

History of Mental Health Services in Oregon

1945-1999

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EXECUTIVE SUMMARY

The history of mental health services in Oregon from 1945 to 1999 is complex and multifaceted. During the last five decades, dramatic changes have occurred in the location of care and treatment, in treatment philosophy and interventions, and in the administration of services. These changes have occurred against the backdrop of changing perceptions about mental illness, increased civil rights, the development of new medications and the federal governments growing influence in local programs through funding requirements. The range and availability of mental health services has improved throughout the state and the complexity of the administrative structure has increased in tandem with these changes.

The hallmark of the changes in the mental health system has been the movement of treatment from the state hospitals to the local communities. Lengths of stay in hospitals have gone from many years to a few days as patients are stabilized and returned to their communities for follow-up services.

The role of the state government has gone from provider to overseer and planner. Many of the decisions about the nature and range of services are made at the county level today rather than at the state level, as they were when hospitals were the primary site for treatment services. Community providers and the consumers of service have become partners with the state and county governments in planning and policy development.

Much of the funding for mental health services today comes from the federal government through entitlement programs such as Medicaid rather than through the General Fund as it did in the early years. The result has been less autonomy at the state and local level and more restrictions on who will be served. As funding requirements have changed, so have the groups of people who have been eligible for services.

The following paper describes the changes in the provision of mental health services from 1945 to the present by examining three processes:

- The movement of services from the state hospital to the community
- The evolution of care and treatment of the patients and
- The growth of the state administrative structure to develop and oversee mental health programs and services.

The first section, *Where Services are Provided*, traces the decline of the state hospitals as the primary treatment location to the increased development of treatment resources in the community. It describes the development of adult, children and forensic services and discusses how access has varied over time for the different groups of people.

The second section of the paper, *Evolution of Treatment*, discusses the use and development of the treatment modalities in the state hospitals and in community mental health centers. It begins with a discussion of shock therapies, brain surgery and hydrotherapy and continues through the development of antipsychotic medications that made milieu therapy and group therapy possible. It concludes with a discussion of community treatment emphasizing community support and case management. This section also includes a description of the

state hospital community, the Board of Eugenics and the evolution of the patients' civil rights.

The final section, *The Administration of Services*, traces the development of the management of mental health services from the creation of the Board of Control to the current Mental Health and Developmental Disabilities Division within the Department of Human Resource.

The thread that binds all sections together is the effort by the state and local communities to provide the best possible mental health care to the citizens of Oregon, given the knowledge, the culture, and the resources of the time.

INTRODUCTION

H. S. Dickles' *History of Psychiatry in Oregon* (1977) describes the first incidence of mental illness in the Northwest Territory. A sailor was found wandering on a beach a few miles from Seattle in the early 1800s. He had been there, apparently, for days, living on raw mussels, becoming increasingly demented and receiving occasional help from the Indians. He was brought to town and placed in the custody of two innkeepers. Because the sailor lacked proper footwear, his feet had been repeatedly frozen and had become gangrenous. Medical help was summoned and a local physician came to the inn. As there were no surgical instruments available in all of the territory, "a large ax was brought in and the dead toes were neatly clipped from the unfortunate body." Discussion then centered on whom was responsible for the cost of the medical treatment and the care of the "non resident pauper." The county commissioner requested the territorial government to pay the bills; however, the historical documents records that "The communication was considered and almost immediately dropped."

In 1880, the first mental hospital, the State Insane Asylum was established and renamed Oregon State Hospital (OSH) a year later. In 1913, a second asylum was created in Pendleton to provide more accessible services for the eastern part of the state. This institution was named Eastern Oregon Insane Asylum and later renamed Eastern Oregon State Hospital (EOSH). Both hospitals were built to

provide care for the citizens of Oregon who had mental illness. However, in a 1928 report, the superintendent of OSH writes about the problems of "...the increasing tendency to commit to the state hospital senile dotards, paralytics and other helpless cripples, who should be cared for by the county in which they reside."

The state hospitals had become a place not only for those with mental illness, but for others with debilitating and disabling conditions who needed sanctuary and had no other place to go.

In addition to providing a vivid picture of the earliest record of mental illness and a description of the patients in the state hospital, these two accounts raised issues about the provision of mental health services that would continue through this century. The questions, where would services be provided, what would be appropriate care and treatment and who would be responsible, would continue to be the topics of debate and discussion.

This paper describing the history of mental health services in Oregon is divided into three sections, reflecting the questions raised above. The first, "Providers of Service," describes the state hospital as the primary provider of mental health services and the transition to community-based services. The second, "The Evolution of Services," describes how the kinds of treatment and services changed over time. The third section traces the development of the administration of services.

Mental health services in Oregon, as in the rest of the country, developed on two fronts: in the community and in state supported mental hospitals. In the early decades, most services were provided in the hospital, with some services present in the community. At the end of the millennium, that trend was reversed

and most services were provided in the community. As the location of services changed, the people who received services and the treatment changed as well, along with sources of administrative responsibility. The evolution of mental health services from 1945 to the present is reflected by these changes.

WHERE SERVICES ARE PROVIDED

In 1945, the citizens of Oregon received mental health services through three venues: the Child Guidance Clinics served children in the communities, the state hospitals provided services to the chronically mentally ill and the Division of Mental Hygiene furnished oversight and management of all programs related to mental health.

Community based services began in 1932 when the first child guidance clinic was established at the University of Oregon Medical School in Portland. In 1937, the Oregon Legislature passed the Child Guidance Extension Act allocating money for the expansion of the child guidance clinics. Staff from the University of Oregon Medical School traveled to many areas of the state providing mental health services, primarily to children. These services were known as "traveling clinics." In 1946, the Mental Health Act passed by the federal government provided grant-in-aid to states for community mental health activities and allowed for the expansion of some mental health services.

The Division of Mental Hygiene was established within the Department of Health in the State of Oregon in 1941. Its goals were (1) to improve the mental health of all people of the state, with special emphasis on children; (2) to improve the effectiveness of all education, prevention and therapeutic programs; and (3) through these means prevent insanity.

The administrative functions of the Division integrated the services of the state institutions, the County Health Units, the State Child Guidance Clinics and social agencies. Through Child Guidance Clinics and educational seminars, the mental health professionals, educators, attorneys and judges would be informed about mental hygiene.

In spite of the traveling clinics, the actual services available for children were very limited. An early report stated there was a waiting list of 140 children. It also noted that it was difficult for adults to get appointments because of the large caseloads, and so they did not get the care they needed. The traveling clinics continued until 1953. While the traveling clinics were providing some services in the community, the populations of the state hospitals continued to rise. In the 40s and early 50s, people with alcoholism, tuberculosis, venereal diseases, various infirmities of old age, as well as those with mental illness, were residing in the hospitals.

The wide range of patients and their long stays in the hospital resulted in lack of treatment and unhealthy conditions. Overcrowding was estimated to be between 16 and 75 percent. Also, the induction of large numbers of nurses and psychiatrists during WW II resulted in staff shortages throughout the country.

After World War II, hospital conditions improved somewhat with more staff, the construction of some new buildings and the gradual improvement of treatment. However, during the late 1940s and through most of the 1950s, overcrowding in the state hospitals continued to be a problem. The total state hospital population in Oregon rose from 3937 in 1946 to 5,073 in 1958, its highest point. The greatest increases were in the elderly population with a diagnosis of senility or arteriosclerosis. There was also a high proportion of voluntary

admissions. The EOSH population in 1950, for example, consisted of 26 percent new voluntary admissions and 52 percent voluntary readmissions. People with alcoholism made up 16 percent of the new admissions. In 1956 voluntary admissions exceeded involuntary admissions. The superintendent of EOSH commented that the numbers of voluntary commitments "indicates a better understanding of the benefits to be received by early treatment." The hospital also continued to be the refuge of last resort for people who had no other place to live either because of infirmity, disability or poverty.

The Development of Community Mental Health Services

After World War II conditions were ripe to begin the change from predominately hospital care to community care. Hospital care was expensive and there was a backlash against state hospitals because of the conditions that had existed before and during WW II. Although attitudes about the hospitals had changed, the development of new programs lagged and hospital populations continued to increase until 1958. Shortly thereafter major changes began to occur.

