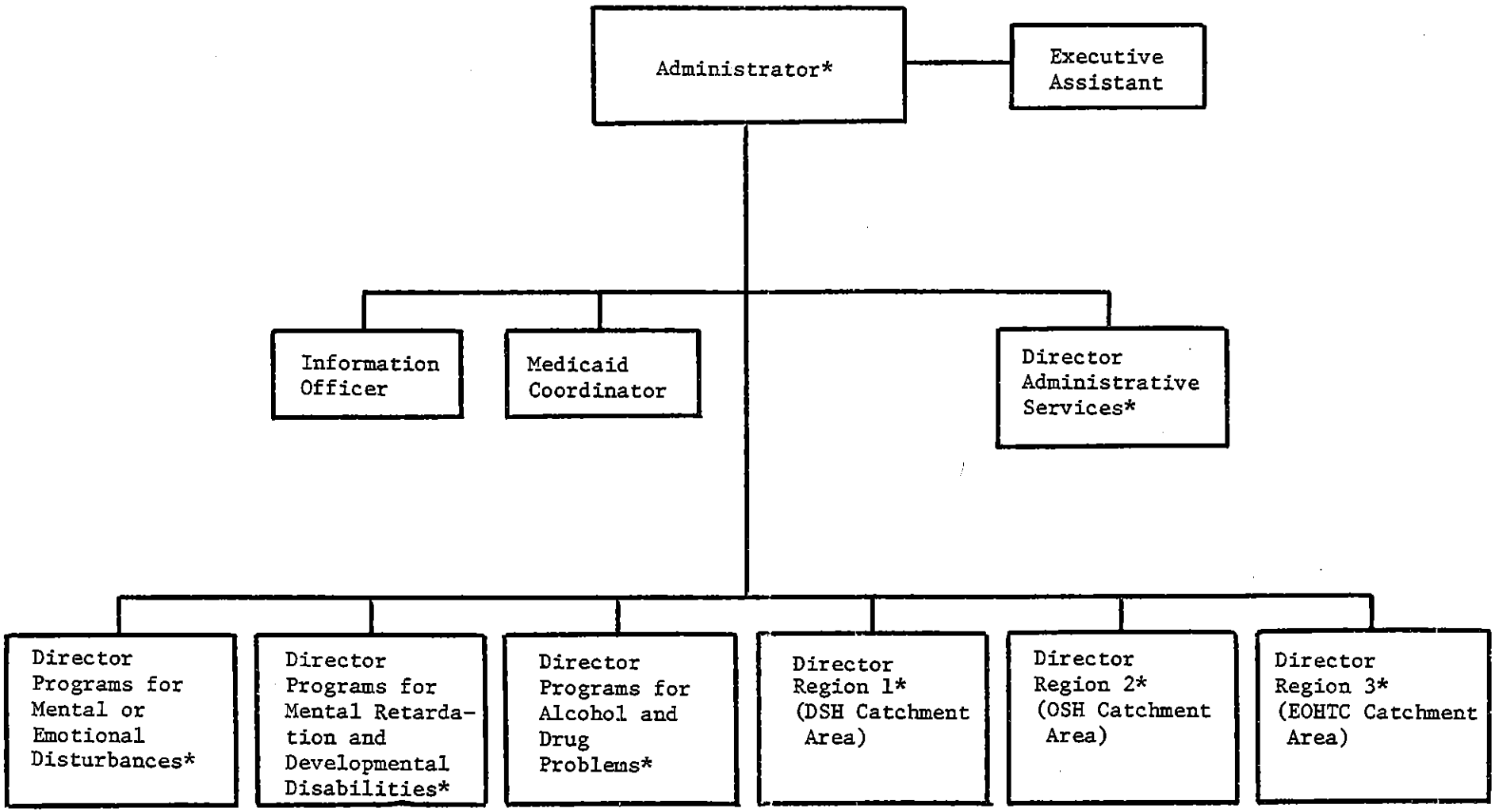
The mental health authority for each service area would be responsible for an annual progress report to the regional director, documenting needs and describing the steps taken to develop comprehensive mental health services within the area, including: (1) outpatient services, (2) inpatient care in general hospitals and state hospitals, (3) partial hospitalization--day, night, or weekend care, (4) intermediate care--halfway houses and group homes, (5) consultation and education, (6) emergency services, (7) continuity of care, and (8) liaison with other local service agencies and organizations.

In addition to defining types of services, the progress report would show how these services relate to the needs of high-risk populations within the area: (1) mentally ill persons (those who have traditionally utilized state hospitals for part of their care), (2) problem drinkers, alcoholics, and their families, (3) drug-abusing persons and their families, (4) mentally retarded individuals and their families, (5) children and youth, (6) minority groups, and (7) others, such as the aged and the poor.

When consistent with the area plan, the local mental health authority would be encouraged to enter into contractual relationships with those public and private organizations and individuals in the community that can give specified elements of services. Whether provided directly or by contract, programs will be expected to have measurable objectives, a clearly defined action plan, and criteria for evaluation for any new programs or services developed. Contractual arrangements would be expected to be as detailed as possible, defining the roles and responsibilities of both parties, and clearly defining lines of supervision. Responsibility for evaluation of subcontracts would rest with the service area authority.

This proposed organization is essential to the orderly development of a Comprehensive Community Mental Health Program for Oregon.

PROPOSED ORGANIZATION OF MENTAL HEALTH DIVISION



*Members of Executive Council

MENTAL HEALTH DIVISION
2570 CENTER STREET N.E.
SALEM, OREGON 97310

J. C. BRAY, M.D. Administrator

for your information...

VOLUME I, No. 1 August, 1973

A WORD FROM THE EDITOR *This publication is designed for employees of the Mental Health Division and others who share an interest in the progress of mental health services in Oregon. Our intent is to report timely information on a variety of things, including what is happening at Central Office, in the hospitals, and in communities throughout the state.*

To be fully successful, FOR YOUR INFORMATION... needs your help. What would you like to see in these pages? What Division activities would you like to know more about? Let us know what's on your mind.

Thanks.

Francis K. Smith, Editor

1973-75 MHD BUDGET HIGHLIGHTS

The 1973 Legislature approved a budget of $85,060,257 for the Mental Health Division for 1973-75 -- the largest in the Division's twelve-year history.

This budget represents an 18 percent increase over the 1971-73 estimated expenditures. The increase amounts to $13 million, almost all of which will come from the state General Fund. A comparison between the two biennia is shown on the insert.

A NEW APPROACH In passing the record budget, the Legislature put its stamp of approval on a new approach to mental health services in Oregon. This new approach, labeled "The Comprehensive Community Mental Health Program", is the result of more than two years of exhaustive planning.

The thrust of the Comprehensive Community Mental Health Program, as expressed in the Division's budget presentation to the Legislature, is to "make appropriate help immediately available at the place of emergence of a problem and to relentlessly search for treatment effectiveness -- the intervention that 'works' by producing real results in the lives of people."

This approach places increasing emphasis on community-based alternatives to hospitalization. Moreover, it embodies a redefinition of the role of the five state hospitals as a part of the Comprehensive Community Mental Health Program. The impact will be felt in every part of the Division's operation and, ultimately, in virtually every community in the state.

MHD REORGANIZATION The 1973-75 budget authorizes reorganization of the Division to ensure effective operation of the Comprehensive Community Mental Health Program. The reorganization became operational on August 1. Under the new arrangement, all of the direct and contract programs are being brought together under three geographic regions. Boundaries of the regions correspond with the catchment areas of the three hospitals for the mentally ill -- Oregon State Hospital, Dammasch State Hospital, and Eastern Oregon Hospital and Training Center.

In addition, three program offices have been established, each having responsibility for program quality and for planning and coordinating state-wide programs in their respective areas of concern -- mental or emotional disturbances, mental retardation and developmental disabilities, and alcohol and drug problems.

COMMUNITY ALTERNATIVES One of the most significant features of the 1973-75 budget is provision of almost two million dollars ($1,984,036) for the continued development of community alternatives to hospitalization. Although the basic community mental health programs will continue on a 50:50 match basis with a 6 percent increase during each fiscal year of the biennium, the Legislature approved 100 percent state funding for the alternatives. Full state funding will permit development of alternatives where they are needed most, rather than only in those locations where local matching funds may be available.

The "alternatives" package includes inpatient hospitalization in local general hospitals; day treatment; Antabuse programs for treating alcohol problems; and community living facilities, work-related activity centers, parent counseling and education, preschool programs, and services coordinators for the mentally retarded and developmentally disabled.

OTHER MR AND DD SERVICES With the approval of the community alternatives, the Legislature strengthened the community-based array of lifespan services for the mentally retarded and developmentally disabled. For the first time, state funds have been made available in support of basic community services. Prior to this time, the only program receiving state funding has been classroom services for the trainable mentally retarded.

As indicated on the insert, classroom services for the trainable mentally retarded received a financial increase to accommodate growth in services from about 1,000 to an estimated 1,300 persons. Funds were also approved to expand the Division's diagnosis and evaluation services, which determine eligibility and develop initial treatment-training plans for persons entering all programs for the mentally retarded and developmentally disabled.

COMMUNITY MENTAL HEALTH CENTERS The Eastern Oregon Community Mental Health Center for which funding was secured during the 1971-73 biennium, was awarded a $3 million budget. Eighty-seven percent of these moneys will come from federal sources.

The Legislature denied a $157,000 request for matching state funds to establish community mental health centers in Jackson-Josephine Counties and Southeast Portland. The action was based on the uncertainty of the availability of federal funding for such centers. However, the door was left open to permit the Division to request the required state matching funds from the Emergency Board, should federal funds become available during the coming biennium.

HOSPITALS Construction of a 150-bed Psychiatric Security Unit at Dammasch State Hospital was approved, with $2,351,920 appropriated for this purpose. Upon completion of the new facility in June 1975, the Psychiatric Security Unit at Oregon State Hospital will be closed and its patients transferred to the new unit.

The Legislature directed that by 1975 the program of Oregon State Hospital be adjusted so that, through transfer of the psychiatric security patients and use of community alternatives to hospitalization, the hospital will become a 250-bed Psychiatric Admissions and Treatment Hospital.

An 80 percent SCOPE staffing level was approved for all five hospitals. Evaluation of SCOPE projects over the past two years has shown this to be the optimal level for satisfaction of the physical care requirements of patients. SCOPE staffing studies in the three hospitals for the mentally ill received an appropriation of $100,000.

The future of the hospitals was the subject of lengthy, and at times heated, debate in the Legislature. The issues raised are currently being reviewed and the consequences of various options are being given careful consideration. Developments will be reported as they occur.

MENTAL HEALTH INFORMATION SYSTEM Funds were approved to develop Phase 2 of the Mental Health Information System (MHIS). Phase 1 was developed during 1971-73. MHIS is designed to collect, process, and report information for use in effective and efficient management of Division programs.

The initial phase of MHIS concentrated on client movement and characteristics data. This phase is now completed and is providing valuable information on how mental health services are being used.

Phase 2 will integrate the client data with Division financial systems and such management tools as SCOPE and TRACK. This phase also includes building additional data processing capabilities into the financial system. An expenditure of $225,000 was approved for these purposes.

An additional $50,000 was approved to begin planning for Phase 3, which will broaden the range of data in the system and provide for new management modules. Implementation of Phase 3 is scheduled for the 1975-77 biennium.

ALCOHOL AND DRUG SERVICES The Legislature affirmed its long-standing interest in making quality services available to Oregon residents with alcohol and drug problems.

A major step forward in alcoholism treatment was approval of $1,374,000 as the state's share in providing 120 detoxification center beds and 267 halfway house beds located throughout the state. These funds will provide one-half of the cost of these facilities. The other half will come from county, city, or private sources. Although not included in HB 5079 (the appropriations measure), authorization to expend these funds became a part of the Division budget following passage of HB 3044.

Similarly, funding for demonstration projects in primary prevention of alcoholism and drug dependency was made possible through passage of HB 2745. The measure appropriates $250,000 to the Emergency Board for allocation to the Division, and authorizes the Division to solicit project proposals and award grants to

individuals or groups whose proposals are consistent with priorities identified by the Division. Wherever possible, local sources will provide supplemental funding.

Two new programs, Alcoholism Services Grants and Drug Abuse Services Grants, will enable the Division to make federal formula funds available to public and private organizations in support of special projects that are in accord with state plans developed by the Division.

The Alcoholism Treatment and Training Center and the Drug Treatment and Training project will be combined into the Alcohol and Drug Treatment and Training Center. An appropriation from the General Fund was made to replace federal funds the Drug Treatment and Training Project received during the past biennium.

The Alcohol Safety Action Program, which has been totally federally funded, will be continued under a one-third state and two-thirds federal funding pattern. A dramatic increase in funding for the Methadone Treatment Program is the result of a new contract with the Office of Economic Opportunity, which makes funds available for vastly expanding the services of the program.

The Division was among several state agencies for which the Legislature followed a new budget appropriation pattern. Although the entire biennial budget was *approved*, only the capital construction budget and slightly more than one-half of the operating budget were *appropriated*. Uncertainty of federal funding was cited as the reason for this new pattern. Appropriations for the remainder of the biennium will be made during the Special Session scheduled for early 1974.

