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**Department of Human Services, Addictions and Mental Health Division**  
**Oregon State Hospital**  
Administrative Overview  
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**Introduction**

Oregon State Hospital is Oregon's primary state-run psychiatric facility for adults. Oregon State Hospital (OSH) is committed to wellness, providing a continuum of quality mental health, physical health and addictions treatment services. OSH provides geropsychiatric and medical services; treatment of civilly committed adults; evaluation and treatment of adults who have been charged with a crime; and secure residential beds for treatment of adults under the jurisdiction of the Psychiatric Security Review Board. OSH is accredited by the Joint Commission.

OSH is operated, controlled, managed and supervised by the Department of Human Services (DHS) (ORS 179.321). OSH is part of the Addictions and Mental Health Division of DHS. OSH is overseen by a Superintendent and Deputy Superintendent (ORS 179.331, 179.390); clinical direction is provided by the Chief Medical Officer, Chief Psychiatrist and Clinical Executive Team. OSH opened at its present Salem location in 1883, and has played a key role in the development of Oregon's public mental health services. OSH's Salem and Portland campuses and the Blue Mountain Recovery Center in Pendleton provide mental health services, care and treatment for the mentally ill (ORS 426.010). OSH is funded by state and federal funds; its patients are billed for their cost of care according to their ability to pay.

**History**

Care for the mentally ill in Oregon officially began with the public's approval of the 1843 Organic Law at Champoeg. Adopting the statutes of the Territory of Iowa (first legislative session, 1838-39), Oregon's new Provisional Government required courts to conduct inquests into credible reports of insanity. Utilizing juries of "intelligent and disinterested men of the county," probate courts appointed three guardians for the protection of the person and property of those found insane. Courts were authorized to order the sale of an insane person's property to finance their support, the support of dependents, and the satisfaction of any debts; insane individuals without property were entitled to the relief of paupers (O.L. 1843, pp. 162-63).

Meeting in Oregon City the following year, the Legislative Committee appropriated \$500 to defray the expense of keeping "lunatics or insane persons" in Oregon. Justices of the Peace, upon concluding an individual was indeed a lunatic, were directed to "cause him to be let out publicly to the lowest bidder, to be boarded and clothed for one year" (O.L. 1844, p. 92). As the state's population grew during its territorial period, so did the perceived need for care and segregation of the mentally ill. In 1857, physician Dr. James C. Hawthorne arrived in Portland to care for the indigent of Multnomah County; he was soon caring for mentally ill individuals from throughout the area. In 1861, Dr. Hawthorne and Dr. A.M Loryea erected a facility in Portland for care of the mentally ill, and began advocating for the state's creation of an insane asylum (Larsell, pp.

299, 548). Governor Addison Gibbs, addressing the Legislative Assembly in 1862, expressed his support for public care and treatment for the mentally ill in a state asylum, and supported an interim arrangement with Dr. Hawthorne's private facility in East Portland (State Archives).

The Legislative Assembly authorized a contract with a private institution to care for the state's 'insane and idiotic persons,' which was awarded to Drs. Hawthorne and Loryea's East Portland facility, the Oregon Hospital for the Insane. Commonly known as the Hawthorne Asylum, it was the first institution in the Pacific Northwest dedicated to caring for the mentally ill (Larsell book, p. 169). County judges were directed to inquire into reported cases of insanity, and to send individuals to the asylum upon their examination and certification by a competent physician. Those unable to afford the cost of treatment were maintained at state expense. Individuals with friends willing and able to provide safekeeping and medical treatment were not to be committed (O.L. 1862, p. 53; Deady, Ch. 23). With state financing and influential political and professional allies, Hawthorne Asylum became a state of the art facility. Reformer and activist Dorothea Dix twice visited the asylum in 1869, endorsing the public-private arrangement as the best option for the time, and supporting the work of Dr. Hawthorne and his asylum staff (Larsell book, p. 555).

Success at the Hawthorne Asylum, however, came at a price, and the institution regularly absorbed a third of the state's budget by 1882 (Higgins-Evenson, pp. 14, 184-193). The Portland asylum's high costs and annual population increases combined with intrastate partisan wrangling to put considerable pressure on lawmakers for the construction of a public institution in Salem. Dr. Hawthorne faced criticism for profiting from the public contract, though he repeatedly advocated for a state hospital and recommended collecting and accumulating a small tax for the purchase of land and materials for a publicly owned facility (Larsell, pp. 307-310, 547-554).

In 1880, the Legislative Assembly appropriated funds for a State Hospital for the Insane in Salem. The Governor, Secretary of State and State Treasurer formed a Board of Commissioners to supervise construction of the facility for 412 patients. Its costs were not to exceed \$100,000 (excluding the use of convict labor from the State Penitentiary), though \$84,000 for completion and furnishing was added in the next legislative session. An Insane Asylum Tax of one mill on the dollar was added to the county, school and state taxes collected by the county courts (O.L. 1880, p. 49; O.L. 1882, pp. 4-6). Dr. Hawthorne died in 1881, nationally renowned for his medical care for the mentally ill; he was interred in Portland's Lone Fir Pioneer Cemetery.

The following year, the Governor, Secretary of State and State Treasurer were enlisted as the Board of Trustees of the Oregon State Insane Asylum; an appointed Medical Superintendent post was created for the asylum's day-to-day operations (O.L. 1882, p. 23). Dr. Horace Carpenter, active for years in efforts to establish a state asylum, was named first superintendent. Dr. Simeon Josephi, protégé of Dr. Hawthorne, headed the Hawthorne Asylum until the 1883 transfer of its 380 patients to the new asylum in Salem (Larsell, pp. 311-312; Higgins-Evenson, 214-215).

The Oregon State Insane Asylum's initial layout in rural Salem followed the "Kirkbride Plan" for the design and philosophy of asylum medical care for the mentally ill, as set forth in Dr. Thomas Story Kirkbride's On the Construction, Organization and General Arrangements of Hospitals for the Insane. Dr. Kirkbride, an influential proponent of "asylum medicine," was superintendent of the Pennsylvania Hospital for the Insane. His authoritative treatise was published in 1854, and reissued in 1880, when Oregon's state asylum was in its planning stages. Dr. Kirkbride's philosophy emphasized a "moral" (as opposed to material) treatment of mental illness that "aimed to alleviate the psychological causes of mental disease by radically changing

the individual's environment and daily regimen" by immersing patients in a "new kind of existence" comprised of asylum hierarchy, minimal physical restraint, therapeutic persuasion, monumental architecture, cultivated landscaping and general good order (Tomes, pp. xv-6, 132-149). The influence of Dr. Kirkbride's residential treatment philosophy (and later schools of mental health care) can still be seen in the physical character of OSH today (SHPO).

The new hospital's patient population reached 526 in 1888, and the construction of an additional wing was urged by the superintendent (Larsell, p. 312). The Legislative Assembly appropriated more than \$100,000 for hospital expansion, the purchase of land, and other improvements; additional funds were budgeted for salaries and the transport of patients (O.L. 1889, pp. 31-36).