In 1961 the Old age Assistance Program for Oregon Mental Institutions sponsored by the Public Welfare Agency made it possible to place elderly, indigent patients in nursing homes. By law, patients had to be at least 65. Most of the patients had circulatory disturbances, chronic brain syndrome or psychotic disorders. Additional patients were transferred when federally matching funds became available in 1962 for welfare support, and the additional money allowed for more placements in the community. By 1960 the census for both OSH and EOSH had declined to 4577. That marked the first decrease ever and began a downward trend that continued into the late 1990s. The opening of Dammasch State Hospital in 1962, which was to reflect the state-of-the-art treatment

programs, also provided a mental hospital closer to the Portland area and helped to relieve crowded conditions at the other two state hospitals.

A second factor in the reduction of the hospital population was the development of an outpatient clinic at OSH in 1953. It provided intensive care outside of the hospital. The number of patients requesting services resulted in a 4-month waiting list during the biennium. Psychotherapy and counseling were the primary interventions. Only 7 percent of the patients seen at the clinic entered OSH "due to the clinic's emphasis on reconstructive psychotherapy rather than more superficial forms of treatment." As the clinic continued to grow, it offered follow-up care, which was the only such service offered at the time.

The creation of the Mental Health Division in 1961 was a third factor that contributed to the growing emphasis on community care. It was made responsible for the administration of the state's mental health programs and mental health laws. The programs were developed in cooperation with local government, and these local programs were integrated with the total state mental health programs. Community clinics were developed that offered basic services including mental health counseling, public education and testing, screening, diagnostic and referral service to all age groups.

President John Kennedy further enhanced the development of services in the community when he signed the Community Mental Health Centers Act of 1965 into law. It provided a three-year authorization for construction of mental health facilities. To be eligible, states had to submit a comprehensive plan, designate an agency to administer the plan, appoint an advisory committee with broad based representation, and develop a construction program based on a statewide

inventory of existing facilities and need. Another act was passed in 1965 that provided staffing for the new centers and new services.

Although Oregon was unable to fully utilize the federal funds because of the lack of necessary matching funds, the state responded with its own plan to expand community services. This plan was described in a document entitled *The Ultimate Goal, a Plan for Today*. *The Ultimate Goal* recommended that the Mental Health Division continue the development of community mental health centers, encourage and support psychiatric units in general hospitals as a basic unit of the community mental health center, and develop foster care and halfway houses. It recommended rehabilitation services that included vocational education and vocational placement, sheltered workshops for helping people return to work or to work in a supervised setting, and halfway houses to help people live as independently as possible.

The planning group suggested that the state hospital should continue to be the main service for persons requiring structured management for long periods of time and that it should expand its potential to reduce the disabilities of persons who are hospitalized. *The Ultimate Goal* provided the philosophical and programmatic base for the transfer of patients out of the crowded hospitals and into the community.

Another factor that contributed to the movement from hospital to community was the reduction of time patients spent in the hospital. The average length of stay in the hospitals from March 1 – August 31 of 1961 was 79 days. In 1964, just three years later, the average length of stay had decreased to 11.2 days. New psychotropic medications were also a factor in the discharges. The types of discharges or “outgos” for one year are demonstrated in the following figure.

Figure 1 Types of Initial Out-gos (1961)

<u>Type</u>	<u>OSH</u>		<u>EOSH</u>		<u>DSH</u>	
	<u>#</u>	<u>%</u>	<u>#</u>	<u>%</u>	<u>#</u>	<u>%</u>
discharges	579	62.7	209	66.2	329	53.4
trial visits	224	24.3	68	21.5	253	40.9
deaths	68	7.4	37	11.7	25	4.0
transfers	9	1.0	0	0	6	1.0
escapes	38	4.1	0	0	4	0.6
repatriations	5	.5	2	0.6	2	0.3
<u>Totals</u>	<u>923</u>		<u>316</u>		<u>619</u>	

Although discharges were increasing, EOSH still had 50 percent of its patients staying 10 years or longer. Longer-term stays were still evident at both OSH and EOSH. OSH had 19 percent of its patients staying longer than 25 years and EOSH had 22 percent of its patients staying 25 years or longer. When bus services were provided for patients to travel into town a nurse reported:

One patient, after a trip in the bus, indicated that he had been in the institution for 30 years and had never left the building. This patient was quite amazed at the changes that had occurred in the community and truly appreciated the opportunity.

The community services provided during the early 60s were built on the foundation of child guidance clinics. The services were expanded, based on the planning document, *The Ultimate Goal*, including adult outpatient services and

family and marriage counseling. In 1962 there were 11 clinics serving 14 counties, which included 77 percent of the state population. By 1969, 25 clinics provided services to 99 percent of the states population. Adult outpatient psychiatric treatment was offered by 22 clinics; follow-up care by 21. Although some clinics provided aftercare services for patients discharged from the state hospitals, most discharged mental patients did not receive community outpatient services. The biennium report for 1969-71 stated: "It is evident that gaps in the continuity of care do exist and that one of the major problems is the facilitation of the transition from community to hospital and from hospital to community."

During the decline in state hospital population, community mental health services were seen more and more as a means to reduce the need for inpatient care. In 1971, the Oregon Legislature strengthened its policy of local operation of mental health services by authorizing the establishment of comprehensive community mental health programs operating under the control of county government. The three psychiatric hospitals were integrated with community programs into a regional framework. Funds were granted under a matching formula to encourage counties to expand basic mental health services and to develop alternatives to hospitalization with a match requirement, including day treatment, group homes and local hospital care. The intent of the system was to have a greater portion of the initial assessment and stabilization of the acutely mentally ill occur in the community. However, local inpatient care, identified as an alternative to state hospitalization, was not fully funded by the state. The county was held responsible for the cost of emergency psychiatric care custody and treatment related to such conditions, when state funds were exhausted. Therefore, there was a built-in incentive for the counties to use the state hospital.

In the next biennium there was a new effort made to study the problem of adequate services. This effort culminated in the Budget Request for 1973-75. A major portion of the request was published as *1973 – A Turning Point for Mental Health Programs in Oregon*. This document describes a vision for a Comprehensive Community Mental Health Program in Oregon was described.

The new program envisioned an expansion of existing services and included outpatient diagnosis and treatment, consultation and education, crisis services, outreach services, prehospital screening programs, improved intensive family crisis treatment, prescreening programs and mental health services for children. Alternatives to state hospitalizations were to be developed and include 24-hour emergency services, local inpatient hospital treatment, and day treatment programs. In order to make the goals of *The Turning Point* a reality, new legislation was passed. In addition to more funds allocated for services, the legislation included statutes relating to the involuntary commitment of mentally ill persons and improvement of their civil rights. Of particular importance was the definition of a mentally ill person. It stated that:

A mentally ill person is a person who, because of a mental disorder, is either dangerous to himself or others or is unable to provide for his basic personal needs and is not receiving care that is necessary for his health and safety.

The implications of this statute are demonstrated in the priorities that were developed later in 1981 and which dictated who would receive services in the state hospitals.

In spite of the effort to expand community services through the actions of the 1973 legislature, the hospital population had begun to rise. Although lengths of

stay were shortened, readmissions continued to rise. Counties were still using the state hospitals for their most difficult patients. In order to change the use patterns by the counties of the state hospitals, the 1981 legislature mandated that treatment resources be focused on the most severely mentally ill and that to the "greatest extent possible" services should be delivered in the community. This resulted in the allocation of a bed limit to each county for hospital bed utilization. A priority system was developed to determine who would have first access to state hospital care. The priorities were established as follows:

Priority 1:

A person at immediate risk of hospitalization due to a mental or emotional disturbance

A person in need of continuing services to avoid hospitalization

A person posing a hazard to the health and safety of themselves or others

A person under 18 at immediate risk of removal from their home

A person under 18 at risk for developing a mental or emotional disturbance of a severe and persistent nature

Priority 2

A person who because of the nature of his or her illness, family income, or geographic location is unlikely to obtain services from other providers.

Priority 3:

A person experiencing mental or emotional disturbances but whom is not likely to require hospitalization in the foreseeable future.

In spite of the priority system, community services were still insufficiently funded to assure genuine control over the rate of utilization of state hospital

beds. Barely 50 percent of those in need of services could receive outpatient care in the community. Local inpatient services, which could divert acutely ill patients from state hospital admissions, were unavailable on a voluntary basis in most counties. Therefore utilization of the state hospital beds and overpopulation in the hospitals became a critical problem.