Overall, the Division fared well in the budget process. Funds have been made available to set into motion a number of programs and activities that have been on the drawing board for several years. "This is an action-oriented budget," comments Division Administrator Don Bray. "The immediate task ahead is to translate line items in the budget into action programs."

IN OUR NEXT ISSUE:

* *A look at the reorganized Mental Health Division.*
* *A review of new mental health legislation.*

MENTAL HEALTH DIVISION

2570 CENTER STREET N.E.
SALEM, OREGON 97310

MENTAL HEALTH DIVISION

1971-73 ESTIMATED EXPENDITURES AND 1973-75 APPROVED BUDGET

	1971-73 Estimated Expenditures	1973-75 Approved Budget	Percentage Change
ADMINISTRATION			
Office of the Administrator	$ 295,770	$ 340,300	+ 15%
Program Planning and Development	483,499	812,049[a]	+ 68
Program Administration	510,996	693,258	+ 36
Administrative Services	1,779,617	2,395,569[b]	+ 35
CONTRACT SERVICES			
Community Mental Health Clinics	3,917,292	6,260,487	+ 60
Classroom Services - Trainable Mentally Retarded	1,080,000	1,481,125	+ 37
Developmental Disabilities Services	287,778	574,000	+ 99
ESEA, Title I	334,402	514,476	+ 54
Councils on Alcoholism and Drug Problems	45,416	65,416	+ 44
Alcoholism Detoxification Centers	...	840,000	...
Alcoholism Halfway Houses	...	534,000	...
Alcoholism Services Grants	...	597,616	...
Drug Abuse Services Grants	...	(100,000)[c]	...
STATE-OPERATED SERVICES			
Alcohol and Drug Education	121,161	175,228	+ 45
Alcoholism Treatment and Training Center	223,014	261,800[d]	+ 17
ESEA, Title I	149,784	163,300	+ 9
Drug Treatment and Training Project	539,193	150,325[d]	- 72
Alcohol Safety Action Program	1,929,240	443,118	- 77
Narcotic Addict Rehabilitation Act Program	955,991	991,887	+ 4
Methadone Blockade Treatment Program	226,493	1,007,275	+ 345
Eastern Oregon Community Mental Health Center	1,055,091[e]	3,179,125	+ 201
Diagnosis and Evaluation Services	255,501	284,239	+ 12
Nyssa Multi-Service Center	16,404[e]	47,152	+ 187
Oregon State Hospital	13,445,526	13,730,368	+ 2
Dammasch State Hospital	7,213,910	8,131,953	+ 13
Eastern Oregon Hospital and Training Center	11,663,287	11,775,734	+ 10
Columbia Park Hospital and Training Center	4,353,032	4,480,895	+ 3
Fairview Hospital and Training Center	20,900,518	22,087,972	+ 6
CAPITAL CONSTRUCTION	365,882	3,041,590	+ 731
SUMMARY BY FUND			
General Fund	62,576,030	74,508,253	+ 19
Other Funds	970,501	959,220	- 1
Federal Funds	8,602,266	9,592,784	+ 12
TOTAL	$72,148,797	$85,060,257	+ 18%
MANPOWER			
Authorized Positions	3,084	3,026	- 2
Full-Time Equivalent (FTE) Positions	2,879.2	2,821.5	- 2

[a] Includes $250,000 for primary prevention of alcoholism and drug dependency.
[b] Includes $100,000 for SCOPE projects
[c] Expenditures authorized, but no limitation provided.
[d] Fiscal year 1974 only.
[e] Fiscal year 1973 only.

SUMMARY OF MENTAL HEALTH LEGISLATION

State of Oregon

MENTAL HEALTH DIVISION
Department of Human Resources

J. D. Bray, M.D.
Administrator

October 1, 1973

SUMMARY OF MENTAL HEALTH LEGISLATION

During the Regular Session of the Fifty-seventh Oregon Legislative Assembly, the Mental Health Division followed 299 measures.

Included in this summary are the major Acts relating to mental health--legislative measures introduced at the request of the Division, those to which the staff made substantial contributions, and those that have significant effect on the operations of the Division.

SB 15 Public Meetings

Requires governing body of public body to open all meetings to the public. Defines "meeting." Permits governing body of public body to hold an executive session to consider specified matters. Defines "executive session." Prohibits holding an executive session for purpose of taking any final action or making any final decision.

Requires governing body of public body to give public notice of time and place for holding regular meeting and special meeting and, if an executive session will be held, notice stating specific provision of law authorizing such executive session. Requires governing body to provide for taking of written minutes of all its meetings and to make such minutes available to public. Specifies minimum information to be contained in such minutes.

Authorizes persons to commence suit in circuit court for purpose of requiring compliance with or prevention of violations of this Act. Effective June 27, 1973. (Chapter 172, Oregon Laws 1973)

SB 44 Oregon Safe Employment Act

Revises law relating to occupational safety and health. Enacts Oregon Safe Employment Act. Authorizes Workmen's Compensation Board and its designees to set reasonable, mandatory occupational safety and health standards for conditions and places of employment.

Requires employers to provide healthful place of employment. Authorizes inspection and investigation of place of employment by board in order to determine that occupational safety and

health laws are being complied with. Requires board to issue citation and notice of civil penalty, if any, to employer with reasonable promptness. Effective July 1, 1973. (Chapter 833, Oregon Laws 1973)

SB 48 Marijuana

Authorizes setting aside of certain convictions for possession of marijuana when that crime was punishable as felony only. Effective July 22, 1973. (Chapter 689, Oregon Laws 1973)

SB 73 State Building Code

Authorizes Director of Commerce, with approval of appropriate advisory board, to adopt, publish, and administer building code regulations covering structural standards and standards for mechanical, heating, and ventilating devices and equipment.

Requires director to appoint State Structural Code Advisory Board, consisting of representatives of industries and professions involved in development and construction of buildings and representation from certain agencies, associations, trades, industries, local government governing bodies, and general public. Effective July 22, 1973. (Chapter 834, Oregon Laws 1973)

SB 74 Community Coordinated Child Care Council

Creates Community Coordinated Child Care Council in Children's Services Division of Department of Human Resources. Prescribes duties, functions, and powers of Council, district councils, and division. Prescribes membership and organization of Council and district councils. Effective July 1, 1973. (Chapter 610, Oregon Laws 1973)

SB 80 Criminal Procedure Code

Enacts criminal procedure code. Establishes statutory standards for stopping and investigating suspicious persons by peace officers. Revises arrest and search and seizure procedures.

Amends Uniform Criminal Extradition Act. Repeals existing bail statutes and enacts new criteria for release on recognizance, conditional release, and security release of defendants.

Adopts new provisions relating to pre-trial discovery of evidence. Adopts new provisions relating to grand jury and criminal trial jury. Amends existing statutes relating to

parole, probation, work release, and executive clemency. Makes other substantive and topical changes in criminal law and procedure. Effective January 1, 1974. (Chapter 836, Oregon Laws 1973)

SB 105 Treatment of Alcoholism

Authorizes Mental Health Division to establish treatment program, for eligible persons convicted of driving under influence of alcohol, that involves medical and mental treatment to include at least supplying of agent that causes violent, nauseous physical reaction in human body upon introduction of alcohol into the system.

Requires Division to adopt rules for administration of program. Authorizes Division to accept gifts or grants available to program. Effective July 1, 1973. (Chapter 340, Oregon Laws 1973)

SB 131 Health Facilities Cost Review Commission

Declares policy of state regarding costs of hospitals and other health care facilities. Creates Health Facilities Cost Review Commission in Department of Human Resources to conduct analysis, study, and regulation of health care facilities.

Requires health care facilities to adopt uniform systems of accounting and financial reporting for fiscal periods beginning July 1, 1974. Authorizes Commission to initiate certain review or investigations. Prescribes factors for Commission to consider when determining whether rate charged by health care facility is reasonable. Effective July 1, 1973. (Chapter 837, Oregon Laws 1973)

SB 171 Administrative Procedures

Requires state agency to give notice to persons requesting it in prescribed manner before adopting, amending, or repealing administrative rules. Requires that opportunity for oral hearing be granted certain interested persons upon request. Requires agency to postpone date of its intended action, as specified, upon timely request of an interested person.

Delays effective date of rules, other than certain temporary rules, until ten days after publication in bulletin. Authorizes Secretary of State to omit certain rules from bulletin if bulletin contains notice summarizing omitted rule and notice where it may be obtained. Requires Secretary of State to publish bulletin in at least monthly intervals.

Places jurisdiction for judicial review of agency declaratory rulings in Court of Appeals rather than circuit court. Effective July 21, 1973. (Chapter 612, Oregon Laws 1973)

SB 173 Basic Science Examination

Repeals provisions requiring physicians, chiropractors, naturopaths, and other healing arts practitioners to successfully complete basic science examination to qualify for license.

Requires applicant for license as chiropractor to submit certificate of proficiency in fundamental science issued to him after 1970 by National Board of Chiropractic Examiners. Effective April 18, 1973. (Chapter 31, Oregon Laws 1973)

SB 176 Health Insurance Benefits

Requires insurer offering group health insurnace benefits to offer certain minimum inpatient and outpatient benefits for treating mental or nervous conditions. Applies to health insurance policies issued or renewed after December 31, 1973. Effective October 5, 1973. (Chapter 613, Oregon Laws 1973)

SB 275 Psychologists

Revises law relating to licensing of psychologists. Increases membership on Board of Psychologist Examiners from five to seven. Expands powers and duties of board, including but not limited to establishing standards of training and service and instituting procedures to enjoin unlawful practice.

Requires persons engaging in practice of psychology to be licensed by board. Prescribes qualifications for licenses, licensing procedures, and penalties.

Authorizes issuance of two kinds of licenses, one for applicants having doctoral degrees and another for applicants without doctoral degrees whose practice is limited to designated functions. Effective July 1, 1973. (Chapter 777, Oregon Laws 1973)

SB 298 Psychosurgery Review Board

Creates Psychosurgery Review Board to review, approve, or disapprove petition of licensed physician, institution, or hospital intending to perform psychosurgery or intracranial brain stimulation.

Requires hearing to determine if patient or legal guardian has given voluntary and informed consent to such operation. Prescribes hearing procedure. Requires board, subsequent to consent hearing and prior to approving or disapproving operation, to determine if treatment consented to has clinical merit and is appropriate for such patient.

Requires petitioner and physician performing operation to submit report of operation results to board. Provides for civil liability of person, institution, or hospital performing psychosurgery or intracranial brain stimulation without obtaining permission of board.

Expands grounds for suspension or revocation of license to practice medicine to include psychosurgery or intracranial brain stimulation performed without permission of Psychosurgery Review Board. Effective July 1, 1973. (Chapter 616, Oregon Laws 1973)

SB 314 State Health Commission

Creates State Health Commission. Abolishes State Board of Health and Comprehensive Health Planning Authority. Transfers all duties, powers, and functions of State Board of Health and Comprehensive Health Planning Authority to Commission.

Transfers certain rights and obligations of State Board of Health and Comprehensive Health Planning Authority to Health Division. Effective October 5, 1973. (Chapter 358, Oregon Laws 1973)

SB 383 Medical Experimentation or Research

Prohibits medical, psychiatric, or psychological experimentation or research with inmates in penal or correctional institutions of this state. Defines "medical experimentation or research." Permits inmate to maintain an action to restrain violation of Act or an action to recover damages caused by violation of Act. Effective July 20, 1973. (Chapter 371, Oregon Laws 1973)

SB 407 Guardianships and Conservatorships

Repeals present guardianship and conservatorship provisions. Adopts guardianship and conservatorship provisions of Uniform Probate Code. Provides for appointment of guardians and conservators and prescribes powers and duties. Effective January 1, 1974. (Chapter 823, Oregon Laws 1973)

SB 411 Public Employe Retirement Provisions

Revises public employe retirement provisions. Increases percentage figure in pension computation formula for police officers, firemen, and miscellaneous employes. Provides unreduced benefits for police and firemen at age 55 with 25 years creditable service or age 57 with 20 years creditable service, and for miscellaneous employes at age 60 with 30 years creditable service or age 62 with 25 years creditable service.

Permits employes option of placing up to 75 percent of current contributions in variable annunity program. Increases benefits of present retired members. Establishes minimum benefits for retiree with 15 or more years of membership. Effective July 1, 1973. (Chapter 695, Oregon Laws 1973)

SB 447 Commitment of Sexually Dangerous Persons

Requires that person be advised of his right to legal counsel prior to proceedings for his commitment as sexually dangerous person. Requires that person committed as sexually dangerous be advised of his right to be reexamined and to hearing once every 12 months after original commitment.

Authorizes superintendent of facility to file petition for reexamination and hearing for discharge any time he deems patient no longer sexually dangerous.

Lowers age for voluntary admission without parental consent from 21 years to 18 years for treatment of person in need of treatment as sexually dangerous.

Authorizes superintendent of facility to grant trial visit to patient. Repeals provisions relating to parole of sexually dangerous persons from state institutions. Effective October 5, 1973. (Chapter 443, Oregon Laws 1973)

SB 448 Community Mental Health Programs

Redesignates community mental health clinics as community mental health programs. Adds mentally or emotionally disturbed, developmentally disabled, and drug-dependent persons to those persons required to be served by community mental health programs.