Before leaving office in 1891, Superintendent Dr. Harry Lane (grandson of Joseph Lane; later U.S. Senator) recommended constructing cottages instead of another wing to the hospital; the Legislative Assembly agreed, appropriating funds for these and other needed buildings in the next two sessions (O.L. 1891, pp. 89-90; O.L. 1893, p. 16). The superintendency in this period "alternated between Republican and Democratic doctors, depending on which party held the Governor's chair." The asylum continued to acquire land and expand agricultural operations, consistently producing a surplus of vegetables and dairy products and reducing its per capita costs. Its population neared 1,200 by 1898 (Higgins-Evenson, pp. 215, 217-218; Larsell p. 313).

In 1907, the Legislative Assembly created the State Institution for the Feeble-Minded to train and care for feeble-minded, idiotic, and epileptic persons (O.L. 1907, Ch. 83). Located on 670 acres southwest of Salem, its first residents were transferred from the State Insane Asylum in 1908. Known later as Oregon Fairview Home (O.L. 1933, Ch. 56), Fairview Hospital and Training Center (O.L. 1965, Ch. 339), and Fairview Training Center (O.L. 1979, Ch. 683), it provided residential and outpatient care for the developmentally disabled until closing in 2000.

In January 1913, 325 patients were transferred from OSH to the new Eastern Oregon State Hospital in Pendleton. The Legislative Assembly had appropriated money for this institution 20 years before (O.L. 1893, p. 136), but its construction had been delayed due to debate and litigation regarding a state constitutional provision requiring that state public institutions be located at the seat of government (in Salem). A constitutional amendment eliminating this requirement was passed by the voters in 1908, and legislators appropriated \$200,000 for its construction the following year (O.L. 1909, Ch. 88). Voters approved the creation of the new branch asylum location in 1910 (Blue Book; Isseks, pp. 102-104; Larsell book, p. 563).

Oregon State Insane Asylum was renamed Oregon State Hospital (OSH) in 1913. The Board of Control was created to coordinate the management of state institutions and construction of state buildings. OSH and Eastern Oregon State Hospital were two of many institutions the board was charged with overseeing; various institutional boards of trustees (see above) were abolished in the reorganization (O.L. 1913, Ch. 78). The commitment standard was also amended in this session, requiring a judicial finding that an individual "by reason of insanity is unsafe to be at large or is suffering from exposure or neglect" (Larson/Williams, p. 467; O.L. 1913, Ch. 342).

In 1915, the Legislative Assembly heeded Superintendent Dr. R.E. Lee Steiner's call for a parole law for the temporary or permanent release of "harmless" OSH patients, and created a provision for those individuals with friends or relatives willing and financially able to provide care upon release (O.L. 1915, Ch. 18). The following year, Dr. Steiner reported arranging 184 paroles, with some patients requiring a return to OSH, but many others discharged as cured (Larsell, p. 317).

In the interest of discontinuing the production of individuals likely to be “social menaces or wards of the state,” Oregon became one of 33 American states in the early 20<sup>th</sup> century to enact a eugenic sterilization law, focusing on individuals deemed likely to produce offspring with “inferior or anti-social traits.” Dr. Bethenia Owens-Adair, one of the first female medical doctors in the country, was Oregon’s leading proponent of a sterilization law, and representative of the progressive/scientific reformers who advocated for sterilization to “humanely” improve the quality of the population (Largent, p. 195). A Board of Eugenics was created by the Legislative Assembly to better the “physical, mental, neural, or psychic condition” of particular inmates and patients, and to protect society from the “menace” of their procreation. Composed of the State Board of Health, and superintendents of OSH, Eastern Oregon State Hospital, State Institute for Feeble-Minded and Oregon State Penitentiary, the board decided who should be sterilized by a majority vote. Sterilization decisions required a conclusion that the procedure would improve the individual’s overall condition; sterilization was not to be used punitively (O.L. 1917, Ch. 279).

Oregonians had rejected a similar sterilization law in a referendum four years earlier, despite wide support (O.L. 1913, Ch. 63; [State Archives](#)). Wartime stress and a worldwide eugenics campaign, however, had changed public opinion (Largent, p. 196-197). The sterilization law was incorporated into the state’s health code in the next legislative session (O.L. 1919, Ch. 264, secs. 85 to 95). Facing constitutional problems, the law was revised in 1923 to require the Board of Eugenics to obtain a court order upon receipt of an objection to a sterilization recommendation (Largent, p. 200; Larsell book, p. 470; O.L. 1923, Ch. 194). In the 1930s, additional categories of patients and inmates were listed as eligible for sterilization, and the appeals process was further defined (O.L. 1935 SS, Ch. 39). The board was later renamed the Board of Social Protection (O.L. 1967, Ch. 441); transferred to the Health Division of the Department of Human Resources (O.L. 1971, Ch. 650); and finally abolished (O.L. 1983, Ch. 460). Governor John Kitzhaber later acknowledged the “great wrong” of forced sterilization as performed in state institutions ([State Archives](#)). A more careful law, ORS 436, now governs sterilizations in the State of Oregon.

A 1919 change in the commitment law permitted competent individuals to apply for a 30-day hospitalization at OSH (O.L. 1919, Ch. 125). Abuse of this law by those seeking general medical care soon became an issue; state hospitals also reported an increase in county court commitments of elderly, paralyzed and other non-mentally-ill individuals. In 1925, legislators again authorized the avoidance of commitment, provided a friend or relative willing/able to accept responsibility for their treatment, and judicial agreement that is in the individual’s best interest (O.L. 1925, Ch. 221). In 1931, the county courts were required to show cause why the patient, family or estate should not be held financially responsible for the patient’s care (and to pay the difference for those not violently insane or dangerous to life or property); county commitments subsequently declined (O.L. 1931, Ch. 187; Bloom/Williams; Larsell, p. 318; Larsell book p. 561-562).

In a second special session, the Legislative Assembly proposed the construction of a third state hospital in Multnomah County (O.L. 1933 2<sup>nd</sup> SS, Ch. 56); Oregon voters defeated the proposal in a special election in May 1934. Overcrowding at OSH became a serious problem at this time; the Legislative Assembly continued to appropriate funding for an increase of 28 beds per year, while the actual average annual population was increasing by 50 patients per year. The treatment and housing of criminally insane patients from the State Penitentiary was a particular problem. Dr. Steiner resigned as OSH superintendent in 1937; he was succeeded by Dr. John C. Evans, who strongly reiterated the need for additional facilities and equipment at OSH (Larsell, p. 318).

The requirement of competency for those seeking voluntary hospitalization at OSH was eliminated in 1941. Allegedly insane individuals underwent examinations by two physicians, and could request a third exam (O.L. 1941, Ch. 397). The Legislative Assembly ordered the terms “mentally diseased” and “mental disease” to be respectively substituted for the words “insane” and “insanity” (O.L. 1941, Ch. 434). In the next session, the allegedly mentally ill were granted an opportunity to retain legal counsel upon request ( O.L. 1943, Ch. 396; Bloom/Williams).