The problem was most evident at Dammasch, which served the majority of adult patients. To combat overcrowding, voluntary admissions were eliminated in 1986. However, hospital population peaked at 392 in January of 1987, well above the 330-bed capacity, and the loss of voluntary commitments created as many problems as it solved.

A 1988 Governor's report on *Improving the Quality of Oregon's Psychiatric Inpatient Services* stated:

The elimination of voluntary admissions raises both equity and program issues. Hospitalization is a recurrent need for many chronically mentally ill individuals, and community programs that emphasize early intervention are undermined by restricted access to voluntary hospitalization that is required to restabilize their acutely psychotic patients. Patients are admitted only on emergency hold or court commitment. A predictable result has been the forcing of patients to become more severely ill before their treatment can begin.

The restrictions in service also affected who would receive services in the community. Only those who were the most ill qualified for services. Dr Prasanna Pati, a psychiatrist at OSH from 1958 –1985 commented:

If a housewife in Corvallis says that "I am depressed, I don't have anywhere to go to," she should be able to come to the mental health clinic and have the psychiatrist, social worker and psychologist assess her and start her on treatment and medications. She shouldn't be rejected because she is not chronic.

After the 1988 Governor's report on psychiatric inpatient services in the hospital, more funds were allocated for mental health. Through the 1980s and 1990s a wide range of community services have been developed to both provide acute psychiatric care and long-term care in the community in place of hospital treatment. Medicaid funding has played an important role in the development of those services, and more recently, the Oregon Health Plan. However, the priorities established in 1981 still determine to a large extent who has access to both hospital and community care.

In 1965, a new law was passed that fundamentally altered the way services were funded and consequently changed who would have access to services. When Title XIX, Medicaid, was made into law, funding became available for community placement of the elderly. But, more importantly, it also provided medical assistance for the disabled, including those with psychiatric disabilities. This law was described as "the broadest social security act in the Nation's history," by Wilbur Choen, Undersecretary of Health Education and Welfare. It laid the financial foundation for the development of services in the community because it included funding for those persons who had a disability. By the end of the 1980's Medicaid accounted for 35 percent of the state's mental health budget. By the end of the 1990's the amount had increased to 72 percent.

While Medicaid increased the number of services available, it also limited who was eligible based on financial need. In the Oregon Health Plan (OHP), which receives 60 percent of its funding from Medicaid, eligibility is also based on need. In order to receive the benefits of the OHP, or any other Medicaid funded program, patients must have a Priority 1 status.

The 1995-97 biennium report describes the effect of these requirements:

The Division has experienced significant growth in its Medicaid budget. The mental health service system has financed this growth by using already budgeted General Fund dollars to provide the required state match to the federal contribution. This has meant the "working poor" are unable to access services until their mental illness reaches a crisis.

There are some exceptions to this caveat. In rural counties, the guidelines offer more leeway. Another exception is a small welfare program that provides women with dependent children mental health care through the Jobs Program. Service at all levels is available for persons who have private insurance or can pay out-of-pocket.

Children's Services

Historically there had been a paucity of services for children in Oregon. It was estimated that of the quarter of a million people in Oregon, 10 percent of the population needed professional help. Of those, more than 55,000 were young people under the age of 18 who were believed to be functionally impaired by emotional disorders; nearly 2000 were severely emotionally disturbed.

Prior to the 1960s children were placed in adult wards at the state hospitals if they needed extensive care. It was estimated that about 50 children were in the hospital at any one time. Some of the young people were also sent to the Fairview Home for the Mentally Retarded, and if they were not too disturbed they stayed there. They might also have been placed at the inpatient services in the Department of Psychiatry at the University of Oregon Medical School.

In 1961, OSH began its first formal children's program, a program for 10 boys in the "J" Ward, the receiving ward for men. It was known as "Little J." Although it was a first step, more services were necessary and estimates in 1964 stated that 320 beds for children and adolescents were needed. Only 80-90 beds were available. Early in 1965 Howard J. Blanding, Judge for Circuit Court of Clakamas County declared:

This matter is of serious proportion and needs immediate attention. In our county alone we have a considerable number of seriously disturbed children who need institutional care and treatment, and the need is increasing rapidly.

To respond to this growing need, the 1967-68 biennium budget allocated over 1 million dollars from the General Fund to build a children's psychiatric center. The biennium report stated "This act being necessary for the immediate preservation of the public peace, health and safety, an emergency declared to exist, and this Act shall take effect July 1, 1967." Rather than build a new facility, however, the decision was made to remodel and integrate existing building and agencies. Additionally, legislation also expanded services for children by providing funds to purchase care from existing in-patient or residential services.

One contract to purchase care was negotiated between the Division and Multnomah County's Edgefield Lodge in July 1968. The contract was to provide intensive diagnostic, evaluative, and early treatment to children 12 years of age and younger and to serve as a pilot project to further clarify the needs of this young population. At the same time, however, a large number of adolescent boys and girls were still being hospitalized at Dammasch and OSH. Few were hospitalized at EOSH.

Then in 1971, the Children's Division was created at the same time the Department of Human Resources was created, in recognition of the need for an integrated children's service system. Beginning in 1972, the first elements of the mental health system for children were developed. The Day and Residential Treatment Services (DARTS) Programs system began with the establishment of six programs. Although the programs were originally operated by the state, it was decided that all DARTS programs would be developed and operated by community non-profit corporations in accordance with state policy. The philosophy on which the system was developed stated that all treatment should be child-centered, family-focused, and community based. The DARTS program model called for a collaborative effort between the public and private systems, and a partnership between state and local systems. These relationships were formalized by administrative rules of the Mental Health Division, the Children's Services Division and the Department of Education.

Community mental health services in Oregon began as traveling clinics, serving mostly children. In 1969, approximately 50 percent of the persons seen in the community mental health programs were children. By 1973 only 27 percent

were children. No state funded community day or residential programs for children age 13 years or older existed in Oregon.

In 1976 the Director of the Department of Human Resources and the Administrator for Children's Services were subpoenaed by the courts and ordered to provide treatment for the children for whom adequate services did not exist. At that time, with state and private programs, only 26 percent of those children in need received services. The following biennium budget included money for the establishment of a new day treatment program and a new residential treatment center for emotionally disturbed children as well as a new long-term residential treatment program. Financing for the residential program was to be provided through anticipated payments under the federal Title XIX Medicaid program. Wards were developed or expanded for services to adolescents at OHS, DSH and EOSH.

Another federal law, the Education for All Handicapped Children Act, played an important role in the evolution of the DARTS program. It expanded the role of the schools in providing services to children and adolescents through Special Education Programs guaranteeing that education be provided in the least restrictive environment.

Other programs were developed with the creation of the Children's Division. The Partner's Project, funded by Medicaid, and the Robert Wood Johnson's Project helped to develop a children's' mental health system that reflected the values of the CASP program. The transfer of the Children's' Residential Services from the Child Welfare System to the Mental Health Division also improved the integration and range of services available for those with serious emotional disturbances.

Forensics

Another special population that required services were people with mental illness who had become involved with the legal system. In 1941, a commitment law was passed which made county officers responsible for the care and custody of "mentally diseased patients" against whom warrants had been issued to enable their removal from jails. This defined the county as the responsible party for people with mental illness who were believed to have committed a crime. The number of persons in that category continued to expand over time, and to accommodate this new population, OSH started a psychiatric security unit in 1962. Later the psychiatric security unit was expanded from one ward to three. A few rooms of one ward were used for female patients needing a secure placement.

Over time the forensics population continued to grow and an incident occurred in the mid-1960s that led to the establishment of a formal program. Dr Geroge Suckow, a psychiatrist who was the first administrator of the Forensics Program, relates this story:

There was a man who was known in the newspapers as the fat man rapist from Portland. He committed a series of rapes. He pleaded insanity so they sent him to the state hospital. He broke out by charging a security screen and taking out the whole window, casement and all with his body. He was a great big guy. That lead to a big furor about why we didn't have a more secure treatment place for patients like that. The governor, who was then Hatfield, said, "Develop a program." The mental health division responded and developed a program. Fortunately, I came out of the service right at that

time and got asked to run it. It was an interesting program. It started off with ninety beds and has grown since then.

In 1966, the state established the Forensic Psychiatric Services at OSH. It provided treatment and care to mentally ill persons who had been found guilty except for insanity by the criminal justice system and had been placed under the jurisdiction of the Psychiatric Security Review Board (PSRB). In addition to those patients, other patients who received treatment in the program were those determined to be sexually dangerous, those admitted for court evaluation, those committed from the penitentiary or county jails or were civilly committed persons deemed too dangerous to be admitted to other mental health facilities.