Redefines basic services required of community mental health programs. Requires community health programs to submit an annual plan and progress report and maintain records and submit

other data as required by Mental Health Division. Changes matching fund formula for financing community mental health programs to require that matching formula be 50 percent state funds to 50 percent county funds.

Authorizes Mental Health Division to contract with counties and provide up to 100 percent funding for defined alternatives to state hospital care. Requires counties receiving state funding for alternatives to state hospital care to ensure that their contribution to community mental health programs will not be reduced because of such payments.

Requires that any county funds derived from federal revenue sharing moneys and expended by county for community mental health purposes be considered portion of county's contribution for purpose of determining net amount of county funds expended for purposes of state reimbursement under designated provision. Effective July 1, 1973. (Chapter 639, Oregon Laws 1973)

SB 508 Smoking at Public Meetings

Prohibits smoking at any meeting of any public body. Defines "meeting" and "public body." Provides penalties. Effective June 27, 1973. (Chapter 168, Oregon Laws 1973)

SB 510 Involuntary Commitment of Mentally Ill Persons

Modifies provisions relating to involuntary commitment of mentally ill persons. Defines "mentally ill person." Provides for commitment to Mental Health Division rather than specific state hospital.

Requires probable cause investigation prior to issuing citation. Defines conditions for treatment of persons detained for hearing. Establishes new hearing procedures and expands existing hearing procedures relating to involuntary commitment.

Permits courts to allow mentally ill persons to participate in treatment programs on voluntary basis. Places time limitations on length of commitment. Provides for periodic hearings, upon petition of patient, to determine whether or not person should remain patient in facility.

Requires that patient committed to Division be given statement of rights guaranteed to him and that such statement be posted in certain rooms frequented by patients. Effective July 1, 1974. (Chapter 838, Oregon Laws 1973)

SB 544 Drug Abuse and Dependence

Declares drug dependence to be an illness. Directs Mental Health Division to provide program for prevention of drug abuse and early identification, treatment, and rehabilitation of drug-dependent persons. Provides procedures for treatment of drug-dependent persons; requires arresting officer or person to inform arrestee of his right to and possible consequences of examination for drug use; makes treatment an alternative to criminal prosecution in certain cases; operative July 1, 1974.

Replaces Alcohol and Drug Education Committee with Council on Alcohol and Drug Problems. Divides Council into Committee on Alcohol Problems and Committee on Drug Problems, each composed of at least 12 members. Prescribes membership qualifications, powers, and duties of committees. Effective October 5, 1973. (Chapter 697, Oregon Laws 1973)

SB 614 Emergency Board

Enlarges composition of Emergency Board by six members, five rather than two from Senate and six rather than three from House. Increases from six to ten number of members of board that must be present before certain authorizations are effective. Effective July 6, 1973. (Chapter 201, Oregon Laws 1973)

SB 619 Health Insurance for State Employes

Increases contribution of state to health insurance plan for state employes from $10 to $15 per month. Effective July 1, 1973. (Chapter 225, Oregon Laws 1973)

SB 620 Vacation Benefits

Increases minimum vacation period for state employes by one day per year. Increases maximum vacation accrual from five work weeks to 250 hours of vacation pay. Effective July 1, 1973. (Chapter 471, Oregon Laws 1973)

SB 622 Public Employe Retirement Benefits

Permits public employes to be compensated for their unused sick leave in form of increased retirement benefits. Provides for adjustment to final average salary by addition of monetary value of one-half of accumulated sick leave. Effective July 1, 1973. (Chapter 646, Oregon Laws 1973)

HB 2001 Treatment of Drug Dependence

Revises definitions for certain provisions relating to alcoholics and drug-dependent persons. Declares drug dependence an illness and that drug-dependent person is ill and should be afforded treatment.

Provides for procedure in treatment of person under influence of dangerous or narcotic drugs. Provides for treatment facilities.

Requires Mental Health Division to direct, promote, and coordinate activities and services for alcoholic and drug-dependent persons. Authorizes Division to provide treatment facilities for care of drug-dependent persons and conduct certain other activities related to drug dependence.

Adds to prohibitions against adoption of certain local laws, imposition of sanctions or penalties for certain activities involving use of drugs. Modifies provisions relating to sale of alcohol and dispensers' licenses; effective on approval of constitutional amendment proposed by SJR 11. Effective October 5, 1973. (Chapter 795, Oregon Laws 1973)

HB 2042 Immunization of Minors

Requires immunization of every child five through 14 years of age prior to initial enrollment in any public, private, or parochial school for certain communicable diseases specified by Health Division.

Exempts child where medical certification indicates such immunization would endanger health; or parent or guardian certifies it is against religious beliefs; or parent submits statement that he will arrange for necessary immunization within 30 days. Requires exclusion of children who fail to comply. Effective July 21, 1973. (Chapter 566, Oregon Laws 1973)

HB 2114 Acquittal and Supervised Release
Mental Disease or Defect

Authorizes court, upon acquittal in criminal proceeding of person by reason of mental disease or defect, to release such person on supervision and to appoint any person or state, county, or local agency the court consideres capable of supervising such person on release pursuant to direction of court. Effective October 5, 1973. (Chapter 137, Oregon Laws 1973)

HB 2157 Public Records

Revises law relating to public disclosure by public bodies of public records. Requires public bodies to make public records available to any person, subject to rules that public bodies may adopt to prevent interference with public duties, unless specifically excepted. Provides for exemption of specified public records from disclosure requirement. Authorizes public bodies to establish fees to reimburse actual cost of making public records available.

Authorizes person claiming wrongful withholding of public records to apply, to Attorney General in case of state agency or district attorney in case of any other public body, for order requiring disclosure. Authorizes person claiming wrongful withholding of public records by elected official to institute proceedings for injunctive or declaratory relief in circuit court. Provides that aggrieved applicants or public bodies may obtain court review with early hearing on issue of whether public records should be disclosed. Requires award of attorney fees to successful applicants.

Modifies or repeals certain provisions relating to public records and their disclosure. Effective July 1, 1973. (Chapter 794, Oregon Laws 1973)

HB 2223 Political Activity Notices

Requires public employer to post notice informing public employes of their status under state law with regard to engaging in political activity. Effective October 5, 1973. (Chapter 53, Oregon Laws 1973)

HB 2243 Prescriptions

Requires that pharmacists dispensing prescriptions label prescriptions. Requires that prescriptions label contain directions for use of drug or medicine, name of physician, name and place of business of pharmacy or pharmacists, name of patient or owner of animal and, if applicable, expiration date.

Requires that label contain name of drug or medicine and its quantity per unit unless physician otherwise directs. Provides that if drug or medicine is compound, quantity per unit need not be stated.

Requires State Board of Pharmacy to determine drugs and medicines that must bear expiration date. Effective October 5, 1973. (Chapter 533, Oregon Laws 1973)

HB 2258 Habitual Traffic Offenders Act

Enacts Habitual Traffic Offenders Act whereby person having specified number of certain kinds of convictions involving motor vehicles, within five-year period, may be declared to be "habitual offender" and ordered not to drive for ten years.

Establishes certain procedures. Provides for hearing before court and appeal from any final action or order. Authorizes court to restore driving privilege after expiration of ten years. Prohibits driving contrary to order.

Permits issuance of one-year renewable probationary license to habitual offender under certain conditions. Provides penalties. Effective October 5, 1973. (Chapter 301, Oregon Laws 1973)

HB 2263 Collective Bargaining

Revises law relating to collective bargaining for public employes. Exempts from definition of "public employe," elected officials, persons appointed to boards or commissions, confidential employes, and supervisory employes.

Establishes collective bargaining rights and standard collective bargaining procedures for public employes. Makes collective bargaining mandatory for public employers and public employes. Provides for certification of labor organizations as exclusive representative of public employe groups.

Eliminates prohibition against public employe strikes, except for policeman, fireman, and guard at correctional institution or mental hospital and in other specified instances. Provides for binding arbitration in cases where right of employes to strike is prohibited by law.

Specifies procedures for resolution of labor disputes, including procedures for compulsory arbitration and right to equitable relief against strikes which present clear and present danger to public health, safety, and welfare. Requires such equitable relief to include order that labor dispute be submitted to binding arbitration.

Specifies powers, duties, number, and terms of members of Public Employe Relations Board. Effective October 5, 1973. (Chapter 536, Oregon Laws 1973)

HB 2275 Traffic Safety

Requires courts to impose sentence of imprisonment upon conviction of any person for driving with .15 percent or more by weight of alcohol in his blood with certain exceptions. Provides for enhanced penalty for each subsequent conviction. Permits imposition of fine of not more than $2,000 in addition to imprisonment. Prohibits court from suspending imposition or execution of sentence or from granting probation or parole.

Provides procedures by which a person whose license has been suspended for driving while intoxicated or under the influence of dangerous or narcotic drugs may obtain an occupational driver's license if person enrolls in approved rehabilitation program and if such reinstatement and rehabilitation are recommended by the Mental Health Division. Effective July 22, 1973. (Chapter 798, Oregon Laws 1973)

HB 2430 Relatives' Responsibility

Eliminates relatives' responsibility for cost of care of institutionalized relatives. Provides for continued liability for amounts due prior to effective date of Act. Effective October 5, 1973. (Chapter 546, Oregon Laws 1973)

HB 2444 Special Education for Handicapped Children

Requires schools to provide education for certain children unable to attend school unless such children are receiving instruction in state or regional facility or institution. Repeals provisions that mentally retarded children may be permanently excluded from public schools.

Requires that administrative officers of school districts consult with parents and staff of certain agencies and organizations before handicapped children are placed in special education programs.

Requires district school board to conduct surveys of educational and other needs of children not in school and report results to Department of Education on or before July 1, 1974. Effective October 5, 1973. (Chapter 728, Oregon Laws 1973)

HB 2455 Child Development Specialists

Authorizes school districts operating elementary schools to offer services of child development specialist on or before

July 1, 1977. Provides for reimbursement to school districts. Requires State Board of Education to establish guidelines. Effective July 1, 1973. (Chapter 730, Oregon Laws 1973)

HB 2649 Flexibility in Hospital Care of Mentally Retarded

Entitles mentally deficient persons to admission at Mental Health Division facility for day care, respite care, crisis intervention, and part-time care upon application to Division pursuant to its rules and regulations.

Prescribes manner for establishing, charging, and collecting cost of such care. Effective July 1, 1973. (Chapter 262, Oregon Laws 1973)

HB 2654 Hospital Records

Establishes procedure whereby hospital records may be admitted into evidence by means of copy submitted with custodian's affidavit in proceedings where testimony may be compelled. Provides that use of prescribed statement in subpena duces tecum requires personal attendance of custodian and production of original hospital records. Effective October 5, 1973. (Chapter 263, Oregon Laws 1973)

HB 2667 Capitol Planning Commission

Prescribes membership of Capitol Planning Commission and increases number of members from seven to nine. Modifies authority of Department of General Services to construct and improve state buildings. Requires approval of Commission of all state agency proposals to alter, construct, or site certain state buildings. Makes authority of any state agency to spend money for certain construction or improvement projects subject to approval of Commission.

Requires that each state agency, including Department of General Services, submit its anticipated capital construction requirements for review by Commission. Requires that recommendations of Commission regarding capital construction proposals be included in Governor's budget report.

Requires that state agency, having proposed capital construction or improvement project approved by Commission, request department to employ consultants to prepare preliminary plans and supporting documents for submission by state agency to Legislative Assembly. Effective June 11, 1973. (Chapter 129, Oregon Laws 1973)

HB 2745 Prevention of Alcoholism and Drug Dependence

Declares policy to prevent alcoholism and drug dependence and prescribes duties of Mental Health Division to carry out objectives of Act. Requires Division to award and distribute moneys for prevention programs. Establishes procedures for grants.

Appropriates $250,000 from General Fund to Emergency Board for biennium beginning July 1, 1973, for allocation to Division for implementing programs. Effective July 1, 1973. (Chapter 582, Oregon Laws 1973)

HB 2775 Nurses

Revises licensing laws for registered and practical nurses. Revises membership on Oregon State Board of Nursing. Authorizes civil penalty of not more than $100 for violation of nursing law or rules. Revises fee schedule. Deletes non-practicing list. Gives limited renewal rights to nurses on nonpracticing list.

Expands definition of "practice of nursing." Creates Continuing Education for Nurses Funds. Provides for credit of certain moneys to fund including up to 25 percent of licensing and renewal fees. Effective July 12, 1973. (Chapter 584, Oregon Laws 1973)

HB 2814 Competency Determination of Mentally Retarded by Court Action

Establishes hearing procedure for determining competency or incompetency of persons being treated for mental deficiency in state treatment facilities. Effective July 1, 1973. (Chapter 585, Oregon Laws 1973)

HB 2815 Voluntary Admission of Adult Mentally Retarded

Permits Mental Health Division to accept mentally deficient persons who are over 21 years of age, as well as mentally deficient minors, for treatment as voluntary patients in its treatment facilities. Establishes admission procedures for mentally deficient persons. Effective July 1, 1973. (Chapter 277, Oregon Laws 1973)

HB 2816 Confidentiality of Patient Records

Limits inspection of medical records of patients of any Mental Health Division facility or community mental health program

and medical records of inmates of any state correctional institution. Provides penalties. Effective July 1, 1973. (Chapter 736, Oregon Laws 1973)

HB 2936 Marijuana

Reduces classification of crime of possession of less than one avoirdupois ounce of marijuana to violation punishable by fine of not more than $100. Reduces crime of criminal use of drugs, where use is of marijuana, to violation punishable by fine of not more than $100.