In 1942, a tragedy occurred at OSH when a patient helping in the kitchen inadvertently retrieved poison instead of powdered milk, and the substance was used in feeding patients and staff; 47 were killed, over 400 sickened, and OSH received nationwide attention and scrutiny (see Clements). Addressing the Legislative Assembly, Governor Charles Sprague remarked that “[t]he incident brought freshly into focus the distressing conditions” at OSH despite definite progress at all of the state hospitals (State Archives). Legislators appropriated large sums to OSH in capital outlays, operating expenses, and salaries/wages in the next two sessions (O.L. 1943, Chs. 263, 337; O.L. 1945, Ch. 313). Large construction projects were delayed for the duration of the Second World War, although a psychiatric school for cadet nurses was established. Nurses from Oregon general hospitals were provided an intensive three month training course at OSH; most nurses were subsequently deployed in the armed forces (Blue Book, 1945-46, p. 65).

By 1949, the decreased purchasing power of the dollar and a state population growth of more than 40 percent was exceeding the State Building Fund tax levy approved by the voters at the end of the war (O.L. 1945, Ch. 317). Governor John H. Hall called for appropriations for buildings and salaries at OSH and other state institutions (State Archives). Legislators assented in part, appropriating funds for needed construction, repair and furnishings (O.L. 1949, Ch. 573).

Superintendent Dr. Charles E. Bates confirmed the anticipated rise in the demand for OSH’s services, and reported the completion of three new buildings on the campus. OSH’s nurse training program continued after the war, affiliating with the University of Oregon; a nursing home was also built for registered nurses and students. The patient population was 2,874 (Blue Book, 1949-50, p. 66). Legislators authorized the emergency admission and care of patients at the state hospitals, in the absence a judicial order, for a maximum of 15 days. Attempting to prevent fraud and collusion, and to protect the interests of the allegedly ill, district attorneys were statutorily required to attend commitment hearings in the larger counties (O.L. 1949, Ch. 571).

In the post war years many psychiatrists left the nation’s mental hospitals for private and community practice. By 1955, more than 80 percent of the 10,000 members of the American Psychiatric Association were employed outside of mental hospitals. The National Mental Health Act of 1946 (P.L. 79-487) provided grants to states to establish and support outpatient facilities. Psychiatrists supported community-oriented policies, and “insisted that early identification and treatment in outpatient facilities or private offices diminished the need for subsequent hospitalization and were also cost effective” (Grob). Officials at the National Institute of Mental Health (NIMH), which was established in 1949, persuaded Congress to enhance the policymaking authority of the federal government to strengthen community policies (Grob).

In 1951, the Legislative Assembly authorized a domiciliary state hospital for the aged mentally ill within 20 miles of the Multnomah County Courthouse in Portland; it was submitted to the voters and overwhelmingly approved in the next general election (O.L. 1951, Ch. 195). In the next legislative session, the nascent facility’s purpose was changed to that of a general mental hospital (Oregon’s third); this too was referred to the voters and approved in the next general

election (1953 O.L., Ch. 436). F.M. Dammasch State Hospital (named in O.L. 1957, Ch. 43) was built in Wilsonville, and received its first patients in March 1961. Primarily serving Multnomah, Clackamas and Washington Counties, Dammasch aimed to deliver intensive, non-custodial care, and to grow from its initial 460 beds to 1500; half its patients were voluntary admissions (Blue Book, 1961-62, p. 111). By 1988, the facility was considered “solidly built” but displaying “fundamental problems in design, fire and life/safety protection, patient privacy, and deferred maintenance.” The costs of the necessary renovations at Dammasch were estimated to equal those of its complete replacement. Combined with the elimination of voluntary admissions in 1986, loss of accreditation and federal funding, and the reduction in General Funds caused by the 1990 constitutional limit on property taxes for schools and government operations (Ballot Measure 5), Dammasch’s closure became necessary in 1995 (Governor’s Commission, pp. 8, 38-41; Nikkel). Patients were transferred to the former Holladay Park Hospital in Portland owned by Legacy Health System; this facility became OSH’s Portland campus. The Legislative Assembly later ordered the Dammasch property sold for private redevelopment (O.L. 1999, Ch. 983).

Consistent with the nationwide ‘community mental health’ reform movement, Oregon’s Legislative Assembly authorized state hospital superintendents to establish outpatient clinics to use in lieu of civil commitment and for released patients. The legislation further defined the procedures for emergency admission to state hospitals (O.L. 1953, Ch. 597). Across the country, community mental health reformers criticized long-term institutional care as neglectful, ineffective, and even harmful. The policies of ‘community care’ and ‘deinstitutionalization’ led to dramatic declines in the length of hospital stays and the discharge of many patients from custodial care (Surgeon General). In 1955, OSH received a \$100,000 appropriation for the setup of an outpatient clinic (O.L. 1955, Ch. 741). A judicial process for the restoration of competency was also created by legislators; Oregon’s state hospital superintendents were required to certify upon discharge whether or not the patient was competent (O.L. 1955, Ch. 522; Bloom/Williams).

In 1955, Dr. Dean Brooks succeeded Dr. Bates as OSH superintendent. Dr. Brooks served as superintendent until 1982; he was succeeded by James C. Bradshaw, and by Robert J. Benning in 1985, George W. Bachik in 1987, Stanley Mazur-Hart in 1991, and Dr. Marvin Fickle in 2004.

OSH’s population reached its peak of 3,545 patients in 1958. Mental health care was almost exclusively provided in state institutions at this time (Nikkel). In his inaugural address to the Legislative Assembly in 1959, Governor Mark Hatfield called for an increase in outpatient services for the mentally ill, as a more effective means of treatment and a way to avert further expansion of state institutions (State Archives). In his first budget message, Governor Hatfield recommended appropriating funds for the care and treatment of senior citizens at the Eastern Oregon Tuberculosis Hospital in The Dalles (State Archives). The hospital was subsequently converted by the Legislative Assembly into the Mid-Columbia Home, an institution for the care of geriatric patients (O.L. 1959, Ch. 588). Its name was changed to Columbia Park State Home in the next legislative session (O.L. 1961, Ch. 214). It was later renamed as the Columbia Park Hospital and Training Center, and its role changed to the care of mentally retarded adults (O.L. 1965, Ch. 339), a purpose it served until declining need led to its closure (O.L. 1977, Ch. 571).

In 1961, the Legislative Assembly created the Mental Health Division under the Board of Control. The division was responsible for managing OSH, Eastern Oregon State Hospital, Dammasch State Hospital, Columbia Park State Home, and Oregon Fairview Home. It was directed to assist the counties in establishing and operating Community Mental Health Clinics to offer a range of mental health services, including outpatient psychiatric treatment and follow-up

care for patients from the state hospitals. A Mental Health Advisory Board was created to make recommendations for the development of policies for mental health programs (O.L. 1961, Ch. 706). At this time, the state's public health system was composed of 11 child guidance clinics, three state hospitals, two training centers and one alcohol outpatient clinic (Nikkel).

In 1963, President John F. Kennedy submitted an influential message on mental health to Congress, which quickly passed the Community Mental Health Centers Act (P.L. 88-164), beginning a new era of support for mental health services. NIMH was charged with monitoring community mental health center programs (CMHPs) across the country (NIMH). Oregon's CMHP Act tied its state hospitals and community programs together into three regions, and three program categories: Alcohol and Drug, Mental and Emotional Disturbances, and Mental Retardation and Developmental Disabilities. It provided 100 percent state funding for "alternatives to state hospitalization," including 24-hour emergency care, day and night treatment services, local housing resources, and inpatient care in community hospitals. Most Oregon CMHPs were developed using a 50/50 formula of state and local funds. By the early 1970s, it had 27 CMHPs and 17 contract programs serving all 36 counties (O.L. 1973, Ch. 639; Nikkel).