All persons committed to the state hospital needed treatment and rehabilitative services before they could be released from corrections into the community. After they had been treated, however, the PSRB had been extremely cautious in granting conditional releases because of the fears expressed by the community, the lack of appropriate programs and support, and the high rate of revocation.

In the mid-70s there were 200 sexual offenders at Oregon State Penitentiary and 50 at Oregon State Correctional Institutions. There were approximately 1,500 inmates of local jails or state prisons convicted of crimes against persons. It was estimated that approximately 10 percent of these individuals had severe mental disorders and could be treated for those disorders. All of these prisoners came under the jurisdiction of the PSRB. Recently, the Governor's Task Force on Corrections Planning (1988) estimated that approximately 5% of the current

inmate population might suffer from major mental illness and an additional 10% may have a significant psychiatric disability.

The increase in the forensic population and the reluctance to release those who have been in treatment mean a growing number of long-term patients. These patients account for most of the state hospital beds occupied in the late 1990s.

Dr Stan Mazur-Hart, the current Superintendent of OSH states:

There has been a significant deemphasis on hospitalization for the general adult population. At the same time there has been an increasing emphasis on forensic psychiatric services for people who have been adjudicated as guilty except for mental disease or defect in hospital.

As hospital utilization leveled off to just over 1000 beds statewide by the late 1970s, the role of the state hospitals changed dramatically. The hospital had evolved from a long-term residence for mostly older, dependent persons to a short-term, acute treatment for younger, more active individuals, including a large population of forensic patients. In the 1950s, elderly persons comprised 33 percent of the hospital population. In 1978, that number had declined to 14 percent and then in 1989, to 9 percent. By the late 70s, young, adult males were the group with the highest hospital admission rate, and that trend has continued to the present day.

Discussion

The place where mental health services have been provided has changed over time. During the 1940s and 1950s children received services through the Child Guidance Clinics. Unless adults were mentally ill, few service options were

available for them. In 1945, people who were mentally ill, disabled and elderly were treated in the state hospital. As conditions changed, the hospitals began to transfer elderly patients to long-term care in nursing homes or other state institutions.

Adults with mental health needs, e.g., marriage counseling or personal problems of adjustment and coping, gained access to treatment through the community mental health centers in the 1960s and 1970s. As the adults' access increased, children's access decreased. Clients with mental illness who had been in the hospital were not encouraged to use the community mental health clinics because they were more difficult to treat and didn't show progress like their other, less disabled clients.

With the expansion of Medicaid dollars coming into the state during the 1980s and 1990s, services have improved dramatically for most groups of people. Hospital access has increased for those persons who are eligible for services through Medicaid or through the OHP. The OHP has even made it possible for voluntary admissions to occur as managed care companies realize the importance of timely hospitalizations. With the closure of the state hospitals, more dollars became available for acute-care facilities in the community. However, there is still a shortage. "Every available bed is full, every day," states Madeline Olsen, the Assistant Administrator of the DMH.

Those people who are the least likely to receive mental health care are the poor and disabled who do not have Priority 1 status but who are so ill they cannot routinely hold a job or maintain a home. The state hospital no longer provides for that group of persons. Dr Joseph Treleaven, former Administrator of the Mental Health Division comments:

I have often felt that there was a role in the mental hospital for asylum. Some patients that were very handicapped made a life for themselves there that would have been difficult for them to have in other places. If you don't have decent community facilities they can end up in Jail, get abused and neglected and be worse off.

Others are left out of the system because they do not qualify for Medicaid. They are the working poor who do not have health insurance from their employers and who cannot afford medical care on their own. They are extremely vulnerable because one incident of illness or an accident can completely upset their fragile existence and there is no safety net to catch and hold them while they get back on their feet.

Oregon has improved and expanded mental health services for its citizens over the last 50 years. The place that services have been provided has moved from the hospital as primary provider, to the community as primary provider. During that time different groups prevailed or have had more access than others. At the current time, there is a full range of services available in most communities but the quantity of services has been unable to keep up with the growth in population. There are more agencies and facilities that deliver services but there continues to be more people using the services.

EVOLUTION OF TREATMENT

During the 1930s and 1940s the state hospitals throughout the country were overcrowded and understaffed. In 1946 *Life Magazine* published an article entitled "Bedlam" that showed, through a pictorial essay, the deplorable

conditions of the state hospitals throughout the country. In 1948 a journalist named Albert Deutsch published a book, *The Shame of the States*, revealing the terrible conditions in which patients were living. The point was further driven home when the novel *Snake Pit*, written by Mary Jane Ward, was made into a movie.

The situation in the Oregon state hospitals was reflected in the contents of a letter from the superintendent of OSH, J.C. Evans, to the Board of Control, dated April 21, 1945. He writes:

Due to being faced with a very critical and serious labor shortage, I write you. At the present time we are 30 attendants short and I do not expect the situation to improve perhaps until winter again sets in. This shortage means that the patients are being neglected and we are unable to even get them out into the sunshine and fresh air. The whole picture is dark and discouraging.

The biennium report for OSH for 1944-45 stated that there were 2700 patients in the hospital, 300 over capacity. Beds were set up in the exercising area. Both hospitals, EOSH and OSH, were in need of repair and additional facilities. At OSH tuberculosis was also a serious threat. There were 65 active cases in the hospital and 62 suspected cases. The problem resulted in the lack of space and the scattering of the tuberculosis patients throughout the hospital, causing the spread of the disease.

In 1945, the overcrowded conditions were exacerbated by treatments that were largely ineffective and seem very inhumane by today's standards. One of the major treatments for the patients was shock therapy, which was introduced in the 1930's. It included insulin, metrazol convulsive and, most commonly used,

electroshock therapy. Over the course of the 1950-52 Biennium at OSH, 6000 shock treatments were given with 30 to 40 patients receiving the treatment twice a week. Hydrotherapy was another common treatment. During the 1950-52 Biennium the following treatments were given at OSH. Figure 2 below lists the kind of hydrotherapy treatments administered and the number of each treatment given:

Figure 2 Treatments Given

<u>Treatment</u>	<u>Number Given</u>
Whirlpool	3,054
Sitz Bath	1,628
Continuous Tubs	10,270
Salt Glows	1,334
Hydrotonic	477
<u>Total</u>	<u>19,609</u>

Another common treatment was psychosurgery (lobotomies). It became an acceptable intervention beginning in the early 1940's. It was employed on people with schizophrenia because of the lack of success of other therapies, most notably, shock therapy. At EOSH the following brain surgeries were performed during the 1950-52 Biennium: Prefrontal lobotomy, 31; Transorbital lobotomy, 7; Craniotomy, 1; and Multiple Burr Holes, 1. The number of lobotomies in Oregon reflected a national trend. By 1951 18,608 people in the United States had had lobotomies performed on them.

During this time period, a number of patients spent many years of their lives in the state hospitals because of the lack of treatment that was effective enough for them be reintegrated back into the community. Other patients however, were

treated in the hospitals and then returned home. Early hospital population statistics for OSH indicated that 600 patients or 25% of the hospital were released daily. The intent of the hospital staff was to work with the patients and their families in their own homes rather than have them readmitted. However, understaffing did not allow for pre-parole investigations or follow-up work to determine successful community integration.

Antipsychotic Medications

In 1954, with the development of antipsychotic medications, new hope was born for mental health patients. The major tranquilizers, Thorazine and Serpasil, changed the lives of many mentally ill patients by controlling their symptoms. The minor tranquilizers soon followed the major tranquilizers. In 1956 the antidepressants were available. The use of these medications was the beginning of a major change in the treatment of mental illness and made life in the community possible for many who would otherwise have been hospitalized for life.

The state hospitals quickly made medications part of their treatment regime. In the 1954-56 biennium, 10% of the OSH patients were treated with the new tranquilizing drugs. That percentage increased to 27% in 1957-58. As the new drugs were used there was a noticeable decline in the use of restraints and electroshock. However, the publicity given to the new drugs, according to the biennium report, "led relatives to expect miracles."

The report also stated that although long-term cures were questionable, the effects on the chronic ward were striking. Staff observed that there were increases in patient communication, activity and recreation and decreases in patient agitation. The report also noted that "There is a better turnover in the

inpatient population including the chronic patients who may have been in the hospital for ten years." One of the main effects of the new drugs was that the patients were made more available for counseling and psychotherapy.