Expands provision permitting records to be sealed and conviction set aside to include a conviction of violation. Effective October 5, 1973. (Chapter 680, Oregon Laws 1973)

HB 2979 Cost of Care of Persons in State Institutions

Changes method of determination and review of liability for cost of care of persons in state institutions. Removes review of intial determination from probate court to Department of Revenue and establishes hearing procedure. Provides for review of hearing order by circuit court. Establishes warrant and judgment procedure for collection of unpaid charges.

Places responsibility for establishing reimbursement rates in Mental Health Division. Effective July 22, 1973. (Chapter 806, Oregon Laws 1973)

HB 3003 Pharmacy

Defines "inaptient care facility" and expands definition of "consulting pharmacist" and "drug room." Requires that drug room of inpatient care facility other than hospital to contain only prescribed drugs already prepared for patients therein and emergency drug supply authorized by Health Division. Effective October 5, 1973. (Chapter 743, Oregon Laws 1973)

HB 3005 Health Care Facilities

Modifies provisions relating to health care facilities. Defines "health care facility."

Extends coverage of certificate of need process to long-term care facilities and special inpatient care facilities. Requires health care facilities to obtain certificate of need from State Health Commission prior to construction, expansion, or alteration of facilities. Effective October 5, 1973. (Chapter 840, Oregon Laws 1973)

HB 3044 Detoxification Centers and Halfway Houses

Revises definitions for certain provisions relating to alcoholics and drug-dependent persons. Permits Mental Health Division to grant funds under specified conditions to cities and counties, or any combination thereof, for alcoholism treatment and rehabilitation programs, including but not limited to approved detoxification centers and halfway houses. Grants rule making authority to division.

Provides that grants be made under matching fund agreements. Permits cities and counties to contract with private nonprofit agencies for alcoholism treatment and rehabilitation or to jointly provide such services by agreement. Requires division to recommend fee schedules. Provides that fee schedules as approved by division delimit liability of persons admitted to approved detoxification centers and halfway houses.

Appropriates $687,000 from General Fund for fiscal year beginning July 1, 1973, for purpose of state matching funds to defray costs of detoxification centers and halfway houses. Effective July 1, 1973. (Chapter 682, Oregon Laws 1973)

HB 3048 Appointing Authority in Mental Health Division Facilities

Confers authority on Administrator of Mental Health Division or his designees to appoint, suspend, or discharge employes of Division, and to appoint chief medical officers for Division hospitals. Repeals provision relating to appointment of subordinates within Mental Health Division by Administrator. Effective July 1, 1973. (Chapter 807, Oregon Laws 1973)

HB 3049 Appointment of Administrator of Mental Health Division

Deletes reference to provision that has been repealed and substitutes designated provision as authority for appointment of an Administrator of Mental Health Division. Effective October 5, 1973. (Chapter 247, Oregon Laws 1973)

HB 3056 Group Care Homes

Revises provisions providing for regulation and licensing of group care homes. Redefines group care home. Establishes fee schedule for group care home licenses.

Requires that Health Division cooperate with other divisions of Department of Human Resources and State Department of

Education in promulgation of rules for group care homes. Effective October 5, 1973. (Chapter 285, Oregon Laws 1973)

HB 3067 Voucher Approval
Mental Health Division Hospitals

Permits Administrator of Mental Health Division to delegate authority to other persons to approve claims for supplies or materials furnished or services rendered to Division hospitals. Effective July 1, 1973. (Chapter 248, Oregon Laws 1973)

HB 3068 State Crematories

Repeals provision permitting use of state crematories. Effective October 5, 1973. (Chapter 286, Oregon Laws 1973)

HB 3167 Age of Majority

Lowers certain statutory age requirements and limitations from 25, 21, or 19 to 18 or 19 years of age.

Revises provisions relating to support rights and obligations; provides for support or maintenance of child attending school; provides that child is party for purposes of certain matters related to such support or maintenance.

Defines "child" or "juvenile" as an individual under 21 years of age for purposes of certain provisions relating to child welfare services. Makes transitional provisions relating to effect of Act in regard to certain matters. Effective October 5, 1973. (Chapter 827, Oregon Laws 1973)

HB 3238 Homes for Aged

Revises provisions providing for regulation and licensing of homes for aged. Renames and redefines "home" to "home for aged" or "shelter care home" or "home." Defines "personal services" and "nursing care."

Requires transfer to an appropriate facility of resident of shelter care home who has required nursing care for eight consecutive days and licensed physician or registered nurse certifies such resident requires further nursing care.

Prescribes procedures for denial, suspension, or revocation of license of shelter care home. Effective October 5, 1973. (Chapter 754, Oregon Laws 1973)

HB 5079 Mental Health Division Appropriations

Appropriates $34,704,259 from General Fund to Mental Health Division of Department of Human Resources for designated fiscal expenses.

Limits designated fiscal expenditures from miscellaneous receipts received by Mental Health Division to $479,147. Limits designated fiscal expenditures from federal funds received by Mental Health Division to $5,404,598.

Appropriates $100,000 from General Fund to Emergency Board for allocation to Mental Health Division for testing new approaches to mental hospital staffing.

Appropriates $3,041,590 from General Fund to Mental Health Division for designated capital construction projects.

Authorizes Mental Health Division to transfer $11,809 of designated appropriation and $72,000 of designated appropriation for expenses of Fairview Hospital and Training Center for biennium ending June 30, 1973, and to transfer $6,639 of designated appropriation for building safety improvements for biennium ending June 30, 1973. Effective July 1, 1973. (Chapter 324, Oregon Laws 1973)

HCR 8 Rights of Mentally Retarded and Other Developmentally Disabled Persons

Declares rights of mentally retarded and other developmentally disabled persons concerning opportunities for normalization.

HJR 31 Job Classifications and Qualifications

Directs Personnel Division of State Executive Department to review job classifications, qualifications requirements, and tests in classified and nonacademic unclassified services and revise them or remove from them any elements that perpetuate arbitrary barriers to fair and equal employment or that tend to discriminate unfairly between persons on basis of race, religion, national origin, cultural background, or sex.

Requires quarterly report to President and Speaker and report to next Legislative Assembly.

MENTAL HEALTH PROGRAMS IN OREGON TODAY

State of Oregon

MENTAL HEALTH DIVISION

J. D. Bray, M.D.
Administrator

February 1, 1973

CONTENTS

BACKGROUND

The Mental Health Division was created by action of the Fifty-first Legislative Assembly in 1961 and became operational on July 1, 1962. At that time, supervision, management, and administration of Oregon State Hospital, F. H. Dammasch State Hospital, Eastern Oregon Hospital and Training Center, Fairview Hospital and Training Center, and Columbia Park Hospital and Training Center were vested in an administrator appointed by, and responsible to the Oregon State Board of Control.

On July 1, 1969, the Mental Health Division became a separate agency of state government under the office of the Governor. This change was one of the results of legislative action reorganizing state government and abolishing the State Board of Control. On that date, the duties and responsibilities of the Board of Control relating to mental health were transferred to the administrator of the Mental Health Division. The administrator became an officer appointed by the Governor and confirmed by the Senate.

With the creation of the Department of Human Resources on July 1, 1971, the Mental Health Division became a division of that Department.

The administrator of the Division is appointed by the director of the Department of Human Resources with the approval of the Governor. He is ultimately responsible for all the prevention, treatment, and restoration programs of the Division and is charged with the care and treatment of more than 4,000 hospitalized persons and thousands of others in community programs.

Statutory authority for Division functions derives primarily from chapters 161, 167, 179, 184, 426, 427, 428, 430, and 475 of the Oregon Revised Statutes.

Three statutory advisory boards and committees assist the Division: Mental Health Advisory Board (ORS 430.050), Oregon Alcohol and Drug Education Council (ORS 430.100), and Drug Addiction Advisory Committee, known as the Methadone Advisory Committee, (ORS 430.107).

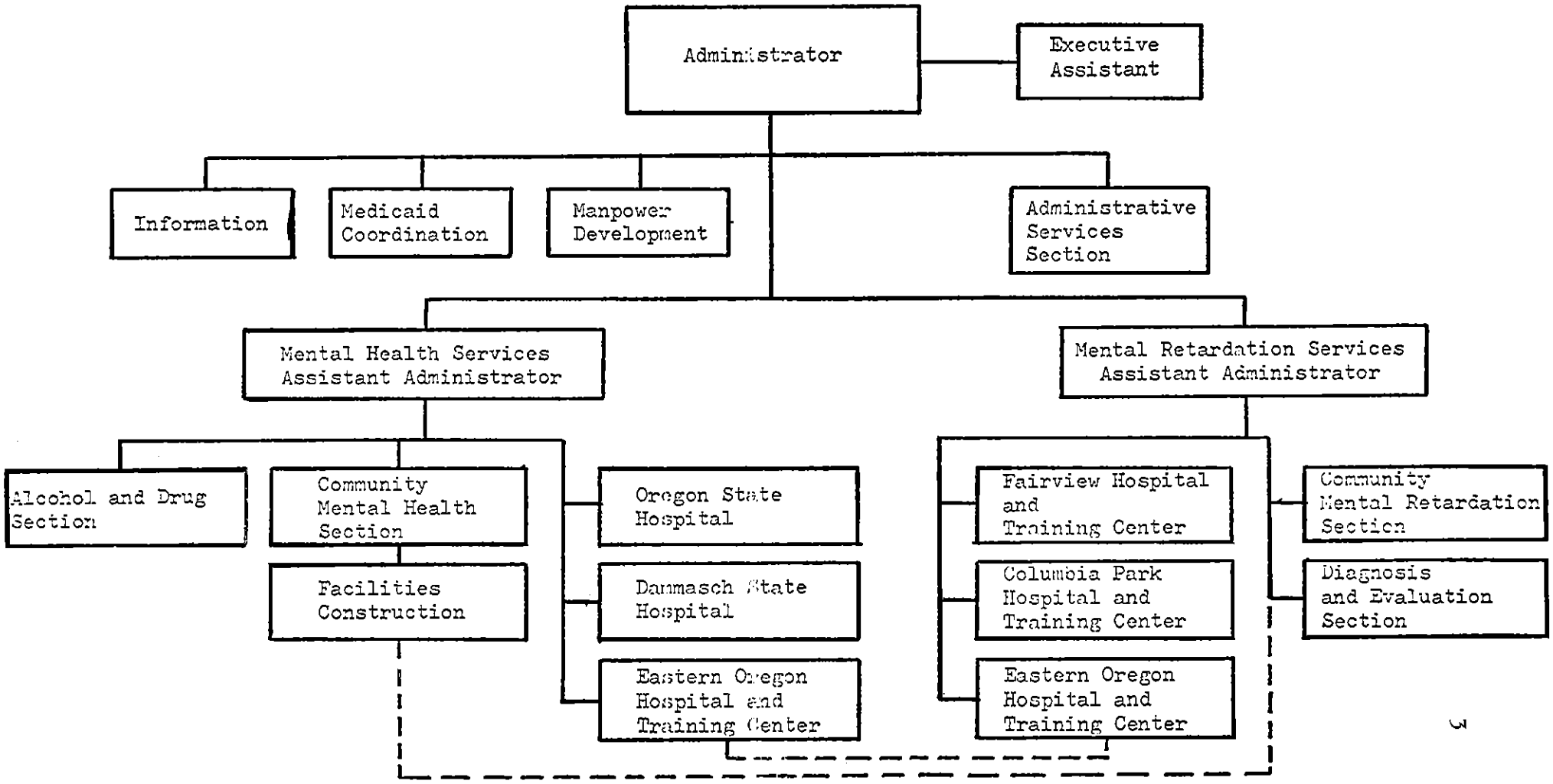
The goal of the Mental Health Division is to reduce the incidence and negative consequences of mental illness, mental retardation and other developmental disabilities, alcoholism, and drug abuse. Implicit in this goal is the need to place emphasis on three major activities: prevention, treatment, and rehabilitation.

The Division administers hospital and community programs for the mentally ill, mentally retarded and other developmentally disabled persons, and alcohol and drug programs. These programs are discussed in detail in the following pages.

The organizational structure for delivering these services is depicted in Illustration 1.

Illustration 1

Mental Health Division
Organization Chart



EXTENT OF MENTAL HEALTH PROBLEMS IN OREGON

Mental Illness

There are few families that are not seriously affected by mental and emotional disturbance as manifested by depression or anxiety, psychosis, severe family conflict or disruption, behavior problems in children, alienation, poor self-image and self-esteem, mental confusion, or poor judgment.

The Baltimore Study, a recognized guide, estimates that 10.86 percent of the non-institutionalized population suffers some degree of diagnosable mental illness. In Oregon, this represents 236,330 persons, based on a July 1, 1972, total population of 2,183,270, of which an estimated 2,176,170 were non-institutionalized. The Baltimore Study also provides a breakdown, by age groups, of the non-institutionalized normal population and the mentally ill population. The following table and Illustration 2 compare this breakdown by number and percentage distribution.

