MENTAL HEALTH IN OREGON

In keeping with its statutory responsibility for the mental as well as the physical health of the people of Oregon (ORS 431.110) the State Board of Health has reviewed very carefully the materials directed to it concerning possible reorganization of the state's social service departments.

Board members and staff alike endorse the general principles expressed in the report of the Mental Health Advisory Committee and proposals of the State Department of Finance and Administration. We join with the many others who already have complimented the Committee for its outstanding job of delineating the breadth of the mental health problem, listing deficiencies and needs, suggesting solutions for many problems, and for its support of state aid to community health services. This study should do much to focus public attention on the importance of mental and emotional health and result in better support of preventive, treatment and rehabilitation programs throughout the state.

At the same time, we cannot help but wonder whether widespread acceptance of the Committee's organizational philosophy might ultimately retard better coordination of state services and reduction in the number of overlapping agencies. There is serious doubt whether the mere importance of a single aspect of public health should cause its separation from the total problem. If so, then we may anticipate many future requests, with excellent basis, for creation of a whole host of new agencies, sponsored by groups with the honest conviction that their area of interest is paramount. Considering the number of even the major health problems, this could lead to decentralization on a truly grand scale, with an attendant competition for already-scarce professional personnel. Still remaining would be the problem of whether to duplicate these organizations at the community
level, or force local officials to make the painful decision of how best to spread their limited resources to meet potentially-uncoordinated program requests.

There certainly is little doubt, as the Committee points out, that many of Oregon's current program difficulties can be attributed to low salary scales, which hamper recruitment efforts for existing staff vacancies. As you know, we have been unable to employ psychiatric personnel despite three years of intensive nationwide recruitment effort. However, care must be exercised in the correction of these deficiencies, because establishing a disparity between salaries would merely transfer the problem from the mental health field to other, and larger, branches of health work.

The importance of the total health program is emphasized by the Committee in its comments on the current trend from centralized institutionalization of the mentally ill to community care on both an in and out-patient basis. Oregon's ability to keep pace with this progressive trend will of course be in direct ratio to the adequacy of local health facilities and services.

There cannot be any question among responsible health authorities of the wisdom of the Committee's recommendation for long-range field research into the cause and prevention of mental problems. It is a tragic fact that there probably is no major area of health about which less is known today, despite the tremendous potential resources for research and epidemiological studies which already exist through our medical schools, public health departments and similar organizations. Putting such projects into effect obviously can be accomplished easiest and at least cost in existing agencies already possessing much of the basic organizational structure.

The success of any health program often is uncertain. Tuberculosis detection and prevention, for example, still is extremely difficult even though the specific
cause is known, and established organizations have had long experience in its control. In fields such as mental health—where so many questions remain unanswered—the difficulties of effective programming and the opportunities for costly error are vastly multiplied.

Too frequently, public concern about a specific health problem has resulted in its being singled out for special consideration. Although the motives may be commendable, this consideration may in fact hinder the program by removing it from close association with those sister services necessary to its success. Again using tuberculosis control as an example, public phases of the successful program depend upon a team of associated health workers assisting the tuberculosis staff: laboratory specialists, local health officers, public health nurses, health educators, statisticians, and such supporting service personnel as fiscal and personnel officers. Duplication of these specialists—who at the present time often can be used for many public health duties—may defeat the initial objective through public dissatisfaction over increased costs once primary enthusiasm for the program has waned.

Progress in mental health unquestionably has been slowed by its being placed apart for another reason: social stigma. In 14th century England, the mentally ill were made wards of the court, and they still are singled out from other ill persons through hospitalization by court procedure.

Today's medical student learns that mental health is inseparable from physical health. In addition, an ever-increasing amount of research into the causes and treatments of mental illness has been done during the past decade by anatomists, physiologists, biochemists, geneticists, pharmacologists and similar basic science
personnel. It is significant that improvements in the effectiveness of therapy have been chiefly through the use of new drugs, resulting from this team approach. Although the harm done by six centuries of isolation obviously cannot be remedied overnight, it is encouraging to see what application of the new concept already has accomplished.

It is also refreshing to note that hospital boards and administrators throughout the state are cooperating in this national trend toward integration of mental patients by including psychiatric departments in long-range general hospital planning. As you know, one Portland general hospital helped pioneer this trend many years ago, in the belief that patients could be helped toward recovery by keeping them in familiar community surroundings, close to family and friends, and free from the stigma attached to state mental hospitalisation. The current trend toward out-patient care is merely an extension of this concept.