Joesph Treleaven, the 1964 Director of the Division of Mental Health stated: "It has been a general experience throughout the nation and in our own hospitals that the rapid reduction in patient population has been concurrent with psychotropic drug consumption." Treleaven also noted that daily dosage levels in Oregon were generally lower than dosages reported in the literature and that the Oregon hospitals differed substantially in the number of patients receiving drugs, the dosage given and the form of the drug given. Comparisons with national statistics were not available but the following figures demonstrate the use of drugs in the state hospitals in Oregon.

Figure 3 Number of Patients Receiving Drugs and the Cost – 1964

<u>Hospital</u>	<u>total # of patients</u>	<u># receiving drugs</u>	<u>% receiving drugs</u>	<u>cost per pt</u>
OSH	1964	937	48	\$.152
EOSH	951	576	61	\$.122
DSH	364	285	78	\$.137

Figure 4 Percent of Diagnosis Receiving Medication – 1964

<u>Diagnosis</u>	<u>OSH</u>	<u>EOSH</u>	<u>DSH</u>
Schizophrenia	55	65	85
Manic Depressive	53	86	100
Psychoneurotic	67	99	58
Involutional Psychotic	56	50	88

Figure 5 Medications Used by Number of Patients – 1964

Thorazine	681	Compazine	43
Merraryl	489	Librium	40
Stelazine	396	Proketazine	31
Reserpine	105	Taractan	29
Trilafon	95	Prolixin	9
Tofranil	80	Nardil	7
Elavil	52		

However, drugs could also be misused to control patient behavior. Dammasch State Hospital had a larger percentage of patients on tranquilizers 80% - compared to 50-55% from the other state hospitals. The Superintendent of Dammasch said

The extent to which patients are placed on drugs often is a result of staff attitudes. Poor morale and poor staff attitudes can result in the overuse and misuse of these drugs.

Treatment Philosophy

Treatment during this time, other than with drugs, placed strong emphasis on the patient's adjustment to his/her environment. A multidisciplinary approach became the norm, replacing the formerly dominant one-to-one psychotherapy. Treatment involved many care providers and emphasized not only the influences of the environment, but interpersonal and social influences as well.

Milieu therapy became the most common new therapy and had its origins in the earlier moral therapies. Moral therapy was a therapeutic system based upon

the belief that the institutional environment could be used to reeducate and retrain patients. A similar philosophy emerged with milieu therapy. After 1945, interest in using the institution itself as a therapeutic tool re-emerged.

Maxwell Jones, a British psychiatrist who joined the staff at OSH, had worked with servicemen who had developed neuropsychiatric symptoms during combat and/or who were repatriated prisoners of war. He found that group discussions with mutual feedback involving patients and staff assisted patients to view their symptoms more objectively. They gained insight from participation in the group process and improved sufficiently to return either to their units or to their communities. Dr. Jones taught the staff at OSH how to use the methods he had developed with the patients.

Other changes in treatment philosophy were reflected in the new hospital policies instituted by Dr. Dean Brooks, the Superintendent at OSH from 1955 to 1981. Dr. Brooks began a number of modifications in the hospital that changed the environment and gave patients a voice in how the hospital was run. He developed a patient council that met once a month with patient representatives from each ward. The purpose of the meeting was to address the patients' concerns. For example, there were no towel racks or hooks in the wards on which patients could hang their towels to dry. There wasn't enough toilet paper for the bathrooms. Patients had ill-fitting, inappropriate clothing that was often ruined by the laundry.

A committee was formed and 25 areas of concern were identified. Small study groups conducted investigations throughout the hospital and changes were instituted, including standards for patients' quality of care. Dances and movies became regular occurrences and religious services were held every

Sunday. Experiments in painting the wards different colors were met with approval by both patients and personnel. The hospital tailors and seamstresses began to use colored thread as well as the black and white thread that had been the norm. Patients were also taken on camping trips and outdoor outings. The hospital was chosen as the setting for the movie *One Flew Over the Cuckoo's Nest* adapted from the novel by Ken Kesey. The patients and staff participated in the filming of the movie.

Dr. Brooks began the humanization policies instituted at the hospital as a result of an experience he had at the hospital. He relates an incident that sensitized him more fully to the needs of the patients. He recalls:

I had a man come to the Administration Building one day and he was gumming it.

I said, "Where are your teeth?" and he said, "The dentist has them."

"Why don't you go over there and pick them up?" I asked.

"He said he would call me."

"How long ago did he tell you that?"

"Eight years."

That was literally true. I had walked by this man all those years. I began to think in terms of individual needs.

The Hospital Community

During the decades between 1940 and 1980, the state hospitals were communities unto themselves. The hospital superintendent was required to live on the grounds of the hospital. Many of the staff did as well, renting lodging from the state on the grounds. The hospitals had their own dentists, doctors, tailors, morticians, carpenters, electricians and others professionals and

tradepersons, whomever was required to keep a community of thousands in operation.

OSH and EOSH were both located on farmland and the livestock and the produce grown on the farm was used to feed the institutional community. It was the policy of the Board of Control that all patients, who could, should work on the farm. Their policy stated:

Wards of the state who are capable of a reasonable amount of work without physical or mental injury to themselves are to be used as fully as possible in the production and manufacture of articles for use by the state in the performance of labor for the state.

As the hospital population declined, fewer workers were available to work in the dietary, custodial, administration, housekeeping and laundry units of the hospitals. A new policy was developed to compensate patients for their labor and encouraged to participate. In order to calculate the cost of replacing workers, it was determined that 955 patient workers worked at 62 percent efficiency, the equivalent of 340 full time staff. Each hospital was provided \$100,000 to hire new staff and to compensate the patient workers. The report stated:

Needy patients performing regular work would be provided a gratuity or spending allowance of from 25 cents to \$2.00 dollars per week. Such gratuities would convey the State's and the hospital's gratitude. They would improve patient morale. They would provide an incentive to patients; and they would provide pocket change, which would assist patients in learning the value of money, how to count it, and how to spend it.

In 1974 the Fair Labor Standards Act was passed and the hospital was required to pay full wages for the patients' work. The 1975-77 Budget Request included a request for \$1,700,000 necessary to pay the required wages. However, the work itself was deemed to be of value to the patients because it helped them develop job readiness skill and marketable work skills. Dr. Brooks reports:

We had job specifications for ninety-five different jobs for patients. We used those as training and certain jobs paid more than others did. We had people working in the kitchen and on the lodge. We had people being trained for custodial work. We tried to train them so that they might do some meaningful work. We developed training programs for patients to be caregivers. We had so many elderly people here. We had what we called patient assistant in nursing. We had student nurses on the campus at the time. These students would take the patients by the hand and show them how to make a bed, how to give a backrub, how to do all of those things. The patients began to graduate. With the proliferation of nursing homes, everyone was looking for help. We had a graduation ceremony every three months.

During the decade of the 1950s the hospital farms gradually ceased operation because they were no longer cost effective. With shortened stays, those patients who would be most likely to be good workers were discharged

The majority of the farm products produced by the farm at OHSU were consumed at the institutions. In 1958 the farm manager reported the value of the food produced was \$18,226. It included some of the following:

Figure 6 Quantities of Farm Produce Harvested in 1958

Milk	10,150 gal
Beef, dressed weight	5,662 lbs
Pork, dressed weight	10,125 lbs
Eggs, medium	3,900 doz
Hens, dressed	1,904 lbs
Onions, dry	5,880 lbs
Carrots	4,600 lbs
Corn	5,600 lbs
Cabbage	4,200 lbs
Green Peppers	2,220 lbs

In spite of what looks like a wonderful diet, the following poem was written by a patient about the food (about 1952):

Macaroni and beans flow to us in endless steams,
No meat in the stuff, though we look in vain, it seems,
We may have loved prunes once for breakfast or once at dinner,
But bowl and bowls of them appear and the juice gets thinner and thinner.
With a teaspoon like a shovel to scoop up our starches,
We get so fat and stupid on the d-urn stuff, I fear fallen arches.

Farming at EOSH, the last institution to maintain its farm, was discontinued in the late 1950s due to cost, lack of labor and the belief that it lacked therapeutic value.

