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Liability of hospital for negligence of nurse assisting operating surgeon. 29 ALR3d 1065.

Hospital's liability for injury or death to patient resulting from or connected with administration of anesthetic. 31 ALR3d 1114.

Liability of hospital for refusal to admit or treat patient. 35 ALR3d 641.

Attending physician's liability for injury caused by equipment furnished by hospital. 35 ALR3d 1068.

Hospital's liability to patient injured going to or using bathroom or toilet facilities. 36 ALR3d 1235.

Liability for negligence in diagnosing or treating aspirin poisoning. 36 ALR3d 1358.

Liability of one releasing inpatient institutionalized mental patient for harm he causes. 38 ALR3d 699.

Medical malpractice in connection with diagnosis, care, or treatment of diabetes. 42 ALR3d 482.

Hospital's liability for injury allegedly caused by improper diet or feeding of patient. 42 ALR3d 736.

Liability for injury allegedly resulting from negligence in making hypodermic injection. 45 ALR3d 731.

Liability for injury or death from blood transfusion. 45 ALR3d 1364.

Liability of hospital for injury caused through assault by a patient. 48 ALR3d 1288.

Hospital's liability to patient for injury allegedly sustained from absence of particular equipment used in diagnosis or treatment of patient. 50 ALR3d 1141.

Hospital's liability for negligence in

**Sec. 18.20.020. License required.** No person or government unit, except the federal government, acting severally or jointly with another person or governmental unit may establish, conduct or maintain a hospital in the state without a license. (§ 40-6-2, 40-6-3, 40-6-4; am § 4 ch 112 SLA 1957)

**Cross references.** — As to requirement for certificate of need to construct or alter a health care facility, see AS 18.07.011 — 18.07.111.

**Opinions of attorney general.** — A nursing home is considered a hospital for the purpose of the licensing provisions. 1963 Op. Att'y Gen., No. 7.

If a person establishes a hospital which gives general and medical treatment and in addition provides nursing service, both

selection or appointment of staff physician or surgeon. 51 ALR3d 981.

Liability for injuries or death resulting from physical therapy. 53 ALR3d 1250.

Liability of hospital, or medical practitioner, under doctrine of strict liability in tort, or breach of warranty, for harm caused by drug, medical instrument, or similar device used in treating patients. 54 ALR3d 258.

Liability of physician or hospital in the performance of cosmetic surgery upon the face. 54 ALR3d 1255.

Liability of hospital, other than mental institution, for suicide of patient. 60 ALR3d 880.

Validity and construction of contract between hospital and physician providing for exclusive medical services. 74 ALR3d 1268.

Tort liability of physician or hospital in connection with organ or tissue transplant procedures. 76 ALR3d 890.

Recovery for mental or emotional distress resulting from injury to, or death of, member of plaintiff's family arising from physician's or hospital's wrongful conduct. 77 ALR3d 447.

Malpractice in connection with diagnosis of cancer. 79 ALR3d 915.

Patient tort liability of rest, convalescent, or nursing homes. 83 ALR3d 871.

Arbitration of medical malpractice claim. 84 ALR3d 375.

Malpractice in connection with electroshock treatment. 94 ALR3d 317.

Application of rule of strict liability in tort to person or entity rendering medical services. 100 ALR3d 1205.

Aspects of hospital operation are nonetheless within the same hospital, and there is no justification for breaking up the operations of one hospital into separable units for licensing purposes; therefore, one license should be required for the entire hospital operation. 1963 Op. Att'y Gen., No. 7.

**Collateral references.** — Licensing and regulation of nursing or rest homes. 97 ALR3d 1187.

**Sec. 18.20.030. Application and fees.** Application for a license shall be made to the department upon a form provided by it, and shall contain the information the department requires, which may include affirmative evidence of ability to comply with the reasonable standards, rules and regulations prescribed under AS 18.20.060 — 18.20.080. Each application for a license shall be accompanied by a license fee of \$10. The department shall deposit all fees received in the state treasury. (§ 40-6-4 ACLA 1949)

**Sec. 18.20.040. Issuance and renewal of license and posting.** Upon receipt of an application for license and the license fee, the department shall issue a license if the applicant meets the requirements established under AS 18.20.060 — 18.20.080. If the applicant does not meet the requirements established under AS 18.20.060 — 18.20.080 but makes continued efforts to comply with them, the department may grant him a temporary or provisional license for a reasonable period of time. A license, unless suspended or revoked, is renewable annually without charge upon filing by the licensee, and approval by the department of an annual report on the uniform date and containing the information in the form the department prescribes by regulation. Each license issued is for the premises and person or governmental unit named in the application and is not transferable or assignable except with the written approval of the department. Licenses shall be posted in a conspicuous place on the licensed premises. (§ 40-6-5 ACLA 1949; am § 4 ch 112 SLA 1957)

**Sec. 18.20.045. Insurance required.**

Repealed by § 40 ch 177 SLA 1978.

**Editor's notes.** — The repealed section ch 177, SLA 1978 in the 1978 Temporary derived from § 39, ch. 102, SLA 1976. and Special Acts and Resolves. As to purpose of repealing act, see § 1.

**Sec. 18.20.050. Denial, suspension or revocation of license.** The department may deny, suspend or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under AS 18.20.060 — 18.20.080. (§ 40-6-6 ACLA 1949)

**Sec. 18.20.060. Regulations and standards.** The department shall adopt, amend, and enforce rules, regulations and standards for all hospitals designed to further the accomplishment of the purposes of AS 18.20.010 — 18.20.130 in promoting safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare. (§ 40-6-7 ACLA 1949)

**Sec. 18.20.070. Compliance with regulations.** Each hospital in operation at the time the department adopts rules and regulations or

STATE OF ALASKA 1984 LEGISLATIVE SESSION  
FISCAL NOTE

Revision Date: \_\_\_\_\_

REQUEST

Bill/Resolution No.: SB 346  
Title: "An act relating to the treatment of mentally ill persons."  
Sponsor: Sen. Josephson & Halford  
Requestor: Senate HESS  
Date of Request: 1-20-84

FISCAL DETAIL

Agency Affected: Public Safety  
Program Category Affected: Administration of Justice  
BRU, Program or Subprogram(s) Affected: Alaska State Troopers

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

This Bill provides law enforcement officers with the latitude to protect both the mentally ill person and the public from the actions of the mentally ill.

ANALYSIS: Attach a separate page for analysis

Prepared By: Francis C. Allan G.C.A. mck Phone: 269-5601  
Division: Alaska State Troopers Date: 01/19/84  
Approved by Commissioner: Robert J. Sundborg Date: 1-26-84  
Agency: Public Safety

Distribution (by Agency preparing fiscal note):

Legislative Finance  
Legislative Sponsor  
Requestor  
Office of Management and Budget  
Impacted Agency(ies)

JUSTICE - Analysis

12/1/83

FISCAL NOTE

Revision Date: \_\_\_\_\_

REQUEST

Bill/Resolution No.: SB 346  
 Title: "An Act relating to the treatment of mentally ill persons."  
 Sponsor: Sen. Josephsen  
 Requestor: Senate HESS  
 Date of Request: 1/17/84

FISCAL DETAIL

Agency Affected: Department of Law  
 Program Category Affected: General Government  
 BRU, Program or Subprogram(s) Affected: Legal Services Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, C/UMS						
900 MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL						
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REVENUE						
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FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS:

This act amends the state's statutes covering the treatment of mentally ill persons. The amendment clarify existing law and provide additional safeguards for the general public and the relatives of mentally ill persons, while seeking to protect the legal rights of persons suffering from mental illness. The amendments will not require any additional legal services, over those currently being provided, and their enactment will not have a fiscal impact on the department's operations.

Prepared By: Richard I. Pegues Director Phone: 465-3672  
 Division: Administrative Services Date: 1-18-84

Approved by Commissioner: Norman O. Gorsuch Date: 1-18-84  
 Agency: Department of Law

Zero LAW Analysis

STATE OF ALASKA 1984 LEGISLATIVE SESSION  
FISCAL NOTE

Revision Date: \_\_\_\_\_

REQUEST  
Bill/Resolution No.: SB 346  
Title: An Act relating to the treatment of mentally ill persons  
Sponsor: Josephson and Halford  
Requestor: \_\_\_\_\_  
Date of Request: 1-11-84

FISCAL DETAIL Division of Mental Health  
Agency Affected: and Developmental Disabilities  
Program Category Affected: API  
BRU, Program or Subprogram(s) Affected: \_\_\_\_\_

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis \* See Attached

Prepared By: James L. Scoles <sup>PS</sup> <sup>(R)</sup> <sup>JCC</sup> Phone: 465-3370  
Division: Mental Health & Developmental Disabilities Date: 1-20-84

Approved by Commissioner: Robert London Smith Date: 1/30/84  
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

HEALTH-ANALYSIS  
12/1/83

The Division of Mental Health and Developmental Disabilities does not foresee any increase or decrease in expenditures as a result of the passage of SB 346 at this time. The primary purpose of this bill is mainly directed at reducing the procedural requirements of A.S. 47.30.655 - 47.30.915, changing the age of majority from 14 to 18 years of age, changing the period of time for the initial commitment from 21 to 30 days and the third period of commitment from 120 to 180 days, expanding the definition of peace officers to include mental health professionals, and slightly relaxing the standards for commitment.

We do not believe that any of these proposed amendments will increase or decrease the number of mentally ill persons that will require hospitalization. The amendments should, however, make it easier to commit the mentally ill which should result in more professional staff time available to provide direct patient care and treatment rather than excessive time being expended in the commitment process.

Council under § 1524(c)(2)(A) of P.L. 93-641, and only after consideration of comment and advice of the Advisory Board on Alcoholism. In awarding grants, the department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic rehabilitation and prevention.

(c) Grants shall be awarded in a ratio of 90 percent state money to 10 percent community money for the costs of providing staff and limited improvement, renovation or new construction of facilities for alcoholic detoxification, rehabilitation or "half-way house" care. The department may waive all or part of the requirement that state money be matched by community money if the department finds that community money is unavailable and waiver of the requirement is in the best interests of the state. No grant for improving, renovating or constructing may exceed \$50,000 except when there is a lack of applicants for available money and then only with the approval of the Review Board on Alcoholism. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available or could reasonably be made available to the applicant.

(d) Money used by the applicant to qualify for state money may be from any source other than the state. The cost of developing an application is not reimbursable from the grant. The value of real property to be used directly in conjunction with the grant may be used in calculating the required amount of community money, as allowed by regulations of the department.

(e) No grant may be awarded under this section unless the application includes a plan which provides for

(1) the expenditure of grant money for education and other preventative measures, or the treatment of alcoholics;

(2) the reception of advice and comment from a local advisory board, or, if a local advisory board cannot be formed because the area is sparsely populated, from the governing bodies of private nonprofit health organizations, regarding the design, implementation, and evaluation of the plan and action to be taken;

(3) goals, expressed in quantifiable terms that express the intended impact of the assistance provided under the plan upon the number of individuals needing or utilizing such assistance;

(4) coordination with the goals and objectives of the health systems plan developed by the health systems agencies under § 1513(b)(2) of P.L. 93-641.

(f) The department shall monitor the implementation of the plan required under (e) of this section, and shall terminate payment of grant money if the plan is not implemented or approval of the program as a public or private treatment program under AS 47.37.110 is not granted within one year of the award of the grant, or is suspended, revoked,

limited or restricted. Modification of the plan required by (e) of this section must be approved by the department before implementation of the modification.

(g) The department shall provide management training for persons administering a program receiving grant money under this section.

(h) If the department determines, after the award of a grant under (c) of this section, that the community is capable of bearing a greater portion of the cost of a program than originally determined, the department may

(1) reduce the award by that portion of the cost of a program which the department subsequently determined the community could bear; or

(2) terminate payment of the grant entirely. (§ 2 ch 101 SLA 1970; am § 1 ch 126 SLA 1975; am §§ 1, 2 ch 116 SLA 1978; am § 33 ch 168 SLA 1978; am § 1 ch 150 SLA 1980)

**Effect of amendments.** — The 1980 amendment substituted "90" for "75", and "10" for "25", deleted "except that in communities designated as poverty areas the ratio shall be 100 percent state money to 10 percent community money" following "community money" near the beginning of subsection (c), inserted the second sentence of subsection (c), and substituted "Review" for "Advisory" near the end of the third sentence of subsection (c).

## Article 6. Mental Health Program.

### Section

655. Purpose

660. Powers and duties of department

**Sec. 47.30.655. Purpose.** The purpose of this major revision of Alaska civil commitment statutes (AS 47.30.660 — 47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in (1) protecting society from persons who are dangerous to others; and (2) protecting persons who are dangerous to themselves, by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:

(1) that persons be given every opportunity to accept voluntary treatment before involvement with the judicial system;

(2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;

(3) that treatment occur as promptly as possible and as close to the individual's home as possible;

(4) that a system of mental health community facilities and supports be available;

(5) that patients be informed of their legal rights and be informed of and allowed to participate in their treatment program as much as possible;

(6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition. (§ 1 ch 84 SLA 1981)

**Editor's notes.** — The parenthetical by the revisor of statutes pursuant to AS expression in the first sentence was added 01.05.0311.

**Sec. 47.30.660. Powers and duties of department.** The department is the mental health authority of the state and shall

(1) administer a comprehensive program for the prevention of mental illness and the care and treatment of the mentally ill, including inpatient and outpatient care and treatment and the procurement of services of specialists or other persons on a contractual or other basis;

(2) take the actions and undertake the obligations which are necessary to participate in federal grants-in-aid programs and accept federal or other financial aid from whatever sources for the study, examination, care, and treatment of the mentally ill;

(3) administer AS 47.30.660 — 47.30.915;

(4) designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for the mentally ill;

(5) provide for the placement of mentally ill patients in designated treatment facilities;

(6) enter into arrangements with governmental agencies for the care or treatment of the mentally ill in facilities of the governmental agencies in the state or in another state;

(7) enter into contracts with treatment facilities for the custody and care or treatment of the mentally ill;

(8) enter into contracts which incorporate safeguards consistent with AS 47.30.660 — 47.30.915 and the preservation of the civil rights of the patients with another state for the custody and care or treatment of patients previously committed from this state under 48 U.S.C., sec. 46 et seq., and P.L. 830, 84th Congress, 2nd Session, 70 Stat. 709;

(9) prescribe the form of applications, records, reports, requests for release, and consents to medical or psychological treatment required by AS 47.30.660 — 47.30.915;

(10) require reports from the head of a treatment facility concerning the care of patients;

(11) visit each treatment facility at least annually to review methods of care or treatment for patients;

(12) investigate complaints made by a patient or an interested party on behalf of a patient;

(13) delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed upon it by AS 47.30.660 — 47.30.915; and

(14) adopt regulations to implement the provisions of AS 47.30.660 — 47.30.915. (§ 1 ch 84 SLA 1981)

**Editor's notes.** — Section 6, ch. 84, SLA 1981, provided: "Except as provided in this Act, the provisions of AS 47.30.660 — 47.30.815 enacted by sec. 1 of this Act do not in themselves impair any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

#### Article 7. Voluntary Admission for Treatment.

Section	Section
670. Standards for voluntary admission	690. Admission of minors under 14 years of age
675. Notice of rights	695. Notice of request for release of minors under 14 years of age from detention and commitment
680. Discharge of voluntary patients	
685. Notice of intent to leave facility, commitment	

**Editor's notes.** — Section 6, ch. 84, SLA 1981, provided: "Except as provided in this Act, the provisions of AS 47.30.660 — 47.30.815 enacted by sec. 1 of this Act do not in themselves impair any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

**Sec. 47.30.670. Standards for voluntary admission.** A person 14 years of age or older may be voluntarily admitted to a treatment facility if he is suffering from mental illness and he voluntarily signs the admission papers. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.675. Notice of rights.** (a) Upon the application of a person for voluntary admission, or at the time a person admitted under AS 47.30.690 reaches the age of 14, he shall be given a copy of the following documents which shall be explained to him as necessary:

(1) notice of rights as set out in AS 47.30.825 — 47.30.865 and an explanation of any document served upon him; and

(2) notice that should he desire to leave at a time when the treatment facility determines that he is mentally ill and as a result is likely to cause serious harm to himself or others or to gravely disabled, the facility could initiate commitment proceedings against him.

(b) If an applicant for voluntary admission does not understand English, the explanation shall be given in a language he understands. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.680. Discharge of voluntary patients.** A patient who no longer meets the standards established in AS 47.30.670 shall be discharged from the treatment facility. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.685. Notice of intent to leave facility; commitment.** A voluntary patient who is 14 years of age or older and who desires to leave a treatment facility must submit to the facility a written notice of intent to leave on a form provided to him by the facility. Upon immediate investigation, the patient shall be evaluated in writing and discharged immediately or given written notice that involuntary commitment proceedings will be initiated against him. The treatment facility may detain the patient for no more than 48 hours after receipt of the patient's notice of intent to leave in order to initiate involuntary commitment proceedings. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.690. Admission of minors under 14 years of age.** (a) A minor under the age of 14 may be admitted for 21 days evaluation, diagnosis, and treatment at a designated treatment facility if his parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,

(1) he is gravely disabled or is suffering from mental illness and as a result he is likely to cause serious harm to himself or others;

(2) there is no less restrictive alternative available for his treatment; and

(3) there is reason to believe that the patient's mental condition could be improved by the course of treatment.

(b) The minor may be released by the treatment facility at any time during the 21-day period if the professional person in charge or his designated mental health professional determines the minor would no longer benefit from continued hospitalization and the minor is not dangerous. The minor's parents or his guardian must be notified by the facility of the contemplated release and that, unless they initiate involuntary commitment proceedings, the minor will be released. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.695. Notice of request for release of minors under 14 years of age from detention and commitment.** The parent or guardian of a minor who is less than 14 years of age may request and obtain immediate release of the minor at any time, unless as the result of mental illness, the minor is likely to cause serious harm to himself or others (§ 1 ch 84 SLA 1981)

### Article 8. Involuntary Admission for Treatment.

Section	Section
700. Initiation of involuntary commitment procedures	760. Placement at closest facility
705. Emergency detention for evaluation	765. Appeal
710. Examination	770. Additional 120 day commitment
715. Acceptance of order	775. Commitment of minors
720. Release before expiration of 72-hour period	780. Early discharge
725. Commitment proceeding rights; notification	785. Authorized absences
730. Procedure for 21-day commitment; petition for commitment	790. Return from unauthorized absence
735. 21-day commitment	795. Involuntary outpatient care for committed persons
740. Procedure for 90-day commitment following 21-day commitment	800. Conversion of involuntary outpatient treatment to inpatient commitment
745. 90-day commitment hearing rights	805. Computing periods of time
750. Conduct of hearing	810. Habeas corpus
755. Court order	815. Limitation of liability; penalty for false application

**Editor's notes.**—Section 6, ch 84, SLA 1981, provided: "Except as provided in this Act, the provisions of AS 47.30.660 — 47.30.815 enacted by sec. 1 of this Act do not in themselves impair any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they

apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

**Sec. 47.30.700. Initiation of involuntary commitment procedures.** (a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 — 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to himself or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to himself or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver him to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section shall allege that the respondent is reasonably believed to present a likelihood of serious harm to himself or others or is gravely disabled as a result of mental illness and shall specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.705. Emergency detention for evaluation.** A peace officer who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to himself or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available. Upon arrival at the evaluation facility, the peace officer shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.710. Examination.** (a) A respondent who is delivered under AS 47.30.700 to 47.30.705 for emergency examination and treatment to an evaluation facility shall be examined and evaluated as to his mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to himself or others, and (2) is in need of care or treatment, the mental health professional may hospitalize him, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation. (§ 1 ch 84 SLA 1981)

Editor's notes. — The word "respondent" was substituted for the word "person" in the first sentence of subsection (b) by the revision of statutes pursuant to AS 01.05.031.

**Sec. 47.30.715. Acceptance of order.** When a facility receives a proper order for evaluation, it must accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time and place for a 21-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, his attorney, and the prosecuting attorney of the hearing

arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.720. Release before expiration of 72-hour period.** If at any time in the course of the 72-hour period the mental health professionals conducting the evaluation determine that the respondent does not meet the standards for commitment specified in AS 47.30.700, the respondent shall be discharged from the facility or the place of evaluation by evaluation personnel and the petitioner and the court so notified. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.725. Commitment proceeding rights; notification.** (a) When a respondent is detained for evaluation under AS 47.30.660 — 47.30.915, he shall be immediately notified orally and in writing of his rights under this section. Notification shall be in a language understood by the respondent. His guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

(b) Unless a respondent is released or voluntarily admits himself for treatment within 72 hours of his arrival at the facility or, if he is evaluated by evaluation personnel, within 72 hours from the beginning of his meeting with evaluation personnel, he is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause to detain him after the 72 hours have expired for up to an additional 21 days on the grounds that he is gravely disabled or mentally ill and as a result presents a likelihood of serious harm to himself or others. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS 47.30.700 — 47.30.820.

(c) The respondent has a right to communicate immediately, at the department's expense, with his guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice.

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against him at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 21-day commitment hearing; however, the facility or evaluation personnel may treat him with medication under prescription by a licensed physician or by a less restrictive alternative of his preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to

(1) prevent bodily harm to the respondent or others,

(2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable him to recover; or

(3) allow the respondent to prepare for and participate in the proceedings.

(d) A respondent, if he is represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 21-day commitment hearing and have the hearing set for a date no more than seven calendar days after his arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.730. Procedure for 21-day commitment; petition for commitment.** (a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

(1) allege that the respondent is mentally ill and as a result is likely to cause harm to himself or others or is gravely disabled;

(2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;

(3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;

(4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;

(5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 21 days;

(6) list the prospective witnesses who will testify in support of commitment or involuntary treatment;

(7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, his attorney, and his guardian, if any, before the 21-day commitment hearing. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.735. 21-day commitment.** (a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS 47.30.715.

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the

respondent, within practical limits. At the hearing, in addition to other rights specified in AS 47.30.660 — 47.30.915, the respondent has the right

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to his mental or physical health;

(2) to view and copy all petitions and reports in the court file of his case;

(3) to have the hearing open or closed to the public as he elects;

(4) to be proceeded against according to the rules of evidence applicable to civil proceedings;

(5) to have an interpreter if he does not understand English;

(6) to present evidence on his behalf;

(7) to cross-examine witnesses who testify against him;

(8) to remain silent.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 21 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to himself or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 21 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give him written notice, that if commitment or other involuntary treatment beyond the 21 days is to be sought, the respondent shall have the right to a full hearing or jury trial. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.740. Procedure for 90-day commitment following 21-day commitment.** (a) At any time during the respondent's 21-day commitment, the professional person in charge, or his professional designee, may file with the court a petition for a 90-day commitment of that respondent. The petition must include all material required under AS 47.30.730(a) except that references to "21 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon himself or another since his acceptance for evaluation, or that he was committed initially as a result of conduct in which he attempted or inflicted serious bodily harm upon himself or another, or that he continues to be gravely disabled, or that he demonstrated a current intent to carry out plans of serious harm to himself or another;

(2) allege that the respondent has received appropriate and adequate care and treatment during his 21-day commitment;

(3) be verified by the professional person in charge, or his professional designee, during the 21-day commitment.

(b) The court shall have copies of the petition for 90-day commitment served upon the respondent, his attorney, and his guardian, if any. The petition for 90-day commitment and proofs of service shall be filed with the clerk of the court, and a date for hearing shall be set, by the end of the next judicial day, for not later than five judicial days from the date of filing of the petition. The clerk shall notify the respondent, his attorney, and the petitioner of the hearing date at least three judicial days in advance of the hearing.

(c) Findings of fact relating to the respondent's behavior made at a 21-day commitment hearing under AS 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.745. 90-day commitment hearing rights.** (a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in AS 47.30.350 — 47.30.915, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent, his attorney, his guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to insure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language he understands.

(b) Unless the respondent is released or voluntarily admits himself following the filing of a petition and before the hearing, he is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS 47.30.740(b) to determine if he is mentally ill and as a result is likely to cause harm to himself or others, or if he is gravely disabled. If the respondent voluntarily admits himself following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written notice of intent to leave, the professional person in charge may file with the court a petition for 120-day commitment of the respondent under AS 47.30.770. The 120-day commitment hearing shall be scheduled for a date not earlier than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be

continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine him and to testify on his behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine him and testify on his behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional. A motion for the appointment may be filed in court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS 47.30.700 — 47.30.915, the rules of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If no decision has been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, he shall be released. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.750. Conduct of hearing.** The hearing under AS 47.30.745 shall be conducted in the same manner, and with the same rights for the respondent, as set out in AS 47.30.735(b). (§ 1 ch 84 SLA 1981)

*Editor's notes.* — The words "under AS" by the revisor of statutes pursuant to AS 47.30.745" was added following "hearing" 01.05.031.

**Sec. 47.30.755. Court order.** (a) After the hearing and within the time limit specified in AS 47.30.745, the court may commit the respondent to a treatment facility for no more than 90 days if the court or jury finds by clear and convincing evidence that the respondent is mentally ill and as a result is likely to cause harm to himself or others, or is gravely disabled.

(b) If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days (§ 1 ch 84 SLA 1981)

**Sec. 47.30.760. Placement at closest facility.** Treatment shall always be available at a state-operated hospital, however, if space in

available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to his home unless the court finds that

(1) another treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;

(2) another treatment facility in the state is closer to the respondent's friends or relatives who could benefit him through their visits and communications; or

(3) the respondent wants to be further removed from his home, and the mental health professionals who sought his commitment concur in the desirability of removed placement. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.765. Appeal.** The respondent has the right to appeal from any order of involuntary commitment. The court shall inform the respondent of this right. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.770. Additional 120-day commitment.** (a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 120-day commitment conforming to the requirements of AS 47.30.740(a) except that all references to "21-day commitment" shall be read as "the previous 90-day commitment" and all references to "90-day commitment" shall be read as "120-day commitment".

(b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 — 47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 120 days from the date on which the first 90-day treatment period would have expired.

(c) Successive 120-day commitments are permissible on the same ground and under the same procedures as the original 120-day commitment. An order of commitment may not exceed 120 days.

(d) Findings of fact relating to the respondent's behavior made at a 21-day commitment hearing under AS 47.30.735, a 90-day commitment hearing under AS 47.30.750, or a previous 120-day commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.775. Commitment of minors.** The provisions of AS 47.30.700 — 47.30.815 apply to minors. However, all notices required to be served on the respondent in AS 47.30.700 — 47.30.815 shall also be served on the parent or guardian of a respondent who is a minor, and parents or guardians of a minor respondent shall be notified that they may appear as parties in any commitment proceeding concerning the

minor and that as parties they are entitled to retain their own attorney or have one appointed for them by the court. A minor respondent has the same rights to waiver and informed consent as an adult respondent under AS 47.30.660 — 47.30.915; however, he shall be represented by counsel in waiver and consent proceedings. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.780. Early discharge.** The professional person in charge shall at any time discharge a respondent on the ground that the respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness. A certificate to this effect shall be sent to the court which shall enter an order officially terminating the involuntary commitment. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.785. Authorized absences.** A respondent undergoing involuntary treatment on an inpatient basis under AS 47.30.700 — 47.30.815 may be authorized to be absent from the treatment facility during times specified by the professional person in charge, or his professional designee, when an authorization to be absent is in the best interests of the respondent and he is not likely to cause harm to himself or others. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.790. Return from unauthorized absence.** When a respondent undergoing involuntary treatment on an inpatient basis is absent from the treatment facility without, or in excess of, authorization under AS 47.30.785, the professional person in charge, or his professional designee, may contact the appropriate peace officers who shall take the respondent into custody and return him to the treatment facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.705. Involuntary outpatient care for committed persons.** (a) A respondent who was originally committed to involuntary inpatient care under AS 47.30.700 — 47.30.915 may be released before the expiration of his commitment period if a provider of outpatient care accepts him for specified outpatient treatment for a period of time not to exceed the duration of his commitment, and if the professional person in charge, or his professional designee, finds that

(1) it is not necessary to treat the respondent as an inpatient to prevent him from harming himself or others; and

(2) there is reason to believe that the respondent's mental condition would improve as a result of the outpatient treatment.

(b) A copy of the conditions for early release shall be given to the respondent, his attorney, his guardian, if any, the provider of outpatient care, and the court.

(c) If during the commitment period the provider of outpatient care determines that the respondent can no longer be treated on an

outpatient basis because he is likely to cause harm to himself or others or is gravely disabled, the provider shall give the respondent oral and written notice that he must return to the treatment facility within 24 hours, with copies to the respondent's attorney, his guardian, if any, the court, and the inpatient treatment facility. If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport him to the facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

(d) If the provider of outpatient care determines that the respondent will require continued outpatient care after the expiration of his commitment period, the provider may initiate further commitment proceedings as if he were the professional person in charge, and the provisions of AS 47.30.660 — 47.30.915 apply, except that provisions relating to inpatient treatment shall be read as applicable to outpatient treatment. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.800. Conversion of involuntary outpatient treatment to inpatient commitment.** (a) A respondent ordered by the court under the provisions of AS 47.30.700 — 47.30.915 to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of outpatient care finds that (1) the respondent is mentally ill and is likely to cause serious harm to himself or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates that he now needs inpatient treatment to protect himself or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate to the respondent's need which will accept him as a patient. Treatment for these respondents shall be available at state-operated hospitals at all times.

(b) Upon making the findings specified in (a) of this section, the provisions of AS 47.30.795(b) relating to notice and AS 47.30.745 relating to hearing apply. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.805. Computing periods of time.** (a) Except as provided in (b) of this section,

(1) computations of a 72-hour evaluation period do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility;

(2) a 21-day commitment period expires at the end of the 21st day after the 72 hours following initial acceptance;

(3) a 90-day commitment period expires at the end of the 90th day after the expiration of a 21-day period of treatment;

(4) a 120-day commitment period expires at the end of the 120th day, after the expiration of a 90-day period of treatment or previous 120-day period, whichever is applicable.

(b) When a respondent has failed to appear or absented himself contrary to any order properly made or entered under AS 47.30.660 — 47.30.915, the relevant commitment period shall be extended for a period of time equal to the respondent's absence if written notice of absence is promptly provided to the respondent's attorney and his guardian, if there is one, and if, within 24 hours after the respondent has returned to the evaluation or treatment facility, written notice of the corresponding extension and the reason for it is given to the respondent, his attorney, his guardian, if any, and to the court. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.810. Habeas corpus.** Nothing in AS 47.30.660 — 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.815. Limitation of liability; penalty for false application.** (a) A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS 47.30.700 — 47.30.915 is not subject to civil or criminal liability.

(b) The following persons may not be held civilly or criminally liable for detaining a person under AS 47.30.700 — 47.30.915 or for releasing a person under AS 47.30.700 — 47.30.915 at or before the end of the period for which the person was admitted or committed for evaluation or treatment if the persons have performed their duties in good faith and without gross negligence:

(1) an officer of a public or private agency;

(2) the superintendent, the professional person in charge, the professional designee of the professional person in charge, and the attending staff of a public or private agency;

(3) a public official performing functions necessary to the administration of AS 47.30.700 — 47.30.915;

(4) a peace officer responsible for detaining a person under AS 47.30.700 — 47.30.915.

(c) A person who willfully initiates an involuntary commitment procedure under AS 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to himself or others, is guilty of a felony. (§ 1 ch 84 S.L.A. 1981)

### Article 9. Patient Rights.

Section	Section
825. Patient rights: Medical	845. Confidential records
840. Evaluation of experimental treatments	850. Expungement of records
855. Civil rights not impaired	855. Fostering of rights
860. Right to privacy and personal possessions	860. Notices in languages other than English
	865. Discrimination prohibited

**Sec. 47.30.825. Patient rights: Medical.** Each patient who is receiving services under AS 47.30.660 — 47.30.915 has the following rights:

(1) A patient, or his counsel, guardian, or the adult designated in accordance with AS 47.30.725 if the patient is mentally incapable of participation, is entitled to participate in formulating his individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in his treatment program, and being informed as to his present medical and psychological condition and prognosis. The treating physician may not withhold any of this information from the patient.

(2) A patient has the right to know the name of medication that he is asked to take, what its purpose is, and what side effects may occur with this medication. If the patient is incapable of understanding the purpose and side effects of the medication, the treating physician or mental health professional shall explain it to the patient's counsel or guardian or, if there is no guardian, the adult designated in accordance with AS 47.30.725.

(c) A locked quiet room, or other form of physical restraint, may not be used, except as provided in this paragraph, unless a patient is likely to physically harm himself or others unless restrained. The form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to his preference among forms of adequate, medically advisable restraints including medication, and his preference shall be considered. Nothing in this section is intended to limit the right of staff to use a quiet room at the patient's request or with his knowing concurrence when considered in the best interests of the patient. Patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good medical practice so indicates. Patients in a quiet room must be visited by a staff member at least once every hour and must be given adequate food and drink and access to bathroom facilities. At no time may a patient be kept in a quiet room or other form of physical restraint against his will longer than necessary to accomplish the purposes set out in this paragraph. All uses of a quiet room or other restraint shall be recorded in the patient's medical record, the information including but not limited to the reasons for its use, the duration of use, and the name of the authorizing staff member.

(4) A patient has the right to be free from unnecessary or excessive medication. Psychotropic medication shall be administered only on the order of a licensed physician when the physician determines that such medication is in the best interest of the patient or will prevent serious harm to others.

(5) A patient capable of giving informed consent has the absolute right to accept or refuse electro-convulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given such therapy or conditioning without a court order.

(6) In no event may treatment include psychosurgery, lobotomy, or other comparable form of treatment without specific informed consent of the patient, including a minor unless he is clearly too young or disabled to give an informed consent in which case the consent of his legal guardian is required. In addition, such treatment may not be given without a court order after hearing compatible with full due process.

(7) When, in the written opinion of a patient's attending physician, a true medical emergency exists and a surgical operation is necessary to save the life, physical health, eyesight, hearing or member of the patient, the professional person in charge, or his professional designee, may give consent to the surgical operation if time will not permit obtaining the consent of the proper relatives or guardian or appropriate judicial authority. However, an operation may not be authorized if the patient is not a minor and knowingly withholds consent on religious grounds.

(8) A patient upon discharge shall be given a discharge plan specifying the kinds and amount of care and treatment he should have after discharge and such other steps as he might take to benefit his mental health after leaving the facility. The patient shall have the right to participate, as far as practicable, in formulating his discharge plan. A copy of the plan shall be given to the patient, his guardian, the court if appropriate, and any follow-up agencies. (S 1 ch 84 SLA 1981)

**Sec. 47.30.830. Prohibition of experimental treatments.** (a) Experimental treatments involving any significant risk of physical or psychological harm may not be administered to a patient.

(b) If the personnel of an evaluation or treatment facility are uncertain as to whether a proposed treatment is experimental or is experimental as applied to a particular patient or would involve a significant risk of mental or physical harm to the patient, the matter may be referred to the commissioner for a determination. The patient, his attorney, his guardian, if any, and an adult designated by the patient, shall, simultaneously with the referral to the commissioner, be provided with copies of all the documents by which the referral is made and shall have the opportunity to provide evidence to the commissioner on the question.

(c) A determination by the commissioner that a treatment is experimental and entails significant risks of mental or physical harm is binding upon all persons involved in the administration of treatment to a patient. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.835. Civil rights not impaired.** (a) A person may not deny to a person who is undergoing evaluation or treatment under AS 47.30.660 — 47.30.915 a civil right, including but not limited to, the right to free exercise of religion and the right to dispose of property, sue and be sued, enter into contractual relationships, and vote. A person who violates this subsection commits the crime of interference with constitutional rights under AS 11.76.110.

(b) Court-ordered evaluation or treatment under AS 47.30.660 — 47.30.915 is not a determination of legal incapacity under AS 13.26.005 — 13.26.330. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.840. Right to privacy and personal possessions.** A person undergoing evaluation or treatment under AS 47.30.660 — 47.30.915 shall

(1) not be photographed without his consent and that of his guardian if a minor, except that he may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or his designee unless a court orders otherwise;

(2) at the time of admission to an evaluation or treatment facility, have reasonable precautions taken by the staff to inventory and safeguard his personal property; a copy of the inventory signed by the staff member making it shall be given to the patient and made available to his attorney and any other person authorized by the patient to inspect the document;

(3) have access to an individual storage space for his private use while undergoing evaluation or treatment;

(4) be permitted to wear his own clothing, to keep and use his own personal possessions including his toilet articles if they are not considered unsafe for him or other patients who might have access to them, and to keep and be allowed to spend a reasonable sum of his own money for his own needs and comfort;

(5) be allowed to have visitors at reasonable times;

(6) have ready access to letter writing materials, including stamps, and have the right to send and receive unopened mail;

(7) have reasonable access to a telephone, both to make and receive confidential calls. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.845. Confidential records.** Information and records obtained in the course of a screening investigation, evaluation, examination, or treatment are confidential and are not public records, except as the requirements of a hearing under AS 47.30.660 — 47.30.915 may

necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to

(1) a physician or a provider of health, mental health, or social and welfare services involved in caring for, treating, or rehabilitating the patient;

(2) the patient or an individual to whom the patient has given written consent to have information disclosed;

(3) a person authorized by a court order;

(4) a person doing research or maintaining health statistics, if the anonymity of the patient is assured, and the facility recognizes the project as a bona fide research or statistical undertaking;

(5) the division of corrections in a case in which a prisoner confined to the state prison is a patient in the state hospital on authorized transfer either by voluntary admission or by court order;

(6) a governmental or law enforcement agency when necessary to secure the return of a patient who is on unauthorized absence from a facility where the patient was undergoing evaluation or treatment. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.850. Expungement of records.** Following the discharge of a respondent from a treatment facility or the issuance of a court order denying a petition for commitment, the respondent may at any time move to have all court records pertaining to the proceedings expunged on condition that he file a full release of all claims of whatever nature arising out of the proceedings and the statements and actions of persons and facilities in connection with the proceedings. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.855. Posting of rights.** The rights set out in AS 47.30.825 — 47.30.855 shall be prominently posted in all treatment facilities in places accessible to all patients. A patient who does not understand English shall have his rights explained to him in a language he understands. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.860. Notices in languages other than English.** When practicable all documents and notices required by AS 47.30.660 — 47.30.915 to be served on a respondent, or on his parents, guardian or adult designee, shall be explained in a language the person understands if he is not competent in English. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.865. Discrimination prohibited.** (a) The fact that a person is or has been evaluated or treated for mental illness may not be a basis for discrimination in

(1) seeking employment;

(2) securing or continuing professional practice or previous occupation.

(3) obtaining or retaining housing;

(4) obtaining or retaining licenses or permits, including but not limited to a motor vehicle license, motor vehicle operator's and chauffeur's license, and a professional or occupational license.

(b) Applications for positions, licenses, and housing may not contain requests for information concerning evaluation or treatment experiences.

(c) It is unlawful for a person to aid, abet, incite, compel, or coerce the doing of an act forbidden under this section or to attempt to do so. (§ 1 ch 84 S.L.A. 1981)

#### Article 10. Miscellaneous Provisions.

Section	Section
870. Transportation	900. Disposition of money and personal property subject to claim
875. Nonresident patients	905. Fees and expenses for judicial proceedings
880. Interstate compact	910. Liability for expense of placement in a treatment facility
885. Rights outside state	915. Definitions
890. Provision for personal needs upon discharge	
895. Disposition of personal property and unclaimed money	

**Sec. 47.30.870. Transportation.** When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person's necessary transportation to the designated facility accompanied by appropriate persons and if necessary by a peace officer. The department shall pay return transportation of a person, his escorts, and if necessary a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715. When advisable, one or more relatives or friends shall be permitted to accompany the person. The department may pay necessary travel, housing, and meal expenses incurred by one relative or friend in accompanying the person if the department determines that the person's best interests require that he be accompanied by the relative or friend and the relative or friend is indigent. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.875. Nonresident patients.** (a) The admission papers of a person who is admitted to a treatment facility under AS 47.30.660 - 47.30.915 shall include a statement as to his residence. The department may return a patient who is not a resident of the state to the state of his residence with court approval if the person has been committed. If the state in which he has residence does not accept him as a patient, the person shall be treated as a resident of this state under the provisions of AS 47.30.660 - 47.30.915.

(b) To facilitate the return of nonresident patients the department may enter into a reciprocal agreement or compact with another state providing for the prompt return under appropriate supervision of residents of that state who are mentally ill. A mentally ill resident of this state who has been placed in a facility outside this state may be admitted with the approval of the department to a treatment facility in the state designated by the department. The department may enter into reciprocal agreements or contracts with another state providing for custody, care or treatment, or return of mentally ill residents of this state by the other state and for the custody and care or treatment of mentally ill residents of that state by this state on a reimbursable basis. A resident of this state who has been committed in another state and is returned in accordance with this section shall, within 72 hours of his admission to the designated facility, be examined. After examination the mental health professional in charge shall release him or shall petition for involuntary commitment as prescribed in AS 47.30.740.

(c) In taking action under (a) and (b) of this section, consideration shall be given to the best interests of the patient, particularly to the relationship of the patient to his family, legal guardian, or friends to maintain relationships and encourage visits beneficial to the patient. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.880. Interstate compact.** This state ratifies and adopts by reference "The Interstate Compact on Mental Health" consisting of 14 articles approved on September 30, 1955, by the Northeast State Governments Conference on Mental Health. The department is designated as compact administrator with full power to carry out the purpose of the compact and to make all necessary regulations to implement the compact. (§ 119(c) ch 87 S.L.A. 1957; added by § 11 ch 127 S.L.A. 1959; AS 47.30.180)

*Editor's note.* - This section derives under AS 01.05.031 to accord with the from former AS 47.30.180 and was revision of the mental health statutes in renumbered by the revisor of statutes Chapter 81, S.L.A. 1981

**Sec. 47.30.885. Rights outside state.** Nothing in AS 47.30.660 - 47.30.915 alters or impairs the application or availability to a patient, while hospitalized in another state under contractual arrangements entered in accordance with AS 47.30.660 - 47.30.915, of the rights, remedies or safeguards provided by the laws of this state. (§ 1 ch 84 S.L.A. 1981)

**Sec. 47.30.890. Provision for personal needs upon discharge.** The department shall insure that

(1) a patient is not discharged from a treatment facility without suitable clothing; and

(2) a discharged indigent patient is furnished

(A) suitable transportation to his permanent residence in this state or to another suitable place at the discretion of the department; and

(B) a reasonable amount of money to meet his immediate needs. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.895. Disposition of personal property and unclaimed money.** (a) Articles of personal property and unclaimed money in the custody of a treatment facility that belong to a patient who dies before discharge, or to a patient who leaves the hospital without authority, if unclaimed by the patient or his legal heirs or representatives within one year after the death or departure of the patient, shall be disposed of in the manner prescribed by the department and the proceeds shall be deposited in the state treasury.

(b) If a mentally ill individual has died in a foreign facility and the department desires to recover the patient's personal property under this section, the commissioner or his designated representative may secure the property and for that purpose only is designated the decedent's administrator. Property so recovered shall be disposed of as provided by law. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.900. Disposition of money and personal property subject to claim.** The department shall make diligent inquiry in every instance after departure without authority or death of a patient, to ascertain the whereabouts of the patient or that of his legal heirs or representatives, and shall turn over to the proper person the money or articles of personal property in the custody of the facility to the credit of the patient. Claims to the money or articles of personal property, including claims by the state, may be presented to the department at any time. If a claim other than by the state is established by clear and convincing evidence more than one year after the death or departure without authority of a patient, it shall be certified to the legislature for consideration and the legislature may pay the claim. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.905. Fees and expenses for judicial proceedings.** (a) The witnesses, expert witnesses, and the jury in commitment proceedings under AS 47.30.660 — 47.30.915 are entitled to the fees, compensation, and mileage established by the administrative rules of court for other jurors and witnesses. Compensation, mileage, fees, transportation expenses for a respondent, and other expenses arising from evaluation and commitment proceedings shall be audited and allowed by the superior court of the judicial district in which the proceedings are held. To the extent that services of a peace officer are used to carry out the provisions of AS 47.30.660 — 47.30.915, he is entitled to fees and actual expenses from the same source and in the same manner as for his other official duties.

(b) An attorney appointed for a person under AS 47.30.660 — 47.30.915 shall be compensated for his services as follows:

(1) the person for whom an attorney is appointed shall, if he is financially able under standards as to financial capability and indigency set by the court, pay the costs of the legal services;

(2) if the person is indigent under those standards, the costs of the services shall be paid by the state. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.910. Liability for expense of placement in a treatment facility.** (a) A patient, or his legal representative acting in a representative capacity, or his spouse, or his parents if the patient is under the age of 18, shall pay or contribute to the payment of the charges for the care, transportation, and treatment of the patient when hospitalized under AS 47.30.660 — 47.30.915. Charges assessed after an order for commitment for treatment is issued and charges assessed when a patient is hospitalized at a facility operated by the department, or under a contract for services with the department, may not exceed the actual cost of the care and treatment. The department may order payment by the patient or by the person responsible for payment for the patient's care and treatment under this subsection, according to ability to provide for payment. The department may make necessary investigations to determine the ability to pay and may require sworn statements of income by the patient, or his legal representative acting in a representative capacity, or his spouse or parent. In the exercise of his discretion, the commissioner may impose full liability for the patient's actual cost of care and treatment on the patient, his legal representative, his spouse, or parent for refusal to supply a sworn statement of income. An order for payment shall be issued by the department within six months after the date on which the charge was incurred. The order shall remain in full force and effect unless modified by subsequent court or department order. Liability under this subsection shall be determined as follows: A patient hospitalized under AS 47.30.660 — 47.30.915, or the person responsible for payment of charges for the patient, may be required to pay according to his ability to provide for payment, and in the manner and proportion which the department finds is not detrimental to the patient's rehabilitation. The department shall, at any time that it determines the action will serve the best interests of the state and the patient or the person responsible for payment, relieve the patient or the person responsible for payment from liability for charges for the care, transportation, and treatment of the patient.

(b) As used in (a) of this section, the term "actual cost of the care and treatment" means either the rate provided for by a contract entered into under AS 47.30.660 — 47.30.915, or, in the absence of a contract, a daily rate approved by the department.

(c) The department may charge, or accept from a person money or property, for the care or treatment of an inpatient or outpatient or for

other purposes, even if the payment is not required by an order of the department, so long as the total payments received do not exceed the actual cost of care or treatment.

(d) All money paid by the patient or on his behalf to the department under this section shall be deposited in the state treasury.