Community care and deinstitutionalization policies were implemented across the country in the mid-1960s. Housing and support services, however, were not universally available, and many discharged patients trended to criminal justice institutions, regimented residential settings and homelessness (Surgeon General). Oregon's commitment laws underwent significant changes during this period. One was no longer automatically incompetent by virtue of a commitment (O.L. 1965, Ch. 628). Hearing records were sealed, except to the subject individual, legal representatives and state hospitals providing care (O.L. 1965, Ch. 420). Legislators recognized the civil rights of committed patients, discontinuing the use of mechanical restraints for non-medical purposes, and allowing communication by sealed mail and the petition for competency (O.L. 1967, Ch. 460). Individuals were legally entitled to notice of commitment proceedings, and the right to obtain legal counsel and subpoena witnesses (O.L. 1971, Ch. 368; Bloom/Williams).

In 1969, the Board of Control was abolished (O.L. 1969, Ch. 199), and the Mental Health Division was transferred to the Governor's Office (O.L. 1969, Ch. 597). It was moved to the Department of Human Resources (DHR), upon its creation in the next session (O.L. 1971, Ch. 319). DHR was later renamed the Department of Human Services (DHS) (O.L. 1999, Ch. 421).

The Children's Services Division was created within DHR in 1971; responsibilities included providing comprehensive mental health services for mentally ill, emotionally disturbed and drug dependent children throughout the state (O.L. 1971, Chs. 300, 401). Day and Residential Treatment Services (DARTS) programs were established the following year as non-profit agencies for children with mental health disorders; contract facilities were operated using state funds. OSH began its Child and Adolescent Treatment Services (CATS) program in 1976 as the inpatient backup support for DARTS (MHAWG, pp. 24-25). DARTS ended in 2005 in the transition of mental health services for children to the state's CMHPs and local providers.

In 1973, Oregon's civil commitment law underwent further legislative changes. A mentally ill individual was defined as "a person, who because of 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." An investigation was required prior to commitment hearings to determine whether "probable cause" existed that the person was in fact mentally ill. The indigent were entitled to court appointed legal representation. Commitments required a

judicial finding that the individual was mentally ill “beyond a reasonable doubt” (O.L. 1973, Ch. 838). This high burden of proof was later reduced to “clear and convincing evidence” (O.L. 1979, Ch. 408); and courts were authorized to examine emergency hospitalization records prior to commitment hearings (Bloom/Williams; O.L. 1979, Ch. 885). Oregon, like other jurisdictions, began to shift from a civil rights focus towards a balance between the need to treat the mentally ill with a recognition of individual rights in the commitment process (Bloom/Williams, p. 469).

Oregon was an early-adopter of “assertive community treatment.” Beginning with a NIMH-funded Community Support Project in 1978, Oregon re-structured its service system to be more responsive to those with severe and persistent mental illnesses, emphasizing flexible services in independent settings; CMHPs were encouraged to work with local public housing authorities and other nonprofit housing agencies. Oregon established a priority system that directed funds to those most in need first (OSHEP, p. 7; Nikkel). The Legislative Assembly appropriated large sums to the Mental Health Division for the administration of CHMPs across the state (O.L. 1979, Ch. 753). The success of CMHP/CMHCs varied nationally, with some concluding they did not live up to their promise because they served a different population than state hospitals and provided minimal aftercare services to individuals with severe and long-term mental illnesses (Grob). A fourth reform of the mental health care system began in the mid-1970s and continues today. The “community support” movement calls for acute treatment, prevention and a vision of care that includes the social welfare needs of those with mental illnesses (Surgeon General).

In 1975, Ken Kesey’s 1962 novel, *One Flew Over the Cuckoo’s Nest*, was filmed at OSH with appearances by patients and staff. The movie won all five major Academy Awards and provoked international discussion regarding institutional power and appropriate care for the mentally ill.

In 1977, the Legislative Assembly created the Psychiatric Security Review Board (PSRB) to assume jurisdiction over those found criminally “guilty except for insanity.” It was charged with protecting the public by providing ongoing review of those under its jurisdiction and determining appropriate placement. PSRB was authorized to commit individuals to state hospitals; grant conditional releases to community-based programs; discharge those under its jurisdiction; and revoke conditional releases and order rehospitalization pending a hearing (O.L. 1977, Ch. 380).

The Legislative Assembly declared in 1981 that mental health services should be available to all mentally ill, emotionally disturbed, mentally retarded, developmentally disabled, alcoholic and drug dependent, regardless of age, county of residence or ability to pay, subject to the availability of funds. DHR and other state agencies were directed to provide mental health services in the community where the individual resides in order to achieve maximum coordination of services and minimum disruption in the life of the individual (O.L. 1981, Ch. 750). DHR and the Mental Health Division were directed to facilitate the development of appropriate community based services, including residential facilities, day programs and home care. State operated hospitals and training centers were declared to be back-up facilities to the primary system of community based services for the mentally retarded and developmentally disabled (O.L. 1981, Ch. 287). Health insurance coverage for mental health and psychiatric care in state facilities was provided like other forms of care (O.L. 1981, Ch. 422). The use of psychosurgery was also prohibited in this legislative session; the Psychosurgery Review Board was abolished (O.L. 1981, Ch. 372).

In 1983, the Eastern Oregon Hospital and Training Center was converted to the Eastern Oregon Correctional Institution. The Eastern Oregon Psychiatric Center was created to provide care and treatment for the mentally ill; and the Eastern Oregon Training Center was created to provide



care, treatment, and training for mentally retarded individuals (O.L. 1983, Ch. 505). In 1985, the Mental Health Division was directed to ensure, subject to the availability of funds, that mentally retarded and developmentally disabled individuals were provided access to the community based services needed to achieve independence, productivity and integration (O.L. 1985, Ch. 463).

In 1987, the Legislative Assembly expanded the state's "officially designated protection and advocacy system" for the protection of the developmentally disabled to include mentally ill individuals, and provided access to the records necessary for the investigation and resolution of probable cases of abuse or neglect in care or treatment facilities (O.L. 1987, Ch. 322). The change resulted from Congress' 1986 passage of the Protection and Advocacy for Individuals with Mental Illness Act (P.L. 99-319), amending the underlying Developmental Disabilities Assistance and Bill of Rights Act of 1975 (P.L. 94-103; 42 U.S.C. 6001 et seq.). Oregon's legislators also authorized civil commitment of the "chronically mentally ill" in this session, for purposes of treating individuals with a deteriorating mental illness that required two similar inpatient hospitalizations in the previous three years (O.L. 1987, Ch. 903; Bloom/Williams).