Community Treatment Programs

As the length of hospital stays decreased, more intensive treatment was provided in the community for those who had been in the hospital or needed a high level of care. Treatment consisted of an individually planned, closely supervised and tightly structured program for several hours a day. The programs emphasized individual and group psychotherapeutic and rehabilitative interventions. Intensive day treatment programs, oriented toward persons who could respond to treatment of a relatively short duration (average 8 weeks), helped patients resolve major conflicts and gain or maintain independent living.

Socialization programs were available for those needing less intensive treatment. The programs, less structured and of longer duration, were designed to maintain or improve community adjustment through emotional support, social activities and skills classes in managing problems of daily living. Clients could utilize a day treatment program anywhere from 1/2 day per week to 5 days per week, depending on their need and the level of treatment they required.

Group homes were another aspect of community treatment. However, many could not meet the program standards set by the Mental Health Division. During the 1975-77 biennium, only 48 mentally ill adults living in 7 group homes received the level of treatment and training required by Mental Health Division program standard. Four hundred forty-eight similar residents living in 27 other group homes received no treatment or training. Group homes required that the patients participate in out-of-home activities 5 hours a day, 5 days a week. Day treatment programs, particularly socialization programs, should have been used

for all or part of this requirement but there were not enough day programs available.

In the last several decades many improvements in treatment have been instituted and mental health services have been extensively developed. Medicaid has provided funding for the expansion of the breadth and depth of services in both the community and the hospitals. In the late 1990s, these are the services that are provided:

Acute Services

- Non-Hospital Crisis Services Provides screening, evaluation and crisis stabilization 24-hours per day, 7 days a week
- Pre-commitment services Includes screening requests to determine the advisability of filing petitions alleging mental illness, investigating petition allegations and holds, making recommendations to the courts about the need for a hearing, providing testimony at commitment hearing, and making recommendations for disposition and treatment
- Community Hospital Services Funds hospital and physician related costs for emergency hold and for voluntary and civilly committed patients in community hospitals.
- State Hospital Services Each county is allocated these resources in terms of a number of beds utilized on an average basis. Oregon's public psychiatric inpatient services are provided through three hospitals.

Non-Acute Services

- Community Treatment Services – Children Provides evaluation, brief intensive treatment and less intensive long-term supportive treatment in outpatient settings.

- Community Treatment Services – Adults Provides long-term supportive treatment, medication management, evaluation, brief intensive treatment and less intensive long-term supportive treatment in outpatient settings for serious mentally ill adults.
- Community Support Services Includes case management, outreach, medication management, daily structure and support, employment skill development and residential resource development.
- Community Support Services – Homeless Provides outreach, crisis intervention, diagnostic services, community services, health services, and referral services for homeless persons with chronic mental illness.

Residential Services

- Supported Housing Services Includes skills assessment, support through regularly scheduled staff contacts, assistance with activities of daily living such as grocery shopping, skill training and advocacy.
- Adult Foster Care Services are provided in a licensed home for five or fewer persons with mental illness who are unable to live by themselves without supervision.
- Residential Care Facilities Licensed homes that provide 24-hour supervision.

Vocational Services

Supported Employment Services provide on-going supports needed to maintain a worker on the job following the termination of initial vocational training services provided by the Vocational Rehabilitation Division.

Forensic Services

The Psychiatric Security Review Board (PSRB) services include evaluation of persons for the court and the Board to determine whether they can be treated in the community, and treatment of persons conditionally released into the community. Services include evaluation, supervision, and case management, psychotherapy and medication management.

Case Management

One of the primary features of contemporary mental health services is the use of case management as one of the primary interventions to assist clients to live in the community. Case management services include:

- Screening and evaluation
- Individualized treatment planning
- Assistance with applying for benefits
- Coordinating services with other agencies and resources
- Assurance of 24-hour per day services available through the community mental health program

Case management services vary from county to county. In some counties case managers are county employees who provide overall treatment coordination and broker direct services through private, subcontract agencies. In other counties, case managers provide the entire range of services for clients directly.

Board of Eugenics

The story of the evolution of mental health treatment would not be complete without a discussion of the Board of Eugenics. For many decades the Board of Eugenics was an integral part of the mental health system. Its activities affected many of the citizens of Oregon and reflected the values of its time. The Oregon

Legislative Assembly passed a law creating the State Board of Eugenics in 1917.

The Board had two mandates:

- To handle the approval of the ordering of sterilization of mentally ill, criminal, incurable syphilitics, moral degenerates or sexual perverts who are likely to become a menace to society
- To consider marriage licenses where the physician has decided that the applicants were ineligible because of epilepsy, feeble-mindedness, insanity, drug addiction, chronic alcoholism etc.

The Board of Eugenics membership included the Director of the State Board of Health and the superintendents from the two state hospitals, Fairview, and the State Penitentiary. The Clerk of the Court was directed to transmit to the Board of Eugenics a certified copy of the records of any person convicted of "rape, incest, sodomy, contributing to the delinquency of a minor by a sexual act or an act of sexual perversion or a crime against nature, or attempting to commit any of said crimes." The state hospitals, the State Training School for Boys, and the State Health Officers were also required to report to the Board of Eugenics all persons "who were feeble-minded, insane, epileptic, habitual criminals, incurable syphilitics, moral degenerates or sexual perverts and who are likely to become a menace to society."

The Board was funded by state funds and derived its legal authority from Oregon Law. An example of the board functioning was included in the 1950-52 biennium report which stated that during that time period 93 persons were sterilized by order of the Board: 25 males and 68 females. Fifteen premarital applications were referred to the Board for mental deficiency or disease and 49 cases of sex offenders were identified. It is noted, however, that the courts were

very reluctant to report sex offenders because they saw the Board of Eugenics as sterilizing all offenders.

In 1961 a bill was introduced to abolish the Board of Eugenics on the grounds that there was no scientific basis for the idea regarding the heredity and genetics of mental disease. In spite of this effort, the Board expanded over time and in 1967 included the entire membership of the Board of Health, the superintendents of all the state institutions and the warden of the penitentiary. Membership of the board was changed in 1967 and the Governor appointed several physicians, a clinical psychologist, a psychiatrist, a social worker, and several community members to serve as its members. More restrictive provisions for sterilization were created and the name of the board was changed to the State Board for Social Protection. The Board was transferred to the Health Division in 1971 and abolished in 1983.

Improvement of Patient Rights

The laws passed at both the national and state level had an enormous impact on how services were provided at the state and local level. One of the first laws that began to define patient rights was passed in 1943. It stated that if an alleged mentally ill person requested the assistance of counsel, the court would give him or her the opportunity to obtain legal counsel. However, if the person was indigent, no provision was made for legal counsel.

The concept of patient rights was expanded in 1949. The law stated that, in the larger counties, the district attorney must be present at the commitment hearing "to prevent fraud or collusion and to protect the interest of the alleged mentally ill person." Another important law addressed emergency commitment

and was passed in 1949. It stated that a person could be admitted to a state hospital for "emergency treatment, care, and custody, for a maximum of 15 days" if the probate judge was unavailable to order hospitalization.

In 1953, hospital superintendents were given the authority to establish outpatient clinics providing diagnostic services and treatment in lieu of civil commitments and for people released from the hospitals. In 1955 the hospitalized person was given the right to petition the court to make a finding of competency. When a person was discharged from a commitment, the superintendent of the hospital was required to certify whether or not the patient was competent.

In 1973, patients' rights took a leap forward, reflecting the establishment of expanded civil rights for all people throughout the country. In *The Turning Point* document which developed the plan for an improved mental health system, many new statutes were introduced increasing patients' rights. They included statutes relating to involuntary commitment of mentally ill persons and provided for these actions:

- Precommitment hearings
- Legal counsel for indigent persons
- Appointment of a nonmedical examiner if necessary
- Burden of proof in commitment hearings beyond a reasonable doubt
- Limitation on duration of commitment
- Definition of a mentally ill person

Another statute, passed in 1974, stated that mentally ill persons were to be committed to the Mental Health Division instead of to a state hospital. The commitment was limited to the duration of 6 months.

Discussion

The standards for appropriate care and treatment changed dramatically from 1945 to 1999. The changes occurred for a number of reasons. First was the recognition that the state hospital was not the most therapeutic environment for a person with a mental illness. Dr. Treleaven described the effects of long-term hospital stays that became apparent over time.

It was discovered that much of the disability suffered by long-term-stay mental patients was the result of the isolated, socially constricted, and unnatural way of life found in state hospitals. Intensive treatment, greater patient freedom and responsibility, and early release prevented, in many cases, the development of institutionalization and chronicity.