(e) If an order for payment is entered by the department under this section, and delinquency in the payment of any amount due the state under the order continues for a period of more than 30 days after the notification to the patient or the legal representative, spouse, or parent of the patient by the department, the state may proceed to collect the amounts due by appropriate proceedings. An action to enforce the collection of payments may only be brought within three years after the date of notification of a delinquent payment.

(f) The orders of the department issued under this section may relate only to charges incurred after October 1, 1981. (S 1 ch 84 SLA 1981)

**Sec. 47.30.915. Definitions.** In AS 47.30.660 — 47.30.915

(1) "commissioner" means the commissioner of health and social services;

(2) "court" means a superior court of the state;

(3) "department" means the Department of Health and Social Services;

(4) "designated treatment facility" means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons and for the receipt of these persons by court-ordered commitment, but does not include correctional institutions;

(5) "evaluation facility" means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS 47.30.660 — 47.30.915; or a medical facility licensed under AS 18.20.020;

(6) "evaluation personnel" means mental health professionals designated by the department to conduct evaluations as prescribed in AS 47.30.660 — 47.30.915 who conduct evaluations in places in which no staffed evaluation facility exists;

(7) "gravely disabled" means a condition in which a person as a result of mental illness, is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness or death highly probable if care by another is not taken;

(8) "inpatient treatment" means care and treatment rendered inside or on the premises of a treatment facility, or a part or unit of a treatment facility, for a continual period of 24 hours or longer;

(9) "least restrictive alternative" means mental health treatment facilities and conditions of treatment which are

(A) no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and

(B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury;

(10) "likely to cause serious harm" means a person who

(A) poses a substantial risk of imminent and substantial bodily harm to himself, as manifested by recent attempts at suicide or bodily harm;

(B) poses a substantial risk of imminent and substantial bodily harm to one or more other persons as manifested by behavior causing or attempting harm, including, in regard to evaluations, at least one incident within 30 days before the filing of a petition for emergency hospitalization; or

(C) demonstrates a current intent to carry out plans of serious harm to himself or another;

(11) "mental health professional" means a psychiatrist or physician who is licensed to practice in this state or employed by the federal government; a clinical psychologist licensed by the state Board of Psychologists and Psychological Associate Examiners; a psychological associate with a clinical psychology or counseling specialty licensed by the Board of Psychologists and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; and a social worker with a master's degree in social work and experience in the field of mental illness;

(12) "mental illness" means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of his actions or ability to perceive reality or to reason or understand; mental retardation, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

(13) "peace officer" includes a state police officer, municipal or other local police officer, state, municipal, or other local health officer, public health nurse, United States marshal or deputy United States marshal, or a person authorized by the court;

(14) "provider of outpatient care" means a mental health professional or hospital, clinic, institution, center, or other health care facility designated by the department to accept for treatment patients who are ordered to undergo involuntary outpatient treatment by the court or who are released early from inpatient commitments on condition that they undergo outpatient treatment;

(15) "screening investigation" means the investigation and review of facts which have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons

providing information or making allegations;

(16) "state" means a state of the United States, the District of Columbia, the territories and possessions of the United States, and the Commonwealth of Puerto Rico, and, with the approval of the United States Congress, Canada;

(17) "professional person in charge" means the senior mental health professional at a facility or his designee; in the absence of a mental health professional it means the chief of staff or a physician designated by the chief of staff. (§ 1 ch 84 SLA 1981)

## Chapter 35. Private Institutions.

### Article 1. Foster Homes, Boarding Homes and Institutions.

Section	Section
20 License or permit required	55. Provisional license
40 Licensing	80 Definitions
50 (Repealed)	

**Sec. 47.35.020. License or permit required.** No person may, without a license or permit to do so,

(1) maintain or conduct, for more than 90 days, a boarding home, foster home, group home, institution, or other place for the regular reception or care of children under 16 years of age, or a foster home, group home, or institution for the care of dependent adults; or

(2) engage in the business of receiving or caring for children under 14 years of age, with or without compensation, in a nursery in which five or more children not related by blood or marriage, or legal adoption, to the owner, operator or manager of the business are lodged. (§ 3 ch 17 SLA 1951; am § 3 ch 42 SLA 1973; am § 3 ch 253 SLA 1976; am § 2 ch 45 SLA 1977; am § 1 ch 97 SLA 1982)

*Effect of amendments.* — The 1982 amendment inserted "for more than 90 days" near the beginning of paragraph (1) and made minor changes in style.

**Sec. 47.35.040. Licensing.** (a) The department shall issue a license to a facility if it determines that the facility has met the standards for operation set out in AS 47.35.010 — 47.35.080 and the regulations adopted under AS 47.35.010 — 47.35.080.

(b) A license is valid for two years after the date of issuance unless it is revoked or modified. The department may revoke a license or modify a license to provisional status if it determines that a facility is not in compliance with AS 47.35.010 — 47.35.080 or the regulations adopted under AS 47.35.010 — 47.35.080.

(c) The department may waive compliance with a standard set out in regulations adopted under AS 47.35.010 — 47.35.080 if an acceptable alternative is established that meets the purpose of the provision and reasonably ensures the well being of persons in care.

(d) A license may not be transferred to a different facility or owner.

(e) The department shall give written notice of revocation or modification under (b) of this section 30 days before the effective date of the action. However, if the health or well-being of children or dependent adults is in jeopardy, the revocation or modification action is effective immediately upon the issuance of written notice by the department. (§§ 5, 8 ch 17 SLA 1951; am § 4 ch 42 SLA 1973; am § 2 ch 97 SLA 1982)

*Effect of amendments.* — The 1982 amendment substituted the present provisions of the section for the provisions set out in the main pamphlet.

### Sec. 47.35.050. Duration of license or permit.

Repealed by § 5 ch 97 SLA 1982.

*Cross references.* — For present provisions covering the subject matter of the repealed section, see AS 47.35.040(h) and (i).  
*Editor's notes.* — The repealed section derived from § 0, ch 17, SLA 1951; § 5, ch 42, SLA 1973; § 3, ch 45, SLA 1977; (e).

**Sec. 47.35.055. Provisional license.** (a) The department shall issue a provisional license to a new facility if the facility submits to the department an acceptable plan for operation that is in conformity with the provisions of AS 47.35.010 — 47.35.080 and the regulations adopted under AS 47.35.010 — 47.35.080. After the department determines that the new facility is operating in conformity with the provisions of AS 47.35.010 — 47.35.080 and the regulations adopted under AS 47.35.010 — 47.35.080, the department shall issue a license under AS 47.35.010 to the facility.

(b) The department may issue a provisional license to a facility that is licensed under AS 47.35.040 but is temporarily unable to conform to the provisions of AS 47.35.010 — 47.35.080 or the regulations adopted under AS 47.35.010 — 47.35.080.

(c) The department may issue a provisional license under (b) of this section only if the facility submits to the department an acceptable plan to bring the facility into conformity with the provisions of AS 47.35.010 — 47.35.080 and the regulations adopted under AS 47.35.010 — 47.35.080 within the time specified in the provisional license.

(d) A provisional license is valid for a period not exceeding one year from the date of issuance. The department may renew a provisional license for an additional period not to exceed one year. (§ 3 ch 97 SLA 1982)

### Sec. 47.35.080. Definitions. In AS 47.35.010 — 47.35.100

(1) "boarding home or foster home" means an establishment providing regular care for less than six children not related by blood or marriage to the foster parents.

April 6, 1984

Dear Rep. Davis:

I wish to write and voice my support for CSSB 346 which I understand the senate has sent to the House this week.

My first husband suffers from chronic manic depressive illness. His initial break down was a nightmare for myself and his family - and I believe for him. Although he was obviously seriously disoriented we were not able to get help for him against his will. He had to do serious bodily harm to someone else before he could be treated involuntarily. As a result, I had to spend time hiding from him until he finally injured someone. As I was pregnant at the time and caring for our older small child, I could not risk being the person he would injure.

A few years later, he returned to Fairbanks when our oldest child was critically ill in the hospital - and chose that time to experiment with his mental stability by not taking his medication. Knowing he was at risk for another breakdown, I refused to let him visit his son unsupervised. He became angry and later did indeed have another breakdown in the course of which he was jailed twice and finally sent to API.

When he was released from API,

they notified me that he was being released and that he intended to leave for Seattle BUT they made it clear that they had only notified me because he had given his permission as IN THEIR OPINION he was no threat to any of his family members. I thanked them for notifying me, but told them that in light of the then recent Charles Mueck murders their opinion of who was and was not dangerous did not have much credibility.

Although our situation resolved itself without anyone being injured, our family experienced a very tense summer with one child in the hospital and the other not allowed to play outside without constant direct adult supervision. I believe that patients do have rights, but I also believe that their family members have rights as well. Living with a mentally ill family member can be exhausting, frustrating, frightening and dangerous, especially when the law offers no protection from the patient.

Thank you for your time.

Jane Carson-Sellin  
455-6099

P.O. Box 1699  
Fairbanks Alaska 99707

Alaska State Legislature

REP. MAE TISCHER  
CHAIRMAN



POUCH V  
STATE CAPITAL  
JUNEAU, ALASKA 99811  
(907) 465-3777

House of Representatives  
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

M E M O R A N D U M

May 1, 1984

TO: All Members of the House HESS Committee  
FROM: Representative Mae Tischer, Chairman, House HESS MT  
RE: CSSB 346 (Judiciary), Amended: Presentation by  
Dr. Linus Pauling

The House HESS Committee will continue its hearings on the Senate Judiciary Committee Substitute for Senate Bill 346, Amended, "An Act relating to the treatment of mentally ill persons," on Wednesday, May 2, at 1:15 p.m., in the House Resources Committee Room (C-118), with a special teleconference presentation by Dr. Linus Pauling on the subject of nutritional therapy for the treatment of mentally ill persons.

As earlier correspondence has indicated, Dr. Pauling is regarded as an expert on this issue. The attached information from Who's Who in America will shed some light on his background.

I ask that you review the attached background material in preparation for this hearing. Your cooperation will make Dr. Pauling's presentation more understandable and useful.

Attachments

# ALASKA STATE SENATE

JOE P. JOSEPHSON  
DISTRICT G - ANCHORAGE  
1526 F STREET  
ANCHORAGE, ALASKA 99501  
(907) 277-4419

COMMITTEES  
HEALTH, EDUCATION & SOCIAL SERVICES (CHAIR)  
JUDICIARY (VICE-CHAIR)  
FINANCE  
MAJORITY CAUCUS (CHAIR)

April 12, 1984



The Honorable Mae Tischer  
Alaska State House of Representatives  
Pouch V  
Juneau, Alaska 99811

Dear Representative Tischer:

SB 346, relating to the treatment of mentally ill persons has passed the Senate and has been referred to your committee.

This bill is the result of a year and a half of work by the Senate, and addresses the concerns of all who testified in the many hearings conducted around the state.

I was pleased to incorporate your amendment for the right to a nutritionally sound and medically appropriate diet (Section 21). A significant amount of new patients' rights will be added to the mental health commitment law with the passage of this bill.

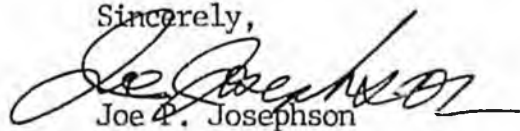
My interest in this legislation was sparked by input from family grounds of the chronically mentally ill, the Alaska Mental Health Association and the Alaska Psychiatric Association. The major revision in the law of 1981 brought about dramatic changes in the treatment of the mentally ill, and I see SB 346 as a refinement of those provisions.

I am enclosing some backup material on this legislation for your perusal. I know this is a difficult and emotional issue, but I find that this bill has a broad base of support.

I will be happy to meet with you at any time to discuss this issue.

With best wishes, I am

Sincerely,



Joe P. Josephson

JPJ/ndc

Enclosure

treatment services under the following categories: inpatient hospital, physician services, and nonphysician services, respectively.

- Almost every state has placed limitations on psychologists' services. In **GEORGIA**, for example, psychological services cannot exceed five hours of evaluation and testing, and therapy per recipient per calendar year; **INDIANA** requires prior approval for ongoing psychotherapy. In **MINNESOTA**, up to ten hourly sessions per recipient a year are covered; and **NEBRASKA** limits psychotherapy to \$500 per patient a year except by prior authorization.

- Two states, **OREGON** and **WISCONSIN**, provide direct reimbursement to other mental health professionals. In **OREGON**, registered social workers can be paid for preauthorized diagnostic services within the scope of their licenses, while certain masters level mental health clinicians (masters of social work, psychology, and psychiatric nurses) may be reimbursed for psychotherapy in **WISCONSIN**.

**MICHIGAN's** legislature is considering a proposal (HB 4358) that creates a new section of the Mental Health Code, specifically focusing on emotionally disturbed children. The bill consolidates and modifies existing sections of the code (procedures for admissions, objections and prerelease planning) and creates several new sections that recognize the special needs and status of children. The bill has passed the House and is being considered by the Senate.

HB 4358 establishes a single-entry system through **MICHIGAN's** community mental health boards for those children in the public mental health system. It requires a certified diagnostic and treatment service to determine a minor's suitability for public mental health services, and a prerelease or postrelease plan for each minor leaving hospitalization. HB 4358 also requires the Department of Mental Health to promulgate rules concerning the admission and discharge procedures for children entering the specialized treatment unit for state wards from the Department of Social Services. The measure would permit a minor 14 years or older to request hospitalization, although consent by a parent or guardian continues to be required for treatment of a minor while hospitalized. However, the provisions of the bill allow minors 14 or older to receive mental

## WAIVERS

- Two states, **MICHIGAN** and **WISCONSIN**, have received waivers to provide mental health services under Section 2175 of the Omnibus Reconciliation Act of 1981 (OBRA). Both states received approval to implement mental health care case-management arrangements which restrict the providers from whom the recipient may obtain services.

- Four states, **CALIFORNIA**, **COLORADO**, **RHODE ISLAND** and **VERMONT**, have received waivers under Section 2176 of OBRA to implement home- and community-based programs for the mentally ill.

## COPAYMENTS

- Six states (**GEORGIA**, **KANSAS**, **NEVADA**, **NORTH CAROLINA**, **VIRGINIA** and **WISCONSIN**) require that recipients contribute to the cost of various types of mental health services.

Federal and State officials may obtain one copy of the survey free of charge. Others may obtain a copy by sending \$9 to IHPP.

health services on an outpatient basis, without the consent or notification of their parents.

**MASSACHUSETTS** is considering a bill (S 742) which would permit minors age 12 and older to receive mental health treatment or counseling on an outpatient basis without the consent of their parents or legal guardians. Although **WASHINGTON** failed to pass a similar measure, legislators agreed to establish a study committee on children's mental health services with the following objectives: 1) to perform a program, management, and fiscal review of existing publicly funded children's mental health and related children and family services; 2) to determine the extent to which certain laws have been implemented (e.g., continuum of care, prevention, early intervention, and diversion from involuntary commitment; and 3) to determine the need for and type of children's mental health and related services focusing on such categories as those mentioned above. The final report must be submitted to the legislature by December 15, 1984, and will include budgetary and statutory recommendations.

At the federal level, the Office of State and Community Liaison, National Institute of Mental Health, has received a total of 44 grant applications under the

## Children's Mental Health Services

Child and Adolescent Service System Program (CASSP). Grants will be awarded to approximately eight states to develop state-level foci for planning, service-system improvement strategy development, and the initiation of community-level demonstrations of service system development. Approximately

\$1.5 million is available for this program. An independent committee will meet March 21-23 to review the proposals. Its recommendations will be presented at the May meeting of the National Advisory Mental Health Council. Officials anticipate that awards will be made in July.

## Dedicated Taxes

A number of so-called dedicated tax bills are currently under consideration in several legislatures. An **IDAHO** bill (HB 464) would create an alcohol awareness account to be financed by a portion of the state tax on liquor and beer. The account would support the operation of the governor's commission on alcohol awareness and training. **MASSACHUSETTS** is considering a measure (S 1769) would add a surtax on alcoholic beverages and direct the funds to alcoholic rehabilitation centers or for matching federal grants designated for prevention of alcohol abuse and alcoholism. A **SOUTH CAROLINA** proposal (H 3459) would levy a 10 percent surtax on all taxes imposed on beer and wine and require that 75 percent of the revenue generated be returned to the counties on a per capita basis to be used for prevention and treatment of alcoholism and drug abuse.

A proposal (SB 3617) under consideration in the **WASHINGTON** state senate would dedicate a portion of the state's highway safety funds derived from penalty assessments on drunk drivers to the operation of an alcohol awareness program. The alcohol awareness program would be directed toward teenage drivers and young adults up to age 25. It would include presentations and educational curricula designed to illustrate the dangers of alcohol misuse, the effects and impairments of alcohol on the body, and to prevent drunk driving. A separate bill in the **WASHINGTON** House (HB 1701) would assess an additional tax of 6.5 cents per liter on wine not bottled in the state and an additional \$3.30 per barrel of beer and deposit the funds in a Drunk Driving Deterrence and Victims Compensation Account. The bill provides that the funds shall be distributed in the following manner: (1) \$2 million per biennium to the state patrol to be used for educational programs in public schools concerning alcohol and drug abuse and traffic safety; (2) a sufficient amount for the Crime Victims Compensation Account to pay claims by those injured by

intoxicated drivers; and (3) \$3 million per biennium to the Department of Social and Health Services' Alcohol Treatment Programs.

**MISSOURI's** SB 514 seeks to create an alcoholism and drug abuse treatment and rehabilitation trust fund by applying a surcharge of 20 cents per gallon on the sale of spirituous liquors. The monies will go for funding community alcoholism and drug abuse treatment and rehabilitation services. Similarly, a **PENNSYLVANIA** proposal (H 1740) would increase the state tax on liquor and devote 10 percent of the revenue derived from the increase to a Drug and Alcohol Programs Augmentation Account. The purpose of the account is to support alcohol rehabilitation and treatment programs, as well as promote education, prevention and early intervention programs designed to eliminate alcohol abuse and drug addiction.

An **OHIO** bill (HB 654) would increase the state's sales tax on liquor by 2 cents a gallon and earmark the additional revenues for adolescent alcohol drug abuse treatment programs. A separate **OHIO** measure (HB 628) would levy an additional 2 cent tax on beer, wine and liquor. Forty percent of the revenues must go to the counties' alcohol and drug abuse treatment and prevention distribution fund; 10 percent would go to the Department of Mental Health's drug abuse special account and 10 percent to the Department of Health's alcoholism special account.

In the past few years, **MAINE**, **UTAH**, and **KANSAS** enacted statutes requiring that a certain portion of their states' taxes on liquor be dedicated to alcohol and drug abuse prevention activities.

A new statute in **NEW JERSEY** establishes the Alcohol Education Rehabilitation and Enforcement Fund (A 3468, Chapter 53). The law increases the wholesale tax on alcohol from 6.5 percent to 7.3 percent, and devotes approximately 11 percent of the revenue generated by the increase to the new Alcohol

# MEMORANDUM


# State of Alaska

TO: Philip Shapiro, M.D.  
Director

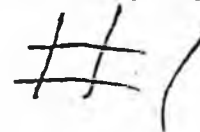
DATE: April 25, 1984

FILE NO:

TELEPHONE NO: 465-3370

FROM: James L. Scoles   
Alternative Care Coordinator  
Division of Mental Health  
and Developmental Disabilities

SUBJECT: Notification of Parent  
or Guardian



The following language is suggested in order to satisfy the request by Representative Tischer for assurance that parents or guardians are notified when a minor presents himself for inpatient psychiatric hospitalization.

Page 3, line 14 add a new section (b) to read:

(b) The parent or guardian of a minor under the age of 18 that presents himself at a designated treatment facility must be notified immediately by the facility of the minor's whereabouts.

Existing subsections (b) and (c) should be changed to (c) and (d).

JLS/vlh

1 dau. Nancy Marie With Aerospace Corp., El Segundo, Calif. 61— head space particles and fields dept., 1968. dir. space sci. lab., 1968-81, v.p. 1981— mem. various ad hoc coms. Nat. Acad. Sci., 1970-73, 79. 30. mem. com. solar and space physics, 1977-80; adv. council geophysics U. Calif., 1973-75, exec. com. space sci. lab. U. Calif., Berkeley, 1978— sci. adv. bd. USAF, 1975—; cons. Lawrence Berkeley Lab., 1961-66. Office Space Sci., NASA, 1975— Recipient Aerospace Corp. Trustee Disting. Achievement award, 1980. Fellow Am. Phys. Soc.; mem. AIAA (chmn. tech. com. space sci. and astronomy 1976-77); Am. Geophys. Union, Sigma XI. Author papers in field; asso. editor Jour. Geophys. Research, 1972-75. Home: 1437 Addison Rd. Palos Verdes Estates CA 90274 Office: 2350 E. El Segundo Blvd El Segundo CA 90245

PAULIN, HENRY SYLVESTER, antiques dealer, Cincinnati educator; b. Clevel., Nov. 8, 1927; s. Sylvester and Mary (Zimmerman) P. B.S. in Edn., Kent (Ohio) State U., 1955, M.A., Ohio State U., 1956, Ph.D., 1964. m. Florence Caroline Schwegman, Aug. 30, 1952. Jr. ind. arts Brimfield Jr.-Sr. High Sch., Kent, 1954-55, Zanesville (Ohio) High Sch., 1955-57. instr. ceramics Art Inst., Zanesville, 1957-57; asst. prof., then asso. prof. ind. arts State U. Coll., Oswego, N.Y., 1956-63; instr. Ohio State U., 1961-63; asso. prof., coordinator Ind. Arts Div., Kent State U., 1963-67; prof. and chmn. dept. design and ind. arts Franconia State U., 1967-80; prof. emeritus, 1980—; progr. Paulin Paint. Fine Antiques and Paintings, Oxford, Ohio, 1960—; six prof. N. Ill. U., summer 1965; served with AUS, 1946-48. Mem. Am. Ind. Arts Assn., Calif. Tech. Assn., Oxford C. of C., Epson Pl. Inc., Phi Delta Kappa. Home: 117 W High St Oxford OH 43056 Office: 115 W High St Oxford OH 43056

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# ORTHOMOLECULAR PSYCHIATRY

TREATMENT OF SCHIZOPHRENIA

EDITED BY

DAVID HAWKINS and LINUS PAULING

THE NORTH NASSAU MENTAL HEALTH CENTER  
MANHASSET, NEW YORK

STANFORD UNIVERSITY  
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## Preface

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In the article *Insanity* in the ninth edition of the Encyclopaedia Britannica (1881) insanity is defined as a chronic disease of the brain inducing chronic disordered mental symptoms. The author of the article (J. Batty Tuke, M.D., Lecturer on Insanity, School of Medicine, Edinburgh) then stated that this definition

possesses the great practical advantage of keeping before the student the primary fact that insanity is the result of disease of the brain, that it is not a mere immaterial disorder of the intellect. In the earliest epochs of medicine the corporeal character of insanity was generally admitted, and it was not until the superstitious ignorance of the Middle Ages had obliterated the scientific, though by no means always accurate, deductions of the early writers that any theory of its purely psychical character arose. At the present day it is unnecessary to combat such a theory, as it is universally accepted that the brain is the organ through which mental phenomena are manifested, and therefore that it is impossible to conceive of the existence of an insane mind in a healthy brain.

By 1929, when the fourteenth edition of the Encyclopaedia Britannica was published, the situation had changed, largely because of the development of psychoanalysis by Sigmund Freud. The earlier definition of insanity was deleted, and replaced by discussions from two points of view: the point of view of the materialistic school

that though in many states of insanity no observable structural changes are found they exist all the same, only they are such that our imperfect methods cannot detect them, and in time they will be discovered . . .

and the point of view of the psychogenic school,

that though mental disease may arise secondarily to physical disorder, the symptoms are psychological reverberations of that disorder and the body of an individual must be regarded as environmental to the ego. . . . The many structural changes which are found in certain forms of insanity should be reviewed as probably secondary to a perverted mentality.

Psychoanalysis has failed, and psychiatry is now rapidly returning to the scientific approach, the recognition of the corporeal character of mental disease, with manifestations determined to some extent by environmental stress and past experience. Supportive psychotherapy has great value—an example is the explanation to the schizophrenic patient and his family that his disturbed behavior and thinking are the result of an imbalance in the molecular composition of his body, and that this imbalance can be corrected (Hawkins, Chapter 29 of this volume). The recognition of the effectiveness of phenothiazines and other drugs (and the ineffectiveness of psychoanalysis) has accelerated the reacceptance of the concept that mental disease is disease of the brain, and that the brain itself needs to be treated, by changing its molecular composition.

The relation of vitamins to mental disease became evident as soon as vitamins were discovered. One manifestation of pellagra is psychosis. Pellagra is a vitamin-deficiency disease, and the psychosis is cured (averted) by the provision of an adequate intake of the vitamin (niacin). It is estimated that in the first decades of this century 10 percent of the persons in psychiatric hospitals were pellagrins (Kety, 1970). The discovery in 1937 that niacin is the pellagra-preventing vitamin soon led to its trial in controlling mental disease in patients not suffering from pellagra. Cleckley et al. (1939) and Sydenstricker and Cleckley (1941) reported some success in treating 48 subjects with acute mental illness of one sort or another by use of moderately large doses of niacin (300 to 1,500 mg per day, as compared with the pellagra-preventing intake of about 12 mg per day).

In 1943 Kaufman described the deterioration in mental and physical health of 150 patients with a disease to which he gave the name aniacinamidosis, and in 1949 he published a larger book on this subject, with discussion of 455 patients. Measurements of impairment of joint mobility and increase in blood sedimentation rate gave objective information about the progress of the disease. He found that most of the patients improved greatly on a regime of 1 to 5 g of niacinamide per day, in divided doses (6 to 16 per day), continuing for as long as nine years (Kaufman, 1955). He observed no untoward reactions from niacinamide in several thousand patient-years of continuous use. His recommended intake of niacinamide for treatment of restricted mobility of joints and other manifestations of aniacinamidosis is 4 or 5 g per day. Many of his patients showed striking improvement in mental health as well as physical health on this regime.

to physical disorder, the symptoms and the body of an individual must undergo many structural changes which are viewed as probably secondary to a

rapidly returning to the scientific method of mental disease, with manic-depressive illness, and past experience. A simple explanation to the abnormal behavior and thinking are the changes in the chemistry of his body, and that this is the basis of this volume). The recognition of the ineffectiveness of psychotherapy and the ineffectiveness of psychosurgery as a concept that mental disease is to be treated, by changing its

is evident as soon as vitamins were administered. Pellagra is a vitamin-deficiency disease. The provision of an adequate intake of niacin in the decades of this century 10 percent of the population is (Kety, 1970). The discovery in 1937 led to its trial in controlling pellagra. Cleckley et al. (1939) and Hoffer et al. (1957) success in treating 48 subjects with moderately large doses of niacin prevented pellagra-preventing intake of about

mental and physical health of 150 patients with niacin deficiency, and in 1949 the admission of 455 patients. Measurement of blood sedimentation rate gave a good index of disease. He found that most of the patients receiving 4 or 5 g of niacin per day, in divided doses over five years (Kaufman, 1955). He found that in several thousand patient-years of niacinamide for treatment of restricted pellagra is 4 or 5 g per day. The improvement in mental health as well as

The effective introduction of megavitamin therapy for schizophrenia came in the period from 1952 on through the work of Hoffer and Osmond, as described in several chapters of this book. After making some studies on a few patients with encouraging results, they carried out several double-blind and blind comparisons of niacin, niacinamide, and a placebo. A study with 171 subjects (73 receiving 3 g of niacin per day for all or part of the period of study, 98 receiving a placebo) gave a statistically significant difference in the number transferred to the mental hospital and a difference in the number of suicides (0 and 4, respectively) with borderline statistical significance (Hoffer et al., 1957). Another study with 82 subjects (43 receiving 3 g of niacin per day and 39 receiving a placebo) gave a difference with high statistical significance in the number classified as improved or unimproved (Hoffer, 1962).

It is evident from the published accounts of these studies that amounts larger than 3 g per day of niacin or niacinamide are needed for a pronounced therapeutic effect in many schizophrenic patients. Hoffer and Osmond had in fact observed that daily amounts of niacin or niacinamide larger than 6 g seemed to be required by some patients, and also that many patients benefited from receiving 3 to 6 g per day of nicotinic acid. Other vitamins, especially pyridoxine in amounts 600 mg to 1,500 mg per day, have been found to be beneficial. In addition, many schizophrenics, probably more than 80 percent, suffer from hypoglycemia, which needs to be corrected, as described in some chapters in this book. The orthomolecular treatment of schizophrenia includes more than the routine administration of 3 g of niacin or niacinamide per day.

The importance of good nutrition to good health cannot be denied. There is much evidence to support the thesis that for most people the optimum daily intake of ascorbic acid is far larger than the usually recommended daily allowance (Pauling, 1970); 3 to 6 g per day, the amount customary in megavitamin treatment of schizophrenia, may well be only the average optimum for most human beings. Little effort has been expended in the study of the amounts of vitamins required for optimum health. The decision by most psychiatrists who do not accept the principles of orthomolecular psychiatry to restrict the intake of vitamins by their patients to certain arbitrary levels, without checking the possible benefit for the patient of an increased intake, cannot be justified.

Part of the resistance to megavitamin therapy is based on the idea that an increased intake of a vitamin should be subjected to as thorough testing as a new synthetic drug. This is nonsense; the vitamins are substances to which the human body has long been accustomed, and the toxicities of the water-soluble vitamins are known to be low and the side effects few. Another part of the resistance is the result of a misunderstanding of the meaning of statistical significance. Investigations described as attempts to replicate Hoffer and Osmond's results are reported to have failed to show a statistically significant difference between the subjects receiving niacin or niacinamide and those receiving a placebo. This conclusion is then incorrectly interpreted as meaning

that the investigations have shown niacin or niacinamide to have no greater value than a placebo.

For example, Hoffer had reported that mentally ill children receiving niacinamide and ascorbic acid benefited more than those receiving a placebo. Greenbaum (1970) then reported that he was unable to confirm the claimed value of niacinamide in his double-blind study of 17 children receiving niacinamide (1000 mg per day per 50 lb. body weight) and 24 children receiving a placebo (also 16 receiving niacinamide and a tranquilizer). The principal criterion was the increase during the six months of the study in the score on a clinical scale of observable behavior categories. Greenbaum reported that "there was no significant difference attributable to niacinamide." This statement is seriously misleading. The average improvement in the score was in fact 4.0 units for the niacinamide group and 2.6 units for the placebo group. The difference between 4.0 and 2.6 is reported as not statistically significant. But we see that Greenbaum found 54 percent greater improvement in the niacinamide group than in the placebo group. From Greenbaum's result we can say that it is more likely that niacinamide has an effect (54 percent greater than the placebo) than that it has no effect, but it is not 20 times more likely ( $P < 0.05$ , accepted as statistically significant).

The statistical significance is determined by the design of the investigation. If Greenbaum had got the same result (54 percent more improvement for the niacinamide group than for the placebo group) with a larger number of subjects the null hypothesis of equal effect of niacinamide (in the dosage used) and placebo could have been rejected with statistical significance ( $P < 0.05$ ).

Ban (1971) states that "The hypothesis, based on these findings [by Hoffer], that nicotinamide therapy is useful in childhood schizophrenia was not verified by Greenbaum in a carefully designed—placebo controlled—study." I consider this statement to be wrong. Greenbaum found 54 percent more improvement in the niacinamide group than the placebo group. Surely 54 percent more improvement is useful. The amount of improvement, 54 percent, is unreliable, but that is what he found.

I have discussed this matter in some detail because much of the objection to the use of orthomolecular methods in psychiatry is based upon similar misrepresentations of the reported studies.

Another investigation that is quoted as having provided evidence against the hypothesis that niacin or niacinamide has value in the treatment of schizophrenia was published by Ananth et al. in 1970, with the title "Nicotinic acid in the prevention and treatment of artificially induced exacerbation of psychopathology in schizophrenics." It is known that a substance, such as the amino acid methionine, whose molecules can donate methyl groups to other molecules has the property of exacerbating the mental illness of schizophrenics when it is ingested, and it has been suggested that the effectiveness of niacin and niacinamide in controlling schizophrenia results from the action of their molecules as methyl acceptors—that is, they remove methyl groups

from some methylated compounds in the body that may be causing the mental illness. In the investigation by Ananth et al. schizophrenia patients were given daily doses of methionine. Some of the patients also were given niacinamide. All of the patients showed a pronounced exacerbation of their mental illness. The result has been interpreted as showing that niacinamide does not neutralize the methyl-donating effect of methionine in exacerbating schizophrenia by virtue of its function as a methyl acceptor. This conclusion is, however, not justified, because there was a serious flaw in the design of the experiment. The patients were given 20 g of methionine per day. Over 16 g of niacinamide per day would be required to accept the methyl groups donated by 20 g of methionine, but the patients were given only 3 g. It could have been predicted that the experiment would fail.

There is thoroughly convincing evidence that the methods of orthomolecular psychiatry discussed in this book have great value. Some aspects of the scientific basis of these methods are presented in the earlier chapters. Some of the chapters are of most interest to biochemists. Most of the chapters can, I believe, be read with understanding and profit by physicians and by laymen who have some acquaintance with the terminology of chemistry and other sciences. Despite the progress that has been made in controlling it, mental illness is still the cause of a tremendous amount of suffering. The work of Hoffer, Osmond, Hawkins, and others has shown that the methods of orthomolecular psychiatry can be used to decrease the amount of this suffering. I join my co-editor, Dr. David Hawkins, and the other contributors to this book in expressing the hope that it will be found useful not only by scientists and physicians but also by those who suffer from schizophrenia and by their families.

I thank Dr. Gustav Albrecht for his help.

August 1972

Linus Pauling

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## Orthomolecular Psychiatry

LINUS PAULING

### INTRODUCTION

The methods principally used now for treating patients with mental disease are psychotherapy (psychoanalysis and related efforts to provide insight and to decrease environmental stress), chemotherapy (mainly with the use of powerful synthetic drugs, such as chlorpromazine, or powerful natural products from plants, such as reserpine), and convulsive or shock therapy (electroconvulsive therapy, insulin coma therapy, pentylenetetrazol shock therapy). I have reached the conclusion, through arguments summarized in the following paragraphs, that another general method of treatment, which may be called orthomolecular therapy, may be found to be of great value, and may turn out to be the best method of treatment for many patients.

Orthomolecular psychiatric therapy is the treatment of mental disease by the provision of the optimum molecular environment for the mind, especially the optimum

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concentrations of substances normally present in the human body.<sup>1</sup> An example is the treatment of phenylketonuric children by use of a diet containing a smaller than normal amount of the amino acid phenylalanine. Phenylketonuria (Fölling, 1933) results from a genetic defect that leads to a decreased amount or effectiveness of the enzyme catalyzing the oxidation of phenylalanine to tyrosine. The patients on a normal diet have in their tissues abnormally high concentrations of phenylalanine and some of its reaction products, which, possibly in conjunction with the decreased concentration of tyrosine, cause the mental and physical manifestations of the disease (mental deficiency, severe eczema, and others). A decrease in the amount of phenylalanine ingested results in an approximation to the normal or optimum concentrations and to the alleviation of the manifestations of the disease, both mental and physical.

The functioning of the brain is dependent on its composition and structure; that is on the molecular environment of the mind. The presence in the brain of molecules of *N,N*-diethyl-*D*-lysergamide, mescaline, or some other schizophrenogenic substance is associated with profound psychic effects (see, for example, Woolley, 1962). Cherkin has recently pointed out (1967) that in 1799 Humphry Davy described similar subjective reactions to the inhalation of nitrous oxide. The phenomenon of general anesthesia also illustrates the dependence of the mind (consciousness, ephemeral memory) on its molecular environment (Pauling, 1961; Miller, 1961).

The proper functioning of the mind is known to require the presence in the brain of molecules of many different substances. For example, mental disease, usually associated with physical disease, results from a low concentration in the brain of any one of the following vitamins: thiamine ( $B_1$ ), nicotinic acid or nicotinamide ( $B_3$ ), pyridoxine ( $B_6$ ), cyanocobalamin ( $B_{12}$ ), biotin (H), ascorbic acid (C), and folic acid. There is evidence that mental function and behavior are also affected by changes in the concentration in the brain of any of a number of other substances that are normally present, such as *L*(+)-glutamic acid, uric acid, and  $\gamma$ -aminobutyric acid.<sup>2</sup>

## OPTIMUM MOLECULAR CONCENTRATIONS

Several arguments may be advanced in support of the thesis that the optimum molecular concentrations of substances normally present in the body may be different from the concentrations provided by the diet and the gene-controlled synthetic

<sup>1</sup> I might have described this therapy as the provision of the optimum molecular composition of the brain. The brain provides the molecular environment of the mind. I use the word mind as a convenient synonym for the functioning of the brain. The word orthomolecular may be criticized as a Greek-Latin hybrid. I have not, however, found any other word that expresses as well the idea of the right molecules in the right amounts.

<sup>2</sup> The literature is so extensive that I refrain from giving references here.

mechanisms, and, for essential nutrilites (vitamins, essential amino acids, essential fatty acids) different from the minimum daily amounts required for life or the "recommended" (average) daily amounts suggested for good health. Some of these arguments are presented in the following paragraphs.

### EVOLUTION AND NATURAL SELECTION

The process of evolution does not necessarily result in the normal provision of optimum molecular concentrations. Let us use ascorbic acid as an example. Of the animals that have been studied in this respect, the only species that have lost the power to synthesize ascorbic acid and that accordingly require it in the diet are man, other Primates (rhesus monkey, Formosan long-tail monkey, and ring-tail or brown leopuchin monkey), the guinea pig, and an Indian fruit-eating bat (*Pteropus medius*).<sup>3</sup> Presumably the loss of the gene or genes controlling the synthesis of the enzyme or enzymes involved in the conversion of glucose to ascorbic acid occurred some 20 million years ago in the common ancestor of man and other Primates, and occurred independently for the guinea pig and for one species of bat and one bird, in each case in an environment such that ascorbic acid was provided by the food. For a mutation rate of 1/20,000 per gene generation and for even a very small advantage for the mutant (0.01 percent more progeny) the mutant would replace the earlier genotype within about 1 million years. The advantage to the mutant of being rid of the ascorbic-acid-synthesis machinery (decrease in cell size and energy requirement, liberation of machinery for other purposes) might well be large, perhaps as much as 1 percent; a disadvantage nearly as large (less by 0.01 percent) resulting from a less than optimum supply of dietary ascorbic acid would not prevent the replacement of the earlier species by the mutant. Hence, even if the amount of the vitamin provided by the diet available at the time of the mutation were less than the optimum amount, the mutant might still be able to replace its predecessor. Moreover, it is possible that the environment has changed during the last 20 million years in such a way as to provide a decreased amount of the vitamin. Even a serious disadvantage of the changed environment would not lead to a mutation restoring the synthetic mechanism within a period of a few million years, because of the small probability of such mutations, far smaller than of those resulting in loss of function.

Moreover, the process of natural selection may be expected later on to lead to the survival of a species or strain that synthesizes somewhat less than the optimum amount of an autotrophic vital substance rather than of the species or strain that synthesizes the optimum amount. To synthesize the optimum amount requires

<sup>3</sup> For references, see Stone (1965). The only other vertebrates known to require exogenous ascorbic acid are the red-vented bulbul, *Pycnonotus cafer*, and related passeriform birds.

about twice as much biological machinery as to synthesize half the optimum amount. As suggested in Figure 1-1, the evolutionary disadvantage of synthesizing a less than

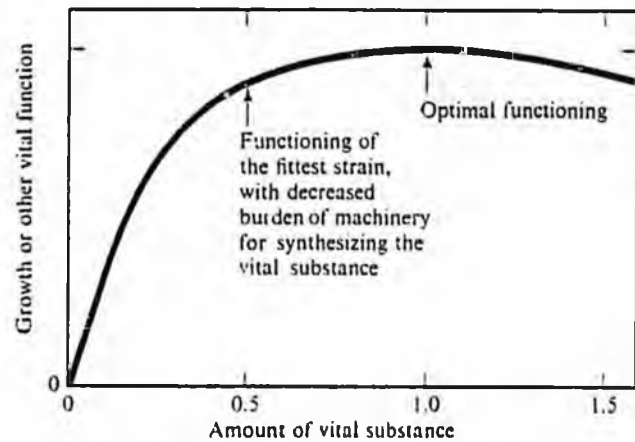


FIGURE 1-1.

Diagrammatic representation of growth rate or other vital property of an organism as function of the concentration of vital substance in the organism, showing the concentration at which the differential advantage of an increased amount of vital substance is just balanced by the differential disadvantage resulting from an increased amount of machinery for synthesis, and the concentration that gives optimum functioning without consideration of the burden of the machinery for synthesis.

optimum amount of the vital substance may be small, and may be outweighed by the advantage of requiring a smaller amount of biological machinery. Evidence from the study of microorganisms is discussed in the following paragraphs.

#### EVIDENCE FROM MICROBIOLOGICAL GENETICS

Many mutant microorganisms are known to require, as a supplement to the medium in which they are grown, a substance that is synthesized by the corresponding wild-type organism (the normal strain). An example is the pyridoxine-requiring mutant of *Neurospora sitophila* reported by G. W. Beadle and E. L. Tatum in their first *Neurospora* paper, published in 1941.

Several species of *Neurospora* that have been extensively studied are known to be able to grow satisfactorily on synthetic media containing inorganic salts, an inorganic source of nitrogen, such as ammonium nitrate, a suitable source of carbon, such as sucrose, and the vitamin biotin. All other substances required by the organism

is synthesized by it. Beadle and Tatum found that exposure to x-radiation produces mutant strains such that one substance must be added to the minimum medium in order to permit the growth at a rate approximating that of the normal strain. Their pyridoxine-requiring mutant was found to grow on the standard medium at a rate only 9 percent of that of the normal strain. When pyridoxine (vitamin B<sub>6</sub>) is added to the medium, the rate of growth of this strain at first increases nearly linearly with the concentration of the added pyridoxine and then increases less rapidly, as shown in Figure 1-2.<sup>4</sup> The growth rate of the normal strain without added pyridoxine is equal to that of the mutant with about 10 micrograms of the growth substance per liter in the medium. At a concentration about four times this value (40 micrograms per liter) the growth rate of the mutant strain reaches a value 7 percent greater than that of the normal strain without added pyridoxine.

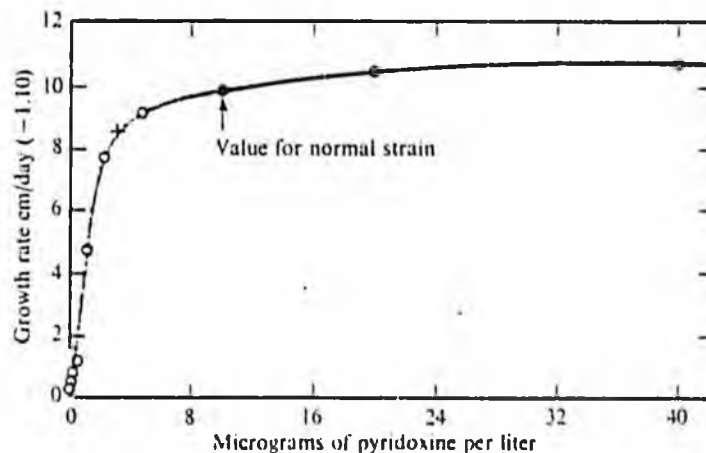


FIGURE 1-2. The observed rate of growth of a pyridoxine-requiring *Neurospora* mutant (Beadle and Tatum, 1941), as function of the concentration of pyridoxine in the medium.

The point of maximum curvature of the curve in Figure 1-2, at about 3.2 micrograms of pyridoxine per liter (indicated by a cross), may be reasonably considered to mark the division between the region of vitamin deficiency (to the left) and the region of normal vitamin supply (to the right), such as might permit the mutant to compete with the wild type, which has the growth rate represented by the filled circle in Figure 1-2. The point marked by the cross might well correspond to an "adequate" or "recommended" amount of the vitamin, in that the growth rate of the mutant is only

<sup>4</sup> The points in Figure 1-2 represent my measurement of the slopes of the growth curves shown in Figure 1 of Beadle and Tatum (1941). They agree closely with the points of their Figure 2, except for one point, that for 1.2  $\mu\text{g/liter}$ , which may have been misplotted.

12 percent less than that of the wild strain, and that the amount of the vitamin would have to be increased threefold to make up this 12 percent.<sup>5</sup>

As shown in Figure 1-2, quadrupling the concentration of pyridoxine that gives the mutant a growth rate equal to that of the wild type causes a further increase in growth rate by nearly 10 percent. The growth rates of the mutant and the wild type at very large concentrations of the vitamin have not been measured, so far as I know, and the optimum concentration is not known. From the work of Beadle and Tatum (1941) the optimum concentration may be taken to be greater than 40 micrograms per liter; that is, more than ten times the "adequate" concentration for the mutant and more than four times the concentration equivalent to the synthesizing capability of the wild type. The growth rate of the mutant at the optimum concentration is more than 22 percent greater than that at the "adequate" concentration and more than 9 percent greater than that of the normal strain.

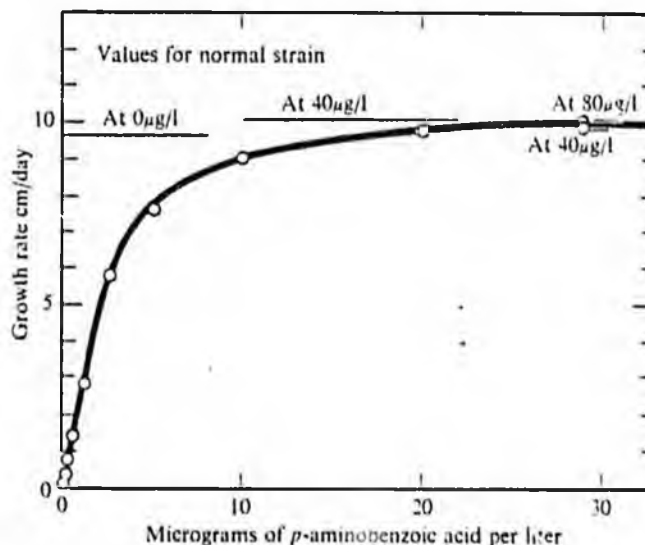


FIGURE 1-3.  
The observed rate of growth of a *p*-aminobenzoic-acid-requiring *Neurospora* mutant (Tatum and Beadle, 1942), as function of concentration of the growth substance in the medium.