Estimated Non-Institutionalized Mentally Ill Population

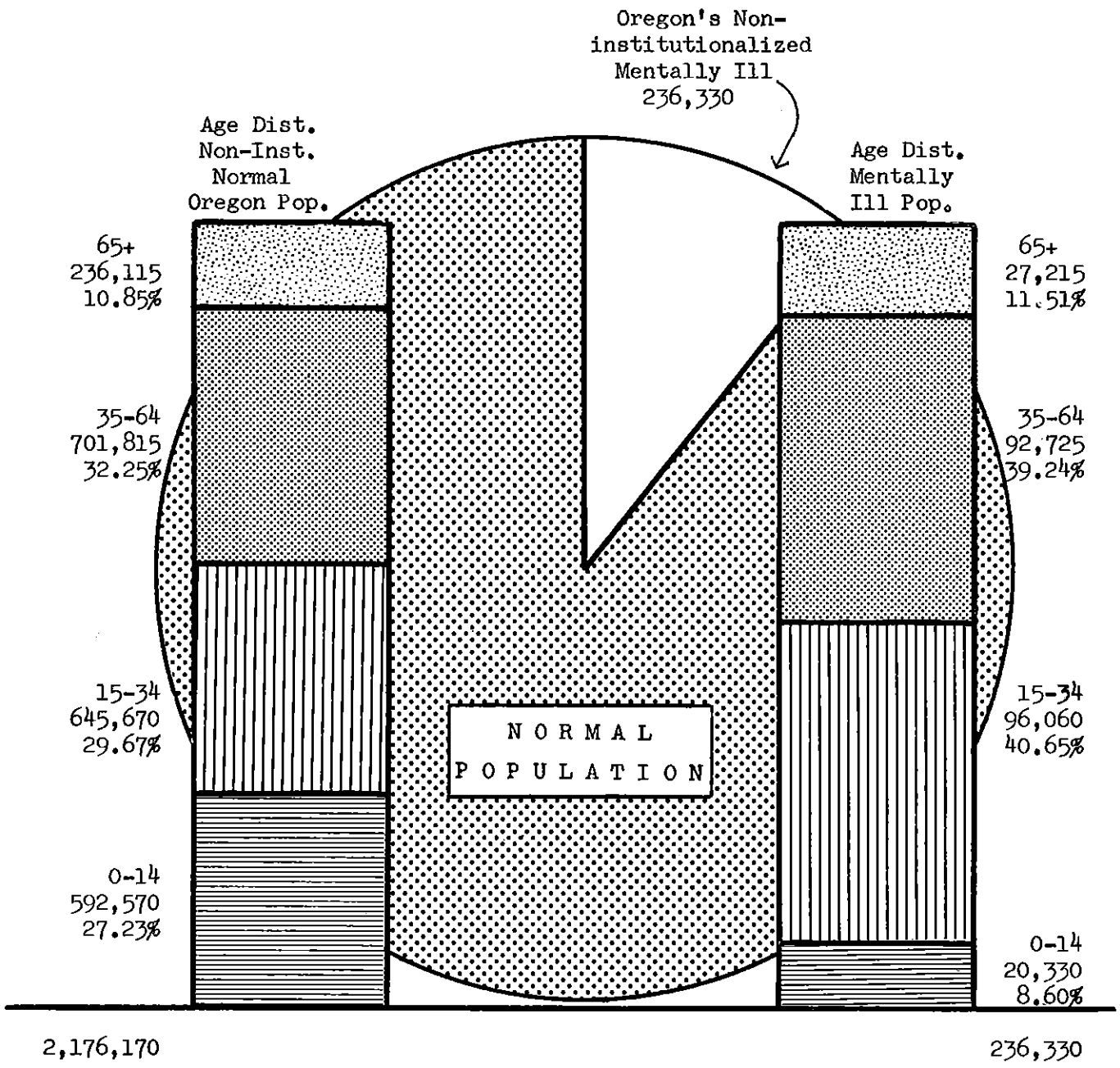
Age Group	1972 Estimated Non-Institutional Population		Estimated Non-Institutional Mentally Ill Population		
	Percent	Number	Age Group Percent	Number M. I.	Percent Dist.
0 - 14	27.23	592,570	3.43	20,330	8.60
15 - 34	29.67	645,670	14.88	96,060	40.65
35 - 64	32.25	701,815	13.21	92,725	39.24
65 and Over	10.85	236,115	11.53	27,215	11.51
Total	100.00	2,176,170	10.86	236,330	100.00

Mental Retardation and Developmental Disabilities

The term "developmental disability" refers to a disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition closely related to mental retardation or requiring treatment

Illustration 2

Prevalence of Mental Health Problems in Oregon
1972



Oregon's Total Population - 2,183,270

similar to that required for mentally retarded individuals. These are disabilities which originate before the person attains age 18, which can be expected to continue indefinitely, and which constitute a substantial handicap to the persons.

Mental retardation is the most handicapping of all childhood disorders. National studies indicate that approximately 3 percent of the population will at some time during their lifetime be identified as mentally retarded. It is estimated that there are 39,675 mentally retarded persons in Oregon. This total is broken down, by age groups and level of retardation, in the following table and Illustration 3 on page 7.

Estimated Mentally Retarded Population

Age Group	1972 Population Distribution Percent	1972 Population Distribution Number	Percent of Prevalence	Estimated Total Mentally Retarded
0 - 5	9.5	207,410	0.5	1,035
6 - 19	27.5	600,400	3.0	18,010
20 and Over	63.0	1,375,460	1.5	20,630
Total	100.0	2,183,270		39,675

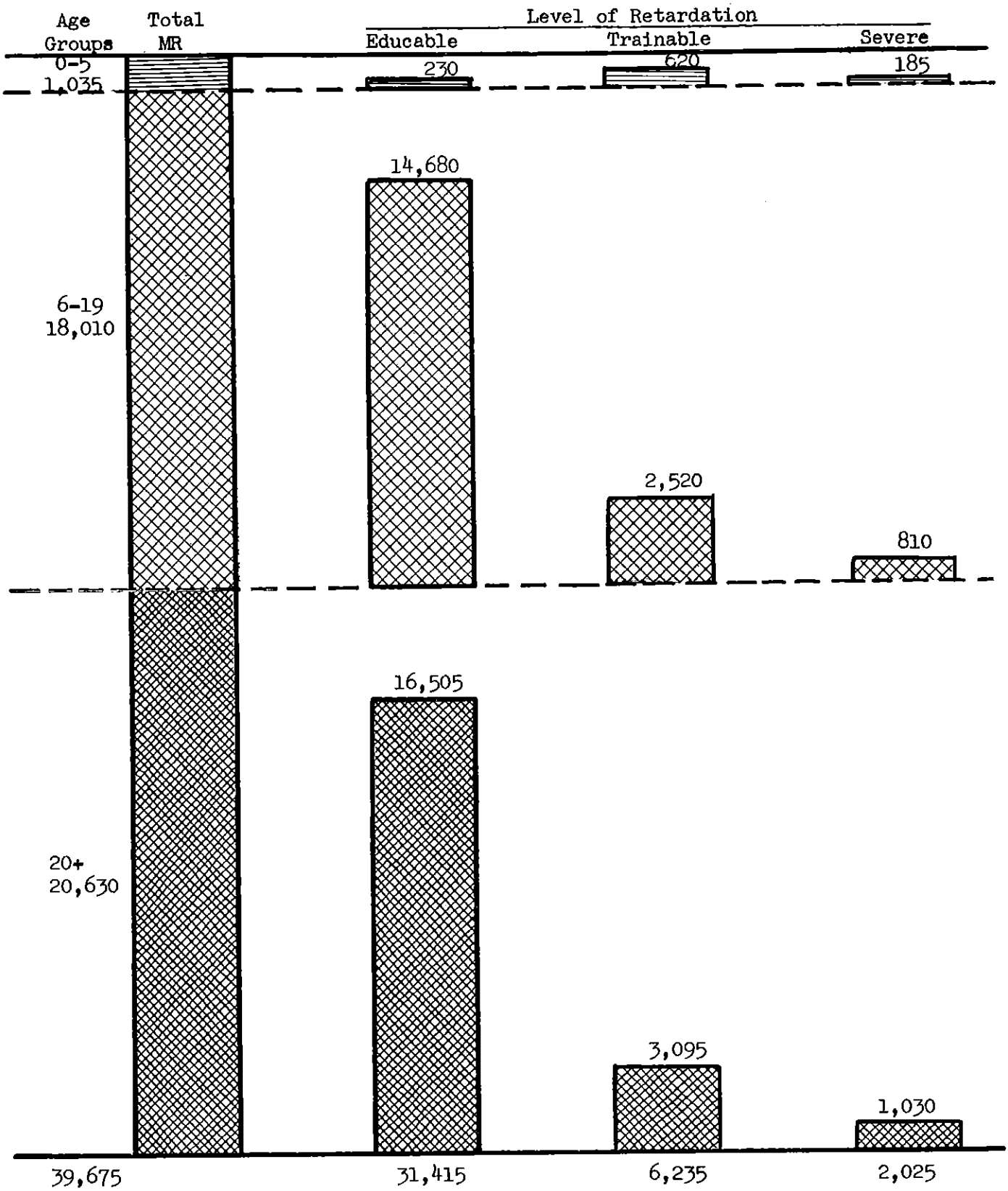
Level of Retardation

Age Group	Educable Percent	Educable Number	Trainable Percent	Trainable Number	Severe and Profound Percent	Severe and Profound Number
0 - 5	22.0	230	60.0	620	18.0	185
6 - 19	81.5	14,680	14.0	2,520	4.5	810
20 and Over	80.0	16,505	15.0	3,095	5.0	1,030
Total		31,415		6,235		2,025

In addition, there are more than 16,000 persons in Oregon with a developmental disability other than mental retardation, according to the State Plan for Developmental Disabilities prepared by the Office of Comprehensive Health Planning.

Illustration 3

Estimated Number of Mentally Retarded Persons in Oregon
By Age Groups and Level of Retardation
1972



Alcohol and Drug Problems

Every Oregonian is affected, either directly or indirectly, by the negative results of alcohol or other drug abuse.

Those families in which a member is an alcoholic or drug abuser feel these effects most keenly, as they experience daily the agonies brought about by these afflictions. Moreover, no Oregonian is immune from the possible hazards of being involved in a traffic accident caused by a drunken driver, or being the victim of a mugging or burglary by an addict seeking money to maintain his expensive drug habit. All Oregon citizens share in the overwhelming cost society is forced to pay in terms of dollars, social disruption, and human suffering.

Current estimates indicate that there are 66,236 alcoholics in Oregon, 20 years of age and over (according to the Jellinek formula based on deaths from cirrhosis of the liver). This represents about 5 percent of the total population in that age group. About half of all traffic fatalities are alcohol-related. Eleven percent of mental health clinic patients seen during 1971 had alcohol-related problems. During that same year, 21.8 percent of admissions to the three state hospitals for the mentally ill were diagnosed as alcoholics or problem drinkers. In Multnomah County, 27 percent of all adult arrests during 1971 were for drunkenness, and an additional 13.5 percent were for drunk driving. Alcoholism is clearly the major drug problem in Oregon.

It is more difficult to estimate the number of Oregonians who abuse or are dependent on other drugs. However, police and treatment personnel estimate that there are approximately 1,500 persons in Oregon addicted to heroin, and that it costs a heroin addict $15,000 per year to support his or her habit, usually by burglary, auto theft, armed robbery, prostitution, dealing in drugs, and other criminal activity.

The Legislative Interim Committee on Alcohol and Drugs has estimated that at least 50,000 Oregonians over the age of 18 years are abusing amphetamines and barbiturates; and another 25,000 use LSD, mescaline, and other potent hallucinogens. About 250,000 Oregon adults and 25 to 65 percent of all high school students have used marihuana. Many others are dependent on legally obtained sedatives and tranquilizers.

PROGRAMS FOR THE MENTALLY ILL

Services for the mentally ill are provided through three state hospitals, community mental health clinics, sub-contract programs, and federally assisted community mental health centers.

The hospitals provide a full range of psychiatric services, while the clinics and sub-contract programs provide a variety of outpatient diagnosis and treatment services to children, families, and adults; aftercare for persons discharged from state hospitals; public education; and consultation to community agencies and related professions. The community mental health centers provide local inpatient, part-day, outpatient, and emergency services, as well as consultation and education for the total population of their service area.

Hospitals for the Mentally Ill

The Mental Health Division has respnsibility for the administration of three hospitals serving the mentally ill. Each hospital serves a designated geographic "catchment area", as depicted in Illustration 4.