Although it became widely recognized that reforms were needed in the state hospitals, the extent of the reforms would not have been possible without the new major and minor tranquilizers and other medications that mitigated or controlled the symptoms of severe mental illness. Early treatments, although they may have helped some patients, did not have the curative properties that the psychotropic medications had and many patients would not have been able to leave the hospital without the use of the medications.

In the current environment with its emphasis on brain research and new medications, there is even more hope that mental illness, while it may not be completely curable, can be managed so that most people, regardless of their diagnosis, can live normal lives.

Another major factor in the evolution of appropriate care and treatment was the increased emphasis on the rights of mental patients. Patients greatly benefited from the civil rights movement of the 1960s. Although there is still stigma surrounding a diagnosis of mental illness, each person's civil rights are guaranteed by law. The dissolution of the onerous Board of Eugenics, and the evolution of the civil commitment laws demonstrated the growing importance of patients' civil liberties. Outside of the hospital and in the community, patients' rights have been further guaranteed with the passage of the Americans with Disabilities Act of 1995.

An additional factor has been the development of the Community Support Services philosophy that has been adopted throughout the state. These principles recognize the mental health client's need for a range of treatments and resources, including housing and personal support. This is demonstrated in the proliferation of case management services in all aspects of mental health care.

ADMINISTRATION OF SERVICES

The administration of mental health services in Oregon has continually evolved. As the service system has expanded and the number of state and federal laws has increased, more complex administrative structures have become necessary. During the last five decades the management staff for the administration of mental health services has moved from an initial oversight board of three people to hundreds of people employed at the state and county levels today.

Early Administrative Structures

In 1880, the Legislative Assembly of Oregon appropriated funds for the state hospital in Salem and created a Board of Asylum Commissions to oversee its construction. The Board was composed of three chief state officers: the Governor, the Secretary of State and the State Treasurer. In 1913, with the development of additional state institutions, the Board of Asylum Commissioners was renamed the Board of Control. The Board of Control maintained responsibility for the state institutions until 1969, when it was abolished.

Responsibility for the administration of community based mental health services in Oregon was formalized in 1941 with the creation of the Division of Mental Hygiene. This Division was part of the Department of Health. Its placement within that department reflected the belief that mental health was a public health issue. The Division's work was to prevent mental illness through education about mental health issues. Although prevention remained a goal of all mental health services throughout the coming decades, prevention at this time was a primary goal.

The Division of Mental Hygiene retained its identity and mission until the mid-fifties when mental health issues had come to the fore nationally because of the conditions within the state hospitals. Efforts were made throughout the country to examine how improvements could be made. With this emphasis on mental health, the name of the Division of Mental Hygiene was changed to the Division of Mental Health. It was charged with continuing to improve education about mental health issues, as well as integrating and coordinating services at the state and local level, examining the mental health needs of the state, and setting standards for the training of mental health professionals.

All mental health programs at this time were under dual administration: the Board of Control, which continued to oversee the state hospitals, and the Oregon State Board of Health, composed of 9 members, which was responsible for the preventative mental health programs in the state, including child guidance.

In 1961, based on the recommendations of a Governor's Advisory Committee on Mental Health, the Mental Health Division was created as a separate entity under the Board of Control. The state hospitals and training centers, the Board of Health and the liquor commission were transferred to the Division. The Governor's Advisory Committee also called for a greater emphasis on community mental health facilities. Mental health programs were then developed in cooperation with local governments and these local programs were integrated with the total state mental health programs. The community clinics, emerging from the Child Guidance Clinics, were the service providers at the local level and offered counseling, public education and testing, screening, and diagnostic and referral services for all age groups.

The Changing Role of the State

The creation of the Mental Health Division initiated a change in the role of the state, from provision of direct services to coordination and oversight. The first director of the Division, Dr. Joe Treleaven, commented about the role of the state in mental health services:

What is the responsibility of the state government in the provision of mental health services? The law of Oregon charges the Mental Health Division primarily with correlation and coordination of mental health facilities throughout the state. It is the job of the Division to study the entire mental

health field, make available to ourselves pertinent information, look at the total picture, see what the needs are, and assist the public in finding solutions for problems.

Oregon's growing emphasis on the need for community services was echoed throughout the country and became federal policy with the passage of the Community Mental Health Services Act of 1965. To facilitate the transition from hospital to community services throughout the state, the Mental Health Division was awarded \$100,000 for planning by the National Institute for Mental Health (NIMH) for planning. A planning board was appointed to study the problems of mental illness, create an increased public awareness of those problems, and develop an action plan to prevent and cure the problems. The mental health plan designed by the planning group was adopted by the 51st legislature and it was to "encourage, aid and financially assist the state and county governments in the establishment and development of mental health services ... through county administered mental health clinics." The planning document was entitled *The Ultimate Goal, A Plan for Today*.

The Ultimate Goal, A Plan for Today provided the early framework for the development of community-based services for mental health in Oregon, with local control being granted to the counties or their representatives. The recommendations made by the Planning Board reflected the latest thinking in mental health service provision. The Board stated:

The development of comprehensive mental health services should be the most important immediate and long-range goal. A comprehensive program, providing a complete range of services: inpatient, outpatient, emergency,

partial hospitalization, community services diagnostic, percare and aftercare, rehabilitation, training and research and education should be available.

Two federally assisted community mental health centers developed as a result of the Community Mental Health Centers Act of 1965: Lane County Community Mental Health Center, which was established in 1968, and Eastern Oregon Community Mental Health Center established in 1972. Other counties also established community-based programs using a match of state and county funds, so that by 1969, 99 percent of the state's population had access to community services. However, there was wide variability from county to county in numbers and types of services available, reflecting the local commitment of funds. Some counties had developed fairly comprehensive services; others had spent very little for mental health services. An issue of contention was the definition of state and local program responsibility. County commissioners generally viewed inpatient treatment as a state responsibility, and therefore were frequently reluctant to become involved in developing inpatient programs or other alternatives to hospitalization.

The Reorganization of the Division of Mental Health

Although all counties had some mental health services by the late 1960s, services were still inadequate. The necessity for reducing the dependency on the state hospitals and for providing services in the local area became clearer as time progressed. In 1971 the legislature authorized the reorganization of the Division which had become part of the Department of Human Resources. The Division was separated into three types of service areas: Mental Health, Mental

Retardation, and Drug and Alcohol. New mental health geographic service areas were brought together, based on population, geographic considerations, and unique local needs. These areas were either counties or several counties, if it was not possible for one county to provide a full range of services. All the direct and contract programs were further combined under three geographic regions whose boundaries corresponded with the catchment areas of the three hospitals. The hospitals were also divided into geographic wards.

Three program offices were established in each of the regions, each having responsibility for program quality, coordination, and planning within their region. Proposed program improvements, combined with existing services, were designed to create a comprehensive community mental health program, integrating community services with each of the three state hospitals.

Reorganization of the Mental Health Division central office and its program staff was designed to reduce the barriers between hospital and community programs and to separate planning, development, and quality assurance from program operations. The use of regional directors throughout the state delineated the lines of responsibility from the community level through the regional directors to the Administrator of the Mental Health Division. It also acknowledged that local people had a better awareness of their communities' needs and resources.

In discussing the new approach to providing mental health services in the local community, the budget request document states:

Such alternatives are more effective than state hospitalization, primarily because of when, where, how, and who helps people. Help will be timely, making long holding periods in community facilities without treatment a

thing of the past. Help will be available at the location that best serves the needs of the patient, including his home or telephone, the local hospital, other local programs, and in many instances, such locations as the schools, courts, jails, and even bars.

The new community mental health programs placed a greater emphasis on serving persons with chronic mental illness in the local community and included outpatient diagnosis and treatment, consultation and education, crisis services, outreach services, prehospital screening programs, improved intensive family crisis treatment, prescreening programs and mental health services for children. Alternatives to state hospitalizations were developed at the county level and included 24-hour emergency services, local inpatient hospital treatment, and day treatment programs.

A new law also changed the matching fund formula for financing community mental health programs to require that matching funds be 50% state funds and 50% county funds. The Mental Health Division was required to contract with counties and provide up to 100 % funding for certain alternatives to state hospital care. This new approach made the counties the local planning and management entities of Oregon's mental health system.