Similar results have been reported for other mutants of *Neurospora*. The values found by Tatum and Beadle (1942) for a *p*-aminobenzoic-acid-requiring mutant of *Neurospora crassa* as a function of the concentration of *p*-aminobenzoic acid added to the standard medium are shown in Figure 1-3. The growth-rate curve is similar in

<sup>5</sup> The reported growth rate for the normal strain in a medium with 40  $\mu$ g of added pyridoxine per liter is 3 percent greater than that for the basic medium, as shown by the slopes of the lines in Figure 1 of Beadle and Tatum (1941).

shape to that for the pyridoxine-requiring mutant. The value of the growth rate for the normal strain of *Neurospora crassa* with no added *p*-aminobenzoic acid is equal to that for the mutant at a concentration of added *p*-aminobenzoic acid of about 15 micrograms per liter. A value about 4 percent greater is found for the normal strain at 20 micrograms per liter and for the mutant strain at 80 micrograms per liter, as indicated in Figure 1-3.

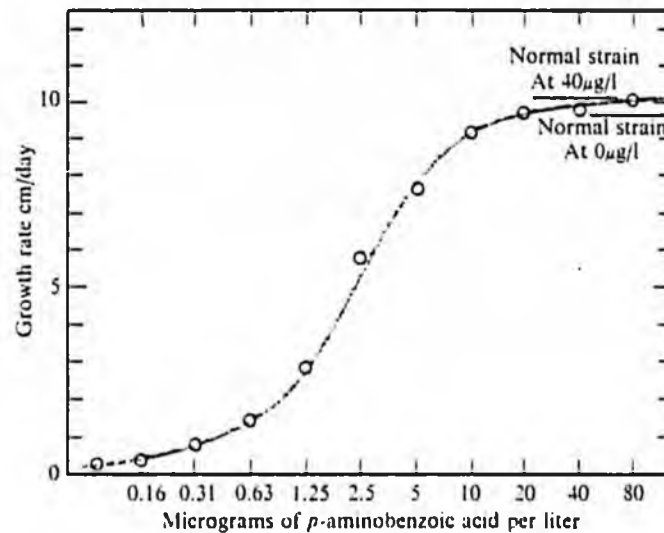


FIGURE 1-4.

Observed rate of growth of a *p*-aminobenzoic-acid-requiring *Neurospora* mutant as function of the logarithm of the concentration of *p*-aminobenzoic acid.

It is customary to plot values of the growth rate against the logarithm of the concentration of the growth substance, as shown in Figure 1-4. The amount of increase accompanying a doubling in the concentration of the growth substance is a maximum at 1.25 to 2.5 micrograms per liter, and decreases thereafter to about half the value for each successive doubling.

From these two examples we see that there may be a significant increase in rate of growth of the normal strain through addition of some of the growth substance that it synthesizes to the medium in which it is grown; that is, that the amount of the growth substance that is synthesized by the normal strain is not the optimum amount, but is somewhat less, leading to a rate of growth approximately 7 percent less than the maximum in the case of pyridoxine (with the normal strain of *Neurospora sitophila*) and 4 percent less for *p*-aminobenzoic acid (with the normal strain of *Neurospora crassa*). Many other examples are known of microorganisms that grow more

abundantly in a medium containing vitamins, amino acids, or other substances that they are able to synthesize than on a minimum medium.

Evidence supporting the above arguments has been presented recently by Zamenhof and Eichhorn (1967) in a paper entitled "Study of microbial evolution through loss of biosynthetic functions: Establishment of 'defective' mutants." These authors carried out experiments involving competitive growth in a chemostat of an auxotrophic mutant (a mutant requiring a nutrient) and a prototrophic parent in a medium of constant composition containing the nutrient. They found that the "defective" mutant has a selective advantage over the prototrophic parental strain under these conditions. For example, an indole-requiring mutant of *Bacillus subtilis* was found to show a strong selective advantage over the prototrophic back-mutant when the two were grown together in a medium containing tryptophan: the relative number of cells of the latter decreased 10<sup>6</sup>-fold in 54 generations. They also found that greater advantage to the auxotroph accompanies a greater number of biosynthetic steps that have been dispensed with (earlier block in a series of reactions), with the final metabolite available. They point out that a mutant with a gene deletion would be at a distinct selective advantage over a point mutant, in that not only the synthesis of the metabolite, but also that of the structural gene, the messenger RNA, and perhaps the inactive enzyme itself would be dispensed with, and that accordingly the mutant with a deletion would replace the point mutant in competition. They mention evidence that some of the "defective" strains occurring in nature have lost one or more of their structural genes by deletions, rather than by point mutations.

### MOLECULAR CONCENTRATIONS AND RATE OF REACTION

Most of the chemical reactions that take place in living organisms are catalyzed by enzymes. The mechanisms of enzyme-catalyzed reactions in general involve (1) the formation of a complex between the enzyme and a substrate molecule, and (2) the decomposition of this complex to form the enzyme and the products of the reaction. The rate-determining step is usually the decomposition of the complex to form the products or, more precisely, the transition through an intermediate state of the complex, characterized by activation energy less than for the uncatalyzed reaction, to a complex of the enzyme and the products of reaction, with a rapid dissociation. Under conditions such that the concentration of the complex corresponds to equilibrium with the enzyme and the substrate, the rate of the reaction is given by the following equation (the Michaelis-Menten equation; Michaelis and Menten, 1913):

$$R = \frac{d[S]}{dt} = \frac{kE[S]}{[S] + (1/K)} \quad (1)$$

In this equation  $[S]$  is the concentration of the substrate,  $E$  is the total concentration of enzyme (present both as free enzyme and enzyme complex),  $K$  is the equilibrium constant for formation of the enzyme complex  $ES$ , and  $k$  is the reaction-rate constant for decomposition of the complex to form the enzyme and reaction products. This equation corresponds to the case in which there are no enzyme inhibitors present.

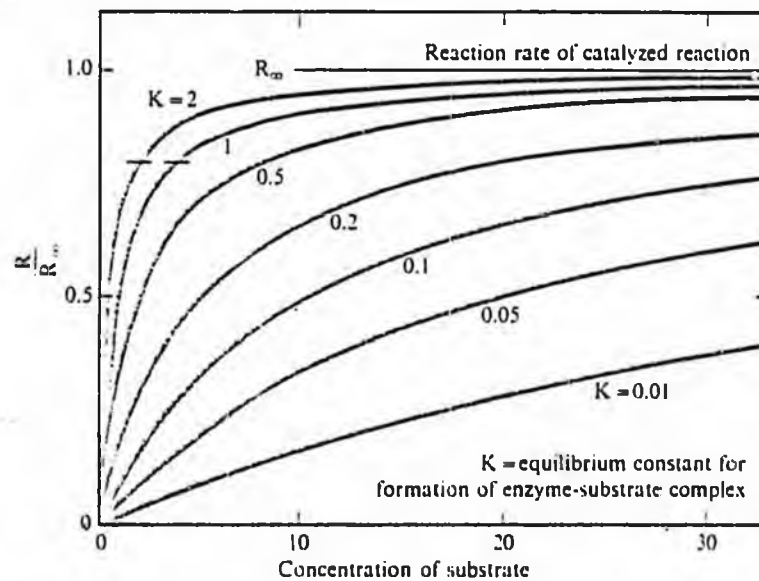


FIGURE 1-5. Curves showing calculated reaction rate  $R/R_m$  of catalyzed reaction as function of the concentration of the substrate, for different values of the equilibrium constant  $K$  for formation of the enzyme-substrate complex.

Values of the reaction rate calculated from this equation for different values of  $K$  are shown in Figure 1-5. The curves are similar in shape to those of Figures 1-2 and 1-3. At concentrations much smaller than  $K^{-1}$  the reaction rate is proportional to the concentration of substrate. At larger concentrations, as the amount of enzyme complex becomes comparable to the amount of free enzyme, the reaction rate changes from the linear dependence. At substrate concentration equal to  $K^{-1}$  the slope of the curve is one-quarter of the initial slope, and the value is one-half of the value corresponding to saturation of the enzyme by the substrate.

The similarity of the curves of Figures 1-2 and 1-3 to appropriate curves in Figure 1-5 suggests that the growth substance may be involved in an enzyme-catalyzed reaction in which it serves as the substrate. The normal strain of the organism manufactures an amount of the substrate such as to permit the reaction to take place at what

may be considered a normal rate, 90 or 95 percent of the maximum rate, which corresponds to saturation of the enzyme. As described above, the gain in rate associated with the manufacture of a larger amount of the substrate, with its corresponding advantage to the organism, might be balanced by the disadvantage to the organism associated with the upkeep of the larger amount of machinery required to manufacture the increased amount of substrate. An increase in rate of this kind could also be achieved by an increase in the amount of the enzyme synthesized by the organism. Here, again, the advantage to the organism resulting from this may be overcome by the disadvantage associated with the increase in the amount of machinery required for the increased synthesis. During the process of evolution, there has presumably been selection of genes determining the concentrations of enzymes catalyzing successive reactions such as to achieve an approximate optimum reaction rate with the smallest amount of disadvantage to the organism.

The rate of an enzyme-catalyzed reaction is approximately proportional to the concentration of the reactant, until concentrations that largely saturate the enzyme are reached. The saturating concentration is larger for a defective enzyme with decreased combining power for the substrate than for the normal enzyme. For a defective enzyme the catalyzed reaction could be made to take place at or near a normal rate by an increase in the substrate concentration, as indicated in Figure 1. The short horizontal lines intersecting the curves indicate what may be called "normal" reaction rate, 80 percent of the maximum. For  $K = 2$  the "normal" rate is achieved at substrate concentration  $[S] = 2$ . At this substrate concentration the reaction rate is only 29 percent of the maximum and 35 percent of "normal" for a mutated enzyme with  $K = 0.2$ ; it could be raised to the "normal" value by a 10-fold increase in the substrate concentration, to  $[S] = 20$ . Similarly, the still greater disadvantage of low reaction rate for a mutated enzyme with  $K$  only 0.01 could be overcome by a 200-fold increase in substrate concentration, to  $[S] = 400$ . This mechanism of action of gene mutation is only one of several that lead to disadvantageous manifestations that could be overcome by an increase, perhaps a great increase, in the concentration of a vital substance in the body. These considerations obviously suggest a rationale for megavitamin therapy.

## MOLECULAR CONCENTRATIONS AND MENTAL DISEASE

The functioning of the brain and nervous tissue is more sensitively dependent on the rate of chemical reactions than the functioning of other organs and tissues. I believe that mental disease is for the most part caused by abnormal reaction rates, as determined by genetic constitution and diet, and by abnormal molecular concentrations of essential substances. The operation of chance in the selection for the child of half

The complement of genes of the father and mother leads to bad as well as to good genotypes, and the selection of foods (and drugs) in a world that is undergoing rapid scientific and technological change may often be far from the best. Significant improvement in the mental health of many persons might be achieved by the provision of the optimum molecular concentrations of substances normally present in the human body. Among these substances, the essential nutrilites may be the most worthy of extensive research and more thorough clinical trial than they have yet received. One important example of an essential nutrilitite that is required for mental health is vitamin B<sub>12</sub>, cyanocobalamin. A deficiency of this vitamin, whatever its cause (pernicious anemia; infestation with the fish tapeworm *Diphyllobothrium*, whose high requirement for the vitamin results in deprivation for the host; excessive bacterial flora, also with a high vitamin requirement, as may develop in intestinal blind loops), leads to mental illness, often even more pronounced than the physical consequences. The mental illness associated with pernicious anemia (a genetic defect leading to deficiency of the intrinsic factor [a mucoprotein] in the gastric juice and the consequent decreased transport of cyanocobalamin into the blood) often is observed for several years in patients with this disease before any of the physical manifestations of the disease appear (Smith, 1950). A pathologically low concentration of cyanocobalamin in the serum of the blood has been reported to occur for a much larger fraction of patients with mental illness than for the general population. Edwin et al. (1965) determined the amount of B<sub>12</sub> in the serum of every patient over 30 years old admitted to a mental hospital in Norway during a period of 1 year. Of the 396 patients, 5.8 percent (23) had a pathologically low concentration, less than 101 picograms per milliliter, and the concentration in 9.6 percent (38) was subnormal (101 to 150 picograms per milliliter). The normal concentration is 150 to 1300 picograms per milliliter. The incidence of pathologically low and subnormal levels of B<sub>12</sub> in the serums of these patients, 15.4 percent, is far greater than that in the general population, about 0.5 percent (estimated from the reported frequency of pernicious anemia in the area, 9.3 per 100,000 persons per year). Other investigators<sup>6</sup> have also reported a higher incidence of low B<sub>12</sub> concentrations in the serums of mental patients than in the population as a whole, and have suggested that B<sub>12</sub> deficiency, whatever its origin, may lead to mental illness.

Nicotinic acid (niacin), when its use was introduced, cured hundreds of thousands of pellagra patients of their psychoses, as well as of the physical manifestations of their disease. For this purpose only small doses are required; the recommended daily allowance (National Research Council) is 12 milligrams per day (for a 70-kilogram male). In 1939 Cleckley et al. reported the successful treatment of 19 patients, and

<sup>6</sup> Hansen et al. (1966) report serum B<sub>12</sub> concentration below 150 pg/ml in 13 of 1,000 consecutive patients admitted to a Copenhagen psychiatric clinic. Henderson et al. (1966) report that 9 of 1,012 unselected psychiatric patients in a region in Scotland were found to have B<sub>12</sub> deficiency, in addition to 5 pernicious anemia patients in the group.

in 1941 Sydenstricker and Cleckley<sup>7</sup> reported similarly successful treatment of 29 patients with severe psychiatric symptoms by use of moderately large doses of nicotinic acid (0.3 to 1.5 grams per day). None of these patients had physical symptoms of pellagra or any other avitaminosis. More recently many other investigators have reported on the use of nicotinic acid and nicotinamide for the treatment of mental disease. Outstanding among them are Hoffer and Osmond, who since 1952 have advocated and used nicotinic acid in large doses, in addition to the conventional therapy, for the treatment of schizophrenia (Hoffer et al., 1957; Hoffer, 1962, 1966; Osmond and Hoffer, 1962; Hoffer and Osmond, 1964). The dosage recommended by Hoffer is 3 to 18 grams per day, as determined by the response of the patient, of either nicotinic acid or nicotinamide, together with 3 grams per day of ascorbic acid. Nicotinic acid and nicotinamide are nontoxic (the lethal dose, 50 percent effective [ $LD_{50}$ ], is not known for humans, but probably it is over 200 grams; the  $LD_{50}$  for rats is 7.0 grams per kilogram for nicotinic acid and 1.7 grams per kilogram for nicotinamide), and their side effects, even in continued massive doses, seem not to be commonly serious. Among the advantages of nicotinic acid, summarized by Osmond and Hoffer (1962), are the following: it is safe, cheap, and easy to administer, and it is a well-known substance that can be taken for years on end, if necessary, with only small probability of incidence of unfavorable side effects.

Another vitamin that has been used to some extent in the treatment of mental disease is ascorbic acid, vitamin C. A sometimes-recommended daily intake of ascorbic acid is 75 milligrams for healthy adults. Some investigators have estimated that the optimum intake is much larger (Kyhos et al., 1945), perhaps 3 to 15 grams per day, according to Stone (1966, 1967). Williams and Deason (1967) have emphasized the variability of individual members of a species of animals; they have reported their observation of a 20-fold range of required intake of ascorbic acid by guinea pigs, and have suggested that human beings, who are less homogeneous, have a larger range.

Mental symptoms (depression) accompany the physical symptoms of vitamin-C deficiency disease (scurvy). In 1957, Akerfeldt reported that the serum of schizophrenics had been found to have greater power of oxidizing N,N-dimethyl-*p*-phenylenediamine than that of other persons. Several investigators then reported that this difference is due to a smaller concentration of ascorbic acid in the serum of schizophrenics than of other persons. This difference has been attributed to the poor diet and increased tendency to chronic infectious disease of the patients (Benjamin, 1958; Kety, 1959), and has also been interpreted as showing an increased rate of metabolism of ascorbic acid by the patients (Hoffer and Osmond, 1960; Briggs, 1962). It is my opinion, from the study of the literature, that many schizophrenics have an increased metabolism of ascorbic acid, presumably genetic in origin, and that the

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<sup>7</sup> References are given in this paper to some earlier work on nicotinic acid therapy.

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ingestion of massive amounts of ascorbic acid has some value in treating mental disease.

Other vitamins (thiamine, pyridoxine, folic acid) and other substances (zinc ion, magnesium ion, uric acid, tryptophan, L(+)-glutamic acid, and others) influence the functioning of the brain. I shall review work on L(+)-glutamic acid as a further example. L(+)-Glutamic acid is an amino acid that is present at rather high concentration in brain and nerve tissue and plays an essential role in the functioning of these tissues (Weil-Malherbe, 1936). It is normally ingested (in protein) in amounts of 5 to 10 grams per day. It is not toxic; large doses may cause increased motor activity and nausea. In 1943 Price et al. reported favorable results for glutamic acid therapy of convulsive disorders (benefit to one out of three or four patients with petit mal epilepsy; Waelsch, 1948). Zimmerman and Ross (1944) then reported an increase in maze-running learning ability of white rats given extra amounts of glutamic acid. Zimmerman and many other investigators then studied the effects of glutamic acid on the intelligence and behavior of persons with different degrees and kinds of mental retardation. L(+)-Glutamic acid is apparently more effective than its sodium or potassium salts. The effective dosage is usually between 10 and 20 grams per day (given in three doses with meals), and is adjusted to the patient as the amount somewhat less than that required to cause hyperactivity. Several investigators<sup>a</sup> have reported an improvement in personality and increase in intelligence (by 5 to 20 I.Q. points) for many patients with mild or moderate mental deficiency.

### LOCALIZED CEREBRAL DEFICIENCY DISEASES

The observation that the psychosis associated with pernicious anemia may manifest itself in a patient for several years before the other manifestations of this disease become noticeable has a reasonable explanation: the functioning of the brain and nervous tissue is probably more sensitively dependent on molecular composition than is that of other organs and tissues. The observed high incidence of cyanocobalamin deficiency in patients admitted to a mental hospital, mentioned above, suggests that mental disease may rather often be the result of this deficiency, and further suggests that other deficiencies in vital substances may be wholly or partly responsible for many cases of mental illness.

The foregoing arguments suggest the possibility that under certain circumstances a deficiency disease may be localized in the human body in such a way that only some of the manifestations usually associated with the disease are present. Let us consider, for example, a vitamin or other vital substance that is normally metabolized by the

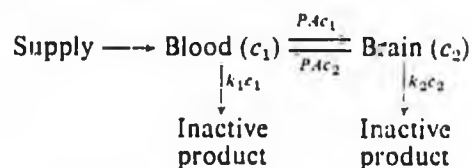
<sup>a</sup> A recent survey of the role of glutamic acid in cognitive behaviors has been published by Vogel et al. (1966). Many references to earlier work are given in this paper.

catalytic action of an enzyme normally present in the tissues and organs of the body. In a person of unusual genotype there might be an especially great concentration of this enzyme in one body organ, with essentially the normal amount in other organs. Through the action of this enzyme in especially great concentration the steady-state concentration of the vital substance in that organ might be decreased to a level much lower than that required for normal function. Under these circumstances there would be present a deficiency disease restricted to that organ.

An especially important case is that of the brain. We may, as a rough model of the human body, consider two reservoirs of fluid, the blood and lymph, with volume  $V_1$ , and cerebrospinal fluid, the extracellular fluid of the brain and spinal column, with volume  $V_2$ . We assume that a vital substance is destroyed in each of these reservoirs at a characteristic rate, corresponding to the rate constants  $k_1$  and  $k_2$ , that it diffuses across the blood-brain barrier at a rate determined by the product of the permeability and area of the barrier and the difference  $c_2 - c_1$  of the concentrations in the two reservoirs, and that it is introduced from the gastrointestinal tract into the first reservoir at a constant rate. The steady-state concentrations are then in the ratio

$$c_1/c_2 = 1 + (k_2 V_2 / PA)$$

where  $PA$  is the product of permeability and the area of the blood-brain barrier. The steady state corresponds to the following system:



From this equation it is seen, as shown also in Figure 1-6, that for small values of  $k_2 V_2 / PA$  the difference in steady-state concentrations in the cerebrospinal fluid and the blood is small, but that through either decrease in permeability of the barrier or increase in the metabolic rate constant  $k_2$  the steady-state concentration in the brain becomes much less than that in the blood.

This simple argument leads us to the possibility of a localized cerebral avitaminosis or other localized cerebral deficiency disease. There is the possibility that some human beings have a sort of cerebral scurvy, without any of the other manifestations, or a sort of cerebral pellagra, or cerebral pernicious anemia. It was pointed out by Zuckerkandl and Pauling (1962) that every vitamin, every essential amino acid, every other essential nutrient represents a molecular disease (Pauling et al., 1949) which our distant ancestors learned to control, when it began to afflict them, by selecting a therapeutic diet, and which has continued to be kept under control in this way. The localized deficiency diseases described above are also molecular diseases, compound molecular diseases, involving not only the original lesion, the loss of the ability to

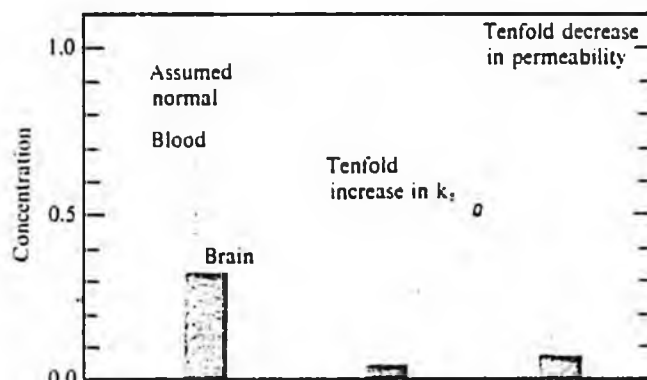


FIGURE 1-6. Values of the concentration of a vital substance in the blood and in the cerebrospinal fluid for three different assumed sets of values of blood-brain barrier permeability and rate of destruction in the cerebrospinal fluid.

synthesize the vital substance, but also another lesion, one that causes a decreased rate of transfer across a membrane, such as the blood-brain barrier,<sup>9</sup> to the affected organ, or an increased rate of destruction of the vital substance in the organ, or some other perturbing reaction.

It has been suggested by Huxley et al. (1964), partially on the basis of the observations of Böök (1953, 1958) and Slater (1958) on the incidence of schizophrenia in relatives of schizophrenics, that schizophrenia is caused by a dominant gene with incomplete penetrance. They suggested that the penetrance, about 25 percent, may in some cases be determined by other genes and in some cases by the environment. I suggest that the other genes may, in most cases, be those that regulate the metabolism of vital substances, such as ascorbic acid, nicotinic acid or nicotinamide, pyridoxine, cyanocobalamin, and other substances mentioned above. The reported success in treating schizophrenia and other mental illnesses by use of massive doses of some of these vitamins may be the result of successful treatment of a localized cerebral deficiency disease involving the vital substances, leading to a decreased penetrance of the gene for schizophrenia. There is a possibility that the so-called gene for schizophrenia is itself a gene affecting the metabolism of one or another of these vital substances, or even of several vital substances, causing a multiple cerebral deficiency.

I suggest that the orthomolecular treatment of mental disease, to be successful, should involve the thorough study of and attention to the individual, such as is

<sup>9</sup> It has been suggested by Melander and Martens (1958, 1959) and by Hoffer and Osmond (1966) that the effects of taraxein (Heath et al., 1958) may result from changing the permeability of the blood-brain barrier.

customary in psychotherapy but less customary in conventional chemotherapy. In the course of time it should be possible to develop a method of diagnosis (measurement of concentrations of vital substances) that could be used as the basis for determining the optimum molecular concentrations of vital substances for the individual patient and for indicating the appropriate therapeutic measures to be taken. My workers and I are carrying on some experimental studies suggested by the foregoing considerations, and hope to be able before long to communicate some of our results.

### SUMMARY

The functioning of the brain is affected by the molecular concentrations of many substances that are normally present in the brain. The optimum concentrations of the substances for a person may differ greatly from the concentrations provided by the normal diet and genetic machinery. Biochemical and genetic arguments support the idea that orthomolecular therapy, the provision for the individual person of the optimum concentrations of important normal constituents of the brain, may be the preferred treatment for many mentally ill patients. Mental symptoms of avitaminosis sometimes are observed long before any physical symptoms appear. It is likely that the brain is more sensitive to changes in concentration of vital substances than are other organs and tissues. Moreover, there is the possibility that for some persons the cerebrospinal concentration of a vital substance may be grossly low at the same time that the concentration in the blood and lymph is essentially normal. A physiologic abnormality such as decreased permeability of the blood-brain barrier for the vital substance, or increased rate of metabolism of the substance in the brain, may lead to cerebral deficiency and to a mental disease. Diseases of this sort may be called localized cerebral deficiency diseases. It is suggested that the genes responsible for abnormalities (deficiencies) in the concentration of vital substances in the brain may be responsible for increased penetrance of the postulated gene for schizophrenia, and that the so-called gene for schizophrenia may itself be a gene that leads to a localized cerebral deficiency in one or more vital substances.

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## Orthomolecular Psychiatry: Treatment of Schizophrenia

DAVID HAWKINS

### INSTRUCTIONS TO THE PATIENT

#### Education of the Patient: Explanation of the Illness and Test Results

Subsequent to the completion of tests and the diagnostic interview, the patient is given an interpretation of all the test findings and the diagnosis, including a biochemical explanation of his illness. It is explained to him how the HOD test reveals faulty perception, and he is told his exact HOD score and its correlation with his symptoms. It is then explained that a medical regimen will be prescribed that is designed to correct the brain's faulty perceptual functioning. An adequate understanding of the illness frequently relieves irrationality rapidly.

Similarly, when it is explained to the patient that paranoia is a result of faulty brain chemistry and it is labeled "paranoia" he becomes less paranoid and more rational. Unless the condition is of considerable duration, so that he has become

systematized with many attendant secondary gains, paranoid symptoms usually diminish rapidly. An adequate explanation to the patient of his illness is an extremely important therapeutic procedure and sets the stage for all the treatment procedures that follow.

We use the term "metabolic dysperception" (see Chapter 19 by Kowalson and Chapter 26 by Robie) to most accurately describe the patient's condition, and we explain that metabolic dysperception, if it gets bad enough, can produce overt clinical schizophrenia. We have yet to see a patient who has rejected this explanation, if expressed correctly. Many of the patients respond very positively and will state that this is the first time a psychiatrist has ever been honest with them.

Telling the patient that he has a specific illness allows him to assume the sick role with all the attendant benefits that accrue in our society, as have been well described by Siegler and Osmond (1969). Once the patient and family understand the nature of the illness they are usually willing to accept it and do something about it. The family no longer has to utilize denial or reaction formation to handle their guilt, anger, and other emotional reactions which automatically stem from psychological formulations of the illness. Under these conditions, families readily assent to counselling in those instances where disturbed family interaction is apparently impeding the patient's progress.

### General Medical Regimen

The patient is told that he will be placed on a regimen consisting of diet, megavitamins, medications, and prescribed periods of exercise, rest, and sleep. No more than 8 hours of sleep is advised as more has been shown to increase fatigue and disability (Globus, 1969). Daily physical exercise is prescribed for its physiological benefit. Anxiety in mental patients has been demonstrated to be accompanied by elevated lactate levels as a result of altered energy systems (Pitts and McClure, 1967; Beebe and Wendell, 1968; also see Chapter 21 by Beebe and Wendell). The beneficial effect of exercise has also been reported by members of Schizophrenics Anonymous; they claim that of all the forms of exercise, swimming is the most subjectively beneficial.

Patients are advised to avoid excessive fatigue and stress and they are placed on a hypoglycemic diet which consists primarily of the avoidance of sugar and sweets, reduction of starch, and elimination of caffeine. Because there is an increasing interest in functional hypoglycemia there are a number of recent books available to the patient (see Chapter 22 by Meiers). A booklet "Hypoglycemia and Me" by the Hypoglycemic Foundation<sup>1</sup> is excellent and provides all the information needed.

<sup>1</sup> Available from Adrenal Metabolic Research Society of the Hypoglycemia Foundation, P.O. Box 48, Fleetwood, Mount Vernon, New York, N.Y. 10552.

Patient self-help groups such as Health Frontiers<sup>2</sup> hold regular meetings, distribute educational literature, and sponsor informative lectures by endocrinologists.

The use of adrenal cortical extract (ACE) in the alleviation of hypoglycemic episodes is occasionally necessary. Our experiences have indicated that in certain patients it can be demonstrated to have a marked benefit and in several instances, the use of the ACE injections has made it unnecessary to hospitalize patients who had precipitated relapses by going off their diets. "Physicians Guidelines to Diagnosis and Treatment of Hypoglycemia or the Hypoadrenocortical State" and "Hypoadrenocorticism" are available from the Hypoglycemia Foundation to physicians only.<sup>3</sup>

We also advise patients that strong aged cheeses such as Roquefort and Camembert should be avoided as these have been reported by the members of SA to aggravate their symptoms.

Patients appreciate the reasons for all of these instructions and are far more cooperative when the rationale is given. It is useful to clarify the difference between a vitamin *deficiency* disease and a vitamin *dependency* disease (Rosenberg, 1970) in which vitamins are being used in pharmacologic rather than replacement doses. To aid in their understanding of the illness, educational literature is made available and most patients and families find helpful the educational package which is available from the Schizophrenia Association of Long Island.<sup>4</sup> In our experience, the more the patient and family know about the illness, the better the result.

Joining Schizophrenics Anonymous is recommended when it appears the patient would benefit, and we suggest to family members that they join one of the schizophrenia associations, become acquainted with the other families, and attend the educational lectures. Many patients become interested in the hypoglycemic aspect of the illness and appreciate being referred to patient self-help groups concerned with this illness.

With the alcoholic-schizophrenic patients, treatment is first concentrated on the schizophrenia and they are referred to SA. In each of the SA groups, there are also members of Alcoholics Anonymous and, as the patient improves, these recovered alcoholics introduce the patient to AA. If the patient is not going to SA then he is referred directly to AA after his HOD score has gone down and the schizophrenic process has abated. Surprisingly, at that point the schizophrenic-alcoholic usually abruptly stops drinking without the prolonged struggle and battle typical of the nonschizophrenic alcoholic. The patient frequently attends both SA and AA groups and as the schizophrenic process dissolves, he usually drifts away from SA and continues in just AA.

<sup>2</sup> Available from Health Frontiers Foundation, 149 Spindle Road, Hicksville, New York 11801.

<sup>3</sup> Adrenal Metabolic Research Society of the Hypoglycemia Foundation, P.O. Box 98, Fleetwood, Mt. Vernon, New York.

<sup>4</sup> Long Island Schizophrenia Association, 1691 Northern Blvd., Suite No. 203, Manhasset, New York 11030.

## MEDICATION

### Psychotropic Drugs

The academic drug researcher operates at a distinct disadvantage—he cannot employ the great variety of techniques which the clinician utilizes almost automatically in his daily practice. Also, the researcher can only handle very limited data and the number of controlled variables must of necessity include only those that are most obvious and that lend themselves to data collection and processing. The parameters of research designs are, therefore, arbitrarily quite limited, as are the results. Unfortunately, the results of such studies are often extrapolated beyond the confines of the data and the results are stated in terms which do not limit the results to the conditions of the study. Because he is unencumbered by such limitations, it is usually possible for the clinician to accomplish more with any given drug than the literature infers. The more complex the illness being treated, the more this general principle holds true, and it is especially so in schizophrenia.

Correct sequencing of medications is important in the psychopharmacology of schizophrenia. By changing the sequence it is often possible to obtain results with the same drug to which the patient was previously unresponsive. A similar observation has also been made by Kline (1969), who noted, in doing cross-over studies, that patients may react differently to the same dose of the same drug when it is later re-introduced and that this phenomenon creates a previously unrecognized problem for drug research. We have learned that this can be done deliberately—a patient can be “set up” to respond to a drug that we intend to administer at a later date. In doing this, advantage can be taken of certain readily observable principles of central nervous system activity such as the rebound phenomenon. For instance, a patient will often readily respond to an “up” drug if it is rapidly introduced during the immediate period following cessation of a “down” drug and vice-versa. Brain function, as a general rule, tends to be compensatory, and this natural tendency can be used to purposely “sensitize” a patient to the effect of the same or another drug. In attempting to induce this reaction, the action of the “sensitizing” drug should be in the opposite direction from the drug whose response we later need to effect a recovery.

Researchers who are not clinically experienced are often puzzled by the “polypharmacy” that they come across, because, from the limitations of a theoretical viewpoint, it “doesn’t make sense.” The clinician, however, often follows by “intuition” certain principles in drug usage which have been learned by experience. Besides sequencing, these include: utilization of mutual synergisms and antagonisms, balancing off of side effects, purposely utilizing desired side effects, extending dosage ranges by concurrent use of antagonists, calculating onsets and durations of action, predicting progressive loss of response, predicting development of tolerance or loss

of tolerance, estimating effective dosage ranges at different stages of the illness, and predicting phases of drug responses. Because of all these clinically important factors, which are not included in research designs, it is common for clinicians to obtain quite different results from those that are received from academic studies. In daily practice the clinician automatically compensates for biological individuality (Williams, 1971) and the difference between patients, which in psychiatric conditions are more marked than in other kinds of illness. In psychiatry it is common for patients to require 10 to 100 times the "average dose" of a given substance before they respond favorably.

Additional reasons for the traditional "town versus gown" difference in the results of treatment between clinicians and academic researchers are provided by understanding Joseph Wilder's "Law of Initial Value," which states that the pre-stimulus state of the organism determines the response as much as does the nature of the stimulus itself. The chemical importance of this concept has been reviewed by Lesse (1971). Because of the antipsychotic effect of the phenothiazines, all patients are placed on either a suitable phenothiazine or other antipsychotic medication if this has not been done previously. According to Hollister (1971), antipsychotic drugs "contribute the most therapeutic benefits in schizophrenia—there is little direct evidence that traditional therapies add more," and all antipsychotics produce a postsynaptic dopamine receptor blockade leading to stabilization of the membrane at the receptor site.

The site of action may also be an enzymatic protein in the presynaptic membrane adjacent to the intersynaptic cleft (Teller and Denber, 1968). They point out that the defective protein at the synaptic site is probably quite small and that the antipsychotic drugs are capable of changing protein structure even in minute doses. The change in structure then causes change in functioning of the enzymatic activity. Utilizing a "framework molecular model" (available from Prentice-Hall, Inc., Englewood Cliffs, N.J.) they demonstrated, for instance, that the "architectural" characteristic of chlorpromazine and mescaline allowed for a demonstration of their mutually antagonistic action by action at the cell's protein membrane discs.

Spontaneous disinhibition of neuronal circuits, because they are connected in series rather than parallel, can result in clinically significant symptoms even though only a few sites are involved. This may lead to production of reverberative circuits in which apparent perceptions may occur, for instance, without external stimulation. Also, in chronic schizophrenia there is a disturbance of internal inhibitory activity (Saarma, 1968), and Saarma and Vasar (1970) have demonstrated that this disturbance is positively influenced by nicotinic acid. Teller and Denber conclude that the symptoms resulting from the endogenous genetic defect in schizophrenics are similar, from the viewpoint of molecular biology, to those that are exogenously caused by the psychotomimetic drugs. Bradley and Johnston made a valuable contribution to future research in this area in their work on "The Molecular

Pharmacology of Hallucinogens" (1968). Animal research until this time had been based only on gross behavioral changes in response to the drugs being investigated. Bradley and Johnston introduced the use of operant conditioning techniques to determine more subtle behavioral changes in response to a series of possible psychotogens. By correlating these more subtle responses to a series of structural changes in the molecules being studied, they have come closer to approximating the human condition in drug research with experimental animals.

It is explained to the patient that the phenothiazines are being prescribed, not as tranquilizers, but for their effect in reducing the HOD score and for their antischizophrenic action. Intelligent patients appreciate a brief explanation of the action of the phenothiazines so that they get to know that chlorpromazine has a "down" action and is, therefore, useful when they are agitated, or upset, or have insomnia, whereas fluphenazine, especially in lower doses, has an "up" action. An explanation is given of extra-pyramidal side effects and the reason for prescribing anti-Parkinsonian medication.

Patients are told that if they get blurred vision, the anti-Parkinsonian drug dose is too high, and that if they get restless legs or cannot sit still, it is too low. An explanation is given that the phenothiazines are not properly called tranquilizers and that that term should be reserved for drugs of the meproamate type. This removes the common prejudice against taking tranquilizers. Many patients are either fearful of tranquilizers or they have reaction formations against them and do not want to become dependent on them. Clarification of this issue is often of considerable importance because some patients will discontinue antipsychotic drugs, with dire results, for these reasons.

The dose of phenothiazines is reduced as the patient improves and his medication is shifted from one end of the phenothiazine spectrum to the other, depending on what phase of illness or recovery he is in currently. We have seen many patients whose impairment was impeded by their being kept on the wrong phenothiazine due to the mistaken notion that all phenothiazines are interchangeable. As an example:

A 28-year-old schizophrenic man was admitted to a hospital with paranoid symptoms. He was placed on 600 mg of chlorpromazine, following which the paranoid symptoms disappeared. He then became depressed and apathetic. During the next year-and-a-half he had psychotherapy three times a week, but did not improve and so was discharged at the end of that time as having achieved maximum hospital benefit. Medication remained the same throughout the entire hospital stay and he was discharged on the same dosage.

When seen at the clinic, he was still "down," apathetic, listless, and indifferent. The notes in the patient's hospital record indicated that this was thought to be due to the schizophrenic process. At the first visit, his medication was changed from 600 mg chlorpromazine to 5 mg fluphenazine three times daily. Within 24 hours the entire symptom constellation disappeared. He became alert, responsive, and energetic, and eventually recovered.

The best clinical principle is that the patient should be on the right dosage of the right phenothiazine at the right time. We tell the patient that as he recovers the dosage will be reduced, but that he will be kept on a small, perhaps "bed-time only" maintenance dose for its beneficial chemical effect even though he has long since not needed a tranquilizer. This again demonstrates to the patient that the phenothiazine is not being used as a tranquilizer, but for its biochemical effect. This explanation results in increased patient cooperativeness.

Antidepressants may be necessary in this connection. We have found that activation of the tricyclic antidepressants by thyroid medication may bring about a prompt response. This has been recently reported by Prange et al. (1969) and Earle (1970). It is important, as mentioned before, that the patient's euthyroid status be ascertained prior to placing him on this combination of medications. The patient's active symptoms should always be first brought under control with a phenothiazine before the antidepressant is introduced.

Another medication which is useful in the treatment of schizophrenia is methylphenidate hydrochloride (Ritalin<sup>®</sup>). If the depression is not too severe, 10 to 20 mg three times per day before meals will alleviate fatigue and depression, as well as any sedation effects from the phenothiazines. This medication at times has relieved depressions of suicidal degree in less than an hour and helps to tide the patient over until his basic condition improves sufficiently that the depression passes. Overreliance on this medication can lead to a diminution of effect. It can be used to potentiate the effects of the tricyclic antidepressants. This synergistic effect results in an increase of blood levels of the antidepressants through enzyme inhibition (Wharton et al., 1971). Overusage by schizophrenic patients is rare, and in our experience has occurred only in those who have a problem with multiple drug abuse.

An additional use for thyroid medication in the euthyroid schizophrenia patient is in the treatment of periodic catatonia. In this condition, between upsets, the patient's HOD score may be within the normal range, and when an attack occurs the score rises precipitously. The typical response to 3 or 4 grains of thyroid daily is exemplified by the following case:

A 41-year-old housewife had been hospitalized *15 times* in the last seven years for recurrent acute schizophrenic episodes uncontrolled by massive doses of chlorpromazine. When seen in the office between attacks, her HOD score was only 10. The attacks were always preceded by a period of insomnia and often occurred during the pre-menstrual period. In addition to megavitamins and a hypoglycemic diet, she was placed on 4 grains of Proloid<sup>®</sup> daily at the first visit. Since then she has not had a single recurrence—she feels and functions as though she had never been ill. She returns to the clinic for follow-up visits every three months.

Although the successful use of thyroid in treating schizophrenia has been the subject of many papers in psychiatry for more than 40 years, apparently many

clinicians do not think of using it because schizophrenics are usually euthyroid. The periodic catatonic is a readily recognizable subgroup of the schizophrenias and the value of using thyroid in this condition has been reported by many researchers, including Gjessing (from 1932 on, but recently see 1964, 1967, 1969), Danziger (1958), Danziger and Kindwall (1953, 1954), Gunne and Gemzell (1957), Sourkes (1962, 1970), Lochner et al. (1963), Minde (1966), Cookson et al. (1967), Jenner (1967), Vestergaard (1969), and Hoffer (1967). Thyroid can be used in treatment of the recurrently ill schizophrenic as well as for other types of schizophrenia.

Hoffer and Osmond (1967) reviewed the literature and noted that the average dose of thyroid used was 5 grains daily. Danziger and Kindwall (1953, 1954) gave doses of 2 to 20 grains but found that few patients required more than 10 grains. All researchers have commented on the considerable resistance of the schizophrenic to thyroid hormone and in our own work we have observed the same phenomenon. Our most common dose is 3 to 5 grains daily, and many patients who were previously unresponsive to treatment will recover when this amount of thyroid is added. Many of these are patients who do not present the classic periodic pattern; one will be described later.

### Megavitamins

We routinely use mega doses of four vitamins for a variety of reasons in treating schizophrenic patients, and this has resulted in increased rates of recovery. It is still not possible to predict exactly which patients will benefit by megavitamins and it remains for future researchers to give us the useful clinical indicators to identify these patients in advance. Work supported by the Canadian Mental Health Association (Ban, 1969; Ananth et al., 1969; Ban and Lehmann, 1970) is proceeding in that direction and preliminary results indicate that there is a segment of the schizophrenic population that responds to either nicotinic acid and pyridoxine or pyridoxine alone and may eventually be identifiable.

Ananth, Ban, and Lehmann report (1972) that the therapeutic effect of nicotinic acid in chronic schizophrenics is potentiated by pyridoxine. This was demonstrated in a 48-week double blind control study in which pyridoxine alone, nicotinic acid alone, or the two together were demonstrated to have a statistically significant therapeutic effect. The therapeutic effect was demonstrable even though the patients had been hospitalized for an average of 10.9 years, were not on hypoglycemic diets, and the doses of both pyridoxine (75 mg daily) and vitamin B3 (3 g a day) were considerably below the dosages we routinely prescribe.

In general, it can be said from our own experience that the higher the patient's HOD score, the greater the likelihood of response to an overall megavitamin treatment regimen. The schizophrenic patient whose illness could be called "metabolic

reception" responds the best. The grown-up childhood schizophrenic with the low OD score, postural stigmata of proprioceptive deficit, and primarily visual perceptual distortions is the least likely to benefit. The most significant visual perceptual distortion in this group of patients is loss of depth. This particular distortion, even if it is induced hypnotically in normal subjects, produces a schizophreniform response with primitivization and regression, as has been shown by Aaronson in his studies (1967a, b, 1968). This type of patient appears to belong to a different chemical subcategory of the subtypes of the schizophrenias.

The megavitamins and the phenothiazines act clinically as though they had a synergistic action, and for that reason patients are kept on a low daily dose of a phenothiazine prophylactically even after they have recovered. Sainz (1964) has demonstrated that the phenothiazines elevate blood ascorbic acid levels, and there are a variety of synergistic effects such that the antipsychotic action of the phenothiazines may be augmented by the megavitamins. Demonstration of the effectiveness of the combination requires correction of co-existing functional hypoglycemia. In any patients, in our experience, recovery was prevented by lack of adherence to a hypoglycemic diet. As an example:

A 26-year-old unemployed schizophrenic man had been ill for several years and had been hospitalized several times, during which he had had shock treatment and all other available forms of therapy. By the time he came to the clinic, he was surly, uncooperative, paranoid, and obese. The Glucose Tolerance Test revealed definite functional hypoglycemia and he was placed on the usual regimen of megavitamins, phenothiazines, and a hypoglycemic caffeine-free diet.

For the next one-and-a-half years no progress was achieved and during visits he was highly uncommunicative, despite high doses of vitamins and phenothiazines. It was then discovered from his family that he was drinking at least half a case of a cola beverage per day and on week-ends he usually drank a whole case daily. Cessation of the cola ingestion resulted in rapid, progressive improvement with noticeable changes in behavior, communicability, and relationship with the family. His inappropriateness and surly, gauche manner disappeared and he is continuing to improve.

When we first began using megavitamins in treating childhood schizophrenics we were unaware of the importance of ameliorating the hypoglycemia and, therefore, our first reports on the use of nicotinamide in schizophrenic children stated that "... niacin and niacinamide were found to be relatively ineffective in childhood schizophrenics and less effective in adult schizophrenics with childhood onset" (Cott, 1967, 1968b). Similar negative experiences have been reported by Roukema and Emory (1970) and Greenbaum (1970b), who also demonstrated that nicotinamide alone in the treatment of childhood schizophrenia, except for improvement in some individual cases, did not produce statistically significant results. It was Cott (1969) who pointed out that recovery of childhood schizophrenics on megavitamins is not possible until the hypoglycemia was corrected, and that unless this was

done it was useless to proceed. The importance of this concept cannot be over-emphasized, as in this group as well as certain other patient groups no recovery at all is possible unless the hypoglycemia is corrected.<sup>5</sup> In this connection it might be well to emphasize again that recovery after the acute phase is over can be delayed for long periods of time if the patient is allowed to sleep beyond 8 hours a day. The apathy and lassitude which ensue from prolonged oversleep can negate attempts at rehabilitation.

Our initial combination of megavitamins usually consists of 1 gram niacinamide, 1 gram ascorbic acid, 50 mg pyridoxine, and 400 I.U. of natural vitamin E, repeated four times daily. Although occasionally an adolescent girl will develop nausea as a result of this dose of niacinamide and require a reduction of dosage, this combination is tolerated by the majority of patients without any side effects. The most frequent complaints are about the nuisance of taking the pills and, occasionally, difficulty in swallowing them.

For a time, we hypothesized that the difficulty in swallowing, especially in adolescent girls, was hysterical in origin, but we discovered this was often due to esophageal dysfunction associated with schizophrenia as reported by Hussar and Bragg (1969, 1970). Their study on the swallowing functioning in schizophrenics using cine-radiographic techniques demonstrated that almost half of the schizophrenic patients showed various degrees of swallowing abnormalities and that chlorpromazine medication had no effect on the swallowing mechanism. The conclusion of their study was that "these results contribute to an understanding of the not infrequent tragic episodes of asphyxiation on food among chronic schizophrenic patients often incorrectly ascribed to tranquilizer medication."

