A SHORT HISTORY OF
THE PUBLIC MENTAL HEALTH SYSTEM IN OREGON

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[The material for this short history is based primarily on an article by O. Larsell, which appeared in the December, 1945 issue of Oregon Historical Quarterly; and a paper by Jim Carlson entitled, "Emergent Issues in the Public Mental Health System," published by the Mental Health and Developmental Disability Services Division in 1995.]

The first references to white men with mental illnesses in the Oregon Territory were focused on Astoria, the oldest of permanent white settlements in the Northwest. Only a few years after Lewis and Clark's rainy winter encampment near Astoria, a massacre of an American Fur Company trading post near Three Forks of the Missouri by a group of Native Americans left a lone survivor who became mentally ill or "demented." The survivor wandered around for weeks until he was captured and cared for by Native Americans in the Snake River country. Larsell attributes his survival to the "superstitious attitude of the savages."

Whatever the cause of this first psychiatric stabilization, John Jacob Astor's overland party in 1811 came across the Native American group which had been caring for the white man, whose name was Archibald Pelton. He had recovered enough to be turned over to the trading party and he reached Astoria with this group in January 1812. Mental illness as manifested by Pelton may have been unusual for the Native Americans he encountered in the Northwest because Pelton's name became a part of Chinook jargon as designating a "mental affliction."

One of the Astor expedition members also became "demented" during the overland journey. His name is very familiar to Oregonians--John Day. Mr.
Day arrived in Astoria about a month after Mr. Pelton, where he too recovered enough that he was able to begin his journey back to the eastern part of the United States in the spring. Here then are the first two white men with mental illnesses in some degree of recovery, a concept which we sometimes mistakenly believe we invented in the recent decades.
John Day, however, became ill again on the trip east, and lost his life, apparently as a result of his becoming violent. In spite of this, there are two rivers named for

John Day in Oregon, one town in Central Oregon, a dam on the Columbia River, and several other geographical features. I believe it to be a source of pride that we work in a state that has so honored one of the first persons identified with mental illness to live here.

The next recorded mention of mental illness in Oregon comes with the establishment of the Oregon Territorial government in 1843. The provisional government formed at Champoeg adopted laws to outline arrangements for the care of the mentally ill. Probate courts were to direct the county sheriff to summon "a jury of twelve intelligent and impartial men" to investigate whether a person was "insane." If this jury so determined, the mentally ill person would be appointed a trio of guardians to sell his or her property and dispose of the proceeds to pay for the person's care.

If there was no property, the guardians were to ensure that the person received care at their own charge and were to ensure that the "unfortunate" receive "relief as paupers and be maintained under the care of the overseers of the poor." The guardians also had responsibility for safekeeping and maintenance of the mentally ill person and his or her family. Finally, If there were not sufficient resources, the county was required to pay for these supports out of the county treasury. Thus, the beginning of tensions and conflicts between state and counties in Oregon over the care of the mentally ill.

Further modifications came quickly. The next year, another law was passed which specified that a mentally ill person should be "let out publicly...to the lowest bidder, to be boarded and clothed for one year...". By 1850, there were 5 such persons identified out of a total population of 13,294. Counties soon appealed for state funds, which were granted in 1855 and then taken away the next year when another law passed which repealed the first. The “tug of war” continues to this day regarding the responsibility and capacity of counties to provide local care for persons with mental illness.

By 1861, Dr. J. C. Hawthorne had opened a private institution in Portland to care for persons with mental illness. His first temporary quarters were established in Portland between 1st and 2nd Streets and Taylor. In the fall of 1862, Dr. Hawthorne was the only respondent when the governor was required to contact suitable persons to care for persons with mental illness and to provide them with medical treatment. This surely must have been one of the shorter procurement processes in state history, since only two days elapsed between the legislature's

passage of the necessary legislation which authorized the governor to seek a provider and the signing of a contract with Dr. Hawthorne.