The Mental Health Division was legislatively directed in 1989 to establish rules for determining a patient's ability to pay for services, considering factors such as the need for personal funds for support after release and the availability of third party benefits. Legislators provided further guidance on billing procedures regarding the division, counties, and medical providers (O.L. 1989, Ch. 348). The Mental Health Advisory Board's membership was mandated to include four disabled individuals, with such individuals constituting a Disability Issues Advisory Committee (O.L. 1989, Ch. 777). The Oregon Board of Licensed Professional Counselors and Therapists was created in DHR's Health Division to assist the public by setting education, experience and examination standards and investigating complaints against licensed and unlicensed counselors and therapists (O.L. 1989, Ch.721). The Mental Health Division was renamed as the Mental Health and Developmental Disability Services Division (MHDDSD) (O.L. 1989, Ch. 116).

In 1991, public and private officials with reasonable cause to believe that a mentally ill or developmentally disabled adult has been the victim of abuse were required to report it to MHDDSD or law enforcement. The division was required to launch a prompt investigation (unless already begun by law enforcement), and directed to maintain a record of all abuse reports. Individuals reporting suspected abuse in good faith were granted immunity; retaliation against reporters was prohibited (O.L. 1991, Ch. 744). The confidentiality of medical records was extended by legislators to private organizations operating as CMHPs and contractors of the division (O.L. 1991, Ch. 175). Preventative mental health services for children and adolescents was transferred from DHR's Children's Services Division to MHDDSD (O.L. 1991, Ch. 777).

Individuals receiving mental health or developmental disability services had a number of rights recognized by the Legislative Assembly in 1993, including the right to: choose from available appropriate services and receive them in the least restrictive and intrusive setting; receive an individualized written service plan and services with a periodic review of needs; participate in the planning of services; receive medications only for individual clinical needs; receive services in a humane environment free from abuse and neglect; assert grievances and have them impartially considered; visit family, friends, advocates, and legal and medical professionals; receive information about rights upon the start of services and periodically thereafter; not receive services without informed voluntary written consent; not participate in experimentation without informed voluntary written consent; not be involuntarily terminated or transferred without notice; and not be required to perform uncompensated labor other than personal housekeeping

(O.L. 1993, Ch. 96). The civil commitment procedures was revised in this session; MHDDSD was directed to draft OARs to carry out the changes, which included the right to postpone a commitment hearing for 14 days, during which time one could receive treatment for an alleged illness and avoid the hearing (O.L. 1993, Ch. 484). The Legislative Assembly also authorized the use of advance medical directives for the delivery of treatment to chronically mentally ill individuals should they require involuntary treatment (Bloom/Williams; O.L. 1993, Ch. 767).

By the end of the 20<sup>th</sup> century, the use of civil commitments was greatly reduced nationwide. The criminal justice system was increasingly used as a “major repository for many seriously mentally ill individuals.” Oregon’s mental health authorities adopted outpatient commitment options, with old debates regarding the use of coercive, involuntary treatment being reprised in the community setting. As in other jurisdictions, Oregon’s evolving civil commitment law reflects a compromise between legislators, interest groups and courts (Bloom, pp. 436-439).

In 1993, Governor John Kitzhaber and the Legislative Assembly completed the Oregon Health Plan (OHP). The OHP aimed to improve health care through resource reallocation, cost containment and targeted Medicaid funds. Mental health services were specifically included in the OHP, to be provided by DHR, in collaboration with MHDDSD, the Office of Medical Assistance Programs (OMAPS), and the Health Services Commission. DHR was directed to serve the range of mental health conditions utilizing a capitated managed care system (O.L. 1993, Ch. 815). MHDDSD was given responsibility for psychiatric residential and day treatment services for children with severe cognitive, physical and medical impairments (O.L. 1993, Ch. 676); its divisional duties were later expanded to include children with mental or emotional disturbances, and developmentally disabled children and their families (O.L. 1999, Ch. 316).

A Task Force on Mental Health was created by the Legislative Assembly in 1995 to establish a steering committee for mental health legislation, and to study the delivery of services by the state, county and other providers; the impact of the OHP; the effect of managed care; the impact of downsizing the state’s psychiatric capacity on the community mental health system; and how best to serve mental health clients whose income exceeds the poverty level (O.L. 1995, Ch. 806). MHDDSD was requested to establish a working group of law enforcement personnel, local government representatives, psychiatrists and other mental health professionals, clients, and families to develop a protocol for the transportation of persons to and from hospitals and other holding facilities, and to recommend transportation contracting procedures (O.L. 1995, Ch. 628).

In 1997, the Legislative Assembly created a statutory form – A Declaration for Mental Health Treatment – for advanced, pre-crisis mental health treatment planning (O.L. 1997, Ch. 563; ORS 127.736 ). Governor Kitzhaber created an Oversight Task Force on Mental Health Integration to analyze and make recommendations regarding the integration of mental health benefits and services under the OHP (EO-97-15). The Task Force found that the OHP’s strategy of managed care, expanded benefits based upon a prioritized list, and expanded Medicaid eligibility would improve the access and efficiency of the state’s public mental health system. It recommended that counties lead the planning and monitoring of the public mental health system, and that the state provide system standards and sufficient support to enable CMHPs to fulfill their statutory responsibility to provide treatment to those not eligible for the OHP (Task Force, pp. 35, 37).

In its next session, the Legislative Assembly established that county mental health programs could only impose standards and conditions that were substantially similar to MHDDSD’s (O.L. 1999, Ch. 524). Group health insurance otherwise providing coverage for hospital or medical

expenses was required to cover the treatment of chemical dependency, and mental or nervous conditions; the minimum benefit levels for these policies were also increased. An Interim Task Force on Mental Health and Chemical Dependency Treatment was created to assess the impact on accessibility, treatment and costs, and to recommend legislative action (O.L. 1999, Ch. 1086).

In 2000, Governor Kitzhaber appointed a Mental Health Advisory Workgroup to recommend strategies for addressing the gaps in funding, services and responsibilities in mental health services. It found a fragmented approach in the delivery of services, especially for children; inadequate resources to meet current needs; need for additional staff training; public misperceptions about mental health disorders; need for additional services for those with co-occurring mental health and substance abuse problems (and frequently in the criminal justice system); and need for a full range of treatment services, including prevention, early screening, assessment and transitional services (MHAWG, pp. 56-59). In its next session, the Legislative Assembly required local mental health authorities to prepare and submit detailed biennial service plans to DHS, which was required to develop guidelines for the production of local plans. DHS was directed to report biennially to the Governor and Legislative Assembly on the progress of the local planning process and its implementation (O.L. 2001, Chs. 694, 899; Biennial 2003).

In 2001, Oregon mental health facilities were directed to establish procedures for the disclosure of information regarding committed individuals and those awaiting commitment hearing to family members and others designated by the individual (O.L. 2001, Ch. 481). MHDDSD was abolished in this session, and its responsibilities were transferred to DHS as a whole (O.L. 2001, Ch. 900); the division became the Office of Mental Health and Addiction Services (OMHAS). In 2007, OMHAS was renamed as the Addictions and Mental Health Division (AMH) of DHS.

In 2003, Governor Ted Kulongoski created a Mental Health Task Force to analyze and recommend changes to Oregon's public mental health system (EO-03-15). It determined that the mental health system faced serious systemic problems, some of which existed throughout health care. It also found that mental health care was significantly underfunded and uncoordinated; responsibilities of the OHP mental health organizations and local authorities were unclear; too many mentally ill individuals were incarcerated; too few community care resources were available; early intervention, prevention, and the integration of mental health care and social services were insufficiently emphasized; significant parity of private insurance coverage for mental health conditions was not required; and the mental health system was not utilizing modern information systems. The task force made a number of recommendations, including OMHAS's implementation of a plan to reinvent OSH-Salem as a facility serving those who cannot be effectively or safely served in a community setting (Blueprint, pp. 8-10, 18-27).