Both niacinamide and ascorbic acid are available in capsules, which are more easily swallowed than pills. The ascorbic acid available in crystalline form can be mixed easily with orange juice.

The maximum therapeutic dose of niacin or niacinamide is about 1 gram per day below the nausea-inducing dose. We routinely begin by using niacinamide and later switch the patient to niacin if there are specific indications to do so, such as the existence of concomitant alcoholism, elevated cholesterol, or hypoglycemia, or if the schizophrenia has been precipitated by LSD. Although the flushing side-effect of niacin can be controlled by cyproheptidine (Periactin<sup>®</sup>) 4 mg four times daily (Robic, 1967), the flush unnecessarily alarms patients even when it has been previously explained to them. Niacin also appears to be more beneficial than niacinamide in treating the alcoholic-schizophrenic, although we do not have statistical studies to prove that this is so.

Recent studies (Davis and Walsh, 1970; Lieber and DeCarli, 1970) have demonstrated metabolic pathways in alcoholics which may account for nicotinic acid's

<sup>5</sup> Hypoglycemic episodes, for instance, will trigger post-LSD "flashbacks."

action in this disorder. Thus, alcohol, by way of its primary metabolite, acetaldehyde, competitively inhibits nicotinamide-adenosine-dinucleotide-linked aldehyde dehydrogenase, which interferes with the metabolic disposition of the biogenic amine dopamine, producing aberrant metabolites. Prolonged consumption of alcohol enhances the activities of the enzyme-reduced nicotinamide-adenosine-dinucleotide phosphate oxidase. In this connection, alcoholics have also been demonstrated to have a deficiency of vitamin C as exemplified by a lower level leukocyte ascorbic acid in control groups (G. Jberg, 1970).

Although Saarna and Vasar (1970) report that with nicotinic acid there is an appearance of clinical improvement between the fourth and sixth week of treatment, in our experience the response to the megavitamins is generally more delayed and not discernible until the third to sixth month. A very noticeable or marked degree of improvement as compared to patients who are treated with just phenothiazines is most obvious by the end of the first year.

Improvement can be speeded up by the use of parenteral injections of the megavitamins, in which case a noticeable improvement begins within a few weeks (see Chapter 25 by Cott). Patients who have been on adequate oral doses for a considerable length of time without improvement will often suddenly respond when switched to parenteral administration. The ability of the intestinal tract to handle a given compound is not the same in all persons (Faloon, 1970). Some patients may have a defect in transport enzyme systems so that a patient may have been on a high dosage of ascorbic acid for some time and yet still show a subnormal blood ascorbic acid level. This level then suddenly increases to normal when much smaller doses of ascorbic acid (500 mg) are given by injection.

Multiple modes of action of nicotinic acid in schizophrenia have been described (see Chapter 11 by Hoffer), including the recent work of Galzigna (1969, 1970) and Galzigna and Rizzoli (1970) showing that nicotinamide reacts rapidly with the aminochromes, reducing them. In the absence of nicotinamide in the brain tissue, the aminochromes react with acetylcholine to form a stable complex which acts as an endogenous hallucinogen. They conclude that "if we consider adrenochrome reduction derivatives as non-toxic excretion products of the psychotogen aminochromes, a rationale for the clinical use of nicotinamide in mega doses as a therapy for mental illness is provided." Further work is in progress to demonstrate the nature of this interaction with ascorbic acid which is central to the authors' "short circuit" theory of the onset of mental illness.

Nicotinic acid has nonspecific properties of blocking the production of stress-induced gastric ulcers in laboratory animals and it also blocks the L-dopa-induced exacerbation of symptoms in schizophrenic Parkinsonian patients (Yaryura-Tobias, 1971). Research is currently being done to determine the effect of nicotinamide in reducing the stress responses (cold pressor test) of normal students to final examinations (Bovard, 1971, personal commun.). The contraindications for using nicotinic

acid have been described by Hoffer and Callbeck (1959), Hoffer (1962, 1969), Hoffer and Osmond (1966), Mosher (1970), and Newbold (1970), and have been reviewed in other chapters. The four main contraindications to niacin are those of peptic ulcer, hypertension, diabetes, and gout. The niacin-induced hyperglycemia may alter insulin requirements in diabetics. The histamine-release, which produces the flush, results in hyperchlorhidria in ulcer patients. The elevation of uric acid may precipitate gout attacks, and if the hypertensive patient is on a reserpine-type anti-hypertensive agent, the patient may possibly go into shock. The cholesterol-lowering effect has been demonstrated in long-term heart studies and the heart studies have discovered the same contraindications (Boyle, 1968). Here, obviously, the lowering of blood cholesterol is sought, and it is a side benefit when niacin is taken by schizophrenics.

In the review articles mentioned earlier concerning the possible side effects of nicotinic acid, several cases of possible hepatic toxicity were reported. When the effect of nicotinic acid in producing false positive liver enzyme tests is discounted, these appear to be questionable. We have not seen any cases of noninfectious jaundice which did not clear up when the phenothiazine was discontinued. In addition, we have seen several cases of intercurrent infectious hepatitis as demonstrated by liver function tests and liver biopsy. The majority of patients who develop phenothiazine jaundice were continued on the megavitamins and the jaundice cleared up with no difficulty. In a few cases, because of the isolated reports in the literature, megavitamins were discontinued along with all other medications, and the patients were subsequently replaced on nicotinamide with no recurrence of jaundice. At this time, we consider that jaundice due to nicotinic acid, although unlikely, may be a remote possibility and treatment will depend upon the judgment of the attending internist.

We explain to patients that both vitamin E and ascorbic acid are prescribed for their antioxidant effects. Ascorbic acid alone has been shown in controlled studies to benefit psychiatric patients as evidenced by improvements in their Wittenborn and MMPI scores (Milner, 1963). The effect of vitamin C in preventing the common cold has been reviewed by Pauling (1970), and this is of benefit to schizophrenic patients, who characteristically show a clinical worsening and an increase of perceptual difficulties as a response to viral infections. For those patients in whom this has been a problem, we recommend the sustained-action form of ascorbic acid in capsule granulated form, which sustains ascorbic acid blood levels during sleep (Riccitalli, 1972) and thereby eliminates recurrent colds in the majority of patients. We frequently have observed minor relapses and setbacks in recovered patients in response to upper respiratory virus infections and a possible mechanism for this observation has been described by Teller and Denber (1968) related to abnormal protein structure (such defects can occur genetically, or be caused by malnutrition, avitaminosis, infection, toxins, or immunologic reactions). The greater retention of

ascorbic acid in schizophrenic patients has been shown by Cowan et al. (1970) and previously by Herjanic and Herjanic (1969) and VaanderKamp (1966). Current studies by Pauling and Robinson and by Herjanic are reported in Chapters 2 and 14 in this volume.

High doses of ascorbic acid may occasionally cause mild diarrhea in some individuals and it may cause false positive urine tests in diabetics who use commercial urine test kits. A case is also reported in which ascorbic acid shortened the prothrombin time in a patient who was receiving a Warfarin (Coumadin<sup>®</sup>) anticoagulant (Senthall, 1971). In treating over 5,000 patients with 4 grams or more of ascorbic acid per day, however, we have not had a single instance of any serious side effects. We explain to patients that vitamin B6, pyridoxine, is necessary as a precursor of nicotinic acid. It is an intermediary step in the biotransformation of tryptophan to nicotinic acid where it is required for the hydroxylation of kynurenine (derived from tryptophan) to 3-OH-kynurenine and for the further metabolism of 3-hydroxykynurenine to 3-hydroxyanthranilic acid (immediate precursor to nicotinic acid; Gibbs and Walshe, 1969). Vitamin B6 deficiency interferes with the metabolism of amino acids, proteins, and biogenic amines, and causes abnormalities of nervous system activity in man, where the pathological effects of deficiency are most marked on the developing brain. Abnormalities of vitamin B6 metabolism have been associated not only with schizophrenia but also with a variety of other abnormalities of the central nervous system, and B6 deficiency at the subcellular level may be produced by a number of antimetabolites (Knapp, 1966; Coursin, 1969). The antagonism between vitamin B6 and L-dopa is a recent illustration (Duvoisin et al., 1969; Cotzias and Avastition, 1971). Pyridoxine in high doses has been used by Cott (1969) in the treatment of childhood schizophrenia. The role of pyridoxine in psychiatric disorders has recently been summarized by Ananth, Ban, and Lehmann (1972) in their paper titled "Potentiation of Therapeutic Effects of Nicotinic Acid by Pyridoxine in Chronic Schizophrenics" presented at the Canadian Psychiatric Convention in Montreal, June 8, 1972. This paper states that pyridoxine potentiates the action of nicotinic acid, possibly by opening up the kynurenine cycle of tryptophan metabolism thereby decreasing the formation of indoles. In their study, already referred to, pyridoxine alone had a therapeutic effect in schizophrenics as well. In more than 100 patients we have not observed a single side effect from pyridoxine administration of 200 mg daily.

It is best to write down the medication schedule and the recommendations for sleep and diet on a card and give it to the patient at the initial visit. It is also advisable to indicate to the pharmacist that all medications be labelled to show the name and dosage size. Unless this is done, there will be mistakes and many call-backs as most patients are perceptually disordered and unable to remember verbal instructions. In summary, the addition of megavitamins is inexpensive and safe, and very positively influences the long-term outcome. Side effects of a serious nature are quite

rare and easily avoided. The occurrence of even the most mild side effects is avoided by giving niacinamide instead of niacin. Precise identification of those patients most likely to respond is not yet possible but, in general, the more elevated the HOD, the more likely the response, provided however, that concomitant hypoglycemia is also corrected.

#### INVOLVEMENT OF THE PATIENT IN AN INTEGRATED COMMUNITY TREATMENT SYSTEM

Because of the severity of a patient's condition or situation, hospitalization may either be required or elective. The average length of hospitalization for intensive hospital treatment (which may or may not include a course of ECT) in our series of patients over the last five years is eight weeks. Ten to twelve weeks may be necessary however, if the patient has been taking large doses of methedrine (speed). ECT rapidly reduces the HOD score, and this effect is most marked in the younger age groups, as will be discussed later.

If the schizophrenia has been exacerbated by LSD or methedrine to the degree that the patient is psychotic, then ECT, in our experience, is often necessary, as the psychosis otherwise tends to persist. It is also very effective with the depressive aspect of the patient's illness, which may be creating a suicidal risk. The response to ECT is different if the patient has been preparatorily pretreated. If, while in the hospital, the patient receives high-dosage megavitamins both orally and parenterally and is on phenothiazines and a hypoglycemic diet, the relapses following cessation of ECT formerly seen in schizophrenics seldom occur and the improvement is maintained following discharge.

Curiously, annoying side effects from medication seldom occur in a hospital setting. The patient who had side effects from practically every medication tried as an outpatient will probably have none from much higher doses of the same medication if he is hospitalized. In the hospital, patients are given 500 mg of ascorbic acid and 200 mg of niacinamide intramuscularly three times weekly in addition to the usual oral doses. Few patients fail to improve from intensive hospital treatment and even many of the severe chronic patients improve sufficiently so that they can be discharged and treated as outpatients.

Patients who appear shaky at the time of discharge or have difficult home situations or who have become disabled by the long duration of their illness benefit considerably from a convalescent period in a halfway house where they can be maintained on the same therapeutic regimen with monthly visits for changes of medication and evaluative follow-up. The use of SA, family groups, day activities programs, and

involvement with other supportive units of a treatment complex are described in Chapters 28 and 29.

Patients' self-help groups, such as Recovery, can also be of benefit to certain patients who have residual symptoms, so that, no matter what the family's financial limitations are, a great deal of supportive help and definitive group psychotherapy is available to both patient and family at no cost.

Pathological family interaction in which abnormal pressures are exerted on the patient by his family, or where there is a disturbed family situation that can impede his recovery, may require either family group therapy or parent counselling to facilitate the patient's recovery. This can be suspected as an operative factor when the patient's HOD score decreases progressively but is not accompanied by a return to normal function. The disability may then be stemming from an overprotective parent who infantilizes the patient rather than from the previously active schizophrenic process, and this pattern may require therapeutic intervention. At times this may be actively resisted by the dominant parent, who has unwittingly utilized the patient's illness for secondary gain or for other pathologic reasons.

Highly specialized group therapy may be necessary for the patient who has become heavily involved with the drug culture because unless this is done he tends to fall back into the same drug usage which precipitated his schizophrenia. In this type of group therapy, we have found that a straight chemical approach brings the best response. In this group setting, which differs markedly from the traditional analytically oriented group therapy, there is considerable discussion of drugs and their biochemical effects and especially the effects of drugs on the HOD score. The therapist needs to have knowledge of the current drug scene and the whole psychedelic subculture, especially language, life styles, and an awareness of what has recently been termed Consciousness III (Reich, 1970).

Once the patients learn that mescaline, psilocybin, LSD, STP and methedrine elevate the HOD score—with the risk of "freaking out"—they begin leaving these dangerous drugs alone. They learn that these drugs are truly psychotogens for them and that many of them have had to be hospitalized for LSD- or speed-precipitated schizophrenia psychoses. Patients inevitably discover that neither marijuana nor hashish has a residual effect on their HOD score and, therefore, for a period of time, excessive use of these two drugs may replace their former involvement with the more dangerous drugs that are likely to precipitate hospitalization and psychosis. As their HOD scores come down, the use of marijuana diminishes and they begin to function again and return to school or to work.

Prolongation of the excessive marijuana smoking may be associated with altered time perception, which should then be tested for with a timing device such as an electronic metronome (see Chapter 18 on *Cychnronia*). Until this specific schizophrenic syndrome is alleviated, attempts to dissuade the patient from excessive pot smoking are almost always unsuccessful.

## PSYCHOTHERAPY

From the model of schizophrenia which we have described, and the description of the diagnostic process, it is apparent that the patient has already been oriented to his illness and that this has been augmented by explanations of the meaning of the laboratory and perceptual test results. In addition to an explanation of the biochemical and perceptual aspects of the illness an explanation is given of how these interfere with functioning, feeling, and relating to others.

Although the illness intensifies pre-existent psychological conflicts and personality problems, it is explained to the patient that the initial phase of therapy will be devoted to medical recovery from the illness and that coexistent psychological problems will not be dealt with primarily until the HOD score is within the normal range. The explanation given for this is that impaired brain function causes so many different kinds of symptoms and effects on the personality that there would be no way of knowing, until the patient gets better, which of them are results of the patient's own personal problems and which are manifestations of an active disease process. The analogy given here is similar to a toxic brain syndrome. A more common example is that of the alcoholic who when actively drinking may develop an enormous range of pathologic symptoms and behavior and when sober may have only mild or no indications for psychotherapy.

Most patients readily concur with this treatment plan. The majority of patients will have already undergone previous psychotherapy, often of a prolonged and intensive nature with a number of therapists, so that they are seldom motivated to take part in any kind of formal psychotherapy. Many patients are actively opposed to psychotherapy as well as being bitter about such previous experiences.

The resentment of patients and families and the turmoil ensuing from previous experience with psychotherapy were responsible for much of the bitter comment about traditional methods of psychiatric treatment for schizophrenia which appeared in the early issues of the *Newsletter* of the American Schizophrenia Association. This same conflict and disillusionment has been reported by professionals themselves when a member of their family has become ill. For example, a Professor of Psychiatry reported his own disheartening experience with this dilemma (Kysar, 1968).

At the North Nassau Mental Health Center, five years of experience using the orthomolecular approach were compared with the previous five years when traditional psychiatry approaches were used. This comparison showed that dynamically based psychotherapy was of very limited benefit in schizophrenia. Although parent counselling and educational and supportive therapy were demonstratively beneficial, and often critically so, therapies based on theories of a psychodynamic etiology of the patient's schizophrenia brought questionable benefit (Hawkins, 1969). Whether psychotherapy or pharmacotherapy was more important was glaringly demonstrated

by the disastrous consequences which occurred when patients discontinued medication. Most patients relapsed upon termination of medication, but showed little response to termination of psychotherapy. One of the most common reasons for hospitalization was discontinuance of medication, yet hospitalization was never required because of a therapist's absence or termination of psychotherapy. Hospitalization was in fact more often preceded and precipitated by the patient's decision to "go for analysis." Those patients placed on the orthomolecular program who continued in psychotherapy with their previous analyst did considerably less well than those patients in whom psychotherapeutic intervention was kept to an absolute minimum.

The clinic's conclusions have been corroborated by similar findings from large-scale research studies done elsewhere as well as by the collective experience of patients and their families.

Information about the value of psychotherapy in schizophrenia can be obtained from three additional decisive areas: (1) controlled studies in the scientific literature; (2) reports from therapists in institutions who have had extensive, long-term experience with the use of psychoanalytic psychotherapy in the treatment of schizophrenia; and (3) the experiences of large numbers of patients and their families.

During recent years, there have been several large-scale authoritative studies on the value of psychotherapy in schizophrenia, the most extensive being that of May (1968, 1969), in which a comparison was made of five different treatment methods in schizophrenia. This study was so extensive and included so many collaborators that a research project of its magnitude on the value of psychotherapy will probably never be duplicated. The study was supported by the State of California Department of Mental Hygiene, U.S. Department of Health, Education and Welfare, U.S. Public Health Service, the National Institute of Mental Health, the University of California Health Services, and the research committee of the Los Angeles Psychoanalytic Society, and there was collaboration with many other authorities too numerous to mention.

In review of this work, Barnes (1971) considers the study to be the most meticulous, intensive, complex, and comprehensive research design in the field of psychiatric therapy. He notes that many will disbelieve the results but

more for emotional reasons than on the basis of any critical analysis of the work . . . these findings are of the greatest importance both to clinical psychiatry and to mental health program administration . . . it also leads us to wonder about the efficacy of the various therapies used in out-patient work with ambulatory patients, both schizophrenics and others.

The conclusions of this immense study were that medication alone, whether combined with psychotherapy or not, was the most effective and efficient treatment for most patients. Electroconvulsive therapy was the second most effective treatment.

Individual psychotherapy and milieu therapy were found to be the least effective, most expensive, and most time consuming.

Another series of important studies on the value of psychotherapy in the treatment of schizophrenia was reported from the Department of Psychiatry, Harvard Medical School, at the Massachusetts Mental Health Center. The conclusion from these computerized studies was that psychotherapy alone, even with experienced psychotherapists, did little or nothing for chronic schizophrenic patients, even over two years time (Grinspoon et al., 1967, 1968). In another study by the same researchers (Grinspoon et al., 1969) the same conclusions were reached: medication with or without psychotherapy had the most marked benefits. These studies confirm the earlier findings of May and Tuma (1965) that psychotherapy alone does not improve the schizophrenic patient's chances for improvement. In a further study by Shaffer et al. (1971) the authors conclude that there was no demonstrable difference in the results whether a patient received psychotherapy by either a "Type A" or a "Type B" therapist.

The findings of these extensive studies are supplemented by the 10-year study done by the American Psychoanalytic Association, in which data supplied by 386 analysts on over 3,000 patients reported an overall rate of symptom cure for schizophrenia of 9 percent (1968).

The second area of informative data is supplied by those institutions with long-term intensive experience in the use of psychoanalytic therapy with schizophrenia. Of these, Chestnut Lodge in Rockville, Maryland, is probably the best known. Two recent books from that institution indicate the failure of this method of treatment. In *Schizophrenia and the Need-Fear Dilemma* (Burnham et al., 1969) the psychoanalytic theory of schizophrenia is deftly presented together with an explanation of the lack of positive clinical results obtained. As a matter of fact, all of their case histories end with the patient either dead or still sick with schizophrenia. In the second book, *Conflicts and Reconciliation: A Study on Human Relations in Schizophrenia* (Stierlan, 1969), a similar lack of clinical results is reported.

Gray (1970) points out in a review article that "Sigmund Freud always held that schizophrenia was not amenable to psychoanalytic cure" and that "the challengers of this statement have failed to disprove the truth of it."

The clinic has had the opportunity to provide treatment for a number of patients who had prior long-term in-patient psychoanalytic treatment. In almost every case these patients who had been unresponsive to intensive, long-term psychoanalytic therapy promptly responded to a medical regimen. After 8 weeks of medication and/or ECT in a hospital, the majority had recovered. They are now employed, or back in college, able to socialize and some married. The following case is illustrative:

This 24-year-old man had been ill with schizophrenia for six years and for the last two years had been in the hospital for psychoanalysis during which time he received no drugs of any kind. The family was alarmed at his deteriorating condition as he had

decided to commit suicide by not eating and the institution refused to use any medications. The family experienced great difficulty in getting the patient transferred to a medically oriented hospital and finally had to threaten legal action to obtain his release. The patient was so disturbed that the hospital had to wrap him in wet sheets mummy fashion and move him by ambulance because of their refusal to use tranquilizer medication.

On admission to the Brunswick Hospital, the patient was mute, withdrawn, severely depressed, negativistic, and uncooperative. After 8 weeks of intensive hospital treatment he recovered sufficiently to be discharged. Within a few months, he was gainfully employed, and was taking college courses in the evening. He then moved away from his family, became independent, and subsequently married.

The foregoing would tend to augment the findings of Will (1970), who concludes an article on psychotherapy in schizophrenia with the statement "*few schizophrenic patients will be helped in this prolonged, expensive and largely unattainable treatment.*"

The general consensus of many schizophrenic patients also has been that the results of psychotherapy were disappointing. Not only are their experiences discussed at meetings of Schizophrenics Anonymous and the various schizophrenia associations throughout the United States, but their collective experience also was expressed resentfully in the first few volumes of the *Newsletter* of the American Schizophrenia Association, as was previously mentioned. Autobiographies by former patients or their families reflect the same attitudes. *In Search of Sanity* by Gregory Stefan (1966) and *Gone is Shadow's Child* (Foy, 1970) are typical examples.

From the foregoing survey of important sources of information, the evidence is that psychotherapy based on psychoanalytic formulations of schizophrenia is of no statistically demonstrable benefit to patients. When done by therapists who are less than expert, psychotherapy may well be deleterious. Therefore, the requests of patients and their families for the inclusion of medication in the patient's treatment is hardly irrational, nor does it constitute "uninformed lay opinion." Many families, especially those who belong to a schizophrenia association, are very well informed and have read extensively. Dr. May's book, for instance, among many others, is for sale at association meetings. (One of the families of the Long Island Schizophrenia Association recently co-sponsored a major professional symposium on Gilles de la Tourette's Syndrome—which indicates a rather high degree of sophistication.)

In the clinic's experience, most patients do not desire or require formal psychotherapy once their HOD scores have returned to normal. During the initial period of the illness, while the patient's HOD score is still elevated, the less interference the patient experiences from the psychiatrist, the better will be the result. Patients who continue in dynamically oriented psychotherapy during this phase recover much slower and to a lesser degree. This conclusion became apparent after several years of experience with patients who were in therapy elsewhere and who were allowed to continue in therapy while the clinic handled their medications. As a group, these patients recovered to such a noticeably lesser degree that the clinic finally had to

recommend that patients discontinue that type of psychotherapy until they had medically recovered from the worst of their illness. When this practice was followed, results were much better—when patients did resume therapy, it was usually for far different reasons than the ones for which they had originally sought it.

After the initial diagnostic visit, patients are usually seen weekly to adjust medications until an effective regimen has been established. This usually occurs by the end of the first month and visits during the second and third months are usually bi-weekly. The average patient is then seen monthly for the remainder of the first year. During the second year patients are usually seen every two or three months, and during the third year they are seen every three or four months.

Inasmuch as the patients go through various stages of recovery, the problems that they present during these periods of time will vary. Initially, the patient needs an explanation and interpretation of the illness followed by support and encouragement. During the first year, the main concerns are associated with symptoms, but these progressively diminish, so that by the end of the first year problems relating to returning to functioning in the various areas of life will be presented. The second year is devoted primarily to the problems of re-entry into a social life, returning to work, or returning to school, and there is a desire to become independent of the family who has supported the patient during the illness. Dependency conflicts become almost routinely manifest and at times family therapy or parental counselling may be required to handle the family's matching anxieties regarding resolution of this conflict. Adolescent-type problems then typify the second stage of recovery, which constitutes the "re-entry" phase.

During the third year, many patients will have grown and progressed beyond the level of functioning which preceded their illness. Many will state that they are "weller" than they were before they became ill, and at this time the actual onset of the illness will be dated retrospectively. This will almost always precede the previously accepted date of onset. This occurs because the patients never knew what it was to feel and function well, and now that they experience this, they will frequently give the exact time in their lives when the internal change had occurred which signalled the real beginning of the illness. Many function with perceptual impairment for years; one characteristic of this state is the subjective certainty that one has "always been this way." Patients may need practical advice as they enter areas of life in which they have never before ventured.

During the second and third years of treatment, when some patients marry and begin having children, their questions concern genetic predisposition and pertain to what percentage of their children may be expected to develop the same illness. Almost routinely, newly married recovered schizophrenics want to know if there are any ways in which they can prevent the occurrence of schizophrenia in their children or detect it early. It is important to advise the women to stay on the medical regimen during pregnancy to prevent post-partum relapses.

Some patients, especially if they became ill during early adolescence, will have developed sizeable, secondary neurotic gains—especially the fulfillment of dependency wishes—and will continue to display immature child-like behavior even though their HOD scores have returned to normal. Some will tenaciously cling to the sick role even though it is no longer appropriate and they may require both explanation of what they are now doing as well as firm encouragement in a more mature direction. Often, these problems become disguised by the patient's adoption of self-serving interpretations of the youth culture "drop-out" pattern. Group therapy techniques are often useful to overcome these delayed maturational problems.

The adolescent rebellion pattern may coexist or predominate, instead of the passive dependent style. As is well known, this may also be a reaction formation. These conflicts associated with the dependence-independence growth phase may require adroit handling, as well as considerable forbearance. Families forget that schizophrenics can demonstrate the same problems that other young people do in our culture and that the problems that they are having with the patients are not all due to schizophrenia. It is frequently necessary to reorient families to this fact, as they lose their perspective from living so intimately with the illness.

In summary, during the acute phase of the illness, when the patient's HOD score is elevated, the most effective psychotherapy is an educational approach, which is of considerable benefit to both patient and family. This is followed by supportive practical advice as the patient recovers and goes through the successive stages of recovery, during which time he may have changing symptoms, which merely indicate that he is passing through a different phase, rather than getting worse, as he may erroneously conclude. The well-known appearance of depression following disappearance of the paranoid and hallucinatory symptoms is an example, and the patient needs to be reassured that the depression symptom will also pass and respond to treatment as did the previous phase.

After the patient's HOD score has returned to normal, specific conflicts may be handled either by supportive, individual therapy or group therapies. At this stage, recurrence of symptoms accompanied by elevation in HOD score indicates that the cause is biochemical and should be treated by a change in the medical regimen. Symptoms unaccompanied by a rise in the HOD score, on the other hand, are probably stemming from interpersonal or psychological conflicts and are, therefore, treated psychotherapeutically.

The approach to the patient during the initial phase of the illness has certain parallels with handling the psychedelic experience, in that every effort is made to influence favorably the patient's set and setting (which includes the therapeutic setting) so that the patient will be subject to benign experiences as much as possible. Following this principle will greatly increase the likelihood of recovery and the prevention of unfortunate sequelae. The importance of respecting the patient's extreme vulnerability when his defenses are inoperative is paramount. Analogies

between the schizophrenic and psychedelic experiences have been made by many authors, including Silverman (1968), Hoffer and Osmond (1967), and Laing (1967).

If the altered biochemistry of some people spontaneously sends them on a "voyage of discovery into inner space" then their experiences should be made as positive as is possible. This is also emphasized by Dabrowski (1964) in his book, *Positive Disintegration*, which demonstrates the possibility of reintegration at a higher level of functioning, as so many of our patients actually do.

In our view it is a serious misunderstanding to consider, as Laing has done, that if some people are defined as having schizophrenia the word itself is an epithet or a damaging "label." A vase can be used to hit someone over the head, but that does not mean that vases are inherently damaging or evil. All labels are potentially damaging—the fact that a person is labelled as American, Catholic or Protestant, black or white, rich or poor, educated or whatever, will put that person in very serious trouble in certain social circumstances. Some groups in society will negatively use any label that can be thought of. We should see to it the word schizophrenia is not used in that way against our patients, but the dilemma is not solved by pretending that the condition does not exist.

Although from a theoretical viewpoint the schizophrenic experience can be made a positive one, it should not be allowed to last indefinitely. Even a voluntary psychedelic experience is emotionally exhausting and the subject is relieved when it is over. Because the situation in which the schizophrenic experience occurs is seldom favorable for any length of time, the "voyage" of the schizophrenic illness is endlessly painful. We have never known a patient to have regrets that the experience was finally over—the plunge into another experiential world was involuntary. Even those patients who became schizophrenic following the intentional use of psychedelics did not intend to go that far—they meant to only spend a day that way—not years or maybe forever.

## RESULTS AND RESPONSE TO TREATMENT

### General Problems in Evaluating Treatment Results in Schizophrenia

Once it becomes known that a particular institution is using a new or helpful approach to an illness it tends to attract a distorted sample of patients. A progressively increasing percentage is made up of difficult and intractable cases. Determining the results of treatment then becomes more difficult and interpretation of statistics is less and less meaningful. Reporting of results in schizophrenia is notoriously fraught with

almost impossible obstacles, so that no matter how carefully research designs have been devised they are still subject to criticism in some area. Each professional discipline has its own criteria of what is meaningful. Control groups can also be grossly misleading, as the variables which one researcher considers essential to control are ignored by another. As Williams (1971) has shown, even identical twins are not biochemically nor even anatomically equal. Matching groups of patients with schizophrenia as to age, classical diagnosis, sex, or occupational group may actually be of minimal importance.

Of considerably more clinical significance would be the matching of groups of patients who are identical with respect to HOD score, incidence and severity of hypoglycemia, type of previous treatment, and favorability of life circumstances. Of importance also are the patient's degree of knowledge of his illness and the manner in which it has been presented to him. The use of the medical model itself, for instance, has an effect in that the patient is allowed to be ill when he is ill. The nonspecific effects of Selye's general adaptation syndrome also have to be taken into account, as the response of the patient during the alarm reaction can be quite different from the response of a patient when he is in the stage of chronic resistance or exhaustion.

We would also have to know whether the average HOD scores in the contrasting groups, even though numerically equal, were on the rise, indicating a worsening of the condition, or were falling, indicating a process of remission. We could not, for example, compare pneumonia patients based just on their temperature. A temperature of 102° might occur because the patient is in the process of going into a fulminating crisis where the temperature might eventually reach 107°, or because his temperature has been previously higher, which would indicate that he is in the process of getting well.

Evaluations of drug responses are difficult to assess, as many such studies utilize fixed dosages instead of the *optimal* dosages which take into account individual variation. Fixed-dosage-schedule studies, therefore, give only mathematical probability figures and fail to indicate the real clinical usefulness of a given medication when used in the proper dosage and in the proper sequence.

Because of the impossibility of meeting all these crucial requirements, results of any treatment method in schizophrenia are probably most usefully conveyed to clinicians by giving as detailed and accurate a description of the clinical response as is possible, so that the results could be duplicated. The average busy clinician is interested in treatment methods that are practical and produce observable results. In daily practice, he tends to be pragmatic and unimpressed by the polemics of theoreticians. Most physicians are aware that the ultimate scientific explanation of most of the treatments they use in daily practice will not be forthcoming in the near future. Practical considerations prevail when the physician is confronted by the sick patient.

### Practical Factors: Acceptability, Applicability, Cost, and Safety

The orthomolecular approach circumvents most of the public's objections to psychiatric treatment. Psychiatry has generally been accused of developing treatments which are totally impractical in that they are either extremely time consuming, expensive, and drastic, they produce serious side effects, they fail to produce results, or they are so objectionably named as to cause them to be rejected and resisted. In addition, many of the treatment modalities require a high degree of motivation, sophistication, verbal ability, and insight, and the absence of factors which would result in their not being accepted for a particular treatment. Intensive psychotherapy, for instance, exemplifies many of these objections, and in addition often results in alienation of the patient from the family, which in itself is an extremely serious side effect.

"Shock" treatment, by its very name, has such dread connotations that its applicability and acceptability have been seriously curtailed. Long-term hospitalizations for psychodynamic therapies are extraordinary in cost and disappointing in results. Imprudent publicity and actions by some agencies have caused many patients to be more concerned with side effects than they are with getting well. This has reached such a degree that recently a depressed patient who wanted to commit suicide was reluctant to take antidepressants because they might cause side effects! She was not even aware of the absurdity of her position, so deeply had this fear been embedded in her mind. Another block in reaching large numbers of patients is the idea that all psychotherapy is "Freudian." Schizophrenic patients especially are not enthusiastic about the prospect of having their personal privacy invaded by interrogation, especially when it does not pertinently relate to what they are experiencing.

In our experience with the orthomolecular-medical model-approach to a wide variety of patients representing the whole socio-economic scale, this treatment method has been extremely well accepted. The involvement of patients and their families in an integrated community system allows them to compare notes, observe results, and compare experiences of different treatment methods. This has had a remarkable effect on morale and cooperation and it results in a beneficial increase in education of both patients and their families.

Because return visits are widely spaced and diminish in frequency with time, this treatment method is economically feasible and compares favorably with more traditional ones. Patients feel that their illness is being monitored by some objective means rather than by just the subjective opinion of the psychiatrist or family.

The treating psychiatrist has objective data upon which to base treatment and verify results so that this treatment method is also well accepted by the professional. In addition, the treatment method can be used in private, hospital, and clinic practice

and is suitable for treating large numbers of patients at significant savings in cost and manpower.

The safety factor is considerable, and this is important in our present society. Because psychotherapy with this treatment system is aimed primarily at educating and increasing the understanding of patient and family, disruption of the family is not a side effect of treatment. Patients are not advised to leave the family unit, because the family is not viewed as pathogenic. A recovered patient may decide to leave a family unit because he feels that the particular family structure is deleterious to his recovery, but that is an individual matter which may be handled by family therapy. In our experience with this method, in the majority of instances when the patient leaves the family unit it is because he is well enough to make it on his own. As patients recover, they develop insight into the fact that the illness caused perceptual distortions, and that many of their perceptions of family interaction were distorted and subsequently remained in that form in their memories. Recognition of this results in reconciliation with the family more frequently than disruption. The storing up of distorted memories of a family interaction has been described by others, including Rubinfine (1971), who stated that

schizophrenics suffer impairment of consciousness from infancy onward so that percepts are registered in this altered state and memories from this state of infancy onward are impaired. These distorted perceptions become openly evident in the decompensated state and treatment requires correcting these altered percepts.

The side effects that we have observed in treating over 5,000 patients with megavitamins have been minimal and minor. We have seen no side effects from vitamin E except for loose stools in one patient. Pyridoxine has not produced side effects in any case. Vitamin C in the routine dosage of 4 grams a day has not resulted in discernible side effects. Although loose stools are supposedly a possibility, we have not observed this. We have three patients with a history of gout on 4 grams per day and there has been no increase in uric acid level, nor attacks of gouty arthritis. There is serious doubt as to whether ascorbic acid produces any significant incidence of side effects. This was reviewed in an article on the subject in *World Medical News*, Vol. 12, Issue No. 8, February 26, 1971. Patients who were pregnant were continued on megavitamins with no untoward effects on either the mother or the baby.

Niacinamide in a dosage of 4 grams a day can produce nausea in a few patients, usually adolescent girls. This can be circumvented by the use of buffered niacinamide in capsule form, the addition of one tablet per day of meclazine (Bonine<sup>®</sup>), or by lowering the dosage.

The side effects of niacin have been extensively reviewed in articles by Hoffer (1969), Mosher (1970), and Boyle (1968); the contraindications remain those of duodenal ulcer, hypertension, gout, and diabetes. If niacin is not used in these conditions (although it can be with adequate medical controls) the only side effects seen are those

of the initial flush and occasional nausea. The flush can be diminished by taking the full starting dosage of 1 gram four times a day with meals and a glass of cold milk in the evening, or by premedicating the patient with cyproheptadine (Periactin<sup>®</sup>). The flush disappears in 24 to 36 hours and is hastened by raising the dosage rather than by lowering it (on a low dosage, patients will continue to flush indefinitely). Inasmuch as the flush is due to a release of histamine from the mast cells, the histamine is sufficiently "washed out" after a day so that insufficient histamine is released by subsequent doses to cause further flushing. Nausea can be controlled by the same measure as with niacinamide. An inositol salt of nicotinic acid, available in Canada as Linodil<sup>®</sup>, also effectively circumvents nausea. Young patients, especially those with red hair and fair complexions are least tolerant of niacin and may develop a recurrent itchy rash requiring its discontinuance. The niacin flush may also produce heartburn or other gastrointestinal symptoms in a minority of cases, also requiring its discontinuance. Niacin may also give false positive liver enzyme tests and should be discontinued two days prior to the testing procedure. It will also cause hypoglycemic changes in the glucose tolerance curve, and accordingly should not be given for 48 hours before that test.

We have seen patients who have taken 20 to 40 grams of niacin daily for prolonged periods with no adverse effect. In general, as both Hoffer and Mosher conclude, and our experience corroborates, niacin appears to be relatively harmless as long as due caution is taken in avoiding its use in the presence of the aforementioned contraindications.

Administratively, the orthomolecular approach provides several sizable advantages. The cost, waiting time, and professional manpower for psychodiagnostic testing are greatly reduced. Psychiatrists can handle large numbers of patients without any special equipment, although having one's own biochemical laboratory is a distinct advantage. Continuity of treatment is not interrupted when there is a change of doctors, which is a frequent circumstance in clinics and hospitals and one that poses difficulties if the therapy is based primarily on psychotherapy. The treatment method results in enormous economic advantages in that seeing a patient once a month costs about one-twelfth as much as seeing patients three times weekly for long-term therapy.

Joining Schizophrenics Anonymous and taking part in the activities of the schizophrenia associations further reduces costs in that they supply specific group therapy at no cost to the patient. When the cost of treatment in the average case is prorated over a three-year period the annual cost of treatment itself will amount to only a few hundred dollars, which compares very favorably with any other available treatment system. Even in those cases where hospitalization is necessary the comparative cost is still relatively low because the average duration of hospitalization with this treatment method is only 8 weeks, and rehospitalization is seldom necessary except in a very chronic and severe case where the patient has been ill since childhood.

Because this treatment method utilizes objective monitoring of the patient's response, it facilitates reporting of improvement by treatment agencies, and this may become of progressive importance. In New York City, for instance, all mental health agencies contracting with the City's Funding Agency must now demonstrate tangible outcome of treatment to justify funding. With this treatment system, response to treatment in individuals or groups can be demonstrated even before the patient's behavior begins to reflect that improvement. The following case is an illustrative example:

A 34-year-old housewife developed schizophrenia postpartum. She had been hospitalized and then treated unsuccessfully for two years. When the patient applied for treatment at the clinic she was depressed and relatively immobilized, with a HOD score of 110. On a treatment regimen of megavitamins, hypoglycemic diet, phenothiazines, antidepressants, and supportive therapy, she clinically remained essentially the same, with neither symptomatic nor behavioral improvement.

Serial HOD testing showed, however, that the score was coming down progressively. It was not until the fourteenth month of treatment, when the HOD score got down to 30, that her symptoms finally disappeared and she resumed total functioning. Two months prior to her behavioral recovery the question of hospitalization had arisen. Because of the trend of the HOD scores, however, hospitalization was not advised, as it appeared to be only a matter of time before the HOD score would finally reach the level where recovery would occur.

In this case, several important things were demonstrated. First, an unnecessary hospitalization was avoided, but had it occurred her recovery two months later would have been falsely attributed to it. Second, a behavior rating scale or multiple interviewing techniques would have erroneously concluded at the end of the first year of treatment that she was no better, when in fact the basic disease process was considerably improved. The obverse is also true, in that, for instance, many patients have worked the very day they committed suicide, and the HOD score could have picked up the increasing severity of their illness despite behavioral status quo. The pressures in our society toward normal behavior are so enormous that relatively normal behavior may still occur in the face of *serious* degrees of illness.

### Evaluation of Effectiveness

In view of the previously described difficulties in evaluating treatment results in schizophrenia, a variety of ways of demonstrating the effectiveness of this treatment approach can be described in terms that are appropriate for different settings.

## OFFICE PRACTICE

The only absolute control which meets all of the essential criteria is the utilization of the patient as his own control. This also eliminates the problem of placebo or transference responses. In this regard, it is useful for the physician to select from his own practice patients with whom he has become familiar, whose failure to recover despite all previous treatments had been personally observed, and about whom he has collected a great deal of subtle and usually unreported data. A change in the patient's response then becomes readily apparent even though transmission of this observation to others may only sound anecdotal and be difficult to demonstrate convincingly. The following two cases are illustrative:

*Case No. 1:* This 33-year-old housewife and mother of three young children had been overtly and severely psychotic with schizophrenia for five years. The family had unlimited means and provided her with the best of professional help. She had been in a number of hospitals and was treated by many highly qualified psychiatrists. She had had all the psychotropic drugs in massive doses and in multiple combinations, as well as several courses of electroshock therapy. Despite all this, her condition became progressively worse. She was openly delusional, suicidal, out of contact, and irrational.

Because of the hopelessness and severity of her condition, a prefrontal lobotomy was finally advised and it was scheduled to be performed. At this point, the family asked if she could be given a trial of megavitamin therapy before resorting to the drastic surgical procedure. The reply was "Lobotomy, yes—niacin, no!" The family then had the patient transferred, against medical advice, out of the hospital and had her admitted to the Brunswick Hospital. The patient was not at all happy about the transfer; she did not like the new hospital, did not believe any treatment would help, and did not like the new doctor—she did, however, agree to take the prescribed medications.

On a combination of megavitamins, thyroid, hypoglycemic diet, and a small dose of tranquilizers, she recovered in 10 weeks. She was discharged from the hospital 4 years ago and during the intervening time has returned to full normalcy, including taking care of her children, running her household, and becoming active in the PTA and other social activities. In addition, she is working at a part-time job. She is seen for after-care visits at the clinic every four months. She looks well, feels well, and has no symptoms. During February 1971, she was interviewed by a correspondent on CBS News on nationwide television and she gave no sign of ever having been ill.

*Case No. 2:* A 24-year-old unmarried, unemployed young woman with a diagnosis of borderline paranoid schizophrenia had spent 10 years in weekly psychotherapy during which time she had three different therapists. Despite everything, she remained "half well" in that her borderline paranoia prevented her from holding a job, keeping a boyfriend, or making close friends. She stayed home and bemoaned her fate that she would always be disabled and would never be able to get married. She felt herself to be a social fifth wheel and an embarrassment to her family, who belonged to a subculture in which for a young woman of her age to be unmarried was a social disgrace. All of the psychodynamic possibilities had been repeatedly explored, but her condition remained static. In addition to different phenothiazines, a variety of medications had

been tried. She usually had unpleasant side effects and her attitude toward medications was suspicious.

At this point, the therapist put her on a sugar-free diet with no explanation, except that it might help her to take off weight. She was also placed on the megavitamin regimen with the explanation that vitamins might give her more energy. Because she suffered from apathy, listlessness, and hypochondriasis, she agreed. Within a few months she began to demonstrate a different emotional tone and lost the hostile, paranoid edge in her interactions with others, so that for the first time in her life she made a friend. Soon after, also for the first time, she was able to keep a boyfriend (prior to this time she had gone out with many young men but she was so hypercritical that seldom did they call her for a second date).

She now was able for the first time to hold a job and get along with her superiors. In the past she had always become paranoid and had either been fired or quit in a huff. She subsequently married, now has two children, and functions normally as a housewife. All medications were prophylactically temporarily increased after the birth of each child to prevent a postpartum episode.

To the clinician then, the efficacy of a new treatment method is most convincingly evidenced by a clinical response in patients who have failed to recover by all previously tried methods.

#### HOSPITAL PRACTICE

Changes in the collective HOD scores of groups of patients demonstrate the effectiveness of a given procedure. A research project done at the Brunswick Hospital demonstrated the usefulness of this method in determining the effect of ECT in the treatment of schizophrenia (Chiossone et al., 1969). In this study, all patients were given both the HOD and OIT tests on admission and again on discharge. The same patients were also evaluated on a clinical rating scale and although there was no statistically significant difference between the two groups at the time of their discharge as far as their degree of recovery, suitability for discharge, and scores on the rating scale, the HOD scores demonstrated that there had been a marked difference in response to treatment.

All patients were treated with phenothiazines, megavitamins, accessory symptomatic medications, group therapy, and all the other usual adjunctive measures, with the exception that 85 patients received ECT and 55 served as controls. When the results were tabulated and graphed, the very significant effect of ECT was observable. This was most marked in the younger age groups (Fig. 30-1).

Figure 30-2 shows the effect of ECT as compared to the control group by graphing only improvement in the percentage of scores above the median on the perceptual subscale of the HOD test.

Figure 30-3 graphs the same results, except that the improved scores have been obtained by totalling the paranoid and perceptual subscales. The purpose of comparing these subscales with the total scores is to eliminate the effect of improvement

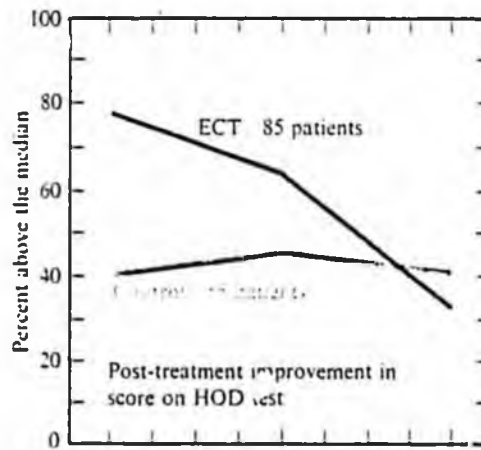


FIGURE 30-1.

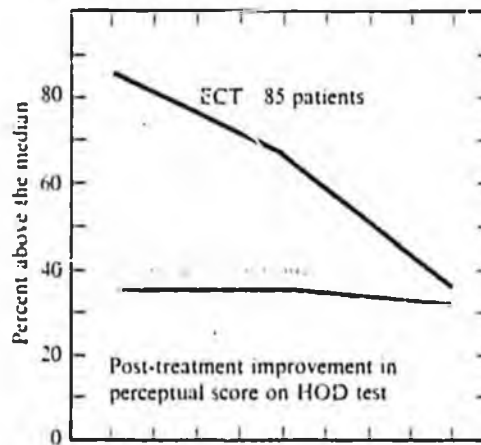


FIGURE 30-2.