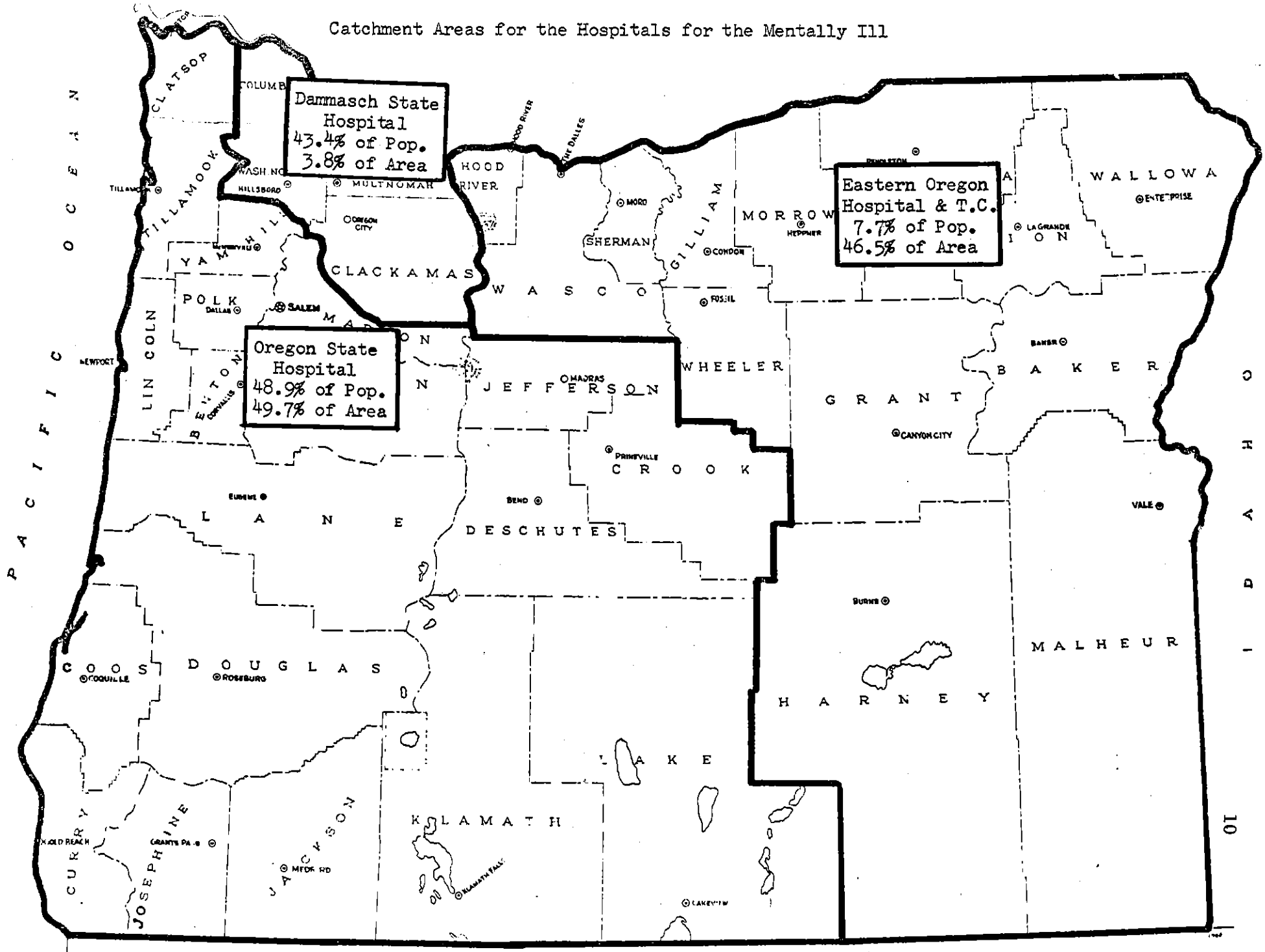
The average state hospital population has been declining steadily during the past several years, primarily because of reduction in number of long-term and elderly patients. In spite of this decline, admission and readmission rates remain high. On June 30, 1972, the population of the three state hospitals for the mentally ill was 1,468, compared to 1,874 on June 30, 1970. During fiscal year 1971-72, there were 4,765 admissions to these hospitals. Thirty-eight percent of the persons admitted represent readmissions.

1. Oregon State Hospital

   Oregon State Hospital has provided care for the mentally ill since 1883. Acute psychiatric treatment is available to persons from Crook, Deschutes, Jefferson, Klamath, and Lake counties; and from all counties west of the Cascade Mountains, except Clackamas, Columbia, Multnomah, and Washington counties. This represents 48.9 percent of the population and 49.7 percent of the area of Oregon. Patients may be admitted by voluntary application or court commitment.

Illustration 4

Catchment Areas for the Hospitals for the Mentally Ill



Special services include care of the elderly and infirm and the psychiatric security unit, the only one in Oregon.

Average daily population is estimated at 661 for 1972-73.

2. F. H. Dammasch State Hospital

Dammasch State Hospital, opened in 1961, provides acute psychiatric hospital care for persons from Clackamas, Columbia, Multnomah, and Washington counties. This represents 43.4 percent of the population and 3.8 percent of the area of Oregon. Patients may be admitted by voluntary application or court commitment.

Average daily population is estimated at 410 for 1972-73.

3. Eastern Oregon Hospital and Training Center

Established in 1913, Eastern Oregon Hospital and Training Center provides acute psychiatric care for persons from all Eastern Oregon counties except Crook, Deschutes, Jefferson, Klamath, and Lake counties. This represents 7.7 percent of the population and 46.5 percent of the area of Oregon. Admission is by voluntary application or court commitment. The Hospital also provides care for mentally retarded persons requiring long-term hospital care.

Average daily population for mentally ill patients is estimated at 356 for 1972-73.

Detailed statistical tables and illustrations of the average daily populations of the hospitals for the mentally ill are included in the Appendix.

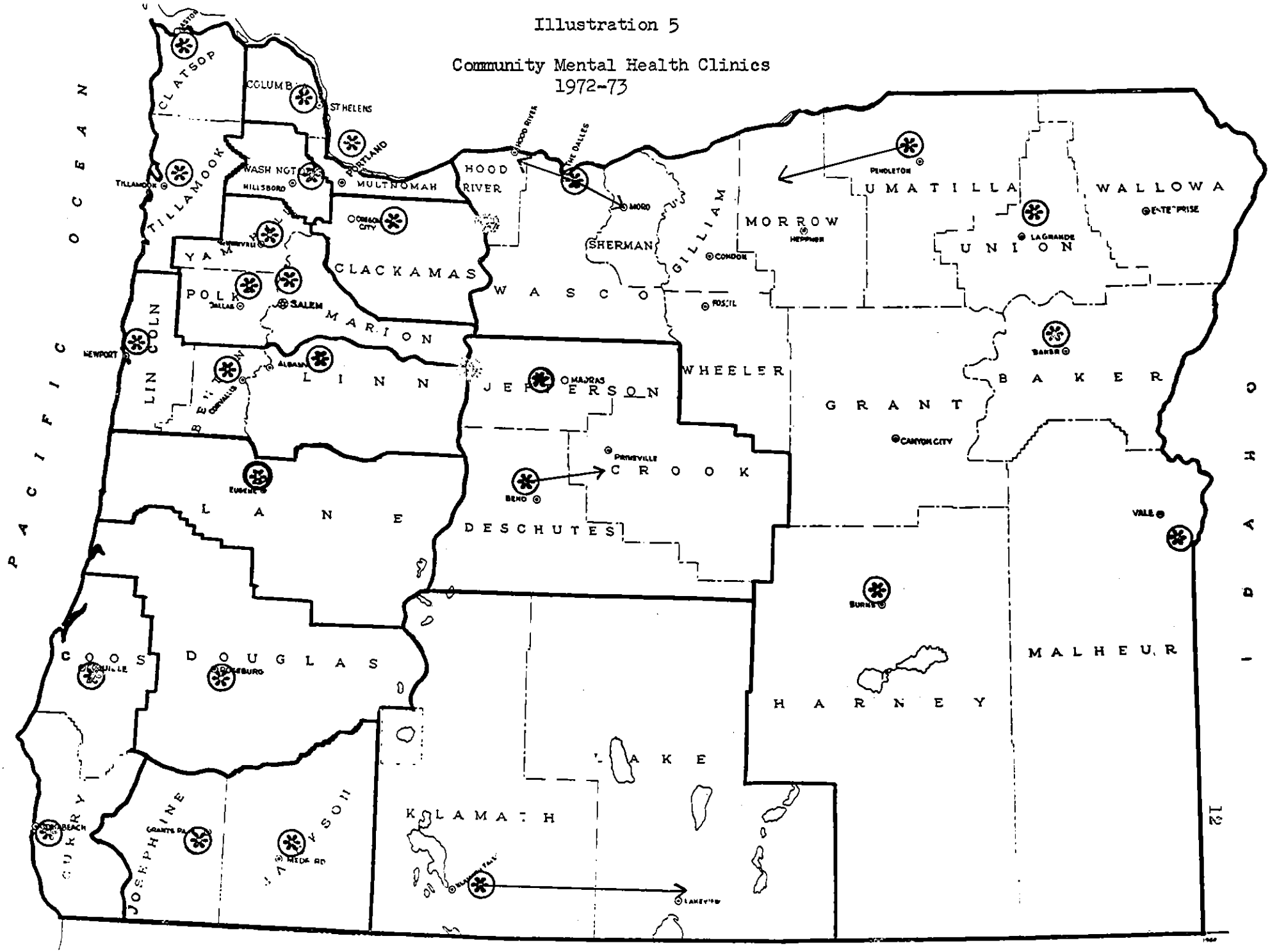
Community Mental Health Programs

When the Mental Health Division was established in 1962, there were community mental health clinics in only eleven Oregon counties. All of the clinics were small (one to two full-time staff persons), and program emphasis was on child guidance.

Today, all of the state's 36 counties have mental health services. A total of 27 locally administered programs (clinics) serve the populations of 32 counties, as depicted in Illustration 5. The remaining four counties (Gilliam, Grant, Wallowa, and Wheeler) receive consultation and some direct service through a state-administered program.

Illustration 5

Community Mental Health Clinics
1972-73



During fiscal year 1970-71 there were 11,486 first admissions and 1,406 readmissions to these community mental health programs. Of this number, 4,016 were children. These figures are shown in Table 1 on page 14.

The total number of persons served during fiscal year 1970-71 was 22,633, of whom 7,000 were children. This total includes those persons cited above and those whose cases were open at the beginning of the fiscal year.

In general, all of the community mental health programs offer child guidance, family and marriage counseling, adult outpatient care, and aftercare. All mental health clinics offer consultation to other community agencies and public information services to the community at large. They work with a broad range of people, including alcoholics, drug abusers, and the mentally retarded.

In addition to these mental health programs, four counties contract with 17 local private, non-profit agencies for the following services (some of the agencies provide more than one service):

5 child and family guidance centers
4 alcohol recovery houses
3 halfway houses for the mentally ill
1 halfway house for the mentally retarded
2 sociomedical aid stations for alienated youth
1 diagnosis and evaluation service for the mentally retarded
1 clinic for neurologically handicapped children
1 residential treatment program
1 teen-mother program
1 emergency telephone service
1 mental health center coordinator's office

Inpatient services at local general hospitals, which often permit a person to be treated in his home community rather than at a state hospital, have been developed in Medford, Corvallis, Astoria, and Ontario. Several other communities are working toward developing these services.

Day treatment programs, which also offer alternatives to hospitalization, are operating in Medford, Eugene, and Pendleton.

Community Mental Health Centers

Nearly four years of planning culminated in the establishment of the Eastern Oregon Community Mental Health Center during the summer of 1972.

Table 1

Community Mental Health Clinics
Total Admissions, Including First and Readmissions, by Clinic, Age and Sex
1970-71

County Name	0 - 11			12 - 17			18 - 44			45 - 64			65+			Totals		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Baker	33	17	50	26	36	62	95	156	251	31	30	61	7	9	16	192	248	440
Benton	31	19	50	49	40	89	139	192	331	12	25	37	-	6	6	231	282	513
Clackamas	116	34	150	92	93	185	177	252	429	12	29	41	3	2	5	400	410	810
Clatsop	15	5	20	8	13	21	38	56	94	8	8	16	-	2	2	69	84	153
Columbia	15	12	27	14	23	37	10	22	32	2	3	5	-	1	1	41	61	102
Coos	24	14	38	25	28	53	25	52	77	3	14	17	-	2	2	77	110	187
Curry	16	6	22	5	21	26	31	43	74	2	7	9	2	1	3	56	78	134
Delaunay	33	15	48	34	25	59	138	212	350	26	23	49	2	2	4	233	277	510
Deschutes	1	1	2	3	6	9	6	15	21	4	2	6	-	-	-	14	24	38
Douglas	69	22	91	62	64	126	111	173	284	22	43	65	4	-	4	268	302	570
Harney	2	1	3	3	4	7	11	25	36	3	11	14	-	-	-	19	41	60
Jackson	46	28	74	77	87	164	174	345	519	27	41	68	2	4	6	326	505	831
Josephine	17	13	30	32	33	65	42	47	89	6	6	12	-	2	2	97	101	198
Klamath	72	31	103	47	62	109	66	132	198	17	32	49	1	4	5	203	261	464
Lane	16	12	28	36	40	76	296	347	643	41	71	112	1	6	7	390	476	866
Lincoln	23	9	32	34	26	60	52	82	134	10	16	26	2	2	4	121	135	256
Linn	36	12	48	38	34	72	173	280	453	26	49	75	5	1	6	278	376	654
Malheur	32	31	63	15	12	27	37	45	82	7	11	18	-	-	-	91	99	190
Marion	48	24	72	48	35	83	121	194	315	15	48	63	3	6	9	235	307	542
Mid-Columbia	38	17	55	49	41	90	66	90	156	14	15	29	1	1	2	168	164	332
Multnomah	88	37	125	79	93	172	630	999	1,629	105	216	321	9	31	40	911	1,376	2,287
Polk	12	6	18	19	15	34	20	26	46	2	6	8	-	-	-	53	53	106
Port. Child Guid.	139	54	193	108	103	211	1	2	3	-	-	-	-	-	-	248	159	407
Tillamook	32	9	41	24	18	42	22	53	75	4	2	6	-	1	1	82	83	165
Tualatin	103	50	153	88	104	192	215	319	534	33	50	83	1	3	4	440	526	966
Umatilla-Morrow	27	10	37	32	38	70	48	122	170	19	33	52	2	2	4	128	205	333
Union	19	13	32	24	33	57	73	117	190	12	25	37	-	3	3	128	191	319
Yamhill	82	32	114	58	41	99	83	121	204	18	21	39	1	2	3	242	217	459
Total	1,185	534	1,719	1,129	1,168	2,297	2,900	4,519	7,419	481	837	1,318	46	93	139	5,741	7,151	12,892

The center is being financed by a federal grant, supplemented by state and local funds.

