MENTAL HEALTH DIVISION

DATE: September 30, 1964

MEMORANDUM

TO: The Honorable Howell Appling, Jr., Secretary of State
State of Oregon
Capitol Building

FROM: J. H. Treleaven, M.D., Administrator
Mental Health Division
J. H. Treleaven

SUBJECT: The decline in mental hospital population; the development of community mental health services; and possible interrelationships.

A. The decline of mental hospital populations.

The decline in the number of hospitalized mentally ill has been general throughout the western world, beginning in the eastern United States in 1956 and in Oregon in 1958. According to U.S. Public Health Service reports, this decline has continued for eight consecutive years. Actual statistics indicate that in 1963 there were 504,947 public mental hospital patients, which was 9.7% lower than the total in 1956. Nationally, the decrease was 2.1% in 1963 in spite of a 6.8% increase in admissions. I am providing these figures for comparison with our experience in Oregon.

The admission rate to all mental hospitals in Oregon was increasing steadily until March, 1961. At that time, Oregon State Hospital began intensive screening of voluntary admissions and education of committing courts regarding the type of patient that should be admitted. At the same time, Dammasch State Hospital opened its doors, screened voluntary applications, and interpreted the function of the Hospital to the courts. Since that time, the annual admission rate has been constant at approximately 4,500 per year to all hospitals. The in-resident population in mental hospitals in Oregon had been increasing steadily until 1958, when a peak population of 5,065 was attained. Since that time, there has been a very rapid decline in the total in-resident population -- in August, 1964, a total of 3,150. Part of the initial decline was due to the transfer of over 300 patients from the jurisdiction of Oregon State Hospital to Oregon Fairview Home with the transfer of Prigg Cottage.

The in-resident population, on June 30, for the past ten years follows:

1954	4,733	1962	4,143
1956	4,980	1963	3,701
1958	4,998	1964	3,284
1960	4,583		

109-M-101

You will note that the greatest decline has been in the past two years. This decline in mental hospital bed occupancy is even more striking when adjusted for changes in the population. The bed occupancy rate per 100,000 population for Oregon in 1953 was 278; in 1958, 294; in 1964, 176. Also note the reduction from the peak year (1958) to the present is 40%.

The reasons for these striking reductions in population appear to be multiple and the weighing of the various factors a matter of opinion. It is my belief that the decline in Oregon is due to the following factors, listed in order of their significance.

1. More effective treatment and attempts at community placement made possible by improved mental hospital staffing;

   more adequately trained staff;

   more psychiatric drugs and new psychotherapeutic techniques, including work therapy and milieu therapy programs;

   and perhaps most important, a change in attitude on the parts of both mental hospital staff and the public from one of hopelessness and indefinite custodial care to one of treatment, rehabilitation, and community placement.

   Perhaps of all these factors, the advent of tranquilizers was the catalyst that produced the other changes. It, therefore, may be regarded as a primary factor.

2. The screening of voluntary admissions and the re-education of community agencies, especially the committing courts, public health departments, welfare agencies, and physicians, regarding the appropriate use of mental hospitals.

3. The opening of Dammasch State Hospital and its efficiency at preventing long-term hospitalization.

   (During the time between the opening of Dammasch State Hospital and December, 1962, 2,769 patients were admitted. A study conducted one year later -- December, 1963 -- found only 45 of all these patients remaining in the Hospital for over one year. These 45 patients staying over one year, or 1.5% of the total number, represent a record beyond that reported by any other hospital to my knowledge.)

4. The Old Age Assistance program began July 1, 1961, and provided funds for the placement of those patients over 65 years who no longer needed special hospital services.

(In March, 1964, we surveyed all patients placed since the beginning of the program and found that of 571 persons placed, 377 were still in residence, 118 had deceased, 50 (8.8%) had to be re-admitted, and 12 were off public assistance and remaining outside the institutions independently.)

5. The increased amount of public and private community services available. The number of psychiatrists in private practice in Oregon has quadrupled over the past decade. The increased availability of private care and the services offered by some of the community mental health clinics has probably reduced the number of patients admitted to mental hospitals and has allowed for earlier release by providing follow-up community care. This was indicated in a study done in 1963 which revealed the admission rate per thousand in counties with local mental health services (and in many cases with private practicing psychiatrists) was 1.9 in contrast to 2.7 per thousand for counties without mental health services. Further, in analyzing the new admissions to the various state hospitals, we find both in 1962-1963 and 1963-1964 that the rate of admission*per 100,000 people served is very much greater in eastern Oregon than in the western part of the State. In 1963-1964, 80.2 per 100,000 were admitted to Oregon State Hospital from its catchment area; 148.3 per 100,000 were admitted to Dammasch State Hospital from the area served by that institution; 255.4 per 100,000 were admitted to Eastern Oregon State Hospital. Lack of community facilities and private resources appear to be two of the major reasons for this discrepancy.

B. The growth of community mental health services.

Prior to the operation of the new mental health program in July, 1962, eleven child guidance clinics had been established in health departments throughout the State under a program operated by the State Board of Health. Only children were seen in these clinics. With the beginning of the grant-in-aid program, the number of clinics increased from eleven to seventeen and the range of services extended beyond child guidance. Not all of these clinics provide follow-up to mental hospital patients, but in the last two years much more effort has been devoted to this by the local mental health clinics. The number of persons under care has increased from the 1961-1962 level of 3,777 to 5,449 in 1963-1964. Staff, stated in full-time equivalents and including psychiatrists, psychologists, and social workers, has increased from 27.3 in 1961-1962 to 50.8 in 1963-1964, and is anticipated to be 62.5 in 1964-1965.

In 1963-1964, sixteen clinics offered child guidance services; thirteen offered family guidance, including marriage counselling; thirteen gave services to the mentally retarded; ten offered follow-up for persons released from state hospitals; six offered outpatient psychiatric treatment; and three, alcohol education and rehabilitation. (The Community Child Guidance Clinic in Portland, the seventeenth clinic, is included as part of the Multnomah County Mental Health Clinic.)

*First admissions are a more accurate index of hospital utilization than total admissions.

C. I do not believe it is possible at this time to adequately assess the significance of the community mental health clinic program in reducing the number of patients in the mental hospitals. My own personal opinion is that it is one of the several factors related to this decline and that the decline in the number of hospitalized mentally ill makes the development of community services even more imperative.

From my own experience in private practice, community clinics, and state mental hospitals, I am convinced that with adequate private care or community-based care, many of the patients now received in state hospitals could be treated more effectively and efficiently in the doctor's office or the community clinics, and that if such programs were fully developed, it would be much easier to return patients to their homes once they were admitted to the institutions and that the total cost of service provided would be much less.

JHT:D