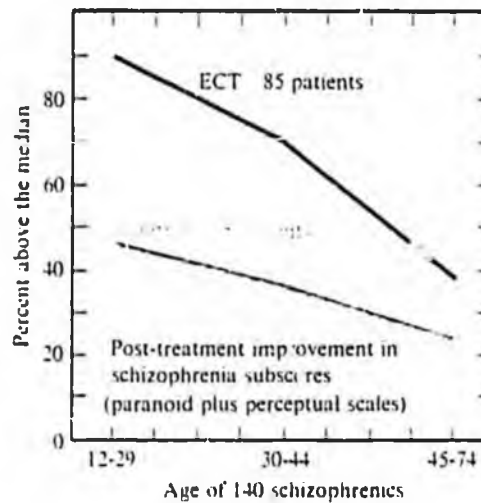


FIGURE 30-3.

in the patient's depressive subscales, as depression in and of itself is not intrinsic to the schizophrenic process and is often only reactive. By eliminating the depressive subscale, comparison of the two groups demonstrates the substantial benefit of ECT in the young schizophrenic and it demonstrates that this is not due to the alleviation of any accompanying depression, but rather to an alleviation of the schizophrenic process itself.

Without the use of the HOD test, this marked difference could not have been demonstrated as rating scales based on behavior showed no difference between the two groups. This study again supports the view that schizophrenia is both an inner experience and a perceptual disorder and not just abnormal behavior, arbitrarily labeled as schizophrenia.

In reporting the above data, a method was selected to by-pass rater bias and to demonstrate that behavioral rating scales would have been grossly misleading. Also, it was assumed for purposes of this study that the patients were in a worsening condition with a rising HOD score at the time of their admission to the hospital. In addition, all patients were on the same diet and all patients were seriously ill. This type of reporting of data is suitable for evaluation of the effectiveness of a treatment which has a rapid response. During a short-term hospital stay it would be impossible to evaluate the effects of other treatment measures such as the use of thyroid or megavitamins, which usually take a few months or even six months to a year to demonstrate results.

A follow-up study was conducted at the Brunswick Hospital during a two-year period to determine the effects of the continuance of megavitamins on the recovery rate (Hawkins et al., 1970). So that results of the study would be comparable to other follow-up studies reported in the literature, it was arbitrarily decided to use the rehospitalization rate as evidence of response, as that is the most frequently cited criterion. The pros and cons of utilization of rehospitalization rates have been well discussed over the years and will not be cited here except to say that in a practical way it represents the resultant of many factors, including social survival. The study included 140 patients who had been hospitalized because of severe schizophrenia, during which time the patients were hospitalized for an average length of 8 weeks. While in the hospital, all patients received phenothiazines, megavitamins, and adjunctive therapy. The diagnoses were confirmed by HOD testing and no cases were included in which there was doubt about the diagnosis. At the time of discharge from the hospital megavitamins were discontinued in 85 patients. The remaining patients were subdivided into subgroups taking the megavitamins for periods of three months or for one year. Tabulation of the rates of rehospitalization (to any hospital) over the two-year period of study revealed that among the control group, in whom megavitamins were discontinued, 35 percent were rehospitalized. Of patients who continued on the megavitamins for three to six months, 25 percent were rehospitalized. The rehospitalization rate for the patients who stayed on megavitamins for one year

or more was 16 percent (9 of 57 patients). The  $\chi^2$  score value for this comparison is in excess of the 5.99 required for a significance at the 0.05 level, indicating a definite correlation between the continuation of the megavitamin therapy and a 50 percent lower readmission rate than for the patients in the control group.

#### CLINIC PRACTICE

In a clinic setting it is possible to follow large numbers of patients for a considerable length of time and also to observe subgroups in which schizophrenia is associated (for example, with alcoholism, drug abuse or homosexuality). In evaluating a new treatment method, several of the most common sources of evaluative error need to be eliminated—rater bias, placebo reaction, and positive transference “cures.”

Placebo effect can be eliminated by studying patients who have had many trials over the years on multiple drugs without success and also by waiting for a year to pass before evaluating results. Rater bias can be bypassed by objective testing, such as the HOD test. Other objective data can also be used, such as achievement of sobriety by the alcoholic, discontinuance of drug abuse, cessation of homosexual activity, return to college, or whatever criteria are appropriate to the sample being studied.

Positive transference reactions can be eliminated by a variety of techniques which are also applicable to private practice. Using patients as their own controls is obviously the best. Looking for a difference in recovery rates between patients who have a positive transference and those who have a negative transference is another common-sense approach. In actual practice, treating large numbers of patients who are chronically ill and who have had a number of therapists and many different drugs eliminates most doubts, as it is obvious that if they were prone to placebo or transference cures they would not still be ill. There is really no answer to the question of spontaneous remissions except that in the comparison of large groups of patients over many years it can be assumed that the spontaneous remission rates in both groups will have equalized.

One criterion for the effectiveness of a medical regimen is the response of the patient when it is discontinued. Another way of ascertaining the specificity of a treatment modality is to determine the type of case or disease entity where it does not work. In schizophrenia, which is most likely a group of different biochemical illnesses, evaluation of drug studies requires clinical interpretation. As an example, if the effectiveness of a given antibiotic in treating pneumonia is reported in percentages, it can well be that of all pneumonias treated by a given drug, only 10 percent might respond. This might be taken to mean that the antibiotic is only 10 percent effective, and therefore hardly warrants marketing. The clinical fact may be, however, that the 10 percent represents a particular type of pneumonia for which the particular antibiotic is close to 100 percent effective and is in fact specific for that type of pneumonia but not for others. It would appear that in the psychiatric

literature similar conditions prevail. The importance of some of these factors was pointed out by Fritz Freyhan in his presidential address to the American Psychopathological Association. The influence of the double-blind study on the actual practice of clinical psychiatry has been curiously nil. Not a single treatment used in psychiatry was discovered by the use of the double-blind method, with one single exception—the first double-blind study done in psychiatry (actually it was a triple-blind study), devised by Hoffer and Osmond to study the effect of niacin in schizophrenia, and the results of this meticulous, long-term study were generally ignored for some years (see Chapter 10 by Osmond on the history of the niacin treatment).

In reporting data, then, the clinical researcher is confronted by a communications problem (Heston, 1970). We have found that the most useful style of reporting results to other clinicians is in terms of definite observations that include enough data about the circumstances to allow the results to be duplicated. To report the total clinical experience of treating 5,000 schizophrenic patients with a new treatment method involving a new conceptual framework over a five-year period presents sizeable difficulties. Because the setting itself influences treatment results, some general description of the situation in which a clinical experience takes place will be described.

The clinic itself is situated in a very informal setting, above a set of stores, and is innocuous and unforbidding in appearance. Each office is decorated differently so that a schizophrenic patient is unlikely to feel depersonalized or lost. The informality extends to the waiting room which lends itself to conversation and is friendly rather than institutional in style and atmosphere. It is not the kind of place where a patient is likely to feel like a number. Each patient and family becomes aware that specific arrangements are being made for them individually. Over the years, many of the families and clinic staff have had meetings under a variety of circumstances and have developed a certain community feeling and mutual concern. To some degree, the well-being of each patient then subsequently becomes part of the total community concern, so that if a given patient is not doing well there is an immediate feedback. This is a unique situation and although it exerts considerable pressure on the staff, it also results in a certain enthusiasm and a heightened therapeutic intention. There is an expectation that every patient is going to improve sooner or later, therefore any self-fulfilling prophecies that occur are likely to do so to the patient's benefit.

The patient most likely to respond to this overall treatment regimen has an elevated HOD score and a discernible perceptual dysfunction. These represent the majority of patients and most of these patients will have improved or recovered by the end of a year. The patients who fail to improve are, as stated previously, usually those in whom the onset was in early childhood, and they are further characterized by low HOD scores, primarily visual distortions, and the stilted postural attitudes indicative of an underlying proprioceptive disorder of long duration. This latter group constitutes the

minority of patients, and of them only about half will improve.<sup>5</sup> Also, they do not show the complete recovery which frequently occurs in the more favorable group. Even so, the improvement may be in areas which are extremely important to patient and family, so that limited improvement may still be of considerable importance. The following case is an example:

A 30-year-old chronic schizophrenic patient was brought to the clinic after having had 15 years of continuous prior treatment, including six hospitalizations where she had a full course of insulin shock treatment plus a total of 125 electroshock treatments. The family indicated that this was to be the last trial of treatment before they would reluctantly have to accept permanent state hospital placement for the patient. The family reported that she was incontinent, refused to wear her false teeth, constantly rocked, and was uncommunicative. She therefore presented a considerable nursing problem for her parents.

The patient was placed on an overall treatment regimen of hypoglycemic diet, megavitamins, phenothiazines, and thyroid. She responded very slowly, but by the end of two years her appearance was markedly improved, she used make-up, wore her teeth, spoke politely, had stopped rocking, and had long since been continent. The family was able to take her on social family visits, and could travel in public with her.

This patient was far from recovered, however, in that her affect was flat, her behavior was still moderately inappropriate, and her overall style was awkward and somewhat stilted, but her family was extremely pleased. The treatment also had been based on bi-monthly and then tri-monthly visits, which were within the family's financial capacity.

The megavitamin approach is effective in other conditions associated with an elevated HOD score, such as alcoholism or post-psychedelic drug reactions. It is the most effective treatment for post-LSD "flashbacks" of the type reported by Horowitz (1969) and far more efficient than psychotherapy (Hoffer, 1972). It also is of benefit to some hyperkinetic children and also to some with learning disorders (Rossi, 1967; Green, 1970, 1971). There are many adolescent patients who present a clinical picture of pseudo-psychopathic behavior due to an underlying, unrecognized schizophrenia disorder, and in these patients the behavior improves on the overall megavitamin regimen.

We have not observed any benefit from megavitamins on convulsive disorders but the hypoglycemic diet has helped several. Megavitamins are also ineffective in manic-depressive or other psychoses. They are also ineffective in the psychoneuroses. (Many "neurotic" patients, however, are greatly helped by the hypoglycemic diet—especially depressed, anxious, phobic, fatigued, irritable, or hypochondriacal patients. In many of these, the diet eliminated the need for psychotherapy.) We have

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<sup>5</sup> These results were confirmed by a research study conducted by the Institute for Child Behavior Research in which it was reported that 50 percent of the children responded to megavitamins (Rimland, 1970, 1972, and Chapter 24 of this book).

treated six patients with prior lobotomies and none of them responded to the treatment although their diagnosis was definitely that of schizophrenia.

The homosexual schizophrenic patient responds quite favorably, and by the end of the first year of treatment the majority report the disappearance of the supposed homosexuality. In these cases, no discussion of the homosexual pattern was entered into during the entire year and the recoveries from these patterns were reported spontaneously. It would seem that the perceptual disorganization impairs the self-image, including sexual identity. This was accompanied in these patients by regression and the development of pseudo-homosexuality, as has been described by Ovesey (1954, 1955a, 1955b). This was most likely to occur with male schizophrenics. Several female schizophrenic patients who were also alcoholic continued a homosexual life style despite abatement of the schizophrenic process.

Postpartum psychotic episodes were completely eliminated in our schizophrenic patients with this treatment method. By prophylactically increasing doses of medications immediately following delivery, this complication was prevented, which was in marked contrast to clinical experience of years past. On the other hand, several patients who had previously recovered and then stopped all medication became pregnant and did have postpartum relapses.

Therapeutic results do not depend on a positive transference. Its presence, however, is helpful, not so much to the eventual outcome as to the ease of clinical management of the case. We have treated a number of patients via family members and also by mail with results equal to those for patients seen in the clinic. The following case is an example:

A 44-year-old man with chronic paranoid schizophrenia of 10-years duration had been given up as hopeless after many years of treatment. The family kept him home in an upstairs room where his condition was disturbed and dishevelled. He screamed obscenities at his hallucinatory enemies, refused to change clothes, refused to take any medication, and exhibited no interest in external events. The family came to the clinic, learned of the megavitamin treatment and worked out a combination of vitamins titrated with bicarbonate of soda and flavored with chicory, which was then placed surreptitiously in all of his beverages.

After a few months he began to respond and improve, and at that point a small dose of thioridazine in liquid form was added to his formula. By the end of the year he had become a clothes dandy, carried on a normal conversation, was no longer hallucinating, was calm, read a daily paper, watched television, and answered the telephone. Two years later he continues to do well and is planning to live on his own, which has created apprehension with the family, as they are still reluctant to inform him of their secret treatment. When they finally tried to persuade him to take megavitamins he said he didn't think he needed them as he had been doing pretty well on his own for the last few years!

Getting patients to take the medication and stay on it is seldom a problem, especially after they have had an opportunity to experience subjective improvement.

A few patients who have recovered will feel so well that they will experiment with discontinuance of the therapeutic regimen and promptly relapse. One reason this occurs is that in altered states of consciousness there is difficulty in remembering what one has learned in another state of consciousness. This has also been demonstrated experimentally in animals and is a common clinical observation. This phenomenon does not appear to be attributable to the mechanism of denial, although that, too, may at times play a role. Recovery from relapses unfortunately is usually slower and more difficult than was the original recovery. This is more true in children than adults, however, and has been reported also by Cott (1969).

As patients recover, certain questions tend to recur. Many of these relate to the ability to concentrate and the question of when to return to college or work. Initially, when the patient's HOD score is high, his ability to concentrate is markedly impaired, and we usually ask patients if they are able to follow a story on television. When the HOD score is close to 100 this is usually not possible, but as the patients recover they will report that they are now able to follow the story, so this is a favorable indicator. It is usually some months and, in many cases, close to the end of the first year of treatment, before concentration returns to the point that the patient is able to remember what he has read, and we advise him not to return to college until this capacity has returned. We recommend that the patient take 6 credits the first semester and if that goes well, that he take 12 credits the following semester and then 15 credits thereafter. Allowing patients to return to school prematurely invites failure and discouragement.

Return to work, on the other hand, is quite different and this may occur almost immediately or as soon as the patient feels "up to it." It is a common observation then that the patient is capable of returning to work sometimes the very day following discharge from the hospital and yet he is unable to take evening college courses for a whole year.

As has been pointed out previously, we avoid invading the patient's personal privacy when his HOD score is elevated and interpersonal contact is painful. This saves a great deal of reparative work later which would otherwise become necessary to undo the deleterious effects of such intrusions. Where the patient has already had this unfortunate prior experience, some reparative therapy to the patient's damaged self-esteem may become necessary as he recovers. A patient's resentment over having had this experience forced upon him in the past can be amazingly severe.

Lastly, it is on the administrative level that the effect of the orthomolecular treatment approach first becomes most strikingly apparent. There is an almost immediate disappearance of waiting lists. There is a marked reduction of diagnostic testing costs and time. There is a progressive increase in the case load within the same budget and manpower limitations, and there is an overall improvement in treatment results which is expressed in a very positive feedback. The level of functioning in group therapy with schizophrenic patients increases noticeably to a higher level and the

percentage of patients who are capable of such interaction also increases greatly. The preoccupation is no longer with "keeping the patient out of the hospital" but rises to the level of counselling him about the advisability of seeking a better job at this time, or on the timing of an impending marriage.

Another response noticeable to administration is that sizeable numbers of patients who were on welfare at the time they began treatment will be off welfare by the end of a year, since their social disablement stemmed from a previously undiagnosed perceptual disorder.

#### GROUP AND HALFWAY HOUSE EXPERIENCE

All of the Schizophrenics / anonymous groups that did not use the orthomolecular-megavitamin approach soon failed and all the groups that were successful had taken the orthomolecular approach. In Alcoholics Anonymous, many members were unable to stay sober until they were placed on a sugar-free diet with megavitamins. In 1972, an estimated 20,000 to 25,000 alcoholics were taking megavitamins.

This approach is an integral part of the therapeutic regimen in many alcoholic rest homes. Of these, the most comprehensive and intensive therapeutic regimen is the one in use at Guest House, Lake Orion, Michigan, for alcoholic priests. In their experience, high-dosage megavitamins and hypoglycemic diets are critically essential in the recovery of a sizeable percentage of their alcoholics. It is notable that they achieve an overall recovery rate of 80 percent (Ripley, 1969, personal commun.).

A more elaborate study by Smith (1971) included 4,243 alcoholics. Of these, a group of 507 patients had been carefully followed for five years. All were long-time-treatment failures, and 400 of the 507 cases had been sober for two years and more, which is quite remarkable considering the severity of their condition. A formal cross-over double-blind study of two sanitarium groups will be completed in 1972. A full report of 3,673 patients will also be forthcoming. In this study, it can already be reported that niacin was superior in effectiveness to niacinamide.

Similar positive results were reported by Hawkins (1967) in the first group of clinic patients treated with this method. In that group there were 53 alcoholic-schizophrenic patients. By the end of a year, 41 patients were active in AA and 36 had achieved sobriety.

When the HOD test was given to residents at a halfway house for soft drug users (Kinsman Hall, New York), almost two-thirds were found to have abnormally elevated scores and they were unresponsive to the intensive therapy until placed on megavitamins (Palmer, 1970; Hepper, 1970, personal commun.). The experience of this halfway house could be expected from the work already done on the use of the HOD test with psychedelic-drug users by the LSD Rescue Service which is in operation in major cities throughout the United States (Peters, 1971, personal commun.).

The LSD Rescue Service has for years relied primarily on giving megavitamin doses and on attempting to raise blood sugar level to counteract adverse psychedelic drug reactions. It is notable that they have discovered that high doses of thiamine hydrochloride have been found to be beneficial in reducing the craving and return to the use of methedrine (speed).

The use of niacin and niacinamide in ameliorating LSD reactions is well known among the more knowledgeable members of the drug subculture and has been reported widely in the underground newspapers. *The Hippy's Handbook* (Bronsteen, 1967) details this use under "Rx for a Bad Trip" and also has this to say about psychiatry, "Without one single exception, every hippy interviewed had, at one point, gone to a therapist—in every single case the experience was negative . . . modern psychiatry is out of touch with young people. . . ." The "Practical Advice" section of Abbie Hoffman's *Revolution for the Hell of It* (1968) includes similar advice to avoid the psychiatric establishment and to use niacin or niacinamide for "freak-outs." The use of megavitamins for the "drug wipeout" is described in the Do It Now Foundation's *Conscientious Guide to Drug Abuse* (Pawlick, 1971).

The evidence then for the effectiveness of the combination of megavitamins and hypoglycemic diets in correcting perceptual disorders, whether they are associated with outright schizophrenia, alcoholism, or drug use, is derived from widespread experience in a variety of patient population groups and settings.

We can compare the results of this treatment with statistics as given by authorities in the field of schizophrenia. For instance, the Chief of the Center for Studies of Schizophrenia for the National Institute of Mental Health, Dr. Lorin Moshier, indicates that only 30 percent of the patients who develop schizophrenia are able to return to work, and according to Caffey et al. (1970) only 15 percent of patients who had been hospitalized for any appreciable length of time ever function in a completely normal way thereafter. Statistics from the New York State Department of Mental Hygiene indicate that 55 percent of patients hospitalized for schizophrenia are readmissions and in this percentage are many patients with multiple rehospitalizations. As compared to these overall large-scale statistical guidelines, it would appear beyond any doubt that the orthomolecular psychiatric approach offers substantial and valid hope to patients and family. As the number of patients increases, the development of an integrated community system for the treatment of schizophrenia evolves to meet the growing needs of the patient population. The strength of the system, however, relies entirely on demonstrable results.

## SUMMARY

Following the diagnostic process, the patient is given the results of the tests and the diagnosis, along with an explanation of his illness based on the orthomolecular

medical model and the significance of his perceptual disorder. The patient is then placed on a medical regimen consisting of a hypoglycemic diet, prescribed rest and exercise, phenothiazines, and other ancillary medications and megavitamins. The importance of detecting and treating functional, relative, or absolute hypoglycemia is stressed.

While the HOD score is elevated, psychotherapeutic intervention is kept to an absolute minimum. Those problems that still remain after the HOD score has returned to normal may be dealt with by psychotherapy if the patient is so motivated. Recovery is facilitated by the use of ancillary measures such as SA, group therapy, family therapy, AA, halfway houses, or specialized drug groups. Case histories and vignettes are used to explain and illustrate many of these principles. Evidence is reviewed to corroborate the experience that psychodynamically oriented psychotherapy does not influence the basic disease process itself to any statistically demonstrable degree.

The patient group most responsive to the orthomolecular approach is identified by an elevated HOD score, which demonstrates perceptual dysfunction. The majority of these patients recover by the end of the first year, re-enter life's activities during the second year, and in the third year are able to function on a higher level than they were before they became ill. We have not seen this response with any other treatment method.

The general problems inherent in evaluating the results of treatment in schizophrenia have been briefly surveyed and an attempt made to report a huge mass of data in terms which are useful to the clinician.

The orthomolecular approach is very practical. There is a high degree of acceptability and it is suitable for a wide range of applications in a variety of settings such as private practice, hospital, clinic, halfway house, and a diversity of groups. Because patient visits are widely spaced, there is a great saving in cost, not only to the patient, but also to the institution. With proper safeguards, there is an ample safety factor. Medical contraindications to the use of certain vitamins in high dosage are enumerated and toxicity is reviewed. The positive safety and cost factors are augmented by the establishment of a specialized laboratory.

We have described the effectiveness of this overall treatment approach with several thousand patients over a five-year period. Its evaluation in private practice has been with an emphasis upon using the patient himself as the ideal control, and we have also discussed how this overall system is used in hospital practice. We included the results of a study utilizing group improvements in HOD scores to demonstrate the effectiveness of ECT. This study demonstrated the defect of behavioral rating scales and the marked effectiveness of ECT in amelioration of the schizophrenic process especially in the younger patient. The results of a two-year follow-up study to evaluate the effect of continuance of megavitamins on the relapse rate have been reported. Using the rehospitalization rate as the criteria of effectiveness, the control group had twice the relapse rate of the megavitamin group.

The patients most likely to respond to this treatment have elevated HOD scores associated with schizophrenia, or schizophrenia plus homosexuality, psychedelic drug abuse, or alcoholism. Although each requires different handling, the overall results are promising and the degree of positive response in the majority of cases was responsible for the development of an integrated community system for the treatment of schizophrenia. The system is related to a variety of other treatment settings where a large body of positive results with this approach have been reported over the years.

The overall results from such a wide range of clinical experience correlates with both theoretical formulations and laboratory research to establish a broad foundation for the concept of orthomolecular psychiatry.

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NUTRITION AND ORTHOMOLECULAR THERAPY

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## NUTRITION AND ORTHOMOLECULAR THERAPY

Nutrition is a branch of biology which studies the requirements for foods, their composition, and the processes by which they are converted into energy and the tissue growth and repair required for health and life. Prior to about 1750, nutrition was naturalistic and ethno-pharmacological. Plant and animal foods of unknown chemical composition were eaten in diets which varied greatly from culture to culture. Centuries of trial and error had demonstrated their value or danger. Certain foods were designated by Hippocrates to have special curative properties which were useful in the treatment of many of man's illnesses. Others were poisonous or taboned for unknown reasons. In the period from 1750 to 1900, as chemistry developed, foods were simply classified chemically as carbohydrates, proteins, fats and the non-combustible ash. Attempts to raise animals on diets containing only these quickly showed the inadequacy of this simple classification. The golden age of nutrition occurred between 1900 and 1950. When the need for micronutrients was discovered, a conceptual revolution occurred with the insight that much of man's illness resulted from the absence of significant dietary constituents. To the established infectious and toxic theories of illness were added the deficiency diseases. With the discovery of vitamins, essential amino acids and trace elements, the nature of common diseases like pellagra, beri beri, scurvy, nutritional anemia and protein malnutrition were quickly understood. The development of quantitative standards for daily requirements of these nutrients for man, animals, and plants stimulated revolutionary changes in food production and several major public health triumphs. It is difficult to recognize that less than 50 years ago there were more than 200,000 cases of pellagra annually in this country. Mortality from this illness averaged 33% and about 10% of the beds in insane asylums

the country were occupied by demented patients with this illness. In the South, where pellagra was endemic because of the staple diet of corn, fatback and molasses, from 1/3 to 1/2 of the state-mental hospital population had physical symptoms of pellagra and dementia (1). Pellagra was also very common among sharecroppers and in prisons, orphanages, and other state institutions. The discovery in 1937 that vitamin B<sub>3</sub> (niacin) was the antipellagra vitamin and the subsequent fortification of most cereal products with this vitamin made pellagra virtually absent in this country. Clinical nutritional research was greatly accelerated in World War II because of the need to develop adequate military rations. It led to the semi-quantitative determination of human needs for most nutrients. It was so successful that World War II was the first war in which more combat troops died from war injuries than from malnutrition and infection (2). The spin-offs to civilian nutrition were large. Today, nutritional science is sufficiently advanced so that, in this country, malnutrition is uncommon and when it does occur, it is likely a function of poverty, alcoholism, or self-selected inadequate diets. This is not true in the Third World where millions of children are stillborn, retarded, or die within the first few years of life because of the unavailability of adequate calories, protein, or micronutrients (3). In the world as a whole, malnutrition today remains as large a public health problem as infectious disease with which it constantly interacts.

In the richer, industrialized world, research in nutrition has moved into more specialized areas. In medicine, there have been significant advances in the study of the nutritional needs of special populations like pregnant women, premature infants, and the elderly. Vitamin requirements have been shown to increase when some drugs are administered for treatment of tumors, convulsions,

or even contraceptive purposes (4). Great advances have been made in furnishing the nutritional requirements of postsurgical patients or those with severe burns by total parenteral feeding. Specialized nutritional needs have been found for some patients with ophthalmological or dermatological disease. Genetic illnesses, like phenylketonuria, have been found to be clinically responsive to minimizing the intake of the amino acid phenylalanine. Rare genetic autosomal recessive illnesses characterized by mental retardation and multiple somatic defects have been found. These can be prevented or cured by the daily administration of very large quantities of particular vitamins (3,5,6).

Nutritional theories of the etiology of common mental illness and behavior disorders and treatments based on these theories are very controversial.

Nevertheless, new diagnostic methods have shown that several psychiatric illnesses may be complicated by nutritional deficiency and may respond to nutritional supplementation. We shall discuss these below. These are all reviewed in an excellent text, Nutritional Support of Medical Practice (7). A comprehensive review is offered in the five volumes entitled Nutrition and the Brain (8):

Many natural foods, especially those from plants, contain chemicals which are biologically active and may be either toxic or therapeutically useful. Many of these substances have been identified and isolated in pure form and now are useful products in our pharmacological armamentarium. In the industrialized world, food chemists supplement natural foods with nutrients and also with natural and synthetic additives which enhance the taste and appearance of foods and diminish spoilage, thus enhancing their useful distribution. Residues from synthetic herbicides and insecticides used to increase crop production and steroids and

antibiotics used to increase animal food production may appear in our food. Because of this, there has arisen the quasi-nutritional subspecialty of nutritional toxicology designed to protect the public from foods which might contain dangerous chemicals like mercury in fish or selenium in wheat or foods to which chemicals are purposely added during processing. There has also been increasing interest in what might be called nutritional pharmacology. Selected, specific nutrients like the amino acids tyrosine and tryptophan or the quaternary ammonium compound choline can be fed in doses greatly above their usual intake levels in order to elevate neurotransmitters in the brain. Such precursor therapy is actively under investigation and its interest to psychiatry will be discussed below. Although the substances used are natural and even essential in our daily diet in small quantities, quantities employed in precursor therapy are so much greater than are ordinarily required that we choose to call the use of the substances in these quantities "pharmacological." Moreover, their biological effects at high concentrations may be different from and unrelated to their primary action. For example, nicotinic acid and nicotinamide have identical nutritional value as vitamin B<sub>3</sub>. In very high doses, nicotinic acid causes vasodilation and lowers blood cholesterol; nicotinamide does not. These actions of nicotinic acid at high doses are considered pharmacological (9).

There is also included under the rubric of nutrition, the study of food allergy and hypersensitivity to either specific foods or to commercial additives. Reactive hypoglycemia, generally attributed to the use of high carbohydrate diets which result in the over-production of insulin which, in turn, leads to hypoglycemia has also been studied in relation to clinical states as diverse as panic disorders, depression, and aggression leading to crime and delinquency (10,11).

Along with the slow, cautious, and steady advances in nutrition, there continues to be what we call "pseudonutrition". Nutritional fads have been promulgated in the lay press, in books, and in a few journals. These attribute many common somatic and psychiatric complaints to inadequate or toxic diets. They promise much: enhancing longevity, diminishing the risk of, or improving the treatment of cancer, heart disease, and the major mental illnesses with appropriate dietary therapies. These generally unproven treatments are especially popular among those with illnesses which are chronic and for which conventional medical or psychiatric treatment is slow, not yet fully adequate, and often, expensive. Patients with cancer and mental illness seem to be extraordinarily susceptible to seduction by these claims. Substantial efforts and quantities of time and money have been spent in scientific trials to test the claims of nutritional faddists. Despite many negative results, the claims persist. We shall, therefore, devote some time and space to a discussion of the theory which underlies the claims of the therapeutic value of orthomolecular psychiatry, additive free diets, hypoglycemic diets, and diets designed to eliminate substances to which patients claim to be hypersensitive and which they feel may cause the major mental illnesses.

## Nutritional Principles

Man, as an evolutionary product of the animal kingdom, has nutritional needs similar to those of other mammals. The complex foods he eats are digested to simpler molecules which are then absorbed and resynthesized under genetic interactions to the multitude of compounds of which he is made. Maintenance of body temperature, movement, growth, repair and reproduction require energy supplied mainly by the oxidation of carbohydrate and fat. Metabolic end products like exhaled carbon dioxide or urinary nitrogen metabolites need constant replacement from dietary intake. Even the body minerals are constantly turning over metabolically and must be replaced by ingested food. For growth and development, a positive balance of calories and essential nutrients must be supplied. For adult maintenance the balance should be zero. Control of appetite and food intake involves a complex set of sensors and feedback systems in the brain and endocrine organs which are beyond the scope of this chapter.

Despite the capacity of each species to synthesize the myriad of compounds unique to it, some things must be supplied in the diet. These include water, the major anions and cations of the cellular fluids and skeleton, and trace elements like copper, manganese, cobalt, fluorine, vanadium, selenium, and zinc. Ten amino acids cannot be synthesized and must be furnished. They are needed for the synthesis of proteins and other nitrogenous compounds. Thirteen vitamins are required, four of these are fat soluble, eight are members of the vitamin B complex and vitamin C is uniquely required by man, primates, the guinea pig, an East Indian bat, and a bird. It is a remarkable testimony to the synthetic capacities of the body that the thousands of compounds of which we are made can all be synthesized from approximately two dozen organic compounds furnished in the diet.

Several features of man's nutrition deserve comment. First, as mentioned previously, he is quite rare in requiring vitamin C. The evolutionary purpose of this is not known. Second, he is an omnivore who eats a greater variety of foods than any other known species except perhaps the rat. Undoubtedly, this offers a great evolutionary advantage since it permits man to survive on the indigenous food of any region on earth. Third, he is apparently the only species whose choice of diets is determined by taste, smell, color, appearance, and even texture. He is the only animal for whom eating is both a necessity and an aesthetic experience. In contrast to most animals who eat the same food every day of their lives, man constantly seeks variety and, whenever possible, gets it. The aesthetic qualities of food have had interesting social consequences. For example, it may be argued that Columbus discovered America while looking for food additives; that is, the spices that help to preserve food and enhance its taste and color. In the industrialized United States, food companies compete vigorously to produce products which are more attractive than their competitors even though they are nutritionally equivalent. This is done with food additives. Many of the food fads are based upon presumed, but unproven, hazards created by commercial food processing. Man still attributes to foods magical properties which can hurt or help him.

Fourth, the precise nutritional requirements for man are less well known than they are for the domesticated animals which supply his food. There are several reasons for this. Experiments can be done on food animals which cannot be done safely with man. Animals are bred to be genetically homogeneous and efficient in their conversion of food to milk, eggs, or edible animal protein. Their daily activities and energy output are much more closely regulated than are those

of man. Finally, the economics of the food industry make it essential to know the minimum food requirements of animals for maximum growth and marketability. Despite the difficulties in precisely determining the nutritional requirements of man, reasonable estimates have been made since 1941, by the Food and Nutrition Board, National Research Council of the National Academy of Sciences. These are revised every five years; the 9th edition (121) was published in 1980. It offers recommended daily allowances (RDA) for calories, protein, minerals, and vitamins for men, women, and children. The RDA are not minimal requirements. Recognizing substantial variance in man's nutritional needs because of genetic heterogeneity and living habits, they are calculated by the Board to exceed average nutritional needs by a "safe margin" allowing for individual differences in a basically healthy population. The magnitude of the safety factor is substantial. For example, the minimal requirement for folic acid is estimated to be about 50 micrograms per day; the RDA is 400 micrograms. The RDA has been accepted by the American Medical Association (122) and is used by the Food and Drug Administration for food labelling. It is also the basis on which the Department of Agriculture and the United States Public Health Service established national food programs and nutritional educational programs. The RDA can be found in most standard texts of medicine, pharmacology, and biochemistry (3,4,7).

In an affluent society, man's omnivorous appetite and his wish for variety makes it easy to obtain a nutritionally sound, balanced diet. RDA requirements are generally met by diets which offer a mixture of four food groups in adequate proportions. These groups are (1) Fruits, vegetables, and fruit juices; (2) Grains and grain products; (3) Meats and meat products; (4) Milk and milk products.

Such diets offer adequate nutrients as well as taste and variety. When they are consumed, vitamin or mineral supplementation is not required. Impoverished populations here or abroad who subsist largely on grain and who have no variety in their diets generally need supplementation with vitamins, minerals, and other proteins.

Under special conditions of illness, severe dieting, heavy alcohol consumption, stress, pregnancy or lactation, supplementation may be desirable with modest quantities of vitamins. Massive supplementation with megadoses of vitamins is required only in three conditions. (1) In the genetic vitamin dependency or insufficiency illnesses, (2) When there are transport difficulties for nutrients in the gut or across other cell membranes, and (3) When antivitamin antimetabolites are used as in the treatment of cancer.

Some orthomolecular psychiatrists believe that the brain may have nutritional requirements so much larger than the other body tissues that cerebral avitaminosis may exist and may account for much major mental illness.

But, malnutrition generally produces mental changes along with somatic changes like weight loss or anemia. In early or minimal nutritional deficiencies mental changes may occasionally appear before readily observable physical changes ensue. But, careful examination will reveal lowered blood or tissue levels of vitamins or minerals. The mental changes associated with vitamin deficiency are nonspecific. Perusal of the literature shows that weakness, irritability, anxiety, anorexia, lassitude, depression, apathy, anergia, headache, dizziness and inability to concentrate have been reported in subjects or patients with mild deficiency of any of the water soluble

vitamins. When the deficiency is severe, memory loss, disorientation, delusions, hallucinations, and other signs of dementia may appear.

Clinical ecologists, advocates of the Feingold diet, and some orthomolecular psychiatrists believe that in some individuals, the brain may be uniquely allergic or hypersensitive to certain foods, food additives, or other environmental chemicals. Such hypersensitivity is considered by them to be related to hyperkinesis in children and a variety of illnesses including schizophrenia, depression, anxiety, drug addiction and antisocial behavior.

But, allergy or hypersensitivity when it exists involves the whole body and is manifested by physical symptoms like asthma and urticaria as well as by nonspecific mental complaints.

In the following sections we shall discuss: Consequences of protein calorie malnutrition, psychiatric manifestations of deficiencies of some of the B complex vitamins and the use of amino acids in pharmacological doses as precursors of neurotransmitters. Finally, we shall devote the remainder of the chapter to an examination of what we call "pseudonutrition" in relation to psychiatric practice.

## Protein Calorie Malnutrition

Many studies conducted in impoverished societies have shown that severe, prolonged protein calorie malnutrition is especially devastating to infants and children and that the consequences are prolonged and likely irreversible. The results of such studies have been summarized in several excellent monographs derived from international conferences on this subject (12,13). The reasons for this high vulnerability is the rapid growth of the human brain in infancy and the effects of malnutrition on its growth and development. Winnick (14) has shown that, in the human, the number of brain cells increases linearly from gestation until birth and then more slowly until about 10 months of age, at which time it virtually stops. Cell size, in contrast to cell number, continues to increase for several years. Myelination occurs rapidly at birth and is still occurring at two years. The weight of the brain increases rapidly through gestation and the first two years of life, its rate of growth diminishes thereafter, but adult weight is not reached until adolescence. Studies on the brains of children who have died from malnutrition show that children dying from marasmus in the first two years of life have from 15 to 50% fewer brain cells than normal children of comparable age. Children with kwashiorkor who become malnourished after being taken off the breast in the second or third year of life have a normal number of brain cells, but the size of the cells is diminished (15). Studies of the behavior of children who survive early malnutrition show that such children have profound disturbances in the acquisition of language, motor skills, interpersonal relationships, and adaptive and motivational behavior. Memory defects have also been found (12,14). Most of these studies have been limited to children studied only a few years after recovery from malnutrition. However,

an ongoing longitudinal study by Cravioto and DeLicardi (16) should ultimately give an answer to the question of whether or not the damaging consequences of early malnutrition are truly irreversible. If they are, it would lead to a vicious cycle in which malnutrition during infancy results in a large pool of poorly functioning people who, because of their poor level of functioning, rear their children under conditions destined to produce a new generation of malnourished people (14,16). Children born in the poverty that leads to malnutrition also live in social and family environments which are themselves capable of retarding mental and behavioral development. Some ingenious experiments on rats, conducted by Francova (13) have shown that protein deficient rats, raised with their mothers and litter mates show about 20% decrement in exploratory activity. Rats on normal diets that have restricted optical and acoustical stimuli show about a 30% decrement in exploratory activity. Rats deprived of both protein and environmental stimuli show a 90% decrement. The effects of both types of deprivation simultaneously are thus more than additive; they are synergistic. The introduction of an "aunt," a nonpregnant virgin female, into the cages of protein deprived infant rats elevated their performance to that of normal rats, even though such a "mother's helper" did not lactate and was unable to offer food. She did, however, stimulate them by grooming and retrieving them. DeLicardi and Cravioto have conducted experiments which led to similar conclusions in impoverished children from an agricultural community in Central America. In this population, 83% of the children showed no clinical signs of malnutrition, 11% showed mild and moderate malnutrition, and 5% showed severe malnutrition. Yet, the families of all of the children had approximately equal incomes, land, and food. Therefore, no correlation could be established between the amount of food available to the

families of these children and the level of malnutrition. However, a significant correlation was found by psychologists who studied this cohort of children while unaware of their nutritional antecedents. They found that the degree of psychological stimulation offered at age six months to those children who later developed severe malnutrition was significantly lower than that of controls from the same population matched by age and birth weight. In children whose diets are marginal nutritionally, psychosocial deprivation predisposes them to severe malnutrition. Malnutrition, in turn, diminished activity, motivation, exploratory behavior, and those complex signals that ordinarily elicit a stimulating and gratifying response from adult parents. A vicious cycle is thus set up in which the effects of malnutrition synergize with those of environmental deprivation. The consequences may lead to irreversible emotional and mental disorders of development. The interaction between nutrition and psychosocial stimulation is not unique to rats or man. All species that have been studied show the same interaction (13).

## Vitamin Deficiency States

### Vitamin Requirements

Several methods have traditionally been used to determine the vitamin requirements of human subjects. One, employed commonly with conscientious objectors during World War II was the deliberate production of nutritional deficiency followed by the measurement of the quantity of nutrient required to eliminate the signs and symptoms of the deficiency and to maintain health. This quantity was then considered the recommended dietary allowance, and was added to the K rations of our troops. Variations on this strategy use populations in which nutritional deficiency is endemic. Another approach is to measure abnormal metabolites of carbohydrate and protein known to exist in specific deficiencies in the blood and urine. For example, elevated blood lactate and pyruvate occurs in thiamine deficiency. The dose of a specific vitamin required to correct this biochemical abnormality is considered to be the daily requirement. The third approach is the direct measurement of the vitamin in the blood and urine by chemical or microbiologic means. "Normal" levels have been established. This strategy involves the use of large populations of healthy subjects of different age, sex, and race in order to obtain normative data. Recently a new approach to the measurement of vitamin requirements has been proposed. This is based on the assumption that the enzymes requiring cofactors should be fully saturated with cofactor at all times and that a vitamin deficiency exists if they are unsaturated. For example, serum or erythrocyte glutamic-oxalacetic transaminase activity is measured with and without added pyridoxalphosphate, the cofactor. If activity is greater with added cofactor, the enzyme is unsaturated and a

deficiency is said to exist. This method is somewhat controversial but it may be useful in detecting cases of vitamin deficiency and vitamin insufficiency illnesses (17).

Using such methods, a number of vitamin deficiency states relevant to psychiatry have been found; usually they are secondary to the use of pharmacological agents. They most commonly follow the long term use of antituberculosis drugs, anticonvulsants, oral contraceptives, and anti-tumor drugs (18).

The functions of the water soluble vitamins in the nervous system, the manifestations of deficiency and their therapeutic utility has recently been reviewed in great detail (8.19). The following emphasizes features unique to psychiatry:

#### Vitamin B<sub>6</sub>

Vitamin B<sub>6</sub> has many neurobiological functions. It is the precursor of a coenzyme required for more than 50 enzymes in the body. It is so widely distributed in our food supply that it has not been found to occur in populations throughout the world. It has been produced experimentally. Mental symptoms associated with deficiency include lassitude, weakness, depression, anorexia, and confusion. Somatic symptoms include a microcytic anemia which fails to respond to iron but improves dramatically following treatment with small doses of the vitamin. Isoniazide and cycloserine form carboxyl addition compounds with pyridoxal or pyridoxal phosphate that make it unable to function as a cofactor in the approximately 50 enzymes with which it is associated. The administration of vitamin B<sub>6</sub> supplement along with antituberculosis medication reveals that both neurologic and psychiatric symptoms disappear when supplementary vitamin is given in appropriate quantities (20). Estrogens have been shown to compete with pyridoxal phosphate for binding sites among its numerous apoenzymes. High estrogen levels which

occur during pregnancy or the use of oral contraceptives seem to increase the requirements for vitamin B<sub>6</sub>. In therapeutic trials on women who developed depression during pregnancy or while taking oral contraceptives, vitamin B<sub>6</sub> supplementation has been reported to improve mood and to correct the abnormal urinary excretion of tryptophan metabolites (21,22,23). Based on such findings some investigators recommend the inclusion of supplemental B<sub>6</sub> into oral contraceptive preparations (22). In Spain, manufactured oral contraceptives contain 25mg of pyridoxine and the combination is reported to produce fewer side effects (24). The RDA for vitamin B<sub>6</sub> for adults is 2.0mg/day. Doses 10 times this are safe and can prevent deficiencies due to drugs administered for other purposes. Although vitamin B<sub>6</sub> is not very toxic, doses several hundred or thousand times of the estimated daily requirement have been reported to cause convulsions and liver hypertrophy ('

#### Vit. in B<sub>3</sub>

Vitamin B<sub>3</sub> (niacin, niacinamide, nicotinic acid, nicotinamide) is combined with adenine, ribose and phosphoric acid in the body cells to form nicotinamide adenine dinucleotide (NAD). This is a cofactor for many enzymes which catalyze oxidation reduction reactions which are involved in energy release from carbohydrate, the synthesis of fatty acids, steroid metabolism, etc. Niacin in the judgment of some is not truly a vitamin because limited quantities can be synthesized from the metabolism of the essential amino acid tryptophan (26). While this is correct, historical usage, plus the fact that niacin deficiency can be produced on diets ordinarily adequate in tryptophan seem to us to warrant continued classification as a vitamin. Corn, which is deficient in both tryptophan and niacin, is the common food staple in countries where pellagra was common and where it continues to exist. Hartnup's disease is an autosomal recessive disease characterized by diminished absorption of neutral amino acids including tryptophan. Some of its

symptoms resemble pellagra and these respond to niacin (27). The recommended daily allowance of niacin is 6.6mg/1000 calories of food or about 10-20mg/day. The requirement increases during pregnancy and lactation (27).

Pellagra is characterized by a triad of symptoms - dermatitis, diarrhea, and dementia. In early deficiency, psychiatric symptoms are diffuse and include apathy, depression, anxiety and memory deficits. In severe pellagra, mania, delirium, organic dementia, bulbar palsy, and visual field deficits may be present. The EEG has excessive theta and delta activity. This returns to normal after niacin treatment. Routine manufacture of wheat flour and all cereal products supplemented with niacin has caused pellagra to virtually disappear in the U.S. Niacin deficiency in the brain, without deficiency in other tissues, has been claimed by orthomolecular psychiatrists to account for schizophrenia and other mental disturbances. This will be discussed later.

In pharmacological doses of 10-30grams/day, nicotinic acid, but not nicotinamide, lowers blood cholesterol and causes transient cutaneous vasodilation manifested by a flush (19). Nicotinamide, but not nicotinic acid, at doses of 250mg/day tranquilizes rodents and diminishes locomotor activity in gerbils (28). At similar doses, it increases REM sleep and it has been reported to be of benefit to some insomniacs (29). Nicotinamide also binds weakly to the benzodiazepine receptor (30). At ordinary dietary doses, the brain concentrations of nicotinamide are likely to be too low for biologically significant binding to this receptor, but at megadoses, this might occur. At such doses, niacinamide might have anxiolytic properties like the benzodiazepines. This has not been tested. Nicotinic acid and nicotinamide are identical as vitamins; the different properties of the two compounds occur only at pharmacological doses. Thus,

there is no evidence to relate their pharmacological properties shown at high doses to their classical vitamin action as precursors of NAD. Niacin and niacinamide are not very toxic even in megadoses, but in view of their use in orthomolecular psychiatry at doses 100-500 times higher than the average nutritional requirement, it is worth noting that reported side effects include hepatotoxicity (31), hypotension, tachycardia, and hyperglycemia (32). There is a very recent report of severe sensory neuropathy from pyridoxine abuse at doses of 2-6mg/day for several months (158,159). These toxicities must be balanced against any presumed therapeutic utility.

### Vitamin B<sub>12</sub>

Vitamin B<sub>12</sub> (cyanocobalamin) is unique in three regards. It is the only vitamin containing a mineral (cobalt) as part of its chemical structure; it is not found in plants and its absorption from the gut requires a highly specialized mechanism the failure of which results in pernicious anemia. The RDA is about 3.0mg/day. 1micro daily causes remission of pernicious anemia. The vitamin is involved in transmethylation reactions, the synthesis of amino acids, purines and pyrimidines. It is vital for blood formation and the maintenance of neuronal integrity.