In 2005, the Legislative Assembly expanded PSRB to ten members, with five person panels for both juveniles and adults; the board was further authorized to utilize commitments to secure adolescent inpatient rehabilitation programs (2005 O.L., Ch. 843). Legislators directed DHS in its investigations of abuse at residential training homes and state hospitals to address whether the person allegedly responsible for the abuse was acting in self-defense (O.L. 2005, Ch. 660).

DHS and OMHAS launched the Behavioral Health Integration Project (BHIP) in 2005, with the goal of acquiring and implementing information technology to better support patient care and operations at OSH, Eastern Oregon Psychiatric Center, community mental health and addiction service programs, and the Junction City facility (upon opening in 2013). BHIP is transitioning OSH from a paper record system to an integrated hospital management system to support the

exchange of information across the continuum of behavioral health services. BHIP is charged with improving the quality of psychiatric care by tracking services, medications, lab results, and other data; scheduling patients for daily activities within a treatment mall milieu; facilitating the transfer of patients to lower levels of care by providing electronic records and discharge plans to community providers; facilitating clinical decisions in the placement of patients by tracking treatment resource availability; and giving patients improved access to their health records as required by the Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

In the next legislative session, in response to the U.S. Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999), DHS was directed by the Legislative Assembly to adopt a policy to support and promote self-determination for those receiving mental health services. The agency was required to remove barriers segregating those with disabilities from full participation in the community in the most integrated setting, and preventing those with disabilities from enjoying a meaningful life, the benefits of community involvement and citizen rights guaranteed by law; it was requested to establish a representative Consumer Advisory Council to advise the director on DHS's provision of mental health services (O.L. 2007, Ch. 805). Eastern Oregon Psychiatric Center was renamed in this session as the Blue Mountain Recovery Center (O.L. 2007, Ch. 14).

In 2004, the Legislative Emergency Board authorized DHS to evaluate the current structure and future role of OSH within Oregon's mental health care system. The first phase of a proposed plan to replace OSH was completed in 2005, and the second in 2006. Governor Kulongoski and state legislators created an OSH Site Selection Criteria Committee in 2006. The following year, DHS was provided \$89 million for land acquisition, design and planning, infrastructure, site improvements, and initial construction costs for two new state-operated psychiatric facilities: a 620-bed facility in Salem (to open in 2011), and a 360-bed facility in Junction City (to open in 2013). Total costs for the OSH Replacement Project were estimated at \$450 million (O.L. 2007, Ch. 742). The developing hospitals are designed as modern psychiatric treatment and recovery facilities for the provision of up-to-date psychiatric practices, supported by a strengthened community mental health system to support healing, recovery and a return to community living.

In 2006, the U.S. Department of Justice (USDOJ) investigated conditions and care practices at OSH and provided a report to the Governor with the necessary remedial steps the state must take to correct the reported deficiencies. USDOJ is responsible for investigating conditions and practices at public psychiatric institutions pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA) (P.L. 96-247; 42 U.S.C. 1997 et seq.). The agency regularly conducts reviews of such institutions throughout the U.S. to ensure protection of the constitutional and federal statutory rights of patients with mental illness. In 2007 and 2008, OSH published a Continuous Improvement Plan to guide improvement in the: protection of patients and staff from harm, provision of psychiatric and psychological care; use of seclusion and restraints; supply of adequate nursing care; and provision of discharge planning and appropriate placement.

In a 2008 special session, the Legislative Assembly directed DHS to evaluate and report on the state's CMHC system, including an analysis of the gap between those receiving and those needing such services (particularly veterans returning from hostile fire areas), an assessment of spending by state and local agencies on such care, a breakdown of the strengths and weaknesses in the state delivery system, an overview of future delivery system needs, and recommendations for improving the quality and effectiveness of the CMHC system (O.L. 2008, Ch. 18).

In 2008, the director of DHS selected Roy J. Orr to succeed Dr. Fickle as OSH's superintendent. OSH's Salem campus was added to National Park Service's National Register of Historic Places. Ground was broken on the OSH Replacement Project in an effort to revitalize and modernize the Oregon mental health care system with new facilities, treatment methods, staff, technology and administrative techniques. The Eastern Oregon Training Center in Pendleton was closed in 2009, and its last residents moved to community settings. The Legislative Assembly created an OSH Advisory Board to conduct comprehensive reviews of federal/state laws, and OSH administrative rules, policies, procedures and protocols regarding patient safety, security and care; to make recommendations to the OSH superintendent, DHS director, and legislators; and to report back annually on its work (O.L. 2009, Ch. 704). Legislators also directed that OSH be transferred from DHS to the new Oregon Health Authority by June 30, 2011 (O.L. 2009, Ch. 595).

OSH's development continues. Like the mental health system generally, its current organization reflects many factors, including reform movements, financial incentives, and advances in care and treatment technology (Surgeon General). As Dr. Jack R. Ewalt observed almost 50 years ago as chair of the Joint Commission on Mental Illness and Health: "The state hospital has been investigated, inspected, reorganized, converted, divided, dispersed, and even abolished, in fact or in theory, by countless imaginative persons motivated by a variety of urges. The state hospital survives, however, and is an amazingly tough and resilient social institution" (Geller, p. 48).

### **Current Organization**

OSH is organizationally part of DHS's Addictions and Mental Health Division (AMH). In addition to OSH's Salem and Portland campuses, AMH provides services locally through community mental health programs (CMHPs) and their contracted providers, and at the Blue Mountain Recovery Center (formerly the Eastern Oregon Psychiatric Center) in Pendleton.

### **Administration**

Administration includes the OSH Superintendent, Deputy Superintendent, Chief Medical Officer, Chief Nursing Officer, Nursing Director, and their support staff. Administration provides direction and leadership to assure coordination and accomplishment of goals and objectives consistent with legislative intent, directives of the governing body and standards of the Joint Commission, and other licensure and regulatory bodies.

### **Psychiatric Services**

Psychiatric services at OSH are provided through two treatment programs – Forensic Psychiatric Services (FPS) and Psychiatric Recovery Services (PRS). FPS conducts psychological and psychiatric evaluations, including determination of an individual's ability to assist their attorney in a trial and determination if a mental disease or defect limits a person's criminal responsibility. PRS serves non-forensic OSH patients who have been civilly committed due to serious and persistent mental illness. Forensic Evaluation Service (FES) provides psychiatric hospital and residential treatment services to those committed by the courts. FPS focuses on persons committed to OSH by the criminal courts, while FES provides the mental health evaluation reports to the courts to help them make legal decisions related to mental health issues.

### **Clinical Services**

Clinical Services is composed of professionals belonging to four clinical disciplines: Psychology, Rehabilitation Services, Social Work, and Vocational and Educational Services. Staff in each of these areas are involved in patient treatment from admission to discharge. Clinical Services is

supported by the Community Reintegration Program (CRP), which provides patients with community placement; confidence in their ability to be self-sufficient; and transition to CMHPs.