It probably is usual for most people to picture only the acute mental case when considering this field, and it might superficially appear that establishment of a specific program to deal with these people would meet our needs. Unfortunately, the situation is not this simple.

A large proportion of our mental and emotional health problems never reach our state hospitals, nor even our community clinics. Most of these people will be seen from time to time by general practitioners or other private physicians, and may at times be hospitalised with some physical complaint of mental origin. The Committee's statement on page 2, item 1, "one out of every two U.S. hospital beds is used for mental patients" includes these cases.

This large and important aspect of the problem is inseparable from the rest of medicine and public health. Mental health plays a very real part, for example,
mental health—5

in such programs as medical rehabilitation of stroke victims, in accident prevention, in venereal disease and tuberculosis control, and many other programs handled daily by physicians and public health personnel. This is the most important reason why mental health education and research are included in our medical school curriculum, and why the community mental health programs are coordinated through our public health departments. In our opinion, the necessary coordination and strengthening of mental health services would be hindered rather than helped by duplicating existing agencies.

It is our alternate recommendation, which we believe is in keeping with the ultimate objectives of the Committee, that:

1. Existing community health agencies be strengthened, as proposed by the State Board of Health to both the 1957 and 1959 sessions of the State Legislature, to permit better integration of generalized mental health services into such programs as well-child conferences, prenatal clinics, expectant-parent classes, general public health nursing services, venereal disease and tuberculosis control, and similar programs;

2. Sufficient well-qualified staff be provided at both state and community levels to permit specialized mental health services for specific problems, such as children and adolescents with behavior problems, including delinquency; emotional disturbances, mental retardation and mental illness; marital problems of the unmarried mother; problems of the aging; and problems of alcoholism;

3. Community service for post-hospital patients and their families be improved;

4. Coordination between public prevention, treatment and rehabilitation programs be strengthened, and personnel and other resources be used more economically and efficiently, by consolidation within a medically oriented agency with suitable advisory committees representing other interested groups.
The Present Program

I. Objectives

The staff of the Mental Health Section has for several years considered as some of its primary objectives the following:

1. The promotion of optimum mental health in individuals and communities in Oregon through community education and anticipatory guidance:
   a) To provide maximum opportunity for healthy personality development;
   b) To deter the development of emotional disturbance and mental illness.

2. Through early case finding, treatment, rehabilitation, especially through adequate follow-up care for post-hospital mental patients, and supportive family services to limit, reduce, or, hopefully, prevent:
   a) Spread or harmful impact of illness on others;
   b) Relapse into illness after recovery;
   c) Progression of the illness to greater handicapping.

3. The integration, coordination, and expansion of community mental health programs to provide:
   a) Services to children and adolescents who have emotional and behavioral problems, who are mentally ill, or who have the usual problems associated with mental deficiency. Such service includes participation of parents and guardians and alleviates the impact of such problems on other members of the family;
   b) Services to adults to include: (1) marital, premarital or family counseling for all ages, particularly young adults; (2) unmarried mothers; (3) the aging and their relatives; (4) alcoholics and their families; (5) the mentally ill and their families.

II. Methods

Four general methods were used to attack this problem during the past biennium:

1. Provided staff and financial assistance to nine programs for children and adolescents and their parents in local health departments in Benton, Clackamas, Clatsop (7/1/58 - 6/30/59), Crook, Deschutes, Douglas, Jackson, Jefferson, Klamath, Lane and Marion Counties.
2. Provided staff assistance in community mental health planning and in mental health education for lay and professional people in Baker, Coos, Linn, Malheur, Umatilla, Union, Wasco and Washington Counties and City of Portland, as well as in the counties listed above.

3. Provided staff and financial assistance to special mental health projects in Clackamas, Coos, Deschutes, Klamath, and Lane Counties, including five mental health workshops of from one to four days' duration, two of which were state-wide in scope and not identified with any particular county.

4. Provided staff assistance in Benton, Clackamas, Clatsop, Columbia, Curry, Douglas, Jackson, Josephine, Klamath, Lane, Linn, Marion, Multnomah, Polk, Tillamook, Washington, Yamhill Counties and City of Portland in coordinating the referral and follow-up care for mentally ill patients discharged from Oregon State Hospital.

III. Program Content

A. Clinical Services

The nine outpatient mental health programs for children and their parents, operated by local health departments, received financial and staff assistance from the State Board of Health to provide services in eleven counties (Benton, Clackamas, Clatsop to 6/30/59, Douglas, Klamath, Marion, Lane, Jackson, Deschutes, Crook, Jefferson). Local monies were obtained from county courts, community funds, city and county schools, cities in the area, memberships and patient fees.