By the time of the actual opening of this new service, he had moved the facility about a mile away to what is now 12th and Hawthorne. This site was on the edge of the settled area, adjacent to woods and on a sloping hillside which provided a relaxed and healthy environment. The state contracted with Dr. Hawthorne to care for, at first, 12 patients in the fall of 1862. When spring came in 1863, the population of the institution had already increased to 28 patients. As the population of Oregon increased over the next 15 years, so too did the size and census of Dr. Hawthorne's "Oregon Insane Hospital." In 1866 there were 77 patients; in 1870 there were 111; in 1874 there were 194. In 1877, the costs of caring for these patients took up 52% of the total state budget!

Dr. Hawthorne, by almost all accounts, operated a very safe, sanitary, and efficient asylum, in the best sense of this sometimes misunderstood term. Inevitably, there were critics almost from the beginning, who accused Dr. Hawthorne of charging too much, of keeping patients who were too well--because they represented no challenges. Several investigations into these charges resulted in a complete affirmation of the work to which Dr. Hawthorne had devoted his life. It was not uncommon for Dr. Hawthorne, for example, to pay for the transportation of persons sufficiently recovered so that they could return to their home communities. These inquiries, however, may represent our earliest efforts at oversight and utilization review.

Dr. Hawthorne's thinking about early intervention and the likelihood of recovery bear quotation even today. In his report to the governor in 1878, he stated:

> "The percentage of the recoveries for the past two years shows an increase over that exhibited in my last report. This result is attributable to the condition of the patients when admitted, the form of insanity being acute in a greater number of cases. It is a fact which the experience of all engaged in the treatment of this class of patients shows, that judicious treatment in the early stages of the disease is, in a majority of cases, attended with success, while but a small proportion are restored to reason where a considerable period of time has elapsed before the patient has been put under systematic hospital treatment."

All this nearly a hundred years before our sophisticated antipsychotic medication and antidepressant medications. Dr. Hawthorne died within two years of the opening of what later became Oregon State Hospital. The population of persons in need continued to grow steadily until the legislature decided to open its own state-operated facility in 1883, at which time 370 persons with mental illness were transferred from the Portland facility to Salem.

Oregon State Insane Asylum grew by leaps and bounds. Just over 25 years after it opened, there were over 1,500 patients. By 1901, the county courts were committing so many patients that even the families were objecting that they could and would care for their mentally ill relatives through private resources. In 1913, 325 patients were transferred east to Pendleton where the state had built and opened a second state hospital. Families were assisted to care for their relatives during periods of stability by the passage in 1917 of legislation that allowed for persons to be released temporarily under "parole."

Nevertheless, treatment concepts were gaining in acceptability so that in 1907 Oregon State Insane Asylum's name was changed to Oregon State Hospital. Greater differentiation between types of mental disorders led to the recognition that a separate facility was needed for persons who were mentally retarded or developmentally disabled. For this purpose, Fairview Home was established in 1908.

The perpetual struggle for sufficient capacity and resources is illustrated by the continued inability of funded bed space to keep up with demand. Between 1920 and 1940, the Legislature approved funding for an average annual increase of 28 patients. The actual increase was an annual average of 50 patients. By 1942, the state hospital census had reached 2,622. In about 1958, state hospital census peaked at over 5,000. Our current state hospital census is just under 700.

The Board of Control, which traditionally oversaw the state institutions, reports for this period indicate that many patients were beginning to show improvement as a result of the new psychotropic drugs, like Thorazine, coming along at that time. This trend paralleled the national pattern though possibly a little later in Oregon than the national average. The rate of decrease in state hospital populations nationally for a 40 year period was 83%; for Oregon it was 81%. At the same time, the number of new admissions was also increasing, a trend which continues to this day with Oregon's community-based acute psychiatric hospital system.

Jim Carlson's 1995 paper, "Emergent Issues in the Public Mental Health System," points out that if the trend in hospital census had continued at the 1958 level, by 1994, Oregon would have needed nearly 9,000 state hospital beds (we now have about 725) and the cost even five years ago would have reached $767 million per year--just for state hospitals.