A number of studies have shown that 25-30% of patients with untreated pernicious anemia have either major or minor psychiatric problems (33). These include depression and apathy, irritability, confusion, and paranoid states. Neurological symptoms result from demyelination of the dorsal columns of the pyramidal tracts and result in the syndrome known as combined system disease. As many as 60% of untreated pernicious anemia patients have been found to have an abnormal EEG (33,34). Deficiencies of vitamin B<sub>12</sub> may arise from strict vegetarian diets, but more often follow failure to absorb the vitamin as when there is lack of the gastric intrinsic factor or in ileitis and following bowel surgery. It may also follow chronic ingestion of alcohol or after the administration of neomycin, para-amino salicylic acid or colchicine. There is an increased requirement for vitamin B<sub>12</sub>

during pregnancy. Since folic acid is required for the absorption of B<sub>12</sub>, folate deficiency may be accompanied by B<sub>12</sub> deficiency (35,36).

Although a large percentage of patients with hematologic and neurologic findings of vitamin B<sub>12</sub> deficiency also have psychiatric symptoms,

in a significant number of patients the psychiatric manifestations may be the first symptoms and can antedate anemia or spinal cord disease. A recent report (37) presents two cases of organic psychosis without anemia or spinal cord symptoms that responded dramatically to the appropriate administration of intramuscular B<sub>12</sub>. It is noteworthy that both patients had normal hematologic profiles. Diagnosis was made by finding low serum levels of B<sub>12</sub>. With restoration of appropriate B<sub>12</sub> levels, the presenting symptoms disappeared. Evans et al. (37) recommends consideration of B<sub>12</sub> deficiency and serum B<sub>12</sub> determination of all patients with organic psychiatric symptoms whose cause is not clearly known. Even more recently, Van Tiggelem et al. (38) have suggested that blood levels of B<sub>12</sub> may not always correlate with cerebrospinal fluid levels and that the latter may be much lower.

## Folic Acid

Folic acid (pteroyl glutamic acid) is involved in: hydroxylation reactions required for norepinephrine and serotonin synthesis, transmethylation reactions, the synthesis of the purine bases, adenine and guanine, and the pyrimidine base thymine. Folic acid is, therefore, indispensable for the production of DNA and RNA. Transmethylation reactions are involved in myelin synthesis and in the inactivation of the neurotransmitters norepinephrine and serotonin. The RDA is less than 0.5mg/day. It doubles during pregnancy. Serum concentrations in man range from 5-30ng/ml. Folate deficiency has been produced in experimental animals. Diminished learning capacity and EEG changes have been reported in rat pups born of mothers with folate deficiency.

Folic acid, as the name implies, is present in leafy green vegetables and in meats. In man, folate deficiency occurs endemically in severely malnourished populations. It can be produced experimentally in volunteers on folate deficient diets and iatrogenically in marginally nourished people by the administration of anticonvulsants like diphenylhydantoin, oral contraceptives, or the antifolates used in the treatment of malignancy. In experimental folate deficiency, forgetfulness and insomnia appear at the same time as megaloblastic anemia and can be quickly reversed by the vitamin. In less pure deficiency states, occurring among the aged or chronically institutionalized patients, the spectrum of mental disorders includes apathy, irritability, depression, psychosis, delirium and dementia (39).

Folate deficiency can readily be determined by measurement of blood levels. When this is done, as many as 30% of psychiatric admissions have been reported to be deficient (39). Of a sample of admissions to a psychogeriatric ward, 67% have been reported to be folate deficient (40). Carney and Sheffield found that

about 25% of 432 psychiatric admissions have low blood folate levels. Folate treated patients with organic psychoses, endogenous depression and schizophrenia had shorter hospital stays and left in better clinical state than untreated patients (36).

An association between folate deficiency and gestational difficulties has been recognized for many years. Population surveys have shown that about 15% of women, especially among the poor, have marginal or deficient blood levels. Deficiency during pregnancy is associated with an increase in prematurity and teratogenicity.

In the last few years, evidence has accumulated which tends to relate folic acid deficiency during early gestation to neural tube defects and to the Fragile X syndrome of mental retardation. Both of these are polygenic illnesses in which the phenotypic expression of the genotypic defect is apparently determined by the nutritional state of the uterine environment. Smythells (42) has found that when 493 women who had already given birth to a child with neural tube defect gave birth to a second child, 23 of these had children with such a defect. In 397 similar women who were given a vitamin supplement containing folic acid prior to conception and through the first menstrual period, only 3 had such recurrences. This strikingly significant difference cannot be readily explained except by a direct prophylactic effect of vitamin supplementation very early after conception.

The Fragile X chromosome is a relatively newly discovered cause of mental retardation. The fragility of the X chromosome can be rectified in vitro by folic acid (43). Lejeune (44) has reported that the administration of folic acid greatly reduced symptoms of autism and psychotic complications of mental retardation in 7 out of 8 such patients.

Both of these interesting findings clearly require confirmation. If confirmed, they will represent a major advance in the understanding and treatment of two devastating illnesses of concern to neurologists, psychiatrists, and pediatricians through appropriate nutritional supplementation early in conception. A series of studies have shown that folic acid can be added to staple foods, as nicotinic acid commonly is, and that such fortification is feasible, safe, and effective ( 155 ). Until this is done, oral administration of folic acid tablets at a level of 0.5mg/day to pregnant women, especially those living in poverty, appears to be prudent ( 155 ).

A genetic vitamin dependency illness which required about 20mg of folic acid daily has been reported. These rare cases presented with homocystinuria. One such patient showed mild mental retardation with symptoms of schizophrenia which improved after folate administration and recurred 6 months after the supplementary vitamin was discontinued (41).

## Quasi-Nutrition

### Precursor Therapy

Communication between neurons in the central nervous system, it is generally accepted, is overwhelmingly chemical. Neurotransmitters synthesized in presynaptic neurons are extruded into the synaptic cleft when the neuron fires. They then engage specific receptors on post synaptic neurons and initiate a series of metabolic steps which may excite, inhibit, or modulate their activity. More than 20 neurotransmitters are thought to exist; they range in composition from simple amino acids to complex polypeptides. The classical neurotransmitters, dopamine, norepinephrine, serotonin, and acetylcholine have been the most studied. The paradigm for precursor therapy is the use of L-DOPA in Parkinson's disease. The enzyme for the conversion of tyrosine to L-DOPA is lacking in the striatal neurons of the brain from patients with this disease. But, the decarboxylation of L-DOPA to dopamine can still take place. Hence, L-DOPA in pharmacological doses permits the synthesis of sufficient dopamine to be therapeutically effective for several years.

More than a decade ago, it was discovered by Wurtman and his coworkers (45) that the synthesis and release of several neurotransmitters in presynaptic neurons can be influenced by the concentration of precursors offered to them. The amino acids tryptophan and tyrosine are the precursors of serotonin and norepinephrine respectively. Choline is the precursor for the synthesis of acetylcholine. The conversion of precursors to active neurotransmitters is enzymatic. When saturating concentrations of the precursors are available, the rate at which transmitters can be synthesized is limited by the enzymatic capacity. But, concentrations of the dietary precursors in the blood is not constant and under some conditions the rate limiting enzymes may not be saturated, but can become so if

large doses of precursors are administered. Precursor therapy is relatively safe, because feedback inhibition and other neuronal control mechanisms prevent the synthesis of more transmitter than is needed by the neuron at any particular time. Consequently, few side effects are noted when subjects are given pharmacological doses of tyrosine, tryptophan (46), or choline (47,48) that is, amounts much greater than the quantities usually ingested in the diet.

The finding that levels of neurotransmitters in the brain can be altered by experimentally manipulating the quantity of ingested precursor had led to considerable basic research as well as clinical research on both normal volunteers and patients in whom there is reason to believe that there may be a neurotransmitter deficiency.

Dietary precursors must be absorbed from the gut, transported in the blood, penetrate the blood brain barrier, and finally enter into appropriate neurons. These are complex processes which depend initially on the quantity of the precursor in the diet, the effectiveness of the gut in absorbing them, and the transport mechanisms within the blood. Circulating amino acids then compete with each other for active transport through the blood brain barrier into the brain (45,49). The ratio of plasma tryptophan, for example, to the sum of the concentration of other neutral amino acids like tyrosine, phenylalanine, leucine, isoleucine, and valine determines the penetrability of tryptophan into the brain, and, hence, the brain serotonin concentration. Thus, a high protein meal in which many amino acids compete for transport into the brain depresses serotonin synthesis in the rat brain (45,50). A high carbohydrate, low protein meal raises brain serotonin because it elicits the secretion of insulin which lowers the blood levels of other neutral amino acids without affecting tryptophan. Doses of tryptophan as large as 10-15grams would be

more likely to diminish transport of other amino acids into the brain than doses of 1-3grams.

### Tryptophan and Tyrosine

Tryptophan, administered at a dose of 50mg/kg to healthy young men in the morning, significantly increased self reports of fatigue and inertia and reduced vigor and activity (46). It is interesting to note that in this same experiment, tyrosine at 100mg/kg had undetectable effects. It is also worth noting that tryptophan did not cause depression, anxiety, confusion, nor anger in this experiment.

Tryptophan has also been used in the treatment of insomnia with apparent favorable effects. Doses of 1 to 5 grams before bedtime have been reported to reduce sleep latency without producing distortions of physiological sleep as measured by EEG recordings (51). Doses of 10-15 grams cause EEG changes but these are less pronounced than those resulting from the use of hypnotics. The mechanism for the effectiveness of tryptophan in insomnia is presumed to be due to its effects on serotonin levels in the brain stem (52). The use of L-tryptophan for the treatment of insomnia is still experimental even though the amino acid is available for sale in health food stores. The current literature suggests that it would have substantial advantages over conventional hypnotics, but it appears not to be uniformly effective for insomniacs. Furthermore, the long term effects of doses of 5-15grams per day require further investigation.

Serotonin deficits have been implicated in some depressions and mania and clinical trials with tryptophan were conducted with mixed results (53,54). Since tryptophan is rapidly catabolized enzymatically by liver pyrrolase, the idea occurred that the concomitant administration of an inhibitor could more effectively

raise brain serotonin. Nicotinic acid and nicotinamide are both pyrrolase inhibitors and in a preliminary report, encouraging results were obtained with the combination of tryptophan and nicotinamide in the treatment of depression (55). These results have not been confirmed. In very recent work, it has been reported that tryptophan diminishes sensitivity to mild pain and in people over forty increases the likelihood of errors in performance tasks (56).

The administration of tyrosine can, under certain circumstances, elevate levels of brain catecholamines (45,57). It has been reported to help some patients with depression (58) and mild Parkinson's disease (57). Continued clinical research in which tyrosine or tryptophan is used with depressed patients might help to distinguish depressions in which norepinephrine is involved from those in which the defect may be in serotonin metabolism.

#### Choline and Lecithin

Several studies have shown that the administration of choline or lecithin, the precursors of acetylcholine, increased cholinergic function in the brain (59). On the basis of this finding, clinical research has been conducted in which there is a possible disorder in acetylcholine metabolism. Tardive dyskinesia is one such disorder. Presumably the disorder arises because of prolonged administration of neuroleptics, which chronically block striatal dopamine receptors, cause these receptors to become supersensitive to dopamine (60). Some dopamine receptors are present on cholinergic neurons and their supersensitivity probably causes a chronic decrease in the release of acetylcholine by decreasing the firing rates of the cholinergic neurons. Davis et al. (61) reported marked clinical improvement after giving oral choline to a patient with tardive dyskinesia. Several additional studies have confirmed this (62,63). Unfortunately, large doses of choline have undesirable side effects.

including a socially unacceptable odor which results from the degradation of ingested choline to trimethylamine by intestinal bacteria. Lecithin, a phosphatidyl choline, is the most common source of our dietary choline. Lecithin is more effective than choline in raising plasma choline levels (64). Several reports suggest that it, too, is effective in diminishing symptoms of tardive dyskinesia (65,66). A review of the literature suggests that there is modest improvement in the motor function of about 1/2 of the patients who receive lecithin. Interestingly, the antipsychotic action of neuroleptics has not been reported to be diminished by the administration of either choline or lecithin.

Choline has been administered to schizophrenic subjects and failed to modify their clinical symptoms (67). Lecithin has been administered to manic patients with encouraging results (68). Disorders in acetylcholine function have been suggested in Huntington's Disease, Friedrich's Ataxia, and Tourette Syndrome. The results of therapeutic trials with choline or lecithin in those illnesses are equivocal. They have been reviewed by Growden et al. (69).

Alzheimer's disease, the most common cause of dementia among the elderly, is characterized by impaired functioning of cholinergic neurons. On autopsy, the brains of such patients show a dramatic loss of brain choline acetyltransferase (71,70,45). Memory deficits are characteristic of Alzheimer's disease and many studies have been conducted to measure the effects of acetylcholine precursors in normal people and in patients with Alzheimer's disease (48,72). These studies have not convincingly demonstrated any enhancement of memory after treatment with acetylcholine precursor.

Alternative methods for enhancing cholinergic activity include the use of choline esterase inhibitors and cholinergic agonists. Physostigmine, a reversible

short acting choline esterase inhibitor and arecoline, a short acting cholinergic agonist, improve memory when given in low doses to healthy young adults (73,74). Physostigmine, in a double blind experiment, enhanced the memory processes of patients with Alzheimer's disease for brief periods (75).

It is curious that physostigmine, which enhances cholinergic function by inhibiting the enzyme which destroys acetylcholine, should be more effective than precursors which increase the concentration of this neurotransmitter. The reason is not known, but it immediately raises the question of whether a combination of a precursor and a choline agonist or choline esterase inhibitor might be additive or synergistic. To the best of our knowledge, this has not yet been tested.

The precursor strategy with tryptophan, tyrosine, and choline has thus far yielded results which are of great research interest but have only preliminary and uncertain clinical utility. This type of research is young, and vigorous. We may hazard a guess that greater clinical effects from precursors may be achieved when they are combined with other types of psychotropic drugs. Tryptophan or tyrosine combined with tricyclics might accelerate the therapeutic process or decrease the required dose in depression. Stern and Mendels have reviewed the literature on the use of such combinations in the treatment of refractory depression (76). A recent report suggests that the combination of physostigmine and lecithin improves memory in Alzheimer's disease (75).

Pseudo-Nutrition

## Food Additives and Hyperkinesis

In 1975, the late Dr. Ben F. Feingold, a pediatrician and allergist, proposed that some children have a central nervous system variant that predisposes them to sensitivity to synthetic food additives, particularly to food colors and the antioxidants butylated hydroxyanisole (BHA) and butylated hydroxytoluene (BHT). He claimed that in such children hyperkinetic behavior results from the ingestion of these additives. The use of an additive free diet which he developed led to dramatic improvement or even cure in from 50-70% of hyperkinetic/learning disabled children. He stated that 75% of children who had been treated with stimulant medication could discontinue the treatment (77). The diet, he claimed, became effective in several days to several weeks and the younger the patient, the more rapid and complete his response. Total and permanent adherence to the diet is mandatory, Feingold insisted, because even a minor infringement produces a return of symptoms within about 3 hours, which may persist as long as 72 hours. Feingold based his findings on extensive clinical experience in open studies. He did not conduct controlled, double blind trials to test his hypothesis. The Feingold dietary treatment gained considerable popularity among the lay public and more than 20,000 families of hyperkinetic children were reported to adhere to the diet and to advocate its use (78). Feingold urged that labelling of additives be mandatory and the immediate clinical application of an additive free diet in school food programs to a congressional committee by stating: "it is not necessary to await the availability of basic data, it has been demonstrated that these children respond to dietary intervention" (79). Several uncontrolled clinical studies supported Feingold. Rigorous double blind studies, conducted in 7 centers and involving about 200 children have generally failed to replicate his findings (84).

Two types of controlled studies have been conducted. Harley et al. (80) offered families with hyperactive children two different diets blindly at weekly intervals. One was a conventional diet; the other was prepared solely from foods recommended by Feingold. In 36 school age boys, based on teacher and objective ratings, no significant differences in behavior occurred with the diet. With these school age children, a few parents reported a significant improvement when the additive free diet followed the controlled diet, but they were unable to detect differences when the order was reversed. In preschool age children, where only parental ratings were available, a few parents were able to consistently detect differences with the additive free diet compared to the usual diet.

Most of the double blind studies have been challenge trials; that is, children, who ate additive free diets because their parents believed that they improved on them, were blindly "challenged" by the addition of cookies or drinks which contained food color additives. About 200 children have been tested in several studies conducted throughout the U.S. (81,82,83). A summary of these experiments and the results and conclusions has been reported (84). The National Institutes of Health (88) and the American Council on Science and Health (85) have concurred. The data from these studies have recently been examined statistically by an independent group who have come to the same conclusions (86). The conclusions from these many studies are that Feingold's claims that 50-70% of children improve dramatically on an additive free diet and deteriorate rapidly after minor infractions from the diet cannot be supported in careful double blind trials. At most, 3 of the 200 children were reported by their mothers to deteriorate significantly when challenged with food colors. In these 3 children, objective tests and/or outside observers were not used. The Nutrition Foundation Report (84) concluded that there was

insufficient evidence to require a special symbol on food labels indicating the presence or absence of these food additives for the purpose of treating these behavioral disorders. There is also insufficient evidence to suggest a ban on food containing artificial food colorings in federally supported school programs.

Rimland, Vice President of the Academy of Orthomolecular Psychiatry, has challenged the methods, results; and conclusions of those who failed to confirm Feingold's results (87).

### Food and Environmental Allergy and Hypersensitivity

The notion that hypersensitivity or allergy to foods or other environmental agents like gasoline fumes, soaps, or hydrocarbons results in medical or psychiatric illness is subscribed to by what Brodsky calls a "medical subculture" (89). Clinical ecologists and some orthomolecular physicians are among those who support this view. It has been popularized extensively by books and in the media (90,91,92,93). Symptoms which have been related to such sensitivity or allergy include lethargy, depression, palpitations, sleep disturbance, mood swings, poor concentration, anxiety attacks, aggressiveness, and delinquent behavior. The Feingold hypothesis (77) that hyperactivity and learning disability in children is related to the ingestion of common synthetic food additives seems to be a specific variant of the food hypersensitivity thesis which focuses on synthetic food additives and natural salicylates. Hoffer (94) has claimed that many of his schizophrenic patients who failed to respond favorably to megavitamins do respond to five days of starvation followed by diets in which single items of food to which the patients are not sensitive are carefully introduced.

Pierson et al. recently sought objective evidence for the role of food hypersensitivity in 23 patients who attributed a wide variety of their physical and psychological symptoms to food allergies (95). These patients were seen independently for initial diagnosis by a psychiatrist who withheld his findings from the other investigating physicians. The allergists assessed the patients by medical and dietary history, a physical examination, and skin tests for common inhalant and food antigens. The patients were then put on exclusion diets consisting of uncommon foods to which they had no alleged hypersensitivity. All the patients improved. Single foods which the patients had themselves incriminated were then

added openly. Many patients became ill with their initial complaints. Blind tests were then performed using the same foods, freeze dried, and in opaque capsules. The investigators found that only four of the 23 patients had true food hypersensitivity. None of these four had significant psychiatric symptoms and all of them had physical symptoms characteristic of atopy, i.e., allergic rhinitis, urticaria, asthma or atopic eczema which appeared even when the offending foods were given blindly. The 19 in whom food hypersensitivity could not be confirmed in the blind trials had physical and psychological symptoms not characteristic of the atopic syndrome; 18 of these 19 patients had been diagnosed by the intake psychiatrist as having significant psychiatric illness; 10 of these were considered neurotically depressed, the remainder had other neuroses and personality disorders but none were psychotic. The authors conclude that psychogenic reactions to food are very common and that some form of double blind testing is the only certain means by which the diagnosis of food hypersensitivity can be established. They note that "since the dangers of unwise dietary restriction are real, patients should not be encouraged to restrict their diet without specialist, dietetic advice and without objective confirmation of food hypersensitivity."

There have been claims that food allergies are responsible for delinquency and criminal behavior (96,97,98). Statements are made that food allergies are common in delinquents but prevalence rates are not given. The only reported double blind studies of behavioral change in relation to food allergy have used sublingual testing, a method whose validity is considered doubtful (99).

Clinical ecologists go farther. Patients are initially tested for dietary sensitivity and are placed on elimination diets. If these are not helpful, they are placed in a "chemical free" environment in a hospital. If they improve in

that environment, they are then treated by prescribed avoidance of environments which include the common substances like perfume, smoke, etc. to which they claimed sensitive. Such avoidance inevitably leads to major changes in their lives including a move to a "clean climate". Patients may also receive injections of the indicted substances in order to desensitize themselves. According to Brodsky (89) they spend much of their time on diets, tests for sensitivity, reading about allergies, participating in a support group of similar patients, and tending to worker's compensation claims.

#### Schizophrenia and Gluten

In 1966, Dohan suggested that peptides derived from cereal grain glutens may play an important role in the pathogenesis of schizophrenia in genetically predisposed people. This proposal was based on the observations of considerably higher than chance occurrence of celiac disease in schizophrenics as well as schizophrenia among adults with celiac disease. In addition, both schizophrenia and celiac disease have been reported to be three times more prevalent in Ireland than in England and Wales. Dohan also found a strong correlation between a change in rates of admission of female patients with schizophrenia to psychiatric institutions and a change in wheat consumption during World War II among five

countries (USA, Canada, Finland, Sweden, and Norway) variously affected by the war. Following these observations, he and his colleagues studied the effects of milk free and cereal free diet on schizophrenic patients. 47 schizophrenic patients randomly assigned to a cereal free diet showed a significant increase in rate of release from hospitals compared to 55 patients on a high cereal diet. No difference was found when wheat gluten was added to the cereal free diet in a subsequent double blind study ( 100 ).

Singh and Kay ( 101 ) found that schizophrenic patients who received neuroleptics and a cereal free, milk free diet showed a significant decline when challenged with wheat gluten in a double blind manner. They suggested that clinical improvement on a gluten free diet and subsequent deterioration on gluten challenge may be related to a gluten mediated decrease in neuroleptic absorption. In support of this, Fried et al. ( 102 ) found that wheat gluten given to mice 20 minutes before a 1mg/kg dose of haloperidol reduced the amount of neuroleptic absorbed into the blood stream. Recently, however, Osborne et al. ( 103 ) found that 5 chronic schizophrenic patients did not improve on a gluten free diet; furthermore, the gluten free diet had no effect on blood levels of butaperazine, which had been administered in constant doses throughout the study. The study, however, selected patients who had failed to respond to traditional neuroleptic therapy and who thus might represent an atypical subpopulation. Also, as the authors note, their patients were on the special diet for 36 weeks. Dohan and Grassberger ( 104 ) stressed that chronic patients may require months or years of gluten free diets before significant results are achieved.

Potkin et al. ( 105 ) studied 8 chronic schizophrenic patients who were maintained on a diet free of gluten, cereal grains and milk and who were challenged

in a double blind manner with dietary wheat gluten and placebo. They found no deterioration in clinical status (as measured by the BPRS) on gluten challenge; however, Singh and Kay ( 106 ) have pointed out that with an N of 8, the authors' chances of detecting a true small or medium effect of gluten would be only 7% and 15%, respectively.

Hallert ( 107 ) who has studied many celiacs in Sweden where it has a relatively high prevalence rate found no schizophrenia in adult celiacs, but did find significant depression. He suggests that celiac disease is not an appropriate model. Dohan recently ( 108 ) reviewed the evidence supporting the model and suggests approaches for further study.

Recently, Zioudrous et al. ( 109 ) reported that gluten peptides have naloxone-reversible endorphin activity at brain opiate receptor sites. This finding might explain a link between gluten free diets and clinical response in a subpopulation of schizophrenics. However, such a relationship has yet to be consistently demonstrated and the important observations of Dohan's group and Singh and Kay merit further exploration.

"Reactive, Relative, or Postprandial Hypoglycemia"

In animals and man, food intake is intermittent and yet the blood sugar levels, except for transient rises after eating, remains relatively constant. Such homeostasis requires the synchronized participation of the liver, muscles, pancreas, other endocrine organs and the central nervous system. Most body tissues can tolerate fluctuations in blood sugar but the brain, which is unable to store glucose or glycogen in significant quantities and which uses glucose as its primary fuel, requires a constant supply. In the resting state, the brain accounts for 80% of the glucose consumed by the body.

Glucose homeostasis is remarkably effective. In a normal population, fasting levels of plasma glucose range from 50-115mg/dc. Such levels occur 5-6 hours after feeding and do not change significantly overnight. In well nourished individuals, blood glucose levels change very little after several days of fasting. Many physical illnesses like diabetes or islet cell tumors of the pancreas can either elevate or lower the fasting blood sugar (110,111).

Reactive, relative, or postprandial hypoglycemia is an abnormal degree of depression of the extracellular glucose concentration reflected in the plasma, without a well defined cause. When plasma levels fall below 50mg/dc or blood levels below 40mg/dc, symptoms and signs of adrenergic hyperactivity or nervous system depression or a combination of the two usually appear. Hypoglycemic activation of the adrenergic system causes tremulousness, anxiety, hunger, sweating, palpitations, and tachycardia. Central nervous system hypoglycemia causes perturbations of cortical and subcortical functions with symptoms of fatigue, headache, weakness, diplopia, confusion, amnesia, incoordination, seizures and coma. There is substantial variation in the cluster of symptoms of hypoglycemia from patient to patient.

Several of the symptoms of hypoglycemia resemble those with which anxious, depressed, and hypochrondiacal patients present. Consequently, some patients may diagnose themselves as having hypoglycemia. The tendency to do this is augmented by popular books in the lay press which have featured hypoglycemia as a global cause for a welter of illnesses and antisocial behavior like "nervous breakdown", alcoholism, juvenile delinquency, drug dependence, inadequate sexual performance, and overt aggression in prisoners (112,113,114).

Some orthomolecular physicians and clinical ecologists are among the physician groups who attribute much mental illness and antisocial behavior to hypoglycemia and who treat this condition with low carbohydrate, high protein diets. Psychotropic drugs are frequently added but this is not usually acknowledged. While the majority of endocrinologists, psychiatrists, and criminologists have not accepted nutritional theories and dietary treatments of neurotic and antisocial behavior, these theories have, nonetheless, had an impact on prisons, probation departments, and school systems. The Los Angeles County Probation Department, for example, banned the consumption of chocolates, other sweets, and refined sugar products from juvenile facilities and is attempting to reduce consumption of processed and additive-containing foods in prisons (115). There have also been malpractice suits in which patients have claimed that their physicians missed the diagnosis of reactive hypoglycemia and, therefore, mistreated them.

The concept that postprandial or reactive hypoglycemia is common in the population has not been generally accepted by the medical profession. The American Diabetes Association (116), in collaboration with other societies, has published statements to downplay the prominence of the misattribution of hypoglycemia as a cause of multiple illness. Yager and Young (117) have referred to the epidemic

proportions of the incorrect diagnosis of hypoglycemia as a cause for multiple psychiatric and somatic complaints. Too often the diagnosis is made without a glucose tolerance curve at all. Diagnosis by questionnaires which attempt to relate symptoms to eating habits is inadequate. Many patients who have affective, somatization or anxiety disorders report a relationship of symptoms to food intake which is not borne out in a glucose tolerance test (110,118,119).

The reasons for the conflict between those who emphasize hypoglycemia as a major contributor to multiple psychiatric illnesses and those who discount it lie largely in the rigor with which a 5 hour glucose tolerance test is conducted and in how it is interpreted. In this test, the patient should be prepared by eating a diet containing about 250gm of carbohydrate daily for three days. He is then fasted overnight, and is given 50-100gms of sugar orally in solution. Alterations in plasma or blood glucose are monitored at half hour intervals for the ensuing five hours, while subjective symptoms are recorded. The typical normal glucose tolerance curve shows a rise of 60-70mg/dc in the first 30-60 minutes; this is the period when glucose enters the circulation from the gastrointestinal tract. In normal persons, increasing glucose concentration, abetted by cholinergic signals, stimulate insulin secretion. The increased circulating insulin in conjunction with declining glucagon production results in decreasing hepatic glucose output and a fall of blood glucose to levels approximating or slightly lower than the fasting state over the next four hours. By the fifth hour, there is usually recovery to base levels. At its peak, blood glucose levels in normal subjects seldom exceeds 160mg/dc. Higher levels suggest diabetes. At the nadir, glucose levels below 50mg/dc should raise the suspicion of reactive hypoglycemia. For a definitive diagnosis to be made, the low blood sugar values should coincide in time with the symptoms of adrenergic activation and central nervous system hypoglycemia referred to above. The diagnosis

should not be made on the basis of a low blood sugar without clinical symptoms or on symptoms alone without a low blood sugar. Many patients report symptoms and signs of anxiety with blood sugar levels above 70; others may have the blood sugar fall to levels of below 40 without manifest symptoms or signs of hypoglycemia (118). Since the glucose tolerance test may vary from day to day in any patient, borderline tests should be repeated. Orthomolecular psychiatrists interpret the results of glucose tolerance tests differently from endocrinologists. An example of orthomolecular interpretation is shown in the work of Meiers who claims that 70% of schizophrenics have relative hypoglycemia ( 123 ).

The notion that hypoglycemia is related to panic attacks, reported by patients, has recently been tested by Gorman et al. (11). These investigators measured the blood sugar in ten patients who met DSM III criteria for panic disorder or agoraphobia at the moment when panic was experienced by the patient during an infusion of 0.5molar sodium lactate under single blind conditions. They found that, on the average, such patients had a fasting blood sugar of 98mg/dc and at the moment of panic it was 94mg/dc. None of these patients had serum glucose levels even close to hypoglycemic levels. These findings demonstrate that hypoglycemia is not a necessary condition for panic attacks, but do not, of course, prove that hypoglycemia may not cause panic attacks. To determine the latter, it may be necessary to experimentally lower blood sugar in such patients by an insulin tolerance test and then determine whether it triggers panic and whether the blood sugar levels correlate well with the onset of panic. It is also now possible for patients who suspect that they have hypoglycemia related to panic, or to any other clinical symptoms to screen themselves at home by collecting capillary blood on impregnated filter paper. They can measure the blood sugar levels themselves or send it to a laboratory for analysis (120). In either type of experiment, a close correlation between clinical symptoms and blood sugar

values must be found in order to designate hypoglycemia as a proximate cause of the symptoms. It seems likely that such research will be conducted in the near future.

In summary, there is little evidence from carefully conducted research to support the concept that reactive hypoglycemia is a common condition and that it is causally related to psychiatric or behavioral disorders. Nonetheless, some professionals and patients are convinced a priori that emotional illness and inappropriate behavior is caused by postprandial or relative hypoglycemia which follows a high dietary intake of carbohydrates. Individuals who choose to believe this may alter their diets to diminish intake of simple sugars and to increase protein and complex carbohydrates with little danger or expense. But, the translation of hypoglycemic mythology into dietary regulation on a mass scale in schools or prisons is not justified.

## Orthomolecular Psychiatry

"Psychiatry seems unusually vulnerable to almost any fad which happens to drift into its amoeboid maw."  
(Osmond, 1982)

The theory, practice, and clinical value of megavitamin therapy and orthomolecular psychiatry has been the subject of debate for almost twenty years. An American Psychiatric Association Task Force reviewed the evidence thoroughly in 1973 and was very critical ( 124 ). Orthomolecular psychiatrists responded ( 125 ), calling the Task Force Report biased, unfair, and full of errors. Pauling ( 126 ) was also critical. His criticisms were answered by Klein ( 127 ) and Wyatt (128 ). A book Orthomolecular Psychiatry: Treatment of Schizophrenia which details their theory and practice was published in 1973 ( 129 ). A detailed update of the APA Task Force critique which included a review of the role of the water soluble vitamins in the nervous system was published in 1979 ( 130 ). The present chapter summarizes some older reviews of this subject and adds material published since that time.

### Orthomolecular Theory

The term "megavitamin therapy" was coined in the early 1950s to describe a treatment for acute schizophrenia that employed doses of vitamin B<sub>3</sub> (nicotinic acid or nicotinamide) in the dose range of 3-30 grams daily. The theoretical basis for this treatment was initially pharmacological, not nutritional. The originators of megavitamin therapy attributed the pathogenesis of schizophrenia to the endogenous formation of adrenochrome and adrenolutein which are hallucinogenic condensation products of oxidized adrenaline. Adrenaline is formed by methylation of noradrenaline and in schizophrenia the formation was thought to be excessive. These products caused perceptual distortions which were the primary causes of schizophrenia. The perceptual defects could be detected and quantified by a psychological card sorting test called Hoffer-Osmond Diagnostic Test (H)

They see schizophrenia as primarily a perceptual disorder. For example, Hawkins, co-editor of the book Orthomolecular Psychiatry (129,p627) says, "Clinically, the illness begins as altered subjective experiences associated with changes in perception and these may or may not in time result in the observable changes upon which a diagnosis of schizophrenia has hitherto been based .... At this stage of the illness, the diagnosis may be made by interviewing techniques focused on detection of these subjective changes. The perceptual changes may also be detected by objective measures such as the HOD and EMI tests which parallel changes in the severity of the illness. The stage of the illness may be called metabolic disperception. It precedes the appearance of overt clinical schizophrenia -- the signs and symptoms of schizophrenia are secondary to the perceptual disorders and these in turn precede the tertiary impairments in social functioning." Hawkins then presents evidence to support the proposition that all of the manifestations of schizophrenia can be produced by perceptual changes alone. The HOD score is described by him as being more accurate than the usual clinical criteria in evaluating the degree of the patient's illness and response to treatment. He says (129,p617), "The majority of patients that we see with schizophrenia are not overtly psychotic. Although schizophrenia is technically classified as a psychosis, the development of irrationality indicates an advanced degree of the state of the illness. We, therefore, view schizophrenia as a disease process which is capable of producing psychosis." He continues (129,p602) "The HOD test consists of 145 true-false questions, read and answered by the patient which are designed to measure visual, auditory, olfactory, touch, taste, and time perception as well as thought and mood disturbances. Underlying this work is the assumption now supported by substantial experimental evidence that there is a genetic predisposition in schizophrenics which under certain conditions leads to errors in metabolism resulting in the formation of chemicals that may interfere with the function of the central nervous system which is responsible for maintaining perceptual abilities."

Klein (129,p327-342) defines metabolic disperception as "people who suffer from varying degrees of abnormal perception, with corresponding changes in thought, mood

and behavior who respond favorably to megavitamin B<sub>3</sub> and allied therapy if treated before irreversible damage has developed." Subclinical pellagra is defined as "a deficiency syndrome characterized by the presence of perceptual changes affecting any or all of the five senses associated with neurasthenia. The HOD and related tests can measure the degree of perceptual abnormality and changes in thought and mood."

Hawkins (129,p620) continues, "For routine use, the HOD test. . . is the most useful test, not only to confirm the diagnosis, but also to determine the degree of illness and to monitor the response to treatment. Beneficial measures are followed by a reduction of the HOD score and deleterious measures or an increase in the illness are followed by an increase. It can be administered and scored by anyone in the office. Shock treatment brings the most rapid reduction in the HOD score, the phenothiazines will also lower the score considerably, but usually not to within normal range. The patient can take the test retroactively; that is, he can answer the question according to how he felt when most ill or at any specified time in the past."

Hoffer remains committed to nicotinic acid deficiency as the primary cause of schizophrenia, which he sees as cerebral pellagra. He says (129,p250), "If all the vitamin B<sub>3</sub> were removed from our food, everyone would become psychotic within 1 year. This pandemic psychosis would resemble pellagra and it would resemble schizophrenia. It could not be called pellagra, because none of the antecedents of that disease would exist."

"Schizophrenia and pellagra are not identical since they require different quantities of vitamin B<sub>3</sub>. Most symptoms of pellagra are alleviated by doses of vitamin B<sub>3</sub> below 1 gram/day, but a small proportion may need many times as much. Most schizophrenia respond to 3 to 6 grams, but a small proportion may require more than 20 grams per day" (129,p251).

But, Hoffer also believes in the use of ECT in the treatment of schizophrenics who do not respond to megavitamins. Commenting on the failure of others to confirm megavitamin therapy, he says (129,p206), "Several experiments are underway, but they are testing only 1 part of the program. For example, they do not use ECT. It is, therefore, necessary to reiterate that the megavitamin program is not one which can be completed in a single month or six months or a year. Time alone is no criterion. One starts with the simplest therapy that is chemotherapy alone using megavitamin doses plus all the other chemotherapies available to psychiatry as indicated in each case. The patients who recover are maintained on the program in order to keep them well. Patients who do not recover within 3 months are then given a series of ECT in addition to the chemotherapy. They may require a second or even a third series. With any acute series, using ECT if there is insufficient improvement within three months of beginning chemotherapy, one can expect a recovery rate of over 90% within one year and improvement in the other 10%."

He also says (129,p559), "All patients were treated with phenothiazines, megavitamins, accessory symptomatic medication, group therapy and all the other usual adjunctive measures. The exception was that 85 patients received ECT and 55 served as controls. When the results were tabulated and graphed, the very significant effect of ECT was observable. This was most marked in the younger age groups."

To prevent or treat schizophrenia, it was thought necessary to reduce adrenaline formation. Since adrenaline was formed by methylation of noradrenaline, a means to diminish methylation was sought.

When nicotinic acid or nicotinamide are administered in large doses n-methylnicotinamide is formed and is rapidly excreted; hence, both compounds are methyl acceptors. Since they are relatively non-toxic in large doses, they were chosen as competitive inhibitors of the methylation of noradrenaline. It is worth emphasizing that they were not chosen as nutrients; indeed, in a 1957 publication advocating the use of nicotinic acid in the treatment of schizophrenia, Hoffer et al. ( 131 ) speculated about the mechanism of therapeutic action of nicotinic acid. They chose as the most likely mechanism the ability of nicotinic acid to be a methyl acceptor which would reduce the formation of the endogenous hallucinogen adrenochrome. They rejected its role as a vitamin, saying, "psychosis (sic) association with pellagra does in many ways resemble the schizophrenic psychosis except that it contains qualities of toxic confusion. However, the incidence of avitaminosis among schizophrenic persons is no greater than among the general population. Doses adequate to treat any unknown deficiency are without effect on schizophrenia; it may, therefore, be concluded that this factor is unimportant." ( 131 )

In 1968, Pauling ( 132 ) published a theoretical paper in which he suggested that some forms of mental illness might be due to deficiencies in essential nutrients occurring in susceptible individuals eating an ordinarily adequate diet. Man's genetic heterogeneity leads to biochemical individuality with large variations in the need for essential nutrients, especially vitamins ( 132 ). The brain might differ from other organs in its nutritional requirements so that localized cerebral deficiency could occur. Pauling named his concept "orthomolecular psychiatry" and he defined it as "the treatment of mental disease by the

provision of the optimum molecular environment for the mind, especially the optimum concentration of substances normally present in the human body." With the publication of this interesting theoretical paper, clinicians who had been practicing megavitamin therapy quickly adopted Pauling's concept and claimed that what they had been practicing from 1952 to 1968 was, indeed, orthomolecular psychiatry. This conceptual shift from the transmethylation hypothesis in which nicotinic acid was a pharmacological methyl acceptor to a nutritional hypothesis in which schizophrenia was cerebral pellagra treatable by nicotinic acid functioning as a true vitamin was accompanied by the formation of an Academy of Orthomolecular Psychiatry and a name change of their journal from the Journal of Schizophrenia to the Journal of Orthomolecular Psychiatry. With this shift in theory, many other vitamins and hormones were added to their therapeutic armamentarium. The scope of the conditions which orthomolecular psychiatrists treat has also been expanded to include autism, hyperkinesis, depression, anxiety, alcoholism, drug addiction, delinquency, etc. Their current practice is perhaps best described by Hawkins. "Clinicians practicing orthomolecular psychiatry are using a combination approach which varies from patient to patient depending upon the biochemical peculiarities of a given case and which often includes high doses of niacin or niacinamide, ascorbic acid, pyridoxine, vitamin E, thyroid, vitamin B<sub>12</sub>, hypoglycemic diets, cereal free diets, daily physical exercise, lithium, the phenothiazines, and also the commonly used tranquilizers and anti-depressants." ( 133 ). Electroconvulsive shock therapy is still frequently used ( 125 ). The current theory is expressed by Hoffer ( 134 ), "There is a simple message: The most important treatment for psychosis is nutritional. Other treatments which are considered THE treatment by the American Psychiatric Association are merely palliative."

The change in the theory of schizophrenic pathogenesis from excessive transmethylation to nutritional deficiency broadened the therapeutic ingredients of orthomolecular practice greatly. With the first theory, there was a pharmacological need for nicotinic acid as a methyl acceptor and no special needs for other vitamins and nutrients. With the nutritional theory there is room for the addition of many other micronutrients to the therapeutic program. In current practice, many nutrients are added in megadoses simultaneously. Nonetheless, nicotinic acid seems to be always included in the therapeutic cocktail for schizophrenia and this is because that illness continues to be looked at as cerebral pellagra. Hoffer says, "It is clear that there are no clinical grounds for separating the two diseases. A distinction is artificial". He also says, "schizophrenia is a vitamin B<sub>3</sub> dependent condition or an NAD deficiency disease" ( 135 ). Nonetheless, other water soluble vitamins and minerals are also used in megaquantities.

The concept of reactive hypoglycemia and of food or environmental allergy as causative agents in many types of mental illness and behavioral disorders has also been adopted ( 136 ). Orthomolecular psychiatrists who originally rejected psychotropic drugs as unnecessary poisons imposed on the medical profession and patients by heavy industrial advertising is now accepted as sometimes useful adjunctive therapy. Characteristic of orthomolecular psychiatry is the absence of psychological or social causes for mental illness or aberrant behavior. Nor is there any admission of a useful role for psychological treatment, although halfway houses and self help groups are used.

The transmethylation hypothesis is testable and has been tested by many investigators over the past 20 years. No evidence of any excess transmethylation

has been found. If anything, there may be diminished transmethylation (137,143 ). There is also neither clinical nor laboratory evidence for a metabolic defect similar to that found in pellagra in any of the schizophrenias. This subject was thoroughly reviewed a decade ago in the APA Task Force Report ( 124 ) and no evidence to the contrary has appeared since that time.

The Pauling statement that there is an optimum molecular environment for the neurons in the brain is probably true, but it is not testable, because optimum, especially for any single individual, cannot be defined nor determined. It is like saying that there should be an optimum income, education, and degree of health and freedom for every citizen. There would be enormous arguments by people of different political persuasions about the meaning of the term. Pauling noted that optimum intake of phenylalanine should be very low for the patient with phenylketonuria. But, in general he tended to view optimum as very much larger than the RDA. He suggested that genetic variance in the transport of vitamins across the blood brain barrier might, in selected individuals, result in a cerebral avitaminosis despite normal blood and other tissue levels of these nutrients. He also felt that the protein apoenzymes for which vitamins or their derivatives function as coenzymes might be genetically defective so that much higher concentrations of coenzymes were necessary in order for the enzymes to function. He stated that "the so-called gene for schizophrenia may itself be a gene that leads to a localized cerebral deficiency in one or more vital substances" (126,132).

Roger Williams ( 138 ), more than 30 years ago, had presented evidence for a degree of variability within a species which he called biochemical individuality that might account for differences in nutritional requirements. Pauling's hypothesis was an elaboration of Williams' thesis. Williams' thesis is also not arguable in principle, but the quantitative aspects

need empirical testing. We all readily accept biochemical individuality for things like height, weight, hemoglobin, intelligence, caloric needs, metabolic rate, etc., but generally speaking, such variability is seldom more than 15%. Orthomolecular theory suggests that differences in vitamin requirements might be as great as several thousand percent. Some evidence has been found in rare genetic diseases to support this. There are about 25 known genetic "vitamin-responsive in-born errors of metabolism"(139). These disorders are genetic autosomal recessives and are so rare that a total of less than 1,000 cases have been described in the world literature. All of the water soluble B vitamins except niacin and riboflavin have been implicated. Vitamin dependency illnesses are characterized by an increase in the requirement for a specific vitamin that ranges from 10 to several hundred times the RDA. This is because they have mutant apoenzymes which require high concentrations of cofactor to function. Vitamin dependency illnesses are manifest at birth or in early childhood and they are generally associated with mental retardation as well as with multiple somatic disorders ranging from convulsions to severe anemias. Patients with these illnesses show demonstrable abnormalities in circulating amino acids or other metabolites. Unless they are treated with megadoses of the appropriate vitamin early in life such patients show retardation in growth and development and usually die in childhood. Orthomolecular psychiatrists apparently believe that the large differences in nutritional needs which occur in the rare genetic vitamin dependency illnesses are common in psychiatric patients of all types. Hoifer, for example, believes that schizophrenia is a vitamin B<sub>3</sub> dependent condition or an NAD deficiency disease ( 135 ). Since schizophrenia fails to meet the many other criteria established for the definition of autosomal recessive genetic diseases, it becomes necessary for him to postulate that the vitamin dependency characteristic is localized to the brain.

There is another genetic variant less severe than the vitamin dependency illnesses which Blass calls "vitamin insufficiency illness" (140 ). This occurs in that small fraction of alcoholics who develop Wernicke-Korsakoff syndrome. Such patients are apparently able to grow normally to adulthood on ordinary daily requirements of thiamine and an average diet, but under the unusual circumstances of heavy alcohol consumption when the vitamin intake diminishes and the vitamin requirement may increase, the syndrome develops. This condition can be detected by measurement of a thiamine dependent protein apoenzyme called transketolase which in Wernicke patients requires a much higher concentration of thiamine pyrophosphate in order to function adequately. Folkers et al. (141 ) have reported that patients with carpal tunnel syndrome may also have a vitamin insufficiency syndrome because their erythrocyte glutamate oxaloacetate transaminase (EGOT) is unsaturated at normal dietary levels of pyridoxine. At megadoses the enzyme becomes saturated and new enzyme synthesis is induced. Of interest to psychiatry has been the report of Rimland et al. (142 ) who recently found that massive doses of pyridoxine could improve the symptoms of about 30% of autistic children and that in such children pyridoxine causes a drop in the urinary excretion of homovanillic acid, a major metabolite of dopamine. It is, therefore, possible that a subgroup of autistic children may have a vitamin B<sub>6</sub> insufficiency illness. Detection of this particular subgroup can thus far not be made clinically or biochemically. Moreover, even though some improvement occurs when these children are given pyridoxine, they are still very far from being psychologically well.