### Medical Care

The Medical Clinic provides medical care to patients via unit and clinic visits by physicians and nurse practitioners. It provides specialized nursing procedures and holds regular specialty clinics using outside physician contractors; it also provides radiology services. The Pharmacy supports the pharmaceutical care needs of OSH patients, ensuring their safety by reviewing medication orders for drug interactions, adverse reactions, therapeutic duplication, and contraindications. Laboratory Services conducts laboratory testing ordered by physicians for patients under their care. The Dental Clinic examines and treats the oral conditions of patients. The Infection Control program reduces hospital-associated (nosocomial) infections for patients and occupationally acquired infections for health care workers. Medical Record Services is the core of OSH's medical records system, which includes all of OSH programs and treatment disciplines. The Medical Staff Office maintains credentialing and privileging records for OSH's Medical and Allied Health Professional Staff. It additionally prepares rate-setting information for DHS's Institutional Revenue section, and prepares updates to the OSH Medical Department Manual.

### Operations and Planning

The Strategic Planning program liaises with DHS's Office of Information Services and other state technology organizations. It acquires and implements new technology at OSH, and manages change requests to existing technology. Strategic Planning also administers OSH's Management of Information Services program, which maintains patient population records and reports. The Quality Improvement (QI) program prepares OSH for external regulatory surveys and monitors quality indicators. QI helps to develop and track corrective action plans; coordinates activities relating to OSH's Quality Council, including numerous operating committees; and plays a lead role in the hospital's Continuous Improvement Plan, first initiated in 2007. The Quality Council is responsible for improving performance at OSH. Risk Management is the central repository for incident reports, including medication variance data; it also coordinates litigation response.

Human Resources provides personnel, payroll and training-related services. The Volunteer Services program coordinates the provision of donated time, services and goods to enhance patient care. It assists hospital staff in providing the care necessary to prepare patients to return to the community as quickly as possible, and publishes the newsletter, "OSH Recovery Times." The Education and Development program provides staff with education and training necessary for the acquisition of knowledge and skills essential for the safety, appropriate care and treatment of patients. The Diversity and Cultural Competency program promotes increased understanding of culture, race and ethnicity to meet the needs of a diverse patient population and workforce.

The Finance - Business program is responsible for all of the accounting functions at OSH, including accounts payable, accounts receivable, travel, and patient trust accounts and patient payroll (including tax reporting). The program maintains the official record copy of all contracts and agreements between OSH and local, state and federal public agencies. The Operations program maintains all OSH facilities, and coordinates hospital physical plant accreditation and compliance. Food and Nutrition Services is responsible for supplying patients with meals, and managing records regarding menus, production, purchasing, scheduling, safety, sanitation and inspections. The Security/Communications Center is responsible for providing security for individuals and property; providing transportation of patients; responding to emergencies; investigating incidents; dispatching emergency responders; and maintaining communications.

## **Primary Agency Statutes and Administrative Rule Chapters**

ORS 124	Abuse Prevention and Reporting; Civil Action for Abuse
ORS 127	Powers of Attorney; Advance Directives for Health Care; Mental Health Declarations for Mental Health Treatment; Death with Dignity
ORS 161	Criminal Law General Provisions (PSRB, ORS 161.385)
ORS 179	Administration of State Institutions
ORS 409	Department of Human Services (DHS)
ORS 414	Medical Assistance
ORS 426	Persons With Mental Illness; Sexually Dangerous Persons
ORS 428	Nonresident Persons With Mental Disabilities
ORS 430	Administration; Alcohol and Drug Abuse Programs
ORS 441	Health Care Facilities
ORS 438	Clinical and Environmental Laboratories
ORS 443	Home Health Agencies; Residential Facilities; Hospice Programs
ORS 675	Psychologists; Occupational Therapists; Certified Sex Offender Therapists; Clinical Social Workers; Licensed Professional Counselors and Family Therapists
ORS 676	Health Professions Generally
ORS 677	Regulation of Medicine, Podiatry and Acupuncture
ORS 678	Nursing; Nursing Home Administrators
ORS 679	Dentists
ORS 680	Dental Hygienists; Denturists
ORS 683	Optometrists; Opticians
ORS 688	Therapeutic and Technical Services
ORS 689	Pharmacists; Drug Outlets; Drug Sales
ORS 691	Dieticians
ORS 743A	Health Insurance: Required Reimbursements (State Hospitals, ORS 743A.010)
OAR 309	DHS, Addictions and Mental Health Division: Mental Health Services
OAR 333	DHS, Public Health Division (including Clinical Laboratories)
OAR 337	Board of Radiologic Technology
OAR 339	Occupational Therapy Licensing Board
OAR 818	Oregon Board of Dentistry
OAR 833	Board of Licensed Professional Counselors and Therapists
OAR 834	Board of Examiners of Licensed Dietitians
OAR 847	Oregon Medical Board
OAR 848	Physical Therapist Licensing Board
OAR 851	Board of Nursing
OAR 852	Board of Optometry
OAR 855	Board of Pharmacy
OAR 858	Board of Psychologist Examiners
OAR 859	Psychiatric Security Review Board (PSRB)
OAR 877	Board of Clinical Social Workers

## **Chronology**

- 1843 Oregon's Provisional Government provides protection for those found insane
- 1862 Oregon Hospital for the Insane (aka Hawthorne Asylum) opens in East Portland
- 1880 Legislative Assembly appropriates funds for construction of State Hospital for the Insane
- 1883 Oregon State Insane Asylum opens in Salem

- 1907 Legislative Assembly creates State Institution for the Feeble-Minded south of Salem
- 1913 -Legislative Assembly creates Board of Control  
-Oregon State Insane Asylum as Oregon State Hospital (OSH)  
-Eastern Oregon State Hospital opens in Pendleton
- 1917 Legislative Assembly creates Board of Eugenics
- 1933 State Institution for the Feeble-Minded renamed as Oregon Fairview Home
- 1942 Accidental poisoning at OSH kills 47 and sickens hundreds
- 1946 Congress passes National Mental Health Act
- 1949 National Institute of Mental Health (NIMH) established
- 1958 OSH patient population reaches peak (3,545)
- 1959 -Governor Hatfield calls for increased use of outpatient services for mentally ill  
-Eastern Oregon Tuberculosis Hospital converted to Mid Columbia Home in The Dalles
- 1961 -Legislative Assembly creates Mental Health Division under Board of Control  
-Damasch State Hospital opens in Wilsonville  
-Legislative Assembly renames Mid Columbia Home as Columbia Park State Home  
-Legislative Assembly creates Mental Health Advisory Board
- 1963 Congress passes Community Mental Health Centers Act
- 1965 -Columbia Park State Home renamed Columbia Park Hospital and Training Center  
-Eastern Oregon State Hospital renamed Eastern Oregon Hospital and Training Center  
-Oregon Fairview Home renamed Fairview Hospital and Training Center
- 1967 Legislative Assembly renames Board of Eugenics as Board of Social Protection
- 1969 Board of Control abolished; Mental Health Division transferred to Office of Governor
- 1971 -Legislative Assembly creates Department of Human Resources (DHR)  
-Mental Health Division transferred from Office of Governor to DHR  
-Children's Services Division created in DHR
- 1973 Legislative Assembly passes Community Mental Health Programs Act
- 1975 OSH provides setting for award-winning movie, *One Flew Over the Cuckoo's Nest*
- 1977 -Legislative Assembly creates Psychiatric Security Review Board (PSRB)  
-Columbia Park Hospital and Training Center closes  
-OSH patient population reaches nadir (525)
- 1979 Fairview Hospital and Training Center renamed as Fairview Training Center
- 1981 -Legislative Assembly orders mental health services in community of residence, and  
requires health insurance coverage for state psychiatric care like other medical care
- 1983 -Legislative Assembly abolishes Board of Social Protection  
- Eastern Oregon Hospital and Training Center converted to Eastern Oregon Correctional  
Institution; Eastern Oregon Psychiatric Center, Eastern Oregon Training Center created
- 1986 Congress passes Protection and Advocacy for Individuals with Mental Illness Act
- 1989 Mental Health Division renamed Mental Health and Developmental Disability Services