When fully implemented, the center will provide a variety of mental health services in the 13 counties constituting the catchment area of Eastern Oregon Hospital and Training Center. These counties are now being partially served by six community mental health clinics.

A core team, based in Pendleton, will administer the center and offer consultation, education, and program evaluation services to local programs. Direct services to be provided by the center include emergency care, inpatient hospitalization, outpatient care, day treatment programs, and in-service training. Improved services at Eastern Oregon Hospital and Training Center is another phase of the center's operation.

In addition to the services provided in the 13 counties, mental health programs will be offered on the Warm Springs and Umatilla Indian Reservations.

The Lane County Community Mental Health Center was developed in 1968. The center provides consultation and education, inpatient, outpatient, day treatment, and 24-hour emergency services. Federal, state, and local funds finance the operation of the center. The center is governed by an administrative board, which has responsibility for seeing that there is general compliance with federal requirements. Support services are provided by 37 local agencies, of which only five actually receive federal funds.

Plans are currently being made for similar comprehensive community mental health centers in Southeast Portland and Jackson and Josephine counties. Initial discussions are taking place in Northeast Portland; Deschutes, Crook, and Jefferson counties; Marion, Polk, and Yamhill counties; and Klamath and Lake counties.

Innovative Community Mental Health Activities

As the community mental health clinics carry out their mission of providing mental health services, they are attuned to the particular needs of the community they serve and the resources available to them within that community. The following are some examples of the kinds of innovative programs that have emerged.

1. Douglas County Family Service Clinic uses former hospital patients as aides in its aftercare program. Because of their own background, these people are able to provide invaluable help to other former patients in readjusting to community life and in seeking employment.

2. Tualatin Valley Guidance Clinic assists the Washington County Sheriff's Office in screening and training all recruits for that department.

3. Yamhill County Mental Health Clinic, in cooperation with the County Health Department, checks all children in the county who will be starting school in the fall. Counseling is offered to families having children who are found to have emotional disturbances which may cause difficulty in adjusting to school.

4. Marion County Mental Health Clinic has developed a long-term socialization program for former hospital patients. The clinic has also made arrangements with Oregon State Hospital to assist the hospital in its admissions program. Under the arrangement, which became effective June 12, 1972, the clinic screens all Marion County residents being voluntarily admitted to the hospital.

5. Linn County has developed a project offering group therapy to parents who have been abusive to their children.

6. Lane County and Baker County assist in developing information on all proposed commitments to state hospitals from those counties. The arrangement enables the clinic to become acquainted with the family of the person involved and often obviates the need for commitment by developing an alternative to hospitalization.

7. Improved care and adjustment of former state hospital patients living in Southeast Portland boarding homes has resulted from a recent project funded by the Mental Health Division. Multnomah County Mental Health Clinic aides, supported by social workers and a psychiatrist, offered supportive and counseling services to former patients residing in boarding homes. At the same time, they offered training for the boarding home staffs. An association of boarding home operators has been formed and clinic aides continue to work with them on behalf of the former patients.

8. Both Multnomah County and Yamhill County have companion programs through which college students become involved with children who show inability to adjust to school. The students spend up to three hours a week with each child referred to them by school counselors. There are 30 college students involved in the program in Multnomah County and about 20 in Yamhill County.

PROGRAMS FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED

The Mental Health Division is developing a range of services for the mentally retarded and other developmentally disabled to provide a continuum of care, treatment, and training.

The program objectives are to (1) help maintain the family unit; (2) promote maximum health and social, intellectual, and vocational adjustment; (3) provide protection from exploitation and abuse; (4) establish standards for enlightened care and treatment; and (5) promote a family and community approach toward meeting the needs of the mentally retarded and other developmentally disabled.

Diagnosis and evaluation services are available for determining eligibility of individuals for hospital and community-based services and developing preliminary treatment-training plans.

Hospitals for the Mentally Retarded

The Mental Health Division administers three hospitals for the mentally retarded, which operate collaboratively as a single component in the total range of services for those whose needs cannot now be met in the community. The services of the hospitals are coordinated to meet each individual's need for care, treatment, training and habilitation. The progress and current status of each resident is evaluated periodically, and programs are arranged to enhance the development of each individual.

The location of the hospitals is shown in Illustration 6.

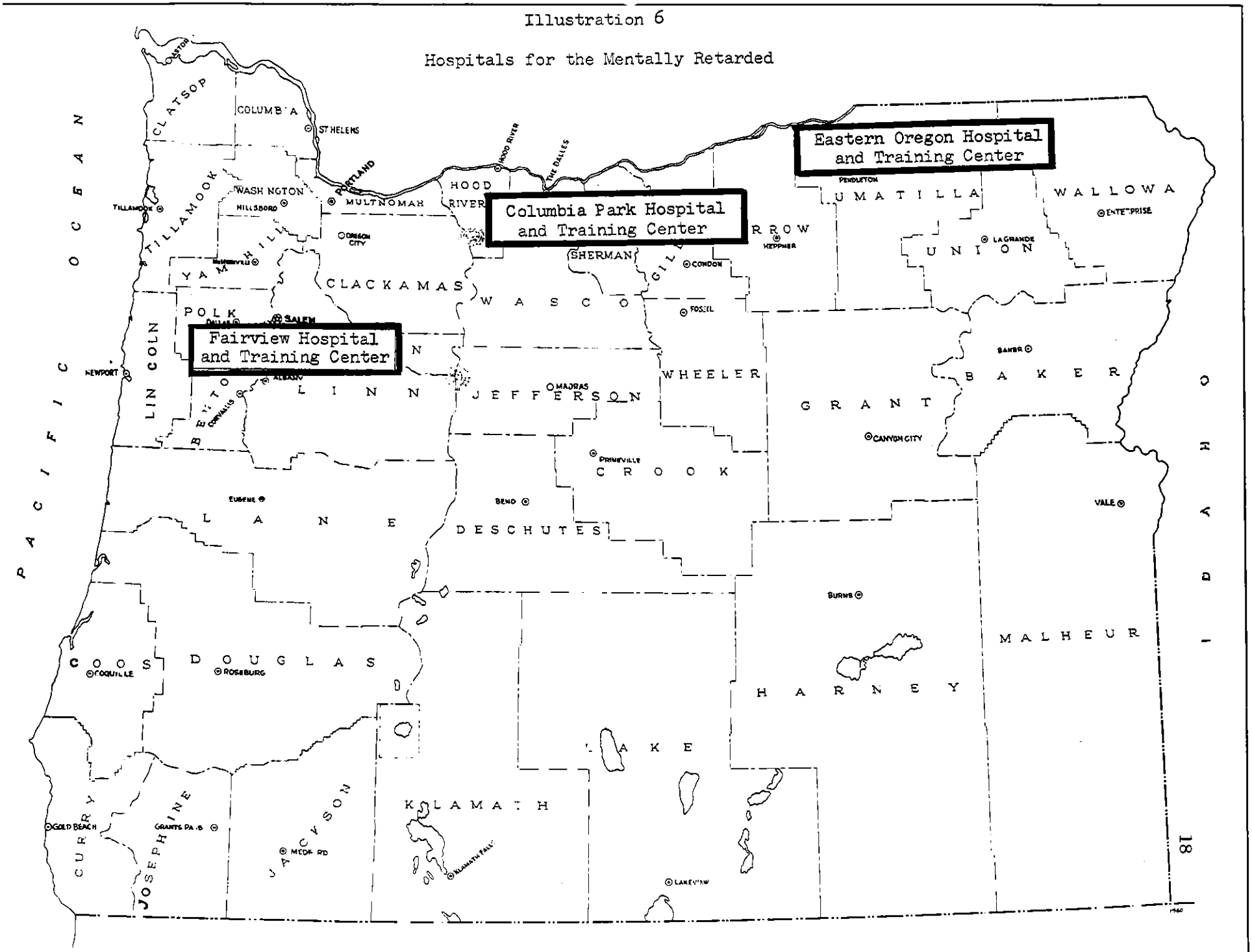
1. Eastern Oregon Hospital and Training Center

   Established in 1913, Eastern Oregon Hospital and Training Center provides services to both mentally ill and mentally retarded patients under separate and distinct programs. The mental retardation program was initiated in 1965 to provide care for persons requiring long-term hospital care. Residents are admitted only by transfer from other hospitals for the mentally retarded.

   Average daily population for mentally retarded residents is estimated at 538 for 1972-73.

Illustration 6

Hospitals for the Mentally Retarded



2. Columbia Park Hospital and Training Center

   Since its conversion from a tuberculosis hospital in 1959, Columbia Park Hospital and Training Center has provided long-term care for adult mentally retarded persons. Residents are admitted only by transfer from other hospitals for the mentally retarded.

   Average daily population is estimated at 470 for 1972-73.

3. Fairview Hospital and Training Center

   Fairview Hospital and Training Center is a residential facility for the care, treatment, education, training, and habilitation of mentally retarded persons of all ages. A complete range of services is available.

   All new admissions to the hospitals for the mentally retarded are received by the Salem Evaluation Center, which is located at Fairview Hospital. Persons to be admitted are placed on a waiting list until a vacancy occurs in a suitable cottage.

   Minors may be admitted by voluntary application or court commitment. Admission of children under the age of five years is discouraged. Adults may be admitted only by court commitment.

   Average daily population is estimated at 1,736 for 1972-73.

Detailed statistical tables and illustrations of the average daily populations of the hospitals for the mentally retarded are shown in the Appendix.

Community Services for Mentally Retarded and Developmentally Disabled

The community mental retardation programs of the Mental Health Division are guided by a "lifespan continuity of services" philosophy. The objectives are to offer community-based services to mentally retarded and other developmentally disabled persons of all ages and to provide an orderly progression from one type of service to another, as the person advances in age.

The major emphasis in this process is on "normalization", that is, giving the person the widest possible access to the normal activities of the community. As a result, there are options other than institutionalization, private care, or seclusion at home.

1. Preschool Programs

Preschool programs are designed to provide children from birth to six years of age with individualized training or educational programs to enhance their physical, intellectual, emotional, and social development. School staff members work with parents to help them provide an environment conducive to learning within the home. As the child becomes ready for school, an individualized program in a classroom setting is developed for him. Regular contact with the parents is maintained throughout the preschool period and assistance is given them in aiding the development of their child.

At age six, the child is placed in a regular school program, educable class, trainable class, or other program in which optimal development can be expected. The placement is determined by staff and parents based on the child's level of development, the recommendations of the child's parents, and the availability of services within the community.

2. Classroom Services for the Trainable Mentally Retarded

Since 1969 the Division has contracted with private or public agencies, primarily school districts or Intermediate Education Districts, to provide classroom services for the trainable mentally retarded. Children from 4 to 21 years of age are eligible for these programs if they do not qualify for programs for the educable mentally retarded.

The purpose is to develop each child to his fullest potential in communication, social, physical, practical, and community living skills. In addition, an attempt is made to include him in as many activities as possible with "regular" school students.

To help achieve these goals, a basic core curriculum and evaluation procedure, which includes a Curriculum Guide and a Student Progress Record, has been developed. In addition, parents are being trained to teach basic skills to their child.

3. Work-Related Activity Centers

A network of work-related activity centers is being formed to meet the needs of the severely retarded and disabled. The centers generally emphasize work, but the production capacity of the individual is secondary to such therapeutic aspects of the work as individual motivation, performance, and dignity.

Normally, because of their disability, these persons are not offered the traditional sheltered workshop experience and cannot qualify for competitive employment. At the centers they are given tasks they are able to accomplish and are supported in developing social skills, prevocational skills, behavior control, personal hygiene, and leisure-time activities.

4. Service Coordinators

Service Coordinators are located in the community to assure the orderly and timely delivery of essential services to mentally retarded and other developmentally disabled persons of all ages. In doing this, they make maximum use of existing services in the community and help make it possible for disabled persons to continue to live and work in their home environment.

There are at present eight Service Coordinators serving a total of 14 counties.

PROGRAMS FOR ALCOHOL AND DRUG PROBLEMS

A variety of services are available to alcohol- and drug-dependent persons through state-operated specialized programs and community-based programs that receive financial or consultative support from the Division.