The possibility that schizophrenia or even a significant subgroup of the schizophrenias is a vitamin dependency illness must be considered very remote. They have multiple somatic abnormalities which have not been found in schizophrenics.

They are generally mentally retarded and they have distinct biochemical abnormalities in the blood or urine which are detectable at birth or in early infancy. They respond quickly and dramatically to large doses of the single vitamin required to remedy their genetic metabolic abnormality. Schizophrenia fails to meet any of these criteria.

Is schizophrenia a vitamin insufficiency illness which resembles the Wernicke-Korsakoff syndrome? Again, it is very unlikely. A vitamin dependent specific enzyme defect has not been found, nor is there any evidence of a metabolic abnormality.

### Recent Studies:

Some literature has appeared in the last several years dealing with megavitamin therapy and orthomolecular principles in autism, learning disability and mental retardation. Rimland et al. conducted a double blind crossover study of the effects of high doses of vitamin B<sub>5</sub> on autistic children ( 142 ). LeLord has studied the effects of high doses of vitamin B<sub>6</sub> and magnesium on autistic children (145 ). Both groups have reported positive findings. The results suggest that in a heterogeneous illness like autism there may be a subgroup that responds to this treatment. The degree of response is modest but statistically significant.

Kershner and Hawke ( 146 ) studied the efficacy of adding megavitamins to a diet low in carbohydrates high in protein with 20 learning disabled children who carried diagnoses of hyperactivity, minimal brain dysfunctions, or both. After a double blind six month period of treatment, the addition of megavitamins failed to produce any significant improvement when compared to the diet alone on a variety of intellectual, school achievement, perceptual, and behavioral measures. The efficacy of the diet alone could not be assessed because no dietary control group was employed. The parents of 18 of these children reported improvement in their children on this diet regardless of whether megavitamins or placebo were added. As the authors cautiously point out, this may reflect parent enthusiasm and/or the child's maturation rather than dietary effects.

In 1981, Harrell et al. ( 147 ) reported the results of a study in which 16 children (age range 5-15) with either Down's syndrome or unclassified mental retardation (IQ 17-70) received either placebo or a supplement containing 11 vitamins and 8 minerals for a four month period. All subjects were also placed on diets which restricted the intake of "sugary foods and soft drinks" and encouraged consumption of fruits and milk. All but one of the subjects were also given thyroid hormone because of low morning axillary temperatures. At the end of four months,

the children were evaluated by 2 of 7 psychologists who did not all use the same IQ testing instruments. One of the psychologists, the principle investigator, was not blind to the conditions of the experiment. During the first four months of treatment, the five children who received supplemental vitamins increased their average IQ by 5-9.6 points and the 11 subjects on placebo showed negligible change. In a second phase of the experiment, all 16 of the subjects received vitamin supplements and the 11 subjects who had been on placebo in the first phase showed an average IQ increase of 10 points. The Harrell study has received considerable attention because of the implications of its conclusions. However, it has also received much criticism because of the weakness of its design and methodology.

Coburn et al. (157) carried out a replication study using mentally retarded young adults. This experiment was conducted entirely on a double blind basis with a uniform IQ testing procedure. None of the subjects, including those on the Harrell supplementation, showed any improvement in performance on the Stanford Binet test at 10 and 20 weeks. Admittedly, the Coburn study examined mentally retarded patients who were older than those studied by Harrell et al. Possibly, improvement in IQ may be limited to very young subjects. However, given the methodological weaknesses in the Harrell study and the absence of confirmatory replication studies at this point, there is reason to be skeptical. Replication studies are required for both professional responsibility and in the public interest.

Conclusion:

The history of medicine clearly shows that theory and practice are often dissociated. Regardless of the weaknesses of orthomolecular theory, the question may be asked, Does it work? The APA Task Force addressed this question by translating the hypotheses into testable questions. In doing so, they focussed only on the testing of the value of nicotinic acid in the treatment of schizophrenia. It was felt that this was justified because nicotinic acid was the cornerstone of megavitamin and, later on, orthomolecular theory and because the original publications for therapeutic efficacy used only this vitamin. The results of studies by many investigators who did double blind controlled studies are given in detail by the Task Force Report ( 124 ). The results were negative. Nicotinic acid as the sole medication for newly admitted schizophrenics was no better than an inactive placebo. As an adjuvant medication to phenothiazines it was worse and increased the duration of hospital stay and the amount of neuroleptic required. For chronic patients receiving neuroleptics, it was also worse than placebo. The Task Force was critical of the use of the Hoffer-Osmond card sorting test for perceptual difficulties which was the primary instrument for diagnosing schizophrenia and for measuring change with megavitamin therapy.

Since the publication of the APA Task Force Report in 1973, many other professional, academic organizations have reviewed the field of orthomolecular psychiatry and have arrived at similar conclusions. The Royal Australian and New Zealand College of Psychiatrists concluded that orthomolecular medicine has "no status in the practice of medicine or psychiatry. Its clinical role is unproven and the pathology tests cannot be justified for the rational practice of internal medicine or psychiatry". The Canadian Mental Health Association collaborative study independently investigated some of the underlying

hypotheses supporting orthomolecular psychiatry and obtained negative results. The American Academy of Pediatrics' Committee on Nutrition, looking specifically at the published evidence on megavitamin therapy for childhood psychoses and learning disabilities, concluded that "megavitamin therapy as a treatment for learning disabilities psychoses in children including autism is not justified on the basis of documented clinical results" ( 144 ).

The reply of Hoffer and Osmond to the APA Task Force Report was published in 1976 by the Canadian Schizophrenia Foundation of which Hoffer is President ( 125 ). The authors are careful to say that it does not necessarily represent the opinion of the Directors nor all of the members of the Foundation. It is 121 pages long; more than twice as long as the Task Force Report. The interested reader should examine it carefully.

Hoffer and Osmond ( 125 ) state that the Task Force Report and the data upon which it was based were grossly unfair and biased. They have many objections: (1) Fixed doses of nicotinic acid at 3 grams/day were used; some patients require 20 to 30 grams; (2) Orthomolecular claims were for acute schizophrenics; the so-called attempts at replication employed chronic schizophrenics; (3) Megavitamin practitioners use ECT as an adjuvant when necessary; it was not used in the replication experiments, which they feel should not be called "replication"; (4) The double blind trials which counted heavily in the Task Force judgment were unnecessary and restrictive. Criticism of megavitamin therapy research which failed to do control studies is unfair because it is unethical for practitioners to withhold treatment which they know is effective; (5) The Task Force Report based its judgment solely on research on vitamin B<sub>3</sub>; megavitamin therapy has evolved to a much more complex therapeutic program which now uses other vitamins, minerals, psychotropic drugs, hormones, and other procedures; (6) The NAD experiments were

were done with a preparation which was not enterically coated. Hoffer had the megavi-  
used with specially coated tablets which resisted digestive enzymes; (7) The  
Task Force selected from the literature all negative reports and did not adequately  
weigh the confirmatory reports.

At a more political level, Hoffer and Osmond feel the report is biased because  
(1) Dr. Lipton, the Chairman, was an avowed opponent, (2) at least two of the other  
members were opponents for different reasons, (3) no orthomolecular practitioners  
were on the Task Force, (4) The Task Force used pejorative adjectives in describing  
the work of the megavitamin therapists.

Most of the work of the orthomolecular psychiatrists is printed in their Journal of Orthomolecular Psychiatry, which is published quarterly by the Academy of Orthomolecular Psychiatry and the Canadian Schizophrenia Foundation. The Journal averages about 75 pages in each issue. It is not indexed in many major citation services, such as Index Medicus, and few medical school or university libraries in this country subscribe to it.

In a one year period (4th quarter 1981 to 4th quarter 1992), half of the full length articles were essays or reviews (15) with an additional 3 editorials, 5 case reports, 14 pages of Letters to the Editor, and 8 pages of book reviews. Only 10 articles presented data, and the vast majority of these were so flawed in methodology and so confused and confusing in purpose so as to prohibit labeling them as scientific reports.

The essays and reviews cover such topics as "Principles of Bio-Ecologic Medicine", "Towards the Orthomolecular Environment" ["We have seen how the migration of our species into space may bring us into the environment that most closely approximates the optimum for human beings, the ortho-environment. . ." (156)], "Allergies and Schizophrenia", and "Stigma and Mental Illness: Theory versus Reality."

Several of the papers and Letters to the Editor make imaginative and, perhaps, correct statements. For example, we are told that *Lactobacillus Casei* in the

human gut serves as an antidepressant and mild euphoriant since their cell walls contain phenylethylamine" ( 150 ). The use of mercury amalgams for filling teeth may result in chronic mercury poisoning (151 ). Manganese and nicotinic acid supplementation prevents tardive dyskinesia in patients receiving neuroleptics ( 152 ). Nearly 100,000 schizophrenic patients have been treated in the past 20 years. There is no doubt in the mind of every physician who has used these vitamins as part of a sophisticated treatment approach that it is remarkably beneficial ( 153 ). But data are seldom given, at most there will be an anecdotal case report.

The orthomolecular psychiatry may be called a belief system or subculture and self correcting as a science should be.

It is not cautious

It should be apparent that few, if any, research psychiatrists would agree with the orthomolecular definition of psychiatric disorders, their concepts of its pathogenesis, and the psychological instruments they use to measure its severity or its change with treatment. Given these vast differences, it is easy to understand why systematic attempts using research criteria to replicate their work invariably fail.

Orthomolecular psychiatrists say that clinical experience is enough to validate their procedures and that controlled blind studies are unethical. There may be other reasons, such as orthomolecular psychiatrists who are mainly in private practice. Only a few hold academic or research positions.

~~Few psychiatric patients have unique nutritional requirements.~~ Nutritional research in relation to psychiatry continues at a steady, if not spectacular pace. The pharmacological use of nutrients as in precursor therapy shows considerable promise. The special nutritional requirements of the early fetus and of geriatric patients are receiving constant attention and it seems very likely that these will be better understood and treated.

1981

POSITION PAPER

Senate Bill No. 346

"An Act relating to the treatment of mentally ill persons."

In October, 1981, Chapter 84, SLA 1981 became effective. This act completely revised Alaska's involuntary commitment laws for mentally ill persons that required involuntary hospitalization or treatment. Upon its effective date, there was considerable concern that the Act was procedurally cumbersome, which would require that an excessive amount of professional treatment staff time be consumed in filling out forms, testifying in court, and other non-treatment related activities. While the Act has proven workable and involuntary commitment of the mentally ill have continued to occur, there are a number of areas in the Act that have proven repeatedly troublesome since its effective date. Senate Bill 346 is an attempt to amend some of those troublesome provisions that have tended to inhibit or hamper the treatment of the involuntarily committed mentally ill patient.

The majority of the amendments that are proposed in Senate Bill 346 are technical rather than substantive in nature, a number of the amendments are intended to change the Act in a way that is seen by many as improving its effectiveness. Those amendments that are considered to require clarification are discussed below:

Page 1, Section 1, Line 20:

During the period of time the Act has been in effect, many areas have applied literal interpretation to the requirement that "every" opportunity be afforded to respondents to accept voluntary treatment. The result has been instances in which a prospective involuntary patient has repeatedly refused to accept voluntary treatment until the court hearing is actually in progress or about to begin and then suddenly decides he will accept voluntary treatment. The court proceedings cease and the petition for commitment is dismissed. If, prior to arrival to API for involuntary admission, the patient changes his mind and again refuses voluntary treatment (as has been the case), the entire involuntary commitment process must be started anew.

This has been cause for considerable concern and confusion. The amendment offered would change "every" opportunity to "reasonable" opportunity to accept voluntary treatment. This would allow for some discretion in its interpretation. Thus, if a patient repeatedly refused voluntary treatment, the commitment process would proceed even if the patient requested voluntary treatment at a later time. This would insure that treatment would be possible and the expensive commitment process would not have to be repeated unnecessarily.

Page 2, Section 2, Line 7:

Under the Act, the age of majority, for purposes of accepting or rejecting voluntary treatment without the consent of a parent or guardian was set at 14 years old. This has created a number of difficulties especially for those children between the ages of 14 and 18 years of age.

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For example, a 14 year old child could present himself at API and request admission without the knowledge or approval of the parent or guardian. As A.S. 47.30.845 (Confidential Records) does not give the hospital the authority to release any information to the parents or guardians of a person 14 years of age or older without the permission of the patient, it may not be legal for us to tell parents or guardians the whereabouts or condition of their child.

Also, a 14 year old child that would benefit from evaluation or treatment at API but does not meet involuntary civil commitment standards may not be admitted at the request of the parents or guardian unless the child voluntarily agrees to accept treatment. Thus, some mentally ill children may not receive necessary mental health care and treatment even though their parents or guardian attempt to provide these services for them. In cases such as this, it becomes even more ludicrous if the Division of Family and Youth Services attempts to file a petition to have the court find the youth as a child in need of aid by alleging that the child's medical needs are being neglected. If the parents or guardian sought voluntary hospitalization of the child that is 14 years old but the child refused treatment, then parental neglect, which would support a finding of a child in need of aid status, is not possible.

The amendment proposed would change the age of majority under this section from 14 to 18 years of age. This would be consistent with other statutes that govern the care of treatment of these children and adolescents as well as correct these legal anomalies.

Page 3, Section 5, Line 12

This would increase the period of time for voluntary hospitalization of a minor by 9 days (from 21 to 30 days). This additional time will increase the ability of the hospital to provide a more thorough and comprehensive evaluation and treatment program for mentally ill children,

Page 3, Section 5, Line 22-23,

This language would broaden the circumstances under which a minor may be accepted for admission at the hospital if the professional person in charge believes that hospitalization is necessary on a voluntary basis. This added provision could prove very helpful in addressing the treatment needs of mentally ill children and adolescents who are at risk of further deterioration and need hospitalization. Under the existing statutes, unless improvement in their condition can be reasonably expected, admission may not be possible. We believe this added provision will prove helpful in providing necessary care and treatment for this group of patients.

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Page 4; Section 6, Lines 6-26

The addition of this language provides needed clarification regarding the circumstances and procedures for releasing or retaining mentally ill minors with or without the consent of the parent or guardian. It is especially pertinent as there have been occasions when the safety of the child or others was questionable and the child was not committable but the parents or guardian have demanded immediate release of the child. This amendment will make it possible to insure the safety of all concerned prior to release of the minor.

Page 5, Section 7, Line 3

By granting mental health professionals the authority to take mentally ill persons into custody under an emergency situation and deliver them to an evaluation facility, a number of problems will be alleviated. Under the existing statutes, if a physician in an emergency room examines an individual that is brought to the hospital by relatives or friends, and the patient is clearly mentally ill and is in need of immediate hospitalization, the physician may have to call the police in order to have a peace officer take the patient into custody and sign an application for the patient's examination. This situation may occur in any hospital in Alaska including API.

Under the proposed amendment, the physician or any other health care professional that is included in the definition of a mental health professional under A.S. 47.30.915(11), can sign the application for examination under A.S. 47.30.705 and have the patient held in custody pending completion of the exam and receipt of an ex part order.

Page 5, Section 7, Lines 9-12

As written, this proposed amendment, if strictly interpreted, could tend to prohibit the completion of examination or evaluations of patients that were detained in jails or correctional centers even if qualified evaluation personnel were available. We certainly agree in principle that jails and correctional centers should not be used to hold the non-criminal, mentally ill; however, in practice, we have found that under certain exceptional circumstances, a jail or correctional center may be the only facility available to detain the patient at the local level for purposes of evaluation and insure the safety of the patient and the community.

It has been our experience that the utilization of these types of facilities is neither widespread nor indiscriminate and is used only on a very short-term basis. Nevertheless, when it is necessary to house patients in jails or correctional centers, we proceed with the examination, evaluation, and involuntary commitment process when the necessary resources are locally available. The time spent by these

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patients under these circumstances is then counted for purposes of the 24 hour and 72 hour time limit that is required for examinations and evaluations to occur by mental health professionals. This tends to insure that patients are not detained longer than necessary and treatment, if indicated, can commence immediately.

Consequently, we recommend that this amendment be deleted and that the existing language in A.S. 47.30.705 on lines 12-15 (in brackets) should be retained.

Page 5, Section 7, Line 24

This amendment would change the period of time for the first involuntary commitment from 21 to 30 days and is repeated throughout Senate Bill 346. The additional 9 days would tend to reduce the administrative workload of our treatment staff while having little or no effect on the period of time patients are actually involuntarily hospitalized.

Rather than interrupt treatment on the 21st day in order to undergo the 90-day commitment process, treatment could continue for an additional 9 days if necessary. This would allow medications and other forms of therapy an additional period of time to stabilize the patient, possibly resulting in a discharge of the patient between the 21st and 30th day.

Page 9, Section 10, Lines 17-19

This amendment is designed to insure that a less formal courtroom atmosphere is possible during the involuntary civil commitment process. This should make the commitment proceedings less painful and frightening to the mentally ill respondent.

Page 9, Section 10, Lines 27-28

The addition of this provision to allow a respondent to call his own experts or other witnesses to testify on his behalf is not seen as necessarily having an impact on the Division of Mental Health and Developmental Disabilities unless the respondent decides to call experts from API to testify on his behalf. It may, however, have a financial impact on the Ataska Court System if the respondent is indigent and the court has to pay the expenses of the experts and other witnesses called by the respondent on his behalf.

Page 12, Section 13, Line 7

This amendment would change the 120-day commitment to 180 days and is repeated throughout the bill. This change will reduce the administrative and procedural requirements necessary for the long-term, chronic mentally ill patients that require extended periods of involuntary hospitalization.

Page 13, Section 16, Lines 23-26

This additional requirement for notification of a patients family or guardian as well as any person known to been threatened by the patient of his unauthorized absence from the treatment facility is supported by the Division of Mental Health and Developmental Disabilities. We feel that this is an appropriate and necessary measure in cases such as this.

Page 14, Section 18, Lines 8-9

The addition of this language is seen as necessary and will correct what appears to have been an oversight when the he Act was drafted. It simply makes specific that computations of time for a patient being evaluated or a patient being detained for evaluation do not include Saturdays, Sundays, legal holidays, or transportation time and are not to be included in the 72 or 48 hour time limitation prescribed by the Act.

Page 15, Section 19, Lines 6-7

This adds mental health professionals among those that may not be held civilly or criminally liable for detaining and transporting a person, under the Act. This amendment is consistent with this section of the Act.

Page 15, Section 20, Lines 15-17

This amendment will require that an adult designated by the respondent must give informed consent in cases in which the patient is unable to give informed consent prior to certain treatments being authorized. We feel this is an appropriate addition to the Act.

Page 15, Section 21, Lines 28-29

This simply requires that an adult designated by the patient must be provided a copy of the patient's discharge plan. This is consistent with A.S. 47.30.845 under the existing statutes regarding confidential information.

Page 17, Section 24, Lines 6-8

This proposed amendment would clarify the circumstances under which the hospital may release confidential information and records to law enforcement agencies when they are concerned that a patient or ex-patient may present as an imminent danger to the community. Under certain circumstances, we feel it is in the best interests of the community and the patient to take such action.

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Page 17, Section 24, Line 13

The addition of this language will include hospitals operated by the federal government, such as the PHS facilities, for use as evaluation facilities for purposes of the Act. Under the existing statutes, these facilities are not included in the definition of an evaluation facility and some of these federal facilities have not been able or willing to be utilized in this capacity.

Page 17, Section 24, Lines 21-25

This addition to the definition of a gravely disabled person will significantly clarify and improve our position with respect to the involuntary care and treatment of these patients. An additional period of hospitalization may help prevent further deterioration of gravely disabled persons in order to avoid or reduce the risk of further tragedy and/or agony.

Page 18, Section 27, Line 1

This amendment offered in the bill will reduce the standard upon which a potentially suicidal person may be taken into custody and involuntarily committed. It is our belief that this is both necessary and appropriate given our current rate of death by suicide in Alaska.

Page 18, Section 27, Lines 5-8

As in the previous section, this language will alter the standard for involuntary hospitalization of a person that may present as a danger to others or to the property of others. This may allow some seriously mentally ill persons to be involuntarily committed before they actually harm another person or another person's property.

Page 18, Section 28, Lines 17-20

This simply requires that a psychologist or a psychological associate must be trained specifically in clinical psychology in order to be considered a mental health professional for purposes of screening, examination, and evaluation under the Act.

Page 18, Section 28, Lines 22-24

This amendment is intended to include in the definition of mental health professionals those registered nurses that have experience in psychiatric nursing in a JCAH accredited psychiatric hospital for purposes of screening, examination, and evaluation under the Act. This is considered an appropriate addition to this definition.

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The Department of Health and Social Services generally supports the amendments contained in Senate Bill 346 and endorses its passage with the exceptions noted above.

Recommended by: Philip Shapiro  
Philip Shapiro, M.D.,  
Director, Division of Mental  
Health and Developmental  
Disabilities

Date: 1/30/84

Approved by: Robert London Smith  
Robert London Smith, Ph.D.  
Commissioner

Date: 1/30/84

STATE OF ALASKA 1984 LEGISLATIVE SESSION  
FISCAL NOTE

Revision Date: \_\_\_\_\_

REQUEST  
Bill/Resolution No.: SB 346  
Title: An Act relating to the  
treatment of mentally ill persons  
Sponsor: Josephson and Halford  
Requestor: \_\_\_\_\_  
Date of Request: 1-11-84

FISCAL DETAIL Division of Mental Health  
Agency Affected: and Developmental Disabilities  
Program Category Affected: API

BRU, Program or Subprogram(s) Affected: \_\_\_\_\_

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis \* See Attached

Prepared By: James L. Scoles <sup>PS</sup> <sup>(R)</sup> Phone: 465-3370  
Division: Mental Health & Developmental Disabilities Date: 1-20-84

Approved by Commissioner: Robert London Smith Date: 1/30/84  
Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

The Division of Mental Health and Developmental Disabilities does not foresee any increase or decrease in expenditures as a result of the passage of SB 346 at this time. The primary purpose of this bill is mainly directed at reducing the procedural requirements of A.S. 47.30.655 - 47.30.915, changing the age of majority from 14 to 18 years of age, changing the period of time for the initial commitment from 21 to 30 days and the third period of commitment from 120 to 180 days, expanding the definition of peace officers to include mental health professionals, and slightly relaxing the standards for commitment.

We do not believe that any of these proposed amendments will increase or decrease the number of mentally ill persons that will require hospitalization. The amendments should, however, make it easier to commit the mentally ill which should result in more professional staff time available to provide direct patient care and treatment rather than excessive time being expended in the commitment process.

STATE OF ALASKA 1984 LEGISLATIVE SESSION  
FISCAL NOTE

Revision Date: \_\_\_\_\_

REQUEST  
Bill/Resolution No.: SB 346  
Title: An Act relating to the treatment of mentally ill persons  
Sponsor: Josephson and Halford  
Requestor: \_\_\_\_\_  
Date of Request: 1-11-84

FISCAL DETAIL Division of Mental Health  
Agency Affected: and Developmental Disabilities  
Program Category Affected: AP1  
BRJ, Program or Subprogram(s) Affected: \_\_\_\_\_

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING		0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

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SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER

*Mental Health Commitment Law*

DATE

*Oct. 14, 1983 (Anchorage)*

NAME

REPRESENTING

ADDRESS

PHONE NUMBER

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MENTAL HEALTH COMMITMENT LAW

Senate HESS

9/23/83

Attendance: Josephson, P. Moss. Sens. V. Fischer, P. Fischer, and Halford excused.

018 Josephson convened meeting regarding mental health commitment law testimony.

093 Josephson: Our purpose today is to receive testimony on the question of mental health commitment. I think our purpose would be better served if those wishing to testify could talk to how you evaluate the existing law, what changes you would like to see, rather than to address any specific work draft as a mark-up vehicle.

120 Sonya Benson, representing Representative Niilo Koponen: I don't have any specific testimony at this time.

129 Mrs. Ann Denardo, Family of Chronically Ill Victims, Fairbanks: Our son is schizophrenic and housed at A.P.I. We've had a lot of experience of with this commitment act and we find it to be burdensome, vague, and emotional. We feel families should have a great role in commitment procedures. A broader criteria for commitment should be studied based on ability to function with thought processes.

198 Denardo: Under paragraph 7, 'gravely disabled' means a condition in which a person is a result of mental illness. We would like to add 'or is not receiving such care in mental medical treatment as is necessary for health and safety' or 'a person who thought processes, perception of reality or judgment is substantially impaired'.

230 Josephson: Has this language been used anywhere else?

273 Denardo: I've studied other acts from other states, and this language comes from a combination of law in two or three other states. We also suggest that a study be done of other commitment acts.

299 Denardo: Commitment procedures should be redefined, with a view to creating a less adversarial situation and family. Court procedures are either civil or criminal. Commitment comes under civil procedure. In civil procedure, there has to be cross-examination and rules of evidence presented. This puts family members in the position of testifying against their child. I would like to suggest that the legislature study the possibility of another procedure, not civil and not criminal, but a procedure just for mental commitments.

335 Denardo: Mentally ill patients should receive better continuity of care as they move from hospital to community. Commitment procedures should reflect this need. We feel that the courts should be better apprised to the mental health system and the whole problem of severe mental illness.

374 Josephson: What do families experience in Fairbanks, being far from API? What happens as the family member enters the system?

389 Denardo: First of all, there aren't very many involuntary commitments from Fairbanks because we do all we can to convince the patient that they should go in on a voluntary admission. It's emotionally easier because the court procedures are skipped. We then have to pay for transportation to A.P.I. I think this is a legislative oversight. When there is an involuntary commitment, the patients airfare is paid to Anchorage. We have asked for designated beds. We desperately need a psychiatric unit here in Fairbanks. There are approximately 200 chronically mental ill people in this area. We have no half-way houses or programs. The Community Mental Health Center struggles along on a few dollars. They have a small day treatment program, but it's insufficient for the needs of the community.

421 Denardo: Because of the high cost of travel, meals, hotel accommodations, rent-a-cars, etc., I am only able to visit my son once a month. We feel that the most important part of treatment for the patient is proximity to family and friends.

477 Denardo: Twenty years down the line, we will look at the neuroleptic medications as pharmaceutical labotomies. With this medication, the patients are not cured. They are put into a medicated miasthma. They can't move. Patients say that the medication makes them feel unpleasant, sick, and tired. My own son was taken off the medication because he couldn't get out of bed. This is the condition in which he returns home.

510 Josephson: For the schizophrenic, is it the only thing we have?

559 Denardo: There are no other therapies that professionals are using at this point. At this time, more than 20% of the patients don't respond to this medication. Some patients do come out of their psychotic state, but many others fall into the pharmaceutical labotomies. Eventually, all patients develop a nervous disorder, which is totally irreversable. In many cases, the liver of the patient is ruined.

601 Josephson: Do you have any anxiety that the language, 'a person whose thought processes, perception of reality or judgment is substantially impaired', could be abused by committing people who are eccentric, etc.?

610 Denardo: No. The screening process is cumbersome and is so comprehensive that I can't see an eccentric person being committed.

621 Josephson: Is your organization part of a national group?

629 Denardo: We are part of The National Alliance for the Mentally Ill.

683 Denardo: There is inappropriate jailing of mental ill patients. People having psychotic crisis are treated as criminals. Once they get into the criminal system, it is quite hard for them to get out of it. They get on probation, they get put into A.P.I. and know that when they are released, they have to return to jail for breaking probation. They, in turn, have no incentive to be released for A.P.I.

740 End of Side A. Turned to Side B

001 Cathleen Nixer, Nurse Manager, Psychiatric Inpatient Unit, Fairbanks Memorial Hospital: Many of the problems we face with the mental health system, is based on a premise that the mental health service delivery system in Alaska is decentralized, when in fact, it is not. When the Mental Health Law was passed in 1981, there was only one in-patient treatment facility in the state, A.P.I. Today, there still remains only one designated in-patient treatment facility in the state.

103 Nixer: The easiest way for a mentally ill person to receive treatment would be through the commitment process. They at least receive care why the legal process is taking place. It's sort of a Catch-22 situation, since we encourage people to accept voluntary treatment, yet we provide no funding for this treatment.

210 Moss: What is the average number of patients in the Fairbanks facility?

216 Nixer: Our average daily count runs around 7 to 8 patients. We have an 11 bed in-patient unit, with a proposal for 1985 for 17 beds.

270 Josephson: What is the longest patient stay you've experienced?

274 Nixer: Approximately 30 days.

305 Moss: Will the 17 beds be additional beds?

308 Nixer: Yes.

318 Moss: Are you receiving any federal funding?

326 Nixer: Sometimes patients are eligible for the standard medicaid programs. We would like to see patients who may voluntarily elect to seek their treatment after a commitment process in Fairbanks, which is close to their home.

458 Maureen Phillips, Board of NARA: The designated bed problem has come up in a recent meeting with the NARA Board. The University of Alaska health coverage for mental illness does not allow for patients to be admitted to anything other than a "designated mental facility", not designated medical floor a hospital. I feel it is important that something be done about the designated bed situation here in Fairbanks.

491 Josephson: That appears to conclude the testimony this afternoon. We will make minutes of this meeting available to our colleagues who are absent today. Thank you very much for coming.

538 Meeting adjourned.

Senate Health, Education & Social Services Committee  
October 14, 1983  
Anchorage

TOPIC: Mental Health Commitment Bill (Work draft of "An Act relating to the treatment of mentally ill persons.")

ATTENDANCE: Senators J. Josephson (Chairman), R. Halford  
Excused - P. Fischer; Absent - V. Fischer, H. Moss

The hearing was commenced at 9:15 by Chairman Josephson.

Introductory remarks by Chairman Josephson:

Previously we've heard testimony in Anchorage and recently in Fairbanks on this issue.

This new draft incorporates ideas from Department of Health and Social Services, family groups and others, particularly those who work with troubled children.

New draft incorporates these changes: involvement of correction system is reduced in terms of dealing with the mentally ill; age change from 14 to 18; time computations changed from 21-90-120 days to 30-90-180 days for commitment periods; commitment period for minors changed from 21 to 30 days; records can be made available to law enforcement agency if substantial concern over any danger to community; qualifier added to right to privacy and personal possessions - if professional in charge determines not in the best interest of patient or will pose a threat to safety, visitors and telephone calls can be denied; approval of psychologist would be added requirement for patient wanting to change from involuntary to voluntary; court proceeding would be as informal as possible; family and guardians would be notified if patient is absent without leave; form consent required of parent or guardian of patient's right relating to alternative treatments; and notification of parent or guardian of discharge plan.

Other areas you may wish to consider today; hearings for minors; equal protection of the law relating to minors; time period commitment for minors; designated facilities; involuntary outpatient commitment; use of correctional system for mentally ill; and transportation costs for voluntary committed people where costs are paid for as required by statutes.

40

Jerry L. Schraider, M.D., Alaska Psychiatric Association

Appreciate the hearing being held, general reaction to working draft is supportive.

Have often been frustrated and confused over commitment law, mental health professionals are not all legalistically minded, don't have available legal counsel when working in these situations (often crisis situation) and must proceed best we can in interest of patient. Because of confusion, believes there's been some people that should've been committed who were not.

Will study draft further and hopes it will be submitted as legislation.

170 Ed Essa, Staff, Rep. Mre Tischer

Submitted letter addressed to Senator Josephson by Rep. Tischer stating that extensive research has suggested that nutritional deficiencies have a correlation with mental illness and that when deficiencies are identified and treated, improvements in the mental health of clients are made. Propose that the draft bill require extensive and mandatory nutritional analysis of each client be made upon admittance. This way the client is treated both mentally and physically.

190 Deborah B. Geeseman, M.D., private psychiatrist (formerly did work with children at API)

Supports most of what's in the bill. Suggested minor changes - 1) Pg 5, ln 19; instead of "21 days" should be 30 days. 2) Pg 4, ln 7; "the person" should be self.

Need a better working relationship with police force and understanding of what goes on with commitment laws.

Admission of minors - child under 14 cannot remain in hospital for evaluation or treatment for no more than 21 days (under current law) without having a commitment hearing. An adult who wants to be voluntary committed may stay in hospital as long as they want or treatment facility deems necessary. Then if they want to leave hospital, it becomes a legal issue.

For children, often a good evaluation cannot be made until after 3-4 weeks. Limited resources are available for treatment of children in Alaska. Only have one facility for extensive psychiatric treatment. Have some facilities for conduct and behavioral management of children (but full and have a waiting list).

260 Supports change in age from 14-18.

Pg 2, lns 23-29; not sure you need any of these three criteria, one just needs to make sure the person is mentally ill or gravely disabled. Or if it remains in #3 (pg 3, ln 1) should be "deteriorate further if" not "treated" (add not to sentence).

290 Sen. Josephson - While at API you noted that severe psychosis does not appear that often below the age of 14, correct?

Yes.

Sen. Josephson - What additional facilities do you feel Alaska needs for young children?

Difficult in state with our small population and distance from other states (where we could jointly share use of facilities). Presently we don't have a sizeable population of psychiatric young children. When we do, they will need a place, the only facility we have now is API. Would like to see other facilities that would address more extensively psychiatric needs of children.

As draft now stands, court has to get involved in 30 days, recommends 30 days be taken out, child could be a voluntary patient.

Many times children need evaluation when they encounter some trauma (ex: divorce of parents). If that evaluation goes beyond the time limit set, they could end up with commitment as legal statement on their record. If it remains on their record, can hamper their future.

Pg 3, Section 47.30.095; support it but has trouble with the wording. #2, lns 18-21, part (a)(b) (lns 22-29) - believes it to imply if child is dangerous, can still discharge them against medical advice. Dosen't feel its consistant. #2, ln 18; should read "treating physician," release of (should be added) "the minor" would be seriously detrimental to child's health that (should be added) "the treating physician may". (b) lns 26-29 the minor is likely to cause serious harm to self or others, or there's reason to believe the release could place the minor in immediate danger (should be added) "refuse to discharge".

60            Joseph Reum, Handicapped Services Coordinator, Municipality of Anchorage

Pg 4, ln 26 - "commitment hearing, to be held if needed", Who determines need?

Sen. Josephson - Depends whether patient is voluntary or involuntary.

80            Dr. Conrad, Superintendent, API

Submitted memorandum on admission statistics for FY'83. Out of 1013 admissions, 500 were voluntary, 36% came involuntary under Title 47. Out of 100 involuntary patients, 73% have dropped out of involuntary channel before 72 hour limit.

Agree with Dr. Geeseman's comment on page 3 that paragraph 2a is inappropriate, not allowed that option with an adult.

Under present statute, cannot release information on history of violence to law enforcement agencies. In our judgement, release of this information (when there's concern about safety) might be helpful.

140            Patient would be better served by expeditious entry into treatment using physician's certificate. Most times used is after a suicide attempt.

150            Sen. Halford - In analysis of American Psychiatric Association guidelines, we don't allow certain types of evidence, we protect communication between patient and doctor. What kind of a problem does this bring up in involuntary commitment?

Has caused a problem by not allowing hearsay evidence at commitment hearing. Often it's highly relevant and meaningful evidence but due to rules of evidence not allowed because it's hearsay.

180            Often relatives and other people are frightened to testify for fear the person being committed will hold a grudge or seek revenge later. Also consider some people (to testify) live far away (would be expensive for transportation cost).

200 Sen. Josephson - What happens during, example a domestic conflict and people exaggerate testimony or state it falsely?

When it does occur, then don't rely on element of danger but fall back on object of evidence of mental illness. Do not proceed to commitment hearing if lacking evidence of mental illness.

210 In vast majority of cases, most do not go forward to hearing, and where there is mental illness, majority of patients accepts need for treatment. When cases do go to court, public defenders and probate masters become very involved.

240 Sen. Josephson - What is treated as confidential?

Commitment hearing itself is confidential.

260 David D. Samson, M.D., Psychiatric Supervisor, Anchorage Community Mental Health Center.

Mentally ill are more prone to be brought in for disturbing peace, public nuisance kinds of things, where their liberties are not essentially protected.

Concept of outpatient commitment should be addressed. What do you do when outpatients don't show up for their scheduled appointments?

Generally supportive of draft and comments that have also been made.

### PART III

Voluntary medication on outpatient is a problem. Sometimes people are crafty enough to manipulate the system and be released (these are the dangerous ones).

30 Natalie Gottstein, Executive Director, Alaska Mental Health Association

Commends Committee for making changes, particularly inclusion of physician to be able to institute commitment procedures and redefinition of gravely disabled.

Pg 2, ln 10; concerned about definition of "timely", what's considered timely?

Dr. Conrad - Would interpret to be 8-12 hours.

70 N. Gottstein - Pg 16, ln 5; definition of mental health professional - important people working in the bush (social workers, etc) be included in this definition. A further clarification of social worker might be in order due to so many areas of social work.

90 Sen. Josephson - There's another bill on licensing of social worker and we may run into some difficulty with that.

100 Sen. Josephson - Is there an official position by Mental Health Association on this?

Not on this, but we will make recommendations before January.

110 Sen. Halford - What does Association think in terms of communication between doctor and patient, should be available in commitment hearings or not?

Don't have an official position. My opinion - if hearings are closed, then in very specific and well defined instances, that privilege should be opened. In individuals right to receive treatment, the doctor's opinion certainly is an important matter.

150 Sen. Josephson - Question of changing or relaxing rule of confidentiality, would it have the effect of causing people not to tell doctors what they would otherwise say? Or would it have a useful affect in bringing these matters out into the commitment hearing? The real danger would be if patients refused to give information to their doctors for fear it would be used against them (in court). That people shouldn't be afraid to see a psychiatrist when they have problems.

These relaxations in confidentiality need to be carefully worded, possibly be limited to psychiatric people for involuntary commitment.

200 Dr. Jay Verkozen, clinical psychologist (private practice)

Pg 13, lns 27-28; issue of psychosurgery, lobotomy, or other comparable forms of treatment. Not specific with other comparable forms. Consider these types of barbarisms and should be done away with. Psychosurgery has been abused.

PART IV

80 Sen. Josephson - (to Dr. Conrad) Has there been any record keeping in Alaska of psychosurgery or lobotomy given?

Dr. Conrad - No, the only way would be to ask all the neurosurgeons. Electroshock - no one to my knowldege at API has been administered with it.

J. Verkozen - But it does go on regularly at Providence.

Pg 14, lns 19-23; suspension of people's rights; if you're going to do something to someone, need to be clear about it with the person and if it's not in their interest to know about it, then it shouldn't be done.

150 You can't treat people psychologically unless you get them involved in it. If somebody might be better off with something, it dosen't mean you can force it on them.

170 Pg 8, ln 20 (#4) "efficient" - efficient for what? For commitment? For civil liberty?

250 Pg 8, ln 15 (#2); Right to view and copy all petitions - they should be given copies and helped to understand it.

Pg 12, lns 25-27; good point that family or guardian be notified on patient's absence.

Pg 11, ln 14; Disagree with 180 days for commitment, more advantageous for longer length of time.

Pg 5, ln 22; "gravely disabled" - too broad.

Pg 6, lns 4-5; replace "maximum extent possible" with absent of violence.

PART V

Dr. Conrad - Two cases of patients at API treated involuntary:  
1. if violent to themself or to others; 2. severly catonic people  
(who don't eat or drink)

J. Verkozen - Pg 6; objects to (e)(2) and (3), lns 14-18; aren't  
necessary.

Pg 13, ln 9; objects to 72 hours, procedure should be  
speeded up rather than be long.

Pg 4; notion of deputizing all physicians in state so they  
can commit someone. This authority should stay with the police.  
All physicians shouldn't have this type of power. You're just  
making a cosmetic change, you're still locking someone up.

80 Dr. Glade Birch, Acting Director, Anchorage Community Mental  
Health Center

It's a good document.

Balance of right of people to receive treatment and their  
civil liberties. That's the balance we're maintaining.

Regarding who has the authority to commit someone, remember  
we're talking about all Alaska (including the bush). Physician  
does have degree of training in recognizing mental illness, where  
police officer dosen't. To protect civil liberties of people,  
it's better for at least someone qualified in mental health to  
make determination of commitment.

As a neuropsychologist, be very careful before you write  
into statute prohibition against treatments.

150 Individuals released as outpatients from API, isn't a com-  
fortable solution to it. You may consider transitional living  
(intermediate type of commitment). (A transitional facility  
where they could receive supervision.)

Has reservations about having licensed social workers being  
able to commit someone (pg 4). You may get a social worker who  
has no actual diagnostic abilities.

180 Topic of confidentiality. Two solutions: 1) treatment (must  
maintain confidentiality in this); 2) examination with notice for  
commitment (person knows it is commitment, does not have to dis-  
close information, takes away effectiveness of examination).

190 Sen. Josephson - What a person discloses when he wants treatment  
is going to be in stream of what is revealed in commitment pro-  
cess, no way to unlearn that material.

That's why I tried to make the distinction. The disclosure  
of patient's statement when presenting himself for treatment  
needs to be protected. If someone is going to testify at commit-  
ment proceeding, may have to be a separate examination by another  
person.

200 Steve Harrison, Regional Administrator for South Central Region, Division of Mental Health

Agrees with Dr. Birch in including mental health professional in emergency detention. If we use a mental health professional, we should use those with national accreditation for social workers.

Law is workable, changes are good.

240 Frances Purdy, Mental Health Program Coordinator, Behavioral Health Division, Municipality of Anchorage

Thanks for nonsexist law.

Pg 3, Part a; lns 22-25 should be deleted, they should not be able to release someone who is dangerous.

Pg 12, lns 25-27; good idea to notify parents or guardians of patient's absence. May also want to add anyone that has been threatened by patient, also may add immediate notification instead of 3 hours.

Pg 14, lns 24-27; good idea.

Consider what other states have done with mental health professional being the office of involuntary commitment. Probably more important for Anchorage than for the bush. Impractical to have officer in bush for involuntary commitment. In Anchorage, specifically we're beginning to need an area of expertise in just emergency cases. Check into Washington state statutes. They have designated person who is trained to do reading of rights, is impartial, not hired by institution or other agency.

#### PART VI

Jim Parsons, Manager, Behavioral Health Division, Municipality of Anchorage (former member of licensing board of psychologists)

Concurs with Purdy's opinion of release of minors when we don't do that with adults.

Most of my concerns have been covered.

Pg 16; licensing law for psychiatrist is generic rather than speciality. There are some psychologist trained in areas other than clinical who may not have expertise in mental illness at all. May be a good idea to say licensed by state with adequate clinical training or something similar rather than clinical psychologist since we don't license in that sense.

Mention of social workers appears to be too broad. Perhaps should use national accreditation with it. Too broad to say experienced in field of mental illness rather than having some type of specific training in that area.

30 Cecilia Kleinkauf, Alaska Chapter, National Association of Social Workers

Pg 16; issue of professional social work, as included in definition of "mental health professional" - just received the draft copy and will have to be reviewed by board before Assoc. takes a position on it and makes recommendations.

Admission of minors at API - the bill, as it is, would constitute age discrimination on state in regards to minors. Minor has a constitutional right to liberty equal to adults. Unconstitutional to deprive minor of right to liberty for a greater amount of time than an adult (in institutionalizing). We have repeated this point at every hearing.

One item not covered in bill is protection of court for child's right regardless of his/her parent's right. Does not provide the child the right to a court hearing which court then hears evidence as to institutionalize the child. The bill leaves the right to child's parents and to mental health professional. Sometimes parents don't act in best interest of their children.

120 There are a number of children institutionalized at API whom mental health professionals say these children are not probably mentally ill but "there's no place else to put them".

The previous director of State Division of Mental Health testified at Senator Parr's Committee stating it is frequently difficult, if not impossible, to make definitive diagnosis with respect to mental illness in children.

130 Sen. Josephson - Which is an explanation as to why we have a longer period to evaluate. I don't think the Constitution requires that you cannot make classification if there is a rational basis for it.

250 Why is it ok to institutionalize a child without court's protection in mental illness, and in statutes of state, it's not ok to institutionalize without court's protection when it comes to delinquency?

#### PART VII

50 Grandfathering clause on social worker - the language and amendments proposed by National Association Social Work Chapter. Only spoke to baccalaureate level of social work. Individuals will not be grandfathered at master's level of social work with training in any other field. Anyone who is grandfathered, who wishes to be called a social worker and be licensed under social work law, could at maximum, only be licenses as a baccalaureate level. Only level grandfather amendments refer to.

60 Meeting was adjourned by Chairman Josephson at 12:50 pm.

# BARANOF MENTAL HEALTH CLINIC

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STANLEY T. LAUGHRIDGE, Ph.D.  
CLINICAL PSYCHOLOGIST

12-16-83

Honorable Joe Josephson  
Alaska State Legislature  
Pouch V  
Juneau, AK 99811

Dear Senator Josephson:

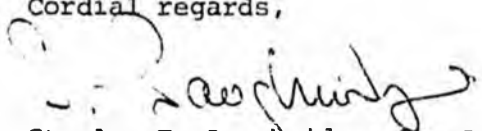
I have read the proposed draft bill that you are submitting to the legislature in the forth coming session. It contains precisely those very important amendments and stipulations that I have been trying to encourage for a number of years regarding mental health commitments.

If you will check the admission record of Sitka over the past six and a half years, that our clinic has been here; you will see that we have an extremely low admission rate. This is because we have treated people in our local hospitals rather than sending them to API. Often in doing so we have had great difficulty getting under the 72 hour limit before having to go into the court room. Usually within 72 hours, I am able to obtain the person's voluntary commitment but on those few cases where I am not able to do so we end up sending some to API that we could very easily have treated in our local hospitals.

Your bill will very nicely resolve that problem and should, if we in the mental health field do our part, reduce the admission rate to API dramatically.

Congratulations on your good work.

Cordial regards,

  
Stanley T. Laughridge, Ph. D.  
Clinical Psychologist

cc: Joe Adelmeyer, ACSW Supervisor  
Susan Will, R.N., M.S.

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Senator Joe Josephson  
Alaska State Legislature  
Senate  
Pouch V.  
State Capitol  
Juneau, AK 99811

Oct. 27, 1983

RE: THE MENTAL HEALTH COMMITMENT LAW

Dear Senator Josephson:

We urge you to incorporate the changes proposed by the Department of Health and Social Services and the Alaska Psychiatric Association and in particular the amendment to add licensed psychologists in changing procedures for emergency detention for evaluation in Sec.47.30.705.

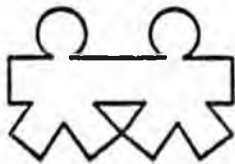
In our experience the present state of things in which a peace officer must be convinced that there is probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to himself or others and should be taken into custody for evaluation is highly precarious. Just recently we had a case of a possible suicide and homicide situation in which help was delayed past a critical point because the peace officer did not believe the physician and licensed psychologist who were urging intervention. When it's a matter of arranging a flight before dark every minute is crucial. It is perhaps unfair to expect a peace officer to understand the dynamics of depression or paranoia without any particular training when years of post-graduate training and supervised experience are needed for a psychologist to do so. It is time Alaska made better use of the unique qualifications that psychologists do provide for intervention in and prevention of tricky situations.