Each service had a position for one full-time psychiatric social worker, and all were staffed by part-time psychiatrists and full-time or part-time psychologists. (In 1959 Clatsop County eliminated its full-time position.)

Services were provided to children with emotional and behavioral problems, including the mentally retarded, and to their parents or guardians. Referrals were accepted from physicians, social and health agencies, schools, courts and parents. The children were required to have a physical examination not more than 30 days prior to admission and active participation by one or both parents or guardians was required. The majority of the clinics charged fees based on the ability of the individual to pay, ranging from no fee to $15.00 per interview.

Interviewed by the psychiatrists, psychiatric social workers and clinical psychologists in the above nine community mental health programs were:

(a) Child patients, individual interviews 4,058
(b) Parents, individual interviews 5,735
(c) Adult patients, individual interviews 513
Total number of interviews 10,306
(d) Group therapy, number of persons 1,096
(e) Group therapy, number of sessions 239
After five years, services were discontinued in Umatilla County in June, 1958, because the local health officer considered such service a function of the schools rather than the health department. After six years, services were discontinued in Clatsop County in June, 1959, primarily because of lack of interest in employing full-time local mental health personnel. It is the present policy of the Board of Health to assist in establishing or maintaining mental health services only through the local health department and only with local full-time personnel.

B. Consultation

Consultation to personnel in local health departments was available from the psychiatrist, psychologist, psychiatric social worker and mental health nurse in the following areas: administrative and personnel problems, community attitudes, program planning and case conferences. Such consultation was usually given on a regular, planned basis.

C. Training and Community Education

1. In-service training seminars were held for professional persons (private physicians, state mental hospital physicians, ministers, public health nurses, welfare workers and in one area a group which included school nurses, special educators and juvenile counselors), who do not have specific training in mental health and mental illness. Appropriate films were used and some of the topics covered included:

   (a) Normal personality development
   (b) Various types of mental illness and service to mentally ill patients and their families.
   (c) Mental retardation and counseling with parents of retarded children.
   (d) Emotionally disturbed children and adults, including particular problems of juvenile delinquency, of multi-problem families known to multiple agencies.

Conducted by local and state staff in 10 counties were 284 in-service training seminars in child psychiatry, mental health and mental illness, attended by a total of 3,126 professional persons, including state mental hospital physicians, school and public health nurses, welfare workers, ministers, special education personnel, juvenile counselors and physicians in private practice.

Participated in by local and state staff were 372 meetings attended by 8,056 persons for community planning and coordination in 11 counties.

Held by state and local staff were 255 meetings for informational and educational services for the general public, by giving talks and showing films in person, by radio and TV.
2. The staff planned and conducted a program in mental health and mental illness for medical student fellows in public health, with emphasis on the preventive aspects of various programs and on the understanding and use of community resources. Some of the health educators also participated in order to gain a broader understanding of mental health programs and resources.

3. Classes accredited by the University of Oregon in "Emotional Problems of Children" and "Emotional Factors in Teaching", attended by teachers, public health nurses and other professional persons, were conducted monthly in several areas.

Conducted by state staff were 13 class sessions of 2½ hours each for 206 teachers and nurses in 7 counties, on emotional problems of children.

4. Conferences about individual children, attended by one or more representatives of the schools, courts, welfare, health department and private physicians were used as a teaching device for better understanding of the emotional problems of all children.

Conducted by state and local staff were 1,661 joint conferences about individual child or adult patients with one or more representatives of agencies and other professional persons, with an average of 6 to 7 persons attending each conference.

D. Special Projects

1. Clackamas County:

A special grant from the Children's Bureau for a mental retardation project became effective 1/1/60 for 1 year. (See Biennial Report of Maternal and Child Health Section, State Board of Health)

2. Coos County:

(a) The educational program in Coos County was continued: (1) seminars by psychiatrist for private physicians, (2) seminars by psychiatric social worker for school and public health nurses, welfare workers, special educators, juvenile counselors, (3) accredited classes for teachers, nurses, etc., by psychiatrist, social worker and psychologist.

(b) Mental Health Conference: A community-wide one-and-one-half day workshop for lay and community persons was held. Staff for the workshop included psychiatrists, psychologists, psychiatric social workers, special education personnel, mental health nurse and local private physicians. Two of the health educators assisted in coordinating the program.
3. Klamath County:

A two-day conference on "The Family and Mental Health", attended by approximately 200 lay and professional persons from Klamath and adjoining counties, was planned and financed by this section. The conference leader was a nationally known child psychiatrist and the conference consisted of professionally trained mental health personnel, other professional persons not specifically trained in mental health, and lay persons in the community.