In the late 1950s, then Governor Mark Hatfield recognized the need for greater attention to the needs of persons in Oregon communities for mental health programming. Until that time, nearly all of the focus of mental health care took place in the state institutions. The Mental Health Division was established in 1961 to work in collaboration with county governments to promote the development of a system of community mental health programs. These and other efforts eventually led to the establishment of community mental health services in all of Oregon's 36 counties. These programs have increasingly offered a variety of mental health services from aftercare to day treatment to children's outpatient services.

At the time of the formation of the Mental Health Division, the public mental health system in Oregon consisted of three state hospitals, two training centers, 11 child guidance clinics, and one alcohol outpatient clinic. The Division, as directed by ORS 430, set about building a network of locally directed community mental health services and to upgrade institutional care and treatment. While federal legislation in the 1960s provided funds for establishing Community Mental Health Centers (CMHPs), Oregon took relatively little advantage of this opportunity--only a few such projects were developed. The areas in which such CMHPs were established included Eastern Oregon, Lane County, Clackamas County, and several in Multnomah County by the 1970s. Most community mental health programs were developed without federal funds using the State's 50-50 matching formula of state and local funds. By the early 1970s, there were a total of 27 CMHPs and 17 contract programs serving all 36 Oregon counties.

Further system and financing refinements took place in 1973 with Oregon's Community Mental Health Programs Act, which set up three regions for tying together state hospitals and community programs. It also established the structure which we currently still have with three program categories--Alcohol and Drug (A&D), Mental and Emotional Disturbances (MED), and Mental Retardation and Developmental Disabilities (MR/DD). This act further divided funding into two major categories--a continuation of the 50-50 mix for outpatient services, aftercare, training, consultation and education, and prevention services. And 100% state

funding for "alternatives to state hospitalization" which included 24-hour emergency care, day and night treatment services, local housing resources, and inpatient care in community hospitals.

However, in spite of the incentives established in 1973, and in recognition of the difficulties in adequately serving persons with severe mental illnesses, Oregon was one of the earliest states to pilot a Community Support Project in the late 1970s. This project highlighted the need for case management and outreach services for serving persons with the most severe disorders. By 1980, Oregon continued its attempt to focus on the most impaired individuals, both children and adults, by establishing in statute the now familiar Priority system for funneling funds to those most in need first.

Off and on, Oregon has demonstrated the effectiveness of focusing on those most in need. When state hospital census pressures have been great, crisis efforts have been increased to develop creative and cost-effective programs as alternatives. In addition, Medicaid Fee-for-Services funding gradually increased from the early 1980s until the mid-1990s, when it had become the primary funding mechanism for a range of services for adults. Services to children were dramatically increased through the early 1990s as a result of a lawsuit over access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Two key initiatives have driven the Oregon public mental health system over the past 10 years. One of these was the implementation of the 1988 Governor's Task Force on Inpatient Psychiatric Services Report--unfortunately in the context of budget constraints induced by the unanticipated Ballot Measure 5--and the integration of mental health services under the Oregon Health Plan. Both initiatives have relied heavily on federal financing. The development of a larger but decentralized extended care treatment system for adults (conversely stated as the closure of Dammasch State Hospital) was the most dramatic example of Oregon's attempt to deal with the values embodied in ORS 430 and the financial realities of fewer state General Funds for the support of state hospitals.

The Oregon Health Plan has been implemented using a capitated, managed care financing model for a portion of Medicaid services to an expanded pool of Oregonians. For persons eligible for Medicaid, the old Priority system no longer applies so that persons with treatable mental disorders are now assured of preventive care and earlier intervention. In this sense, the Oregon public mental health system has moved much farther toward "parity" in the treatment of

psychiatric disorders compared to other physical health care problems. While this system of financing continues to hold much promise, there are many implementation issues remaining to be resolved in both rural and urban areas, of which more will be heard later.

From these historical developments, at least three areas of concern might be noted here in conclusion. These include:

1) the continued evolution of state and county relationships in the delivery of mental health services,

2) the future role of the state hospital and alternatives to extended care such as the Childrens Intensive Services (residential and psychiatric day treatment services) and the PASSAGES-type projects which have been notably successful in reducing reliance on state hospital services for adults; and

3) the development of adequate financing and management mechanisms so that Oregonians with mental health needs are assured of a high quality, stable, and integrated system of health care delivery.