- 1993 -Governor Kitzhaber and Legislative Assembly create Oregon Health Plan (OHP) to provide health care, including mental health services, to low-income Oregonians  
-Legislative Assembly recognizes civil rights of those receiving mental health services
- 1995 -Damasch State Hospital closes; OSH Portland Campus opens  
-Legislative Assembly creates Task Force on Mental Health to study the delivery of mental health services by state, county and other providers, and the impact of the OHP
- 1997 Governor Kitzhaber creates Oversight Task Force on Mental Health Integration
- 1999 -Legislative Assembly requires group health insurance coverage of mental conditions  
-DHR renamed as Department of Human Services (DHS)
- 2000 -Governor Kitzhaber appoints Mental Health Advisory Workgroup  
-Fairview Training Center closes
- 2001 -Legislative Assembly abolishes Mental Health and Developmental Disability Services Division (MHDDSD), transfers duties to DHS as a whole  
-MHDDSD becomes Office of Mental Health and Addiction Services (OMHAS)
- 2002 Governor Kitzhaber apologizes for 60 years of forced sterilizations in state-run facilities
- 2003 Governor Kulongoski appoints Mental Health Task Force on public mental health system
- 2004 State Emergency Board authorizes DHS to evaluate the structure and role of OSH
- 2005 -DHS and OMHAS launch Behavioral Health Integration Project (BHIP)  
-Adolescent Treatment Services unit closed, OSH focuses exclusively on adult patients  
-PSRB expanded to 10 members, with adult and juvenile panels of 5 members each
- 2006 State of Oregon creates Oregon State Hospital Site Selection Criteria Committee
- 2007 -Legislative Assembly funds construction of two new state-operated psychiatric facilities  
-Eastern Oregon Psychiatric Center renamed Blue Mountain Recovery Center  
-OMHAS becomes Addictions and Mental Health Division (AMH) of DHS
- 2008 -State of Oregon breaks ground on OSH Replacement Project in Salem  
-OSH Historic District added to National Register of Historic Places
- 2009 -Legislative Assembly closes Eastern Oregon Training Center in Pendleton  
-Legislative Assembly directs transfer of OSH to new Oregon Health Authority by 2011

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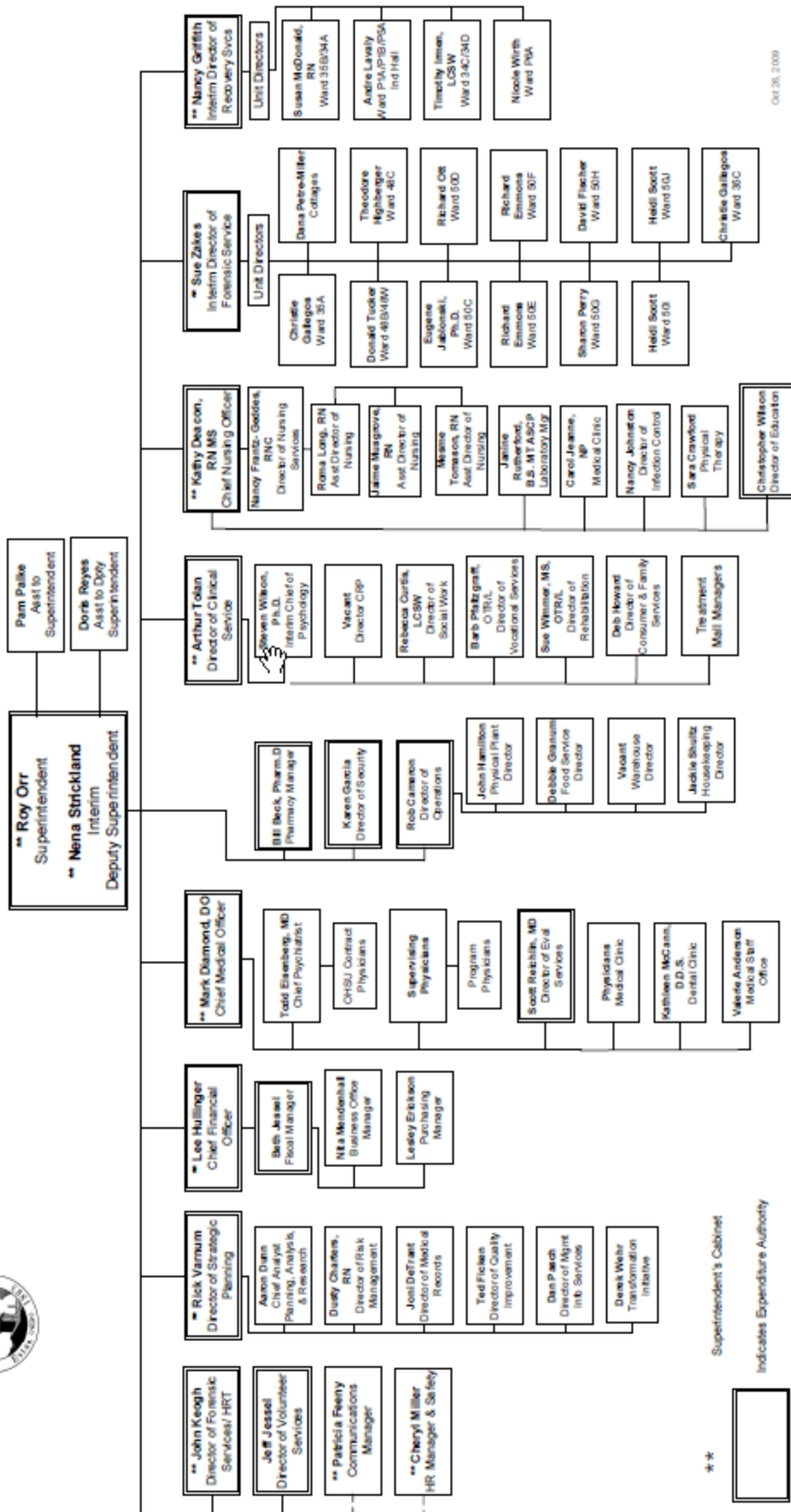
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# OSH ORGANIZATIONAL CHART



Oct 26, 2009

\*\* Superintendent's Cabinet  
Indicates Expenditure Authority