State-operated Specialized Programs

1. Alcoholism Treatment and Training Center

   This outpatient clinic was established in 1949 to assist Oregon residents who are either alcoholics or problem drinkers. Since 1961, the Center has operated under the authority of ORS 430.090, which requires that "the Mental Health Division shall maintain and operate a rehabilitation clinic . . . for the treatment of persons addicted to the excessive use of alcoholic beverages."

   The major functions of the Center are direct patient care, training of community workers (physicians, nurses, psychologists, psychiatrists, social workers, vocational rehabilitation counselors, case workers, and volunteers), case consultation research into the causes of alcoholism, and evaluation of the results of various kinds of treatment alternatives. The Center provides diagnosis and evaluation (psychiatric, social, psychological, medical) and social, vocational, and medical rehabilitation through education and counseling, both group and individual. The current active caseload of the Center is 450 patients, with an average of 1,800 patient contacts per month.

2. Alcohol Safety Action Project (ASAP)

   This $2.2 million, three-year project was funded by the U.S. Department of Transportation on June 17, 1970, as one of the nation's original nine Alcohol Safety Action Programs (ASAP). The objectives of the project are to significantly reduce the number of alcohol related traffic fatalities and serious injury accidents during the operation of the project, and to evaluate various countermeasures and their relative effectiveness toward decreasing the alcohol-related traffic fatality toll on Oregon highways. The project, which has been limited in scope to the Portland and Eugene communities, is directed toward the problem drinker who drives after abusive drinking.

3. Drug Treatment and Training Project

This three-year research and demonstration project was funded on June 1, 1970, by the U.S. Department of Health, Education, and Welfare. The purpose of the project is to study young drug dependent persons and evaluate the effectiveness of three basic methods of treatment--individual counseling, group therapy, and mini-marathon group therapy--to help young people become more useful citizens in school, obtain employment, make better use of leisure time, and reduce criminal behavior. The average active caseload is about 100 patients, with about 30 parents involved.

4. Narcotic Addict Rehabilitation Act (NARA) Program

The NARA program was begun in Oregon in September 1968, under a National Institute of Mental Health contract, to provide aftercare services to narcotic addicts who were civilly committed to the Clinic Research Centers of the U.S. Public Health Service in Fort Worth, Texas, and Lexington, Kentucky, under Public law 89-793, the Narcotic Addict Rehabilitation Act of 1966. The program is 100 percent federally funded. Patients in the NARA program must be committed by the District Court of the United States.

The original contract was modified on August 1, 1969, to allow the State of Oregon to provide examination and evaluation of narcotic addicts, and on July 1, 1971, to provide inpatient treatment services to eligible patients under provision of Titles I and III of the Act. During 1972 the Division contracted with the U.S. Department of Justice, Bureau of Prisons, to provide aftercare services to patients entering the program under Title II of the NARA Act. Thus, the program now provides a full range of services to all persons in need of care as defined by the Act. During the program's four years of operation, about 240 narcotic addicts have been accepted; of that number, about 100 are currently being served.

5. Synthetic Narcotic Maintenance (Methadone Blockade) Program

Established in July 1969 under ORS 475.715, this program provides for the treatment of narcotic addicts through the substitution of a medically and legally approved drug, Methadone, for illegally obtained and abused narcotics. The program goals are to prevent the consumption of illegal narcotics among the population being treated, to restore the addict to a level of self-sufficiency, and to eliminate the necessity for individuals to commit crimes for the purchase of narcotics. The program has admitted 724 patients during the past three years, with 300 currently receiving treatment.

Patients receive their daily Methadone dosages at 27 contract pharmacies throughout the state. The program is currently being expanded to provide more intensive diagnostic and evaluative data and additional treatment and rehabilitation measures.

6. Community Education and Organization Services

This program operates a broad range of activities and services aimed at expanding public awareness and understanding of the problems related to the use and abuse of alcohol and other drugs. Information materials and training opportunities are available to persons with alcohol or drug problems, their families, professional persons, public and private agencies, and the general public.

Field offices are located in Portland, Salem, Eugene, Grants Pass, and Ontario. These field offices are responsible for community alcohol and drug education in the areas they serve and consultation with community organizations in the development of such critical services as detoxification programs, halfway houses, and referral centers.

7. State Hospital Alcoholism Programs

The three state hospitals for the mentally ill have provided services to persons with alcohol problems for many years. During the 1971-73 biennium each hospital has developed a specialized alcoholism program. In August 1972, Dammasch State Hospital received federal funds for its treatment program, "Bridging the Gap Between Hospital and Community Programs", to improve the quality of its alcoholism program and to facilitate the continuity of care of alcoholic patients in its catchment area.

State-Supported Community Programs

In addition to the specialized programs operated by the state, the Division has supported the development of other services for alcohol- and drug-dependent persons throughout the state. This support has been in the form of partial funding, consultation services, or a combination of both.

In many communities, local mental health clinic staff have played major roles in the development of alcohol and drug projects and in providing consultation and treatment services for these projects.

Emergency care stations (detoxification centers) have been established in Portland, Grants Pass, Medford, Klamath Falls, Baker, Eugene, and

Roseburg through federal and local funding. These stations provide up to five days of treatment, counseling, and group therapy for intoxicated persons.

Halfway houses for alcoholics are maintained through state grant-in-aid in Portland, Eugene, and Grants Pass. A halfway house in Pendleton has been funded directly by the Division.

The Outside-In Sociomedical Aid Station in Portland and White Bird Sociomedical Station in Eugene provide services to drug-abusing, alienated youth under subcontracts through state grant-in-aid. The Division is also assisting other communities to develop "store front" clinics without state funding.

Twenty regional councils on alcoholism and drug problems have been established in the state during the past eight years. Their development has been encouraged by the Division, and financial support is currently provided for 16 of these 20 councils. These councils have been responsible for initiating 12 residential group living centers, the seven detoxification centers, 24-hour emergency telephone service in 17 communities, and numerous educational programs for schools, business and professional groups, and the community generally.

APPENDIX

AVERAGE DAILY POPULATIONS
HOSPITALS FOR THE MENTALLY ILL AND MENTALLY RETARDED

Prediction of hospital populations is the basis for computing staffing needs and the consumption of a variety of service and supply items, including drugs and medication, raw foodstuffs, clothing, and dormitory and household supplies.

Highlights of population trends in Mental Health Division hospitals for the mentally ill and mentally retarded are listed below:

1. Average daily populations in the hospitals for the mentally ill continue to decline as shown in Table 2 and Illustration 7. The average daily population peaked in 1957-58 at 5,065, and 15 years later in 1972-73 is estimated at 1,427. This is a reduction of more than 3,600 and the decline is estimated to continue downward to 1,214 during the next two years.

2. It is anticipated that the hospitals for the mentally retarded will experience a decreasing average daily population in the 1973-75 biennium. Although these facilities have much greater control over the intake and release of their patients than do the hospitals for the mentally ill, expanding community-based alternatives to state hospitalization are concurrently reducing the numbers seeking admission to, and increasing the opportunities for community placement from these facilities.

   The average daily population at the hospitals for the mentally retarded peaked in 1967-68 at 3,032, and has slowly declined by about 300 to an estimated 2,744 in 1972-73. Substantial reductions in the average daily populations are budgeted for in the 1973-75 biennium. See Table 3 and Illustration 8.

Table 2

Hospitals for the Mentally Ill
Average Daily Population By Hospital
1957-58 to 1971-72 Actual and 1972-73 to 1974-75 Estimated

Year	Average Daily Population					Change from Prior Year	
	OSH	DSH	EOHTC	CPHTC	Total	Number	Percent
1957-58	3,545		1,520		5,065		
1958-59	3,541		1,499		5,040	- 25	- 0.5
1959-60	3,389		1,521	65	4,975	- 65	- 1.3
1960-61	3,105	42*	1,468	95	4,710	-265	- 5.3
1961-62	2,724	274	1,361	95	4,454	-256	- 5.4
1962-63	2,449	312	1,212	90	4,063	-391	- 8.8
1963-64	2,044	346	1,035	90	3,515	-548	-13.5
1964-65	1,824	360	834	60	3,078	-437	-12.4
1965-66	1,640	399	652	3**	2,694	-384	-12.5
1966-67	1,518	402	564		2,484	-210	- 7.8
1967-68	1,375	397	521		2,293	-191	- 7.7
1968-69	1,236	408	486		2,130	-163	- 7.1
1969-70	1,090	401	454		1,945	-185	- 8.7
1970-71	897	414	417		1,728	-217	-11.1
1971-72	758/	391	365		1,514	-214	-12.4
1972-73 (est.)	661	410	356		1,427	- 87	- 5.7
1973-74 (est.)	588	409	306		1,303	-124	- 8.7
1974-75 (est.)	527	410	277		1,214	- 89	- 6.8
1973-75 (est.)	557	410	291		1,258		

*Dammasch State Hospital opened March 6, 1961.

**Columbia Park Hospital and Training Center transferred last psychiatric patient September 16, 1965.

/Does not include 17 NARA patients at Oregon State Hospital.

Illustration 7

Hospitals for the Mentally Ill
Average Daily Population by Hospital
1958-59 to 1971-72 Actual and 1972-73 to 1974-75 Estimated

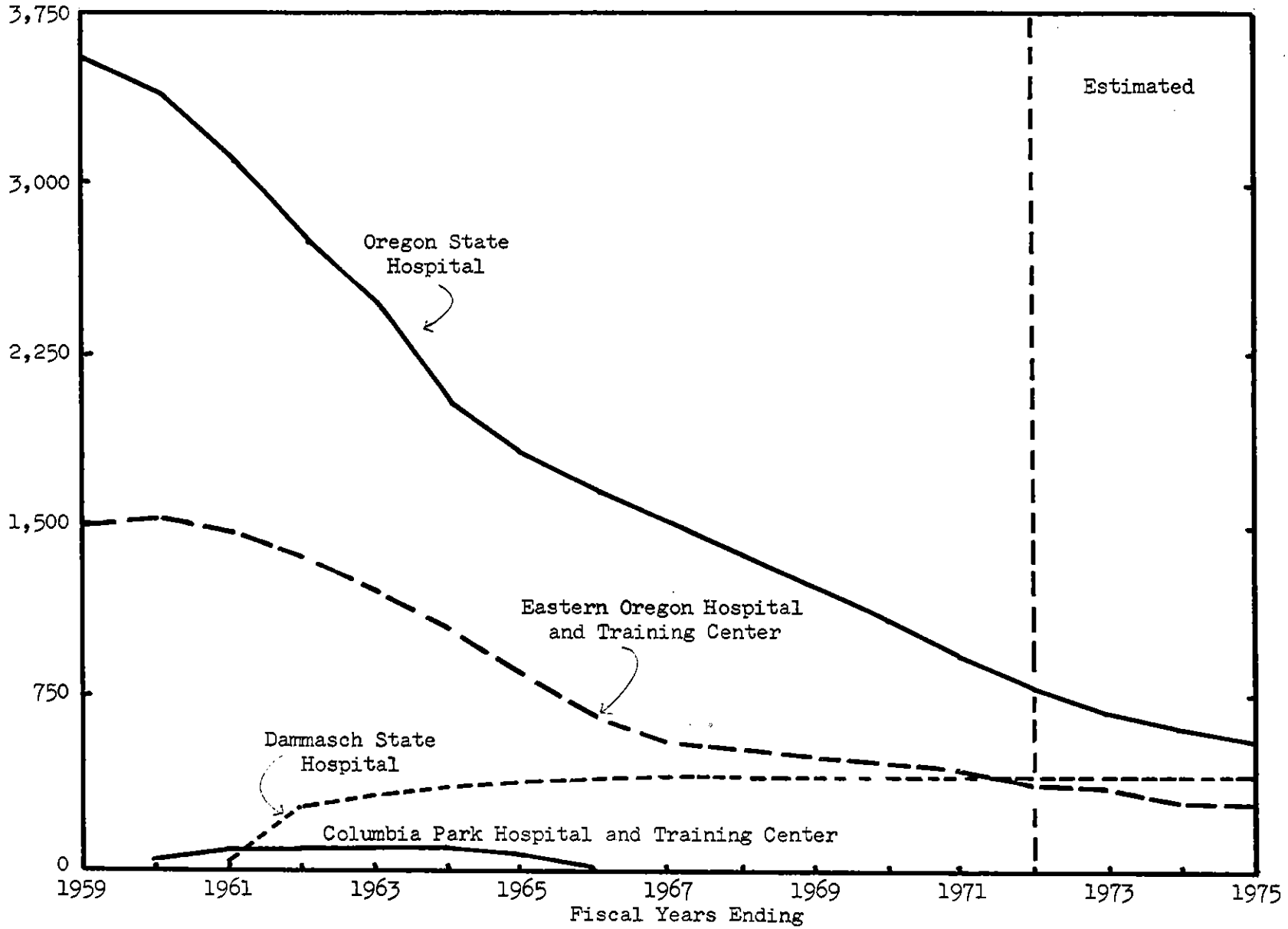


Illustration 8

Hospitals for the Mentally Retarded
Average Daily Population by Hospital
1962-63 to 1971-72 Actual and 1972-73 to 1974-75 Estimated