Increasing comprehensive services in the community had been part of the Mental Health Division's planning effort for several years. Twelve task forces of more than 100 people were at work. Their effort culminated in the biennial Budget Request for 1973-75. A major portion of the request was published as 1973 – *A Turning Point for Mental Health Programs in Oregon*. In this document a vision for a Comprehensive Community Mental Health Program in Oregon was

described, utilizing the federal government's guidelines set down in the Community Mental Health Services Act.

Shifting State Hospital Resources to the Community

To improve the community/hospital connection throughout the country, NIMH developed the Community Support Program model. This federal program was established in 1977 to refocus attention on the community service needs of chronically mentally ill persons. With the assistance of special funding from NIMH, Oregon developed a Community Support Program to assess and redesign the system to more effectively meet the needs of those persons with the most severely limiting mental illness. A Governor's Task Force on Mental Health, which published a report in 1980, was a key contributor to the resulting systems changes.

This report resulted in the enactment of the Local Mental Health Services Act by the 1981 Oregon Legislature. Community Support Services were made available statewide for the most severely disabled mentally ill persons and the 50 percent local funding match was no longer required. The legislature also directed the Mental Health Division to develop a plan for shifting state hospital resources to community programs through projects to reduce hospital usage. After the development and implementation of a pilot project to test the feasibility and outcomes of the proposed plan, a hospital bed reduction plan was implemented statewide. It required counties to project how many beds they would use at the state hospital, making hospitalization a service element in the range of services each county would provide. Funds previously used for hospitals were shifted from the hospital to the communities, based on the resources available and the

counties' capacity to deliver services. A priority system for hospital bed usage, discussed previously, was put into practice.

Changes were also made in other service areas. Residential services became the responsibility of the Mental Health Division in 1979 when all group homes were transferred from Adult and Family Services to the Mental Health Division. During the 1979-81 biennium, limited experimentation with other types of residential services, named LINC (Living in the Community) occurred under the auspices of the Community Support Program sponsored by NIMH. As a result of the success of these programs, the Legislature restructured the statutory mandates of the Division to transfer the jurisdiction of residential programs from the state to the local Community Mental Health Programs. The intent was to integrate residential services with other community mental health programs. Prior to these changes, residential providers contracted directly with the state.

The Legislature also transferred foster homes and homes for the aged serving people with mental illness from the Senior Service Division to the Mental Health Division. Responsibility for licensing residential services remained with the state. The 1983 Legislature also authorized funds to begin the Semi-Independent Living Program, creating new beds for the program.

The State/County Partnership

With the new mandates established by the state legislature, all community mental health services were provided through a partnership between the state and counties. The state contracted with the county mental health authority for the provision of all community services. The county community mental health programs either provided services directly or subcontracted with private providers for service provision.

The County Mental Health Authority, the Board of Commissioners or a judge became responsible for overseeing local mental health service delivery. Each county was also responsible for appointing a local Mental Health Advisory Board to assist with advice planning and monitoring.

Private providers who contracted with the county included non-profit agencies, proprietary establishments and for-profit organizations. In 1989, over 320 private providers existed throughout the system and ranged from comprehensive community mental health centers and local psychiatric hospitals to smaller more narrowly focused programs, such as vocational rehabilitation agencies and residential programs.

To insure effective collaboration and coordination, the roles and responsibilities within the community service system were defined in the Oregon Negotiated Investment Strategy (NIS), adopted in April 1984. NIS Teams representing advocate groups, providers of service, county mental health program directors and the MHD produced an agreement which:

- Defined general roles and responsibilities for each group
- Set performance standards
- Identified the local planning process
- Established contracting practices
- Delineated policy regarding the reallocation of resources
- Described data collection and reporting
- Established payment timelines and cost statement requirements
- Discussed arrangements for specialized, statewide and regional services

Most of the statutes passed by the Legislature in the late 1980's continue to serve as the mandate for current services. The state has developed greater oversight capacity and grants licenses to all services contracted through the county, with the exception of some residential services licensed by the counties.

Discussion

Growth has been the hallmark of the administration of the mental health system in Oregon. In 1945, mental health administration consisted of several people within the Health Department. The Board of Control had oversight for the operations of the state hospitals, often implemented through close personal relationships with the hospital superintendents. With the creation of the Mental Health Division, and subsequently, The Human Resource Department, several layers of management structure were added. With the dissolution of the Board of Control in 1969, the chain of command became more diffuse. As a result, identifying and solving problems became a more complex process.

The current mechanism for making policy has evolved over time. Earlier in its history, the state had a simple process for problem identification and problem solving. It was probably best demonstrated by the story, previously described, of the rapist who escaped from the state hospital. The governor told the hospital administrator to create a program so dangerous people could not escape from the hospital and a program was created. Although the process still went through legislative channels, there was more direct contact between the administrators who provided the services and the Governor and the Board of Control.

Throughout the state's history, when problems concerning mental health services emerged, either through an emergency situation that brought a problem

to the public's attention, or through a federal mandate, the state often responded by setting up a committee to make recommendations to the Governor. The committee formed usually represented the constituents of the community and brought to the table most points of view. Through the committees' recommendations to the Governor, legislation was proposed. On-going policy discussions through the Division also produce recommendations for legislation through the biennium report. People involved in the policy discussions may include representatives from the counties, advocates representing consumer and family groups, the Mental Health Association, the Oregon Advocacy Center, the provider organizations, the health plans, the psychologists and other parts of state government that have an interest.

Once the legislature passes a statute, the Division issues rules related to the implementation of the statute. If the rules are service related, the state contracts with the county for the service provision with the rules as guidelines. The counties are the vehicles through which the state implements its program policies. The state monitors compliance through its Division of Quality Assurance and if the counties do not comply, the state may withdraw the service contract.

Services may vary widely from county to county and this is both positive and negative. Barry Kast, the current Administrator for the Mental Health Division comments:

What distinguishes a county from its neighbors has to do with the political leadership and the demographics. If we want to have one uniform mental health system we have to have one contractor - one provider and then you get

all the problems that come with that. If we want the strengths of local control we get the problems that come with that.

Mental health administration has developed into a system over time from one that concentrated decision-making power in the hands of a few to one that spreads the creation, management and oversight of programs throughout the system. The state/county relationship is particularly important in service delivery and the counties have significant autonomy. The other functions of state government, such as quality control, are carried out by the state office.

CONCLUSION

This paper has summarized and discussed the changes that have occurred in the mental health system from 1945 to the present. The changes have been dramatic and extensive. During this time our vocabulary has changed from "senile dotard" and "insane" to people with mental illness. It is no longer possible to commit someone to life in the hospital without due legal process. Treatment has progressed from brain surgery to medications that alter the functioning of the brain. Placements have evolved from large impersonal institutions to small, home-like apartments. The administration of services has evolved from management by the Board of Control to collaborative policy development utilizing task forces and committees that represent the points of view of the people who provide and receive services.

However, there is still work to be done. Many people go untreated for lack of resources. Poverty is the state's greatest enemy in meeting its goal of providing appropriate treatment for all its citizens. Homelessness is a fact of life for many

for many with severe mental illness, and housing has become a critical issue.

Barry Kast describes the problem:

The people who are on SSI or on state assistance have not had their income support go up consistently with the cost of inflation and it has gone up only a fraction of the rate at which housing costs have gone up. If housing affordability is based on no more than 30 percent of your income, 85 percent of the people with serious mental illness can't afford housing. That is why we have homelessness. It is not because of their mental illness. It is because of their poverty.

At the state level, money is also an issue. Although there are many services available, the number of services and the budget for those services has not increased to keep pace with the population growth. The core of the problem is the lack of financial resources available to the state. Oregon has no sales tax. There is a cap on property tax. Mental Health, which in 1945 made up the majority of the budget, must now compete with education and many other services. The pie piece gets smaller. Again, Barry Kast states:

The state's decision-makers are constantly struggling over what is the right level of investment to make. What is the best strategy? Whom can they trust to tell them what is going on?

Many challenges remain to meet the needs for adequate mental health services for all the citizens of Oregon. The challenges are not only to the state's decision-makers, but to the county governments and mental health providers as well. Consumers and their families could be a more potent force for change by

making their voices heard. Finally, the citizens themselves have the final say through the voting and referendum process.

History has demonstrated that the citizens and the state legislature have tried to effectively meet the mental health care needs of all. There is every reason to believe that this effort will continue into the new millennium.