4. Lane County:

(a) The special project for mentally retarded, established through a grant from the Children's Bureau, was continued. (See Biennial Report of Maternal and Child Health Section, State Board of Health)
(b) Student Health Center, University of Oregon: Psychiatric consultation for students was continued.

5. Marion County:

Student Health Center, Willamette University: The psychiatrist-director of the Mental Health Section continued to provide consultation.

6. Mental Hospital "Follow-Up" Program:

(Benton, Clackamas, Clatsop, Columbia, Curry, Douglas, Jackson, Josephine, Klamath, Lane, Linn, Marion, Multnomah, Polk, Tillamook, Washington, and Yamhill Counties and City of Portland)

The mental health nursing consultant, through assignment to Public Health Nursing Section has been full-time coordinator since 1/1/60 for the referral program for follow-up care for mentally ill patients discharged from Oregon State Hospital. Two days weekly are spent at the hospital with the remainder spent in local counties, except for office time needed for program planning, making reports, attending meetings, etc.

The expansion of this "follow-up" program has been an outgrowth of the research project to study the rehabilitation of mental hospital patients. The research project continued during this biennium and will be published at a later date.

Continued state nursing assistance to local field follow-up of 698 discharged and paroled mental hospital patients.

7. Tri-County:

A one-day conference on mental health was held for ministers from various denominations in the Bend area. Staff consisted of psychiatrists, psychologist, and psychiatric social worker.
8. **State-wide:**

**Mental Health Conference for Ministers:**

(a) A special grant from NIMH made it possible to hold a four-day conference for 50 ministers of various denominations from areas throughout the state. Two nationally known men with training in both the ministry and mental health served as conference leaders. Other staff consisted of psychiatrists, psychologists, psychiatric social workers and mental health nurse. A health educator from the State Board of Health served as conference coordinator. A report of this conference has been published through NIMH funds.

(b) A second conference similar to the one described in the preceding paragraph was held the following year through local financing.

E. **Additional Activities**

1. **Certification for Special Education**

   The psychiatrist-director continued to review medical reports for the State Department of Education on all emotionally disturbed and mentally retarded children, in order to provide consultation regarding appropriate educational plans for the children.

2. **Processing of Drivers' Licenses**

   Processing of all drivers' licenses in which there is a medical question regarding the applicant's suitability for driving has continued as a function of this section.

   Processed 1,617 drivers' licenses in which there was medical question regarding the applicant's suitability for driving.

   Processed 425 medical reports of persons coming under the provisions of ORS 482.140.

3. **Processing of Premarital Forms**

   All applicants for marriage licenses have been processed by this section.

   Processed 40,727 premarital examination reports.

4. **Board of Eugenics**

   Material for the Board of Eugenics has been prepared by this section.
IV. The Staff

The staff of the Mental Health Section has remained unchanged during the biennium and consists of:

1 psychiatrist (director)  
1 psychologist consultant  
1 psychiatric social work consultant  
1 mental health nurse consultant  
1 clerk-stenographer III  
1 clerk-stenographer II

Local employed mental health personnel in the eight currently operating programs include:

8 psychiatric social workers (one vacancy)  
2 full-time psychologists  
2 half-time psychologists  
5 part-time psychiatrists
ACTIONS OF OREGON STATE BOARD OF EUGENICS

FOR THE BIENNIIUM

July 1, 1958 - June 30, 1960

CASES PRESENTED TO BOARD FOR CONSIDERATION FOR STERILIZATION:

By Oregon State Hospital:

29 cases presented
26 cases approved for sterilization
3 tabled

By Oregon Fairview Home:

32 cases presented
26 cases approved for sterilization
6 tabled

By Public Welfare Commission:

6 cases presented
All approved for sterilization

By Private Physicians:

2 cases presented
Both approved for sterilization

There have been 37,790 premarital examination forms processed from July 1, 1958 through May, 1960. Of these examinations, 25 were submitted to the three-man subcommittee of the Board of Eugenics for approval before medical certificate was issued. Of these 25, 17 were because of epilepsy, 3 were mentally deficient and had already been sterilized, 2 had some type of convulsive disorder and 3 had a history of mental illness. Of these 3, two are being married to each other and one had been sterilized and the third had shock treatment. All were approved for marriage.