Sincerely,

*Judy Ringerson-Knutsson*  
Judy Ringerson-Knutsson, Ph.D.  
Clinical Psychologist



The Cordova Community Hospital



# Central Peninsula Mental Health Center

P.O. Box 4683 • KENAI, ALASKA 99611 • (907) 282-7501

February 1, 1984

Senator Joe Josephson  
Alaska Senate  
Pouch V (MS 3100)  
Juneau, Alaska 99811

Dear Senator Josephson,

I am writing relative to Senate Bill No.346 related to certain revisions of Title 47 of the Civil Commitment Statutes.


I am strongly in favor of the revisions relative to admission of minors, changing the age from 14 to 18 years of age.

The procedure for emergency detention for evaluation is improved by allowing the mental health professional in addition to a police office to have an individual taken into custody. The procedure relative to placement or utilization of the jail for protective custody and holding prior to transportation is appropriate and is an accurate description of the need for rural areas such as Kenai.

I am also in favor of the use of a 30 day as opposed to a 21 day commitment procedure.

I sincerely appreciate the opportunity to comment on the revisions in this Statute.

Respectfully Submitted,

  
Paul E. Turner, Ph.D.  
Clinical Psychologist  
Program Director

PET/jvh

Ann DeNardo  
Families of Chronically Mentally Ill  
Victims  
SR Box 30754  
Fairbanks, Alaska 99701

Senator Joe Josephson, Chariman  
Health, Education and Social Services Committee  
Pouch V  
Juneau, Alaska 99811

RE: Chronic Mental Illness

Dear Senator Josephson:

The enclosed article tells you who I am and what I am about.

During last week's teleconference with our Fairbanks legislators, I addressed short comings in Chapter 84, Laws of Alaska, relating to mentally ill persons.

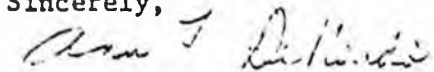
1. Families should have a greater role in and be consulted with regard to commitment procedures.
2. A broader criteria for commitment should be studied, based on ability to function rather than just being a danger to self or others.
3. Commitment and guardianship procedures should be redefined with a view to creating a less adversarial situation between patient and family.
4. Mentally ill patients should receive better continuity of care as they move from hospital to community and commitment procedures should reflect this need.

In this week's teleconference we will address the glaring lack of hospital space for our chronically mentally ill relatives. While other states are grappling with problems of closed wards and community acceptance, Alaska struggles to get patients out of the corridors and into the wards! The only State facility, Alaska Psychiatric Institute, is perpetually overcrowded.

The Fairbanks Memorial Hospital is willing and able to become a designated treatment facility for psychiatric patients. I don't understand the mechanisms involved in such a designation and would appreciate your telling me. I do understand the urgent need for such a facility in the Interior.

I urge you to work toward this goal as a positive step toward a better mental health delivery system for the entire State of Alaska.

Sincerely,



Ann F. DeNardo  
Families of Chronically Mentally Ill Victims

Enclosure

AD:aw

Families of CMI Victims  
512 Box 30757  
Fairbanks, Alaska 99701

RECOMMENDATIONS FOR AMENDMENTS TO ALASKA'S COMMITMENT ACT

The Commitment Act, Chapter No. 84, Laws of Alaska, has caused a great deal of pain to families already engulfed in an ultimate tragedy--the loss of a loved-one; loss through the ravages of a disease as old as mankind, and for which we know no cause or cure.

We are familiar with the Commitment Act on a experiential level and on paper and make the following recommendations for amendments:

1. Families should have a greater role in and be consulted with regard to commitment procedures.
2. A broader criteria for commitment should be studied, based ability to function when thought processes, perception of reality or judgement is substantially impaired.
3. Commitment procedures should be redefined with a view to creating a less adversarial situation between patient and family.
4. Mentally ill patients should receive better continuity of care as they move from hospital to community and commitment procedures should reflect this need.
5. The courts, the judiciary, should be better apprised of the mental health system.

The above five points are overall conclusions. Some specific changes by page, section, and line were given in testimony before Senators Josephson and Fisher of the Hess Committee in Anchorage on March 19, 1983.

The above five points are still pertinent and present a good summary of the attached material presented in testimony before the HESS committee on September 23, 1983, in Fairbanks, Alaska.

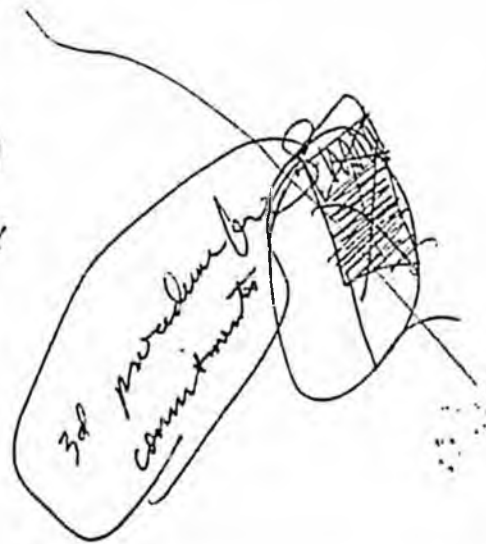
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COPING

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TESTIMONY BEFORE THE SENATE HESS COMMITTEE  
Re: Mental Health Commitment Law  
September 23, 1983 - Fairbanks, Alaska

The families of severely mentally ill victims have worked with the Mental Health Commitment Law for two years. We wish to convey our position regarding the bill.

Section 47.30.660. This section sets out the powers and duties of the Department of Health and Social Services. Paragraph (4) of this section calls for the Department to designate, operate and maintain treatment facilities...to provide...care and treatment for the mentally ill. A treatment facility is defined in 47.30.915(15). In spite of the directive to designate treatment facilities, the API remains Alaska's only such facility.

Section 47.30.670. This section sets out standards for voluntary admission. A patient who accepts voluntary admission can leave the hospital anytime "against medical advice," or AMA. This is why there are so many voluntary admissions as opposed to involuntary. A psychiatrist might do a screening at this point to determine a patient's ability to function and make these decisions.

Section 47.30.705. This section addresses emergency detention for evaluation. It states that a police officer "...may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available... (and) the peace officer shall...be interviewed by a mental health professional at the facility." There are no mental health professionals at the correctional facilities.

Section 47.30.710. Examination. This section states that a person so placed in a correctional facility shall be examined and evaluated within 24 hours. This puts a person in jail for 24 hours because of an illness he cannot control. There is no other illness where, due to the illness itself, a person is incarcerated!

Section 47.30.715. Acceptance of Order. In this section the court is ordered to set a date for hearing and notify the respondent's attorney. There is no directive for the attorney to make an effort to see the respondent. Often the first contact the respondent has with his attorney is in the courtroom itself, immediately preceding the hearing.

Section 47.30.735. This section sets out the civil procedure for a 21 day commitment. These procedures should be redefined in order to create a less adversarial situation between patient and family. Families become the caretakers following hospitalization in 50-55% of the cases. It is important to understand that hospitals do not cure patients. They are only stabilized with neuroleptic medications and returned to the family with their illness intact, and the added belief that the family has turned against them.

Judicial procedures are either civil or criminal. Commitment procedures are civil. Families feel it might be possible to create a new area within which commitments could be handled. We request the Judiciary Committee to study this concept with a view toward lessening the adversarial approach.

Section 47.30.790. This section deals with absence without leave. If a patient is absent from a treatment facility without authorization a peace officer is instructed to take the patient into custody and return him to the treatment facility. This section should include a provision that the family or guardian be notified of such absence with a specified time, say 3 hours.

Section 47.30.795. This section addresses involuntary outpatient care. Paragraph (c). It states that if it is determined that respondent needs inpatient care due to a critical condition, oral and written notice that he must return to a treatment facility within 24 hours must be given him. If the patient is experiencing thought disorder this gives him 24 hours to get out of town. This section further states a police officer shall pick up the patient if he has not complied with the notice. The respondent is not a criminal, to be served and treated as a criminal. We object to the constant posture of addressing mental disease as criminal.

Section 47.30.925. This section deals with patient rights. Paragraph (6) of this section prevents psychosurgery, lobotomy, or other form of treatment without specific, informed consent of the patient and a court order. We would like to see a provision included that would also require specific informed consent given by "an adult designated in accordance with 47.30.725". (This is an adult designated by the respondent.)

Again, paragraph (8) of this section should insure a copy of the discharge plan is given to "an adult designated in accordance with 47.30.725". Families rarely know of any discharge plan and it is the nature of the disease that patients will not follow through without help.

Section 47.30.845. This section deals with confidential records. Paragraph (2) of this section makes it possible for an individual to whom the patient has given written consent to receive records and information on the patient. This release of records should be dated within a specified time period, -say- one year. This release of records to a designated individual should not be open-ended, but lapse within a restricted time frame.

Section 47.30.870. This section deals with transportation of patient and escort to the designated facility following involuntary commitment. (In this State, of course, this means a trip to Anchorage.) There is provision authorizing the Department to pay for transportation of patient and escort the API for INVOLUNTARY commitments only. Provision should be made to authorize payment of transportation costs for VOLUNTARY commitments as well. At present the family, or the patient, must bear this cost. This creates a continuing financial burden for families trying to remain "case manager" over the years. The continuing financial burdens encourage families to give up attempts to maintain relationships beneficial to the patient.

Section 47.30.875. This section addresses nonresident patients and the return of a mentally ill resident of this state who has been placed in a facility outside of this state. Paragraph (c) of this section is the only section of this Act which mentions the importance of maintaining family relationships and encouraging visits beneficial to the patient. It is ironic that this important approach to treatment is mentioned only under such subtitle as "nonresident patients". We would like to see the encouragement of more family involvement.

Section 47.30.915. Definitions. Paragraph (7) defines "gravely disabled" and paragraph (10) defines "likely to cause serious harm". It is the contention of everyone involved with this Act that these definitions must be broadened. This is such a complicated and emotional issue that agreement is difficult. As a consequence many people who need mental health treatment desparately are not being served. Instead of waiting for a person to commit a crime, or attempt to commit a crime, we recommend the following criteria to enlarge the definition of a mentally ill person for purposes of providing treatment:

- (7) "gravely disabled" means a condition in which a person, as a result of mental illness,...
- (8) or is not receiving such care and mental medical treatment as is necessary for health and safety, of a person whose thought processes, perception of reality or judgement is substantially impaired.

We would like to see a study of other states' commitment laws in reference to their criteria for commitment.

*2 or 3 other states*

# ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH  
of  
AMERICAN PSYCHIATRIC ASSOCIATION

February 4, 1983

Senator Joseph Josephson  
Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

Dear Senator Josephson:

The Alaska District Branch of the American Psychiatric Association is a professional organization which represents the majority of the physicians in Alaska who are specialist in the field of psychiatry. The membership is composed of psychiatrists who work in both the private and public sector. The members of our organization have an ongoing interest in any subject which affects the treatment of mentally ill individuals. As a result of this interest we were actively involved in the development and passage of the Alaska Statute for the Civil Commitment of the Mentally Ill (AS 47.30). Our national organization has also been very active in monitoring the subject of civil commitment and has recently developed guidelines on this subject which we recently provided you.

The Alaska District Branch supports fully the objectives of the current Alaska Statute on Civil Commitment of the Mentally Ill which became law in October of 1981. After the first year of experience with this new law and after discussion with judicial and civic leaders, we wish to recommend certain amendments to the law which we believe will assure that its worthwhile goals are more effectively achieved. These amendments are provided in the enclosed material.

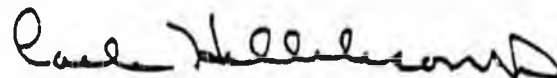
The experience during the past year has indicated to us that the following refinements are needed:

1. The Definition of "Gravely Disabled" needs to be expanded to recognize that some patients, if left untreated, will needlessly lose their capacity to be self-reliant.
2. There are many instances when physicians have clearly psychotic or suicidal persons under care in an emergency setting, and need to arrange for their hospitalization at the Alaska Psychiatric Institute. The current requirement that a peace officer be called to form an independent judgement and duplicate work already accomplished is unnecessarily cumbersome. Allowing the physician the authority to arrange for emergency detention would simplify this procedure. When family and friends are willing and able to transport the patient, the peace officer would be free for more serious business.

3. The patient and society could be better served if the rules governing evidentiary and procedural matters at commitment hearings under this law were promulgated so as to facilitate a more informal and efficient presentation of all the relevant facts.
4. The definition of "likely to cause harm to self and others" has set such a rigid standard that some of the most dangerous clients have not been committed. The issue of dangerousness is a complex one and the judge must be given the opportunity to weigh both the magnitude of the risk and the magnitude of the harm. Also, the law needs to recognize that harm to others may include property.
5. An unanticipated consequence of the current law, has created an undue hardship in the care and treatment of children under the age of 14. The right to be voluntarily hospitalized and treated, which is available to everyone over the age of 14, is curtailed for children and limited to 21 days. After 21 days, even if the parents, the child, and the treating physician agree that continued treatment is needed, the law forces them to obtain an involuntary commitment.
6. Since very few persons actually require involuntary commitment, it would facilitate their care and treatment if the law recognized that patients in this group lack the necessary understanding to accept treatment voluntarily, and authorize the use of medications and other treatments under the direction of a licensed physician subject to the medical rights already guaranteed the patients in Article 9 of Section 47.30.
7. In some instances the law requires the staff of the hospital to respond "immediately" when, in practice, a "timely" response is all that is practical or needed.

As we gain experience with the new commitment statute, I am sure we will have other suggested changes. However, for the present time, we feel these changes are urgently needed to iron out some of the procedural problems and to improve the care and treatment of the mentally ill. We would be happy to provide any additional documentation you may need. We hope you will consider putting the attached amendments in bill form and submitting them to the Legislature.

Sincerely,



Carla Hellekson, M.D.  
President  
Alaska Psychiatric Association

# Alaska State Legislature

REP MAE TISCHER  
CO-CHAIRMAN

REP MILO FRITZ  
CO-CHAIRMAN



MEMBERS:  
REP. MIKE MILLER  
VICE CHAIRMAN  
REP. BETTE CATO  
REP. MIKE DAVIS  
REP. PETER GOLL  
REP. NIILLO KOPONEN

House of Representatives

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

POUCH V  
STATE CAPITAL  
JUNEAU, ALASKA 99811  
(907) 465-3777

October 12, 1983

The Honorable Joe Josephson  
Member of the Alaska State Senate  
Anchorage, Alaska 99501

Dear Senator Josephson:

Thank you for your kind offer to submit a suggestion to your committee during deliberations on the "Mental Health Commitment Law," scheduled for Thursday, October 13.

I am sorry that House HESS hearings in Fairbanks prevent my discussing this matter with your committee personally; however, I have asked Ed Essa to present this letter to you for your consideration.

In recent years, medical science has come a long way in better understanding mental illness. Research has uncovered some very interesting facts. Perhaps the most intriguing discoveries relate to the effects vitamin and other nutritional deficiencies have on our mental well-being. Extensive research has suggested that nutritional deficiencies have a correlation with mental illness, and that when deficiencies are identified and treated with vitamin therapy, some startling improvements in the mental health of clients are made.

Given this information and with the knowledge that our mental health is tied intricately to our physical health, I am proposing that the draft bill you are considering be adapted to require an extensive and mandatory nutritional analysis of each client upon admittance; and that these findings be used as the basis for appropriate intensive therapeutic treatment, along with other applied therapy. In this way, the whole client is treated -- both mentally and physically.

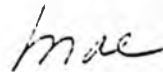
Your favorable consideration of this suggestion may well serve to improve the methods of treating many Alaskans who want to be healthy, while helping to induce a marked decrease in the recurrence of mental illness.

Senator Josephson, thank you for extending me the courtesy to be heard today. I join with many others in seeking a continued dialogue on this encouraging new approach to a long-standing and seemingly worsening

Representative Mae Tischer  
October 12, 1983  
Page Two

problem that faces our state and our nation.

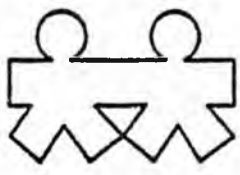
Respectfully,



Mae Tischer  
State Representative

MMT:wtl

Send to Nancy ✓



# Central Peninsula Mental Health Center

P.O. Box 4683 • KENAI, ALASKA 99611 • (907) 282-7501

October 25, 1983

Senator Joe P. Josephson  
1526 "F" Street  
Anchorage, Alaska 99501

Dear Senator Josephson,

I am writing to you relative to recent Senate HESS Committee Hearings on the Title 47 Commitment Statute.

I am writing to request that licensed psychologists be given the same prerogatives as physicians within the Statute. For example in 47.30.705, the recommended change is that emergency detention for evaluation can be made by a police office or a physician. Generally, however, licensed psychologists are much more able in terms of training, expertise, education and practice to be able to make determinations of need for emergency detention. It would seem wise to include this independent profession in this activity. There are also other sections that are being amended in Title 47 adding the medical profession as the identified entity, for example 47.30.815(b)(4). In those instances I think that clinical psychologists should also be included.

Thank you very much for this opportunity to correspond with you relative to this issue.

Respectfully,

*Paul E. Turner, Ph.D.*  
Paul E. Turner, Ph.D.  
Clinical Psychologist  
Program Director

PET/jvh

Send to Hans

Oliver Osborn, M.D.  
Cordova Medical Clinic  
Box 310  
Cordova, Alaska 99574

Nov. 5, 1983

Senator Joe Josephson  
Pouch V  
Juneau, Alaska 99811

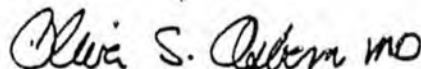
Dear Senator Josephson,

I am writing in regard to the proposed changes to the Mental Health Commitment Law. My concern is that the proposed law will not allow a licensed psychologist in Alaska to initiate emergency detention for evaluation (under sec. 41.30.705).

Here in Cordova, our health team includes a licensed psychologist working in a mental health clinic which is a department of the hospital. The psychologist is often the person most immediately involved with patients who might be a danger to themselves or to others. It is imperative that this professional be allowed to initiate emergency detention for evaluation in cases with serious potential. It has been our experience that the psychologist often works closely with the local police department to defuse crisis situations in Cordova.

Thank you for your attention.

Sincerely,



Oliver S. Osborn, M.D.  
Member, Cordova City Council

# COMMUNITY MENTAL HEALTH CENTER

Box 2274  
Homer, Alaska 99603-2274  
(907) 235-7701



October 25, 1983

Senator Joe Josephson  
1526 "F" Street  
Anchorage AK 99501

Dear Senator Josephson:

It has come to my attention that the Senate Health Education and Social Services Committee is reviewing Alaska's Mental Health Commitment Law of 1981 (SP100). I am essentially in support of the changes which have been proposed.

Under Section 47.30.705 regarding emergency detention for evaluation, I would recommend the following addition to the revised statute:

"A peace officer or a physician licensed in this state or a psychologist licensed in this state who has probable cause to believe that a person is suffering from a mental illness and is likely to cause serious harm to the person or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken in to custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while needing transportation to a treatment facility. The peace officer or physician or psychologist shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility."

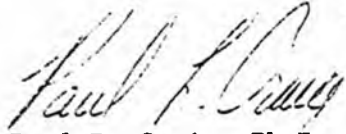
In addition, I would recommend that AS 47.30.815(b) (4) be further amended to read:

"A peace officer or physician or psychologist responsible for detaining or transporting a person under AS 47.30.700-47.30.915."

Alaska has a pool of well qualified psychologists whose competency and training have been carefully scrutinized by the Board of Psychologists and Psychological Associate Examiners as well as the Division of Occupational Licensing. Insofar as many rural mental health practitioners in the state are licensed psychologists, it would seem appropriate and expedient to include this professional group in the emergency detention clause. With regard to

familiarity with psychiatric disorders, conducting mental status evaluations, and determining the appropriateness of civil commitment, licensed psychologists are well prepared to handle the responsibilities involved in civil commitment in a professional manner.

Thank you for considering this input to the legislative process. I appreciate your consideration.

A handwritten signature in cursive script, appearing to read "Paul L. Craig".

Paul L. Craig, Ph.D.  
Psychologist, Director

PLC: cjs

# ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH  
of  
AMERICAN PSYCHIATRIC ASSOCIATION

February 15, 1984

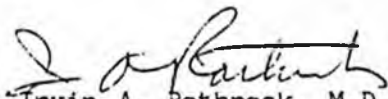
The Honorable Joseph Josephson  
Alaska State Senator  
Pouch V  
Juneau, Alaska 99811

Dear Senator Josephson:

At a recent meeting of the Executive Committee of the Alaska District Branch of the American Psychiatric Association this group voted to support your bills regarding changes in the involuntary hospitalization statutes and also the bill which you have submitted requiring parity coverage for psychiatric services by insurance companies doing business in the State of Alaska. It was the wish of the Executive Committee that I write you and notify you that we strongly support you on both these issues.

Thank you very much for introducing this much needed legislation.

Sincerely yours,



Irvin A. Rothrock, M.D.  
President, Alaska District Branch  
American Psychiatric Association

IAR:bw



# ALASKA MENTAL HEALTH ASSOCIATION

2611 Fairbanks Street, Suite A  
Telephone 276-1705

Anchorage, Alaska 99503

*A Division of the National Mental Health Association*

March 6, 1984

**RECEIVED**

Senator Joe Josephson  
Pouch "V"  
Juneau, Alaska 99811

MAR 19 1984

Josephson,

Dear Senator Josephson:

The Alaska Mental Health Association commends the Senate HESS committee for undertaking the review of the Mental Health Commitment Statute. As you know, implementation of the current Statute which was enacted in 1981 has revealed some major problems which the current bill addresses. We wholeheartedly support this effort.

Our concern is that the mentally ill of Alaska receive the best available treatment in a timely manner, in their home community or as close as possible. We believe the procedures established by this Statute must protect individual civil/human rights AND provide for the protection of society. These goals must be accomplished in a manner that recognizes that the primary purpose of this statute is to enable individuals who are mentally ill to receive appropriate treatment. On the whole we believe the Bill does this quite well.

When we consider that mental disease is today's most common disabling condition, one of its least understood, one of its most difficult to treat and yet, the major disease group we spend the least amount of research dollars to study, we can see why the central purpose of the Statute must be to provide care and treatment.

We believe that the current Statute needed to be reviewed and improved. Before commenting specifically on the proposed changes in the Statute, we would offer the following proposal:

Since one of the original purposes of the Statute was to provide for evaluation and treatment as close to the individual's home as possible, we suggest the Legislature conduct a study of the commitments during the past year to determine whether or not this purpose is being met. Another important purpose the Statute attempted to include was to provide for a timely judicial review and supervision of the commitment process. The study should also focus on the actual length of time required for judicial involvement.

Senator Joe Josephson  
March 6, 1984  
Page Two

With respect to some of the specific proposed changes, in AS 47.30.655-915 we have the following comments and suggestions:

#1 AS 47.30.690 Admissions of minors, line 12:

The limitation on the involuntary admission of a minor should be increased to 60 days. It is generally recognized that therapy with minors, when hospitalization is necessary, requires a longer average length of stay than do adults. Even this requirement will place a needless burden on the facility and the parents if they live in remote portions of Alaska.

#2 Sec. 47.30.705 Emergency detention for evaluations -  
Line 3:

The extension of the emergency detention's powers to all "mental health professionals" has both advantages and disadvantages. It greatly expands the numbers of people who will have the power in the bush areas. This will create the kind of flexibility that is needed to provide timely and local action. The disadvantage is that many, if not most, non-medical mental health professionals have not received training or experience in the legal and clinical issues involved in the commitment process. As a consequence, we recommend that these powers be somewhat more limited. The law should limit this power to (i) peace officers and (ii) physicians and mental health professionals who have had sufficient training to properly perform this function. In conjunction with this, we would like to see the establishment of a system to train and designate "mental health professionals" who will have the expertise to exercise this function. Although this will require an additional state expenditure, it should not be prohibitive.

#3 AS 47.30.730(b) - 30 day commitment, line 26:

The extension of the commitment to provide 30 days of treatment is recommended because it is a reasonable length of time considering the seriousness of these disorders.

#4 AS 47.30.735(b)(4):

The attorney member of our Board of Directors informs us this section does not make sense because the rules of civil procedure and evidence would not be "informal but efficient presentation of evidence" in that they are formal rules. It appears the intent is for the respondent to be given a choice between (i) the formal rules of evidence and the rules of Civil Procedure and (ii) an informal set of rules. The draft we have reviewed does not make this at all clear.

#5 AS 47.30.845(7) - Confidential Records, Line 7:

We feel that the "presumed mentally ill person" standard is (i) not defined and (ii) too broad. "Presumed" by whom? What does "presumed mentally ill" mean anyway? If the intent is to release records of former mental patients, that is what should be stated. If the intent is something else, that should be stated. In any event, the standard should be in language that is susceptible to clear interpretation and implementation.


#6 AS 47.30915 (7) - Definition of "gravely disabled":

We strongly support the passage of this amended language as many psychotic patients' symptoms prevent them from seeking the treatment which may restore them to a nearly normal state of mind.

#7 AS.47.30.915 (10) - Definition of likely to cause serious harm:

We strongly recommend the amendments to this section since, in our opinion, the former language created a "standard" which was too restrictive and led to persons being released who were actually dangerous.

Sincerely

  
Dr. Jerry Schrader  
President



# ALASKA MENTAL HEALTH ASSOCIATION

2611 Fairbanks Street, Suite A  
Telephone 276-1705

Anchorage, Alaska 99503

*A Division of the National Mental Health Association*

February 29, 1984

Senator Joe Josephson  
Pouch V  
State Capitol  
Juneau, Alaska 99811

Dear Senator Josephson:

On February 15, 1984, I was involved in an emergency commitment situation which occurred at approximately 4:30 p.m., and which I think exemplifies one of the basic problems with the current commitment law. A patient came to the Fairbanks Community Mental Health Center for treatment and expressed an intent to kill herself. After evaluating her, the mental health professional called Carol Davis, the Probate Clerk who ordinarily handles these cases for the Magistrate. Ms. Davis stated she could not order an involuntary emergency commitment after hours because she could not do the paperwork. She would give the order if a physician at the hospital requested it. She advised the Center to call the police and have them exercise their authority to Emergency Commit the patient.

When the municipal police arrived, they said they knew they could commit, but refused to exercise their power because it is their agency's policy to avoid this responsibility except when they "encounter" a person in the usual course of their duties. They appeared to feel that the court system was "dumping" the responsibility on their shoulders after hours.

As you know, under current law, neither the mental health professional or a physician can act in this type of situation alone. In fact, the policemen involved were aware of this and also aware that they were the only ones empowered to act alone. Needless to say, this stalemate tied up the mental health professional - who was forced to cancel other patients - the court representative, and the police. It was finally resolved by an extra-legal (in my opinion) act. The police officer said that he would transport the patient to the Fairbanks hospital emergency room if the emergency room doctor would agree to see her and, in effect, authorize the involuntary transport. This freed the Center to resume its activities and seemed to shift the responsibility to the hospital.

I think you can see that the Mental Health Center and the patients are caught in a kind of territorial dispute between the municipal police and the court

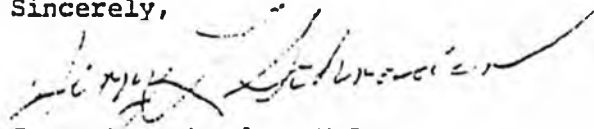
Senator Joe Josephson  
February 29, 1984  
Page 2

system. Since both of these systems feel free to operate independently, the "system" of care breaks down. It results in one emergency commitment system for 9:00 a.m. to 5:00 p.m., and another for 5:01 p.m. to 8:59 a.m. A similar stand-off has occurred in Anchorage, although the situation in Fairbanks is more complicated because the system must depend upon a private hospital.

The provision in the revised commitment bill which reinstates the physician certificate (or mental health professional certificate) would alleviate this this problem.

It would also be alleviated if the courts and the police would work cooperatively.

Sincerely,



Jerry L. Schrader, M.D.  
President, Alaska Mental Health Association

cc: Chief Mathew Kiernan  
Charles M. Mac Gibson  
Phyllis Vanairsdale

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

POUCH H 04  
JUNEAU, ALASKA 99811  
PHONE:

DIVISION OF MENTAL HEALTH AND  
DEVELOPMENTAL DISABILITIES

March 6, 1984

The Honorable Bill Sheffield  
Governor  
State of Alaska  
Pouch A  
Juneau, AK 99811

Dear Governor Sheffield:

Your Mental Health Advisory Council has been following the developments of Senate Bill Number 346 amending an Act entitled: "An act relating to the treatment of mentally ill persons." We are aware that many public hearings have occurred prior to its introduction January 11, 1984 by Senators Josephson and Halford. Additionally, individual professionals, the Alaska Psychiatric Association and the Alaska Psychological Association have had consultation and input into these revisions with strong support for these amendments. These amendments are thought to represent improvements in the treatment of adolescents and adults from the standpoint of both providers and consumers.

Your advisory Council heard today that this bill is being held "hostage" pending untold bargaining possibilities. Since these amendments would improve the quality of care and likely result in more efficiently and less cost for both the Mental Health and Judicial Divisions, it seems unfortunate to delay its enactment.

Your Mental Health Advisory Council recommends your support for the quick passage of this act. On behalf of all Council Members thank you for your consideration.

Sincerely,



Herbert G.W. Bischoff, Ph.D.  
Chairperson

Council Members

David R. Samson, M.D.  
Anchorage, Vice Chairperson  
Ann Egrass, McGrath  
Mabel Rosvold, Petersburg  
Alice Wardlow, Bethel  
Barbara T. Wihloborg, Fairbanks  
Robert Hunter, M.D., Mt. Edgecumbe  
Kevin C. Ritchie, Juneau

cc: Bill Ray, Chairman, Judiciary Committee  
All Judiciary Committee Members  
HGWS/dmb



## American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900  
Melvin Sabshin, M.D., Medical Director

Alaska Psychiatric Association  
4001 Dale Street, Suite 101  
Anchorage, Alaska 99508

The Assembly  
1982-1983

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*Speaker*

Harvey Bluestone, M.D.  
*Speaker-Elect*

Fred Gottlieb, M.D.  
*Recorder*

Lawrence Hartmann, M.D.  
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Judah M. Maze, M.D.

John S. McIntyre, M.D.

Oscar Legault, M.D.

Erwin R. Smarr, M.D.

Norman Rosenzweig, M.D.

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Melvin M. Lipsitt, M.D.  
*Past Speaker*

Robert J. Campbell, M.D.  
*Parliamentarian*

Henry H. Work, M.D.  
*Deputy Medical Director*

February 28, 1984

Senator Josephson  
Pouch V  
Juneau, Alaska 99801

Dear Senator Josephson:

The Legislative Committee of the Alaska Psychiatric Association has reviewed Senate Bill 346 - "An Act relating to the treatment of the mentally ill." We support the proposed amendments. We have one additional suggestion pertaining to page 18, line 24. We believe the inclusion of a period of experience for psychiatric nurses is a good idea, but we do not believe this should serve to eliminate a Masters Degree in Psychiatric Nursing from the list of mental health professionals. A simple "or" in line 24, page 18 would suffice to change this.

Thank you once again for your efforts on the behalf of the mentally ill.

Sincerely,

Jerry L. Schrader, M.D.  
Legislative Representative  
Alaska Psychiatric Association

JLS/saw  
Enc.

# MEMORANDUM

# State of Alaska

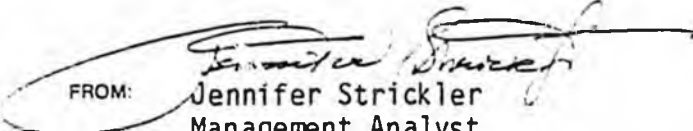
TO: Nancy Deitrick  
Aide to Senator Josephson  
Alaska State Senate

DATE: April 4, 1984

FILE NO:

TELEPHONE NO:

FROM:

  
Jennifer Strickler  
Management Analyst  
Division of Occupational Licensing  
Department of Commerce and Economic  
Development

SUBJECT: SB 303 and SB 346

This is to inform you that at a meeting held on March 13, 1984, the Board of Psychologist and Psychological Associates reviewed SB 303, "An Act relating to the practices of social work and establishing the Board of Social Worker Examiners; and providing for an effective date"; and, also, SB 346, "An Act relating to the treatment of mentally ill persons."

Determinations were made by the Board to support both SB 303 and SB 346.

JS/shA/20-3  
4484a



1650 Cowles Street, Fairbanks, Alaska 99701  
April 6, 1983

Dennis DeWitt  
Alaska Hospital Association  
319 Seward Street  
Juneau, Alaska 99801

Dear Dennis,

I have reviewed the work draft that would amend the current act relating to the treatment of the mentally ill persons and have the following comments.

Much of this work draft simply cleans up the language of the current legislation. (Apparently the law is going to allow for those rare instances when a female is mentally ill!)

Several areas in the work draft propose significant content changes. In all cases these content changes would significantly improve the current legislation.

1. AS 47.30.915 (7) and AS 47.30.915 (10) change the definition of 'gravely disabled' and 'likely to cause serious harm.' The proposed changes in these definitions, if enacted, would greatly improve the ability of the legal system and providers of mental health care to intervene appropriately in situations where emergency detention is in the best interest of the patient.
2. Section 47.30.705 This proposed change allows a physician to initiate the involuntary commitment procedures. This is an essential addition to the current legislation and entirely appropriate.
3. The other content changes (dealing with the detention and commitment of minors, etc.) also upgrade the current legislation and make it more workable.

Overall there are no objections in the changes proposed by this work draft. The content changes deserve support and would markedly improve the current legislation governing the treatment of the mentally ill.

I would recommend that the Alaska Hospital Association support a bill that reflects the content and intent of the work draft.

Sincerely,

A handwritten signature in dark ink, appearing to read "M. J. Emmert", is written over a faint, larger version of the signature.

M. J. Emmert, R.N.  
Director of Nursing Service

MJE:mc

# STATE OF ALASKA

**DEPT. OF HEALTH AND SOCIAL SERVICES**  
**OFFICE OF THE COMMISSIONER**

BILL SHEFFIELD, GOVERNOR

POUCH H 01  
JUNEAU, ALASKA 99811  
PHONE: 465-3030

April 14, 1983

Document No. 83-152

The Honorable Joe Josephson  
Senator  
Alaska State Legislature  
Pouch V  
Juneau, AK 99811

Dear Senator Josephson:

RE: AS 47.30.655 - 47.30.915  
(Involuntary Commitment Act for  
Mentally Ill Persons)

We appreciate the work you are undertaking and would like to add our comments to those you have already received regarding possible amendments to Alaska's recently enacted civil commitment statutes for mentally ill persons. As you know, the Division of Mental Health and Developmental Disabilities supports the general intent of the Act but feels it is procedurally too cumbersome. This seems to have resulted in treatment staff wasting their time in complying with procedures and filling out numerous forms rather than providing treatment for mentally ill persons.

I have enclosed a copy of our earlier suggested amendments that were prepared during the previous administration. The status of these suggested amendments is unknown to us. Upon review, however, I believe that you will agree that they are primarily designed to facilitate treatment. In addition, I am confident that the Attorney General's Office will be able to assist your staff in determining which forms, notices and procedures that are presently required can be deleted while still protecting the rights of the mentally ill.

Another area of extreme importance in the successful implementation of this Act has been the availability, or lack thereof, of detoxification facilities and other alcohol and substance abuse programs and services. Experience has shown that the emergency involuntary hospitalization at API of persons with a primary diagnosis of alcoholism has increased dramatically since the new Act became effective. This is cause for considerable concern to us as our bed space for legitimate psychiatric emergency cases is in extremely short supply. We believe that if additional alcoholism and substance abuse programs offering emergency

inpatient care were available, especially in Anchorage, that the number of referrals of intoxicated persons to API would be substantially reduced. You may be interested to know that the provisions of the Uniform Alcoholism and Intoxification Treatment Act (AS 47.37.010 - 47.37.270) have never been fully implemented, partially as a result of a lack of inpatient facilities that offer various types of alcoholism services and treatment.

The most utilized provision of the Uniform Alcoholism and Intoxification Treatment Act seems to have been what is called the "12-hour drunk law." This provision allows persons that are seriously incapacitated as a result of alcohol to be placed in a local jail or state correctional center for up to 12 hours with no criminal charges being filed. In the past, this has permitted law enforcement agencies the opportunity to take intoxicated persons into custody and house them in a jail or correctional center until the person has regained sobriety and is no longer in danger of harm as a result of his inebriated condition.

Unfortunately, as a consequence of the extreme shortage of bed space in all of Alaska's correctional centers, law enforcement agencies are no longer able to deliver these incapacitated persons to correctional facilities and have them held in custody until they are no longer incapacitated by alcohol. More simply put, as a result of serious overcrowding in our correctional systems, drunks are being taken to API and kept there until they sober up sufficiently to make a diagnosis. More often than not, the diagnosis reveals that they are suffering primarily from alcoholism and not a major mental illness. At that point they are discharged and referred elsewhere. This results in a serious misuse of the few psychiatric resources we have. It is our position that these limited resources should be exclusively available to the seriously mentally ill person that presents himself, or is presented, to Alaska's only designated psychiatric hospital.

In addition to the recommended amendments contained in the enclosure, as well as the previously mentioned concerns, we have listed below a number of other changes to the Act that we would like to support:

- 1) We recommend that the period of commitment be changed from 21 days, 90 days, and 120 days to 30 days, 90 days, and 180 days. It is our opinion that this would reduce the administrative workload of our treatment staff while having little or no effect on the period of time patient's are actually involuntarily committed.

Rather than interrupt treatment after 21 days in order to undergo the 90-day commitment process, treatment could continue for an additional 9 days if necessary. This would allow medications and other forms of therapy some additional time to stabilize the patient, possibly resulting in a discharge between the 21st and 30th day. The change from 120

days to 180 days is simply to reduce the administrative and procedural requirements necessary for the long-term, chronic mentally ill patients that require extended periods of hospitalization.

- 2) We propose that all references to a minor child be changed from age 14 to age 18 throughout the Act. Numerous situations have arisen as a consequence of this provision that indicate it has fostered confusion as well as placing young people and API in an awkward position with regard to their status. It is also not in concert with other provisions of Title 47 that address the care and treatment of minors in Alaska.
- 3) Under AS 47.30.730(a)(3), we recommend that the following language be added with regards to gravely disabled: "... or that painful or dangerous regression could be prevented and the respondent could maintain the capacity for self-reliance;...". It has been our experience that some gravely disabled individuals may not be expected to actually improve during hospitalization, but if left untreated can be expected to suffer substantially, even to the point of requiring permanent institutionalization as a result.
- 4) Under AS 47.30.840(4), (5), (6), and (7), we suggest that provision be made to restrict these rights in unusual circumstances in which harm to the patient or others may result if these rights are exercised. We propose adding "... unless the professional person in charge determines it is not in the best interests of the patient and will pose a threat to the safety or well being of the patient or others;..." to these sections.
- 5) We recommend that AS 47.30.845 be amended to add a provision that would allow confidential information or records to be disclosed to law enforcement agencies in emergency situations involving a current or former patient. In order to restrict this disclosure we suggest the following section be added: "(7) a law enforcement agency when there is substantiated concern over imminent danger to the community by a presumed mentally ill person."

This would allow the disclosure of information to law enforcement agencies that may be helpful in preventing needless injury or death occurring as a result of the actions of a mentally ill persons during an emergency situation.

- 6) An additional area that, in our opinion, should be revised is the area of involuntary outpatient commitment. Thusfar, there have only been a limited number of these types of commitments. It seems, however, that none have proven successful for various reasons. While the idea of involuntary outpatient

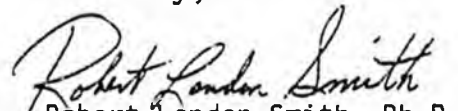
commitment appears sound, the provisions of the Act appear to militate against the successful utilization of this less restrictive alternative. Perhaps your proposed revision to the definition of "likely to cause serious harm" will have a positive influence on the successful use of outpatient commitment.

It should be noted, with regards to outpatient treatment, that AS 47.30.800(a) requires persons seeking conversion from involuntary outpatient commitment to inpatient commitment must have direct knowledge that the respondent is mentally ill or gravely disabled. If the respondent fails to report to the provider of service, than the provider will be unable to substantiate the allegations necessary to convert the commitment to inpatient treatment.

- 7) In AS 47.30.745(b), the last sentence should read "... not later than 90 days..." rather than "... not earlier ...." as it currently reads.
- 8) The final area in which we would recommend revision is the requirement that all patients be given the opportunity to be voluntarily admitted. We do not dispute the value of this option in the vast majority of cases that require psychiatric hospitalization; there are, however, instances in which it may not be wise or prudent to be required to offer or allow the voluntary admission of some patients to the hospital. Certainly, the substitution of "reasonable" for "every" in Section 1 of your draft is a step in the right direction. We would hope that it would be interpreted to mean in cases in which it was deemed unreasonable, that involuntary commitment proceedings would commence.

While I am confident that these recommendations for amendments do not represent a panacea for all that is wrong with such a complicated set of laws, I am certain that these, along with many other suggestions that you have received, represent a substantial improvement in providing for the care and treatment of Alaska's mentally ill. Again, I would like to thank you and your staff for giving this information your review and consideration. My staff and I look forward to working with you and other members of the Legislature in revising our civil commitment laws.

Sincerely,

  
Robert London Smith, Ph.D.  
Commissioner

Enclosure

# STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

BILL SHEFFIELD, GOVERNOR

POUCH 401  
JUNEAU, ALASKA 99811

PHONE: 465-3030

February 3, 1984

DOCUMENT #84-32

The Honorable Joe Josephson  
Alaska State Senator  
Alaska State Legislature  
Pouch V  
Juneau, AK 99811

Dear Senator Josephson:

RE: Senate Bill 346  
(Suggested Amendment)

The language listed below is suggested as an amendment to Senate Bill 346 to allow persons under the age of 18 to be voluntarily hospitalized by their parents or guardians for additional 30 day periods. Under the existing statute, children and adolescents may not be voluntarily hospitalized by their parents or guardians for a period longer than 21 days even if they meet the criteria for hospitalization under A.S. 47.30.690. The amendment would rectify this oversight.

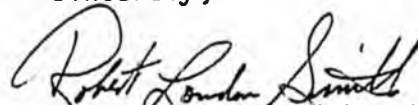
On page 4, line 3, Section 5 of Senate Bill 346, we recommend that the following subsection be included:

"(c) Additional 30-day voluntary admissions of a minor under the age of 18 may be sought by parents or guardians if, in the opinion of the professional person in charge, the conditions under subsections (1), (2), and (3) continue to exist."

This amendment is considered especially important, even critical, in providing the necessary and appropriate level of care for this oftentimes fragile group of patients.

We will be happy to provide you or other members of the Senate Health, Education, and Social Services Committee with any additional information you may require concerning this proposed amendment as well as any questions you may have regarding our Position Paper which was submitted earlier.

Sincerely,

  
Robert London Smith, Ph.D.  
Commissioner

MSG 84-00028880 PRTY 1 03/27/84 16:24:35 ORIG: LA01 IN= 0007 OUT= 0115  
FROM: KAREN, ANC LIO TO: POM - JUNEAU INFO  
TARGET: LJHK SUBJ: POM

TO: ALL SENATORS

FROM: G. KENT EDWARDS  
2113 DUKE DRIVE  
ANCHORAGE, AK. 99508  
H. 276-1664; W. 274-3576

MARGARET BROWN, 2957 EMORY, ANCHORAGE, AK. 99508  
H. 272-6039; W. 272-3454

RECEIVED

MAR 23 1984

Josephson

I URGE YOUR SUPPORT OF SB 346,, THE MENTAL HEALTH BILL.  
SECTIONS 26 AND 27 ARE ESPECIALLY IMPORTANT SINCE CURRENT  
DEFINITIONS ARE INADEQUATE TO DEAL WITH MANY  
MENTALLY ILL PATIENTS WHO MAY CAUSE BODILY HARM.

3/28/84, SHIRLEE ANC LIO, 29182

TO: ALL MEMBERS  
ALASKA SENATE

[RECEIVED]

FROM: PAT EDWARDS  
2113 DUKE DRIVE  
ANCHORAGE, AK 99508  
(H) 276-2264 (W) 271-3735

MAR 28 1984

Josephson.

SUBJ: SENATE BILL 346 (TREATMENT OF MENTALLY ILL PERSONS)

I URGE YOUR SUPPORT OF SENATE BILL 346, ESPECIALLY SECTION 27.  
PSYCHOTIC HISTORIES AND ACTS OF VIOLENCE TOWARDS PROPERTY  
MUST BE CONSIDERED WHEN EVALUATING MENTAL PATIENTS.

\*\*\*\*\*

RECEIVED

MAR 30 1984

Josephson.

MSG 84-00029328 PRTY 1 03/28/84 14:47:49 ORIG: LA09 IN= 0005 OUT= 0105  
FROM: KIM / ANCH LIO TO: POM / JNU INFO  
TARGET: LJHK SUBJ: P O M

---

TO: ALL SENATORS  
FROM: JOHN BROWN, 1936 BEAVER PLACE, ANCHORAGE 99504  
H 337-2755 W 272-3454

SB 346, TREATMENT OF MENTALLY ILL PERSONS

URGING YOUR SUPPORT, SPECIFICALLY SECTIONS 26 AND 27. MY FAMILY HAS BEEN FLAGUED BY A PARANOID SCHIZOPHRENIC. HE'S BEEN IN AND OUT OF API FOR THE PAST 8-10 YEARS. HE'S 6'4, 300 POUNDS PLUS AND I AM AN EX-STATE HEAVYWEIGHT WRESTLING CHAMP WHOM HE TOSSED AROUND LIKE A RAGDOLL LAST CHRISTMAS EVE.

FROM: LINDA THAGGARD  
4701 CANTERBURY WAY  
ANCHORAGE, AK. 99503Q  
561-8085

I URGE YOU TO SUPPORT SB 443 BRINGING POWER LINES TO THE CASWELL LAKE AREA.

-----EOM

BEING THE DEPRIVATION OF MEDICAL CARE TO THESE INDIVIDUALS.  
WAS BEING LEGAL PATIENTS. SUPPORTING BILL 349 AS PASSED WOULD  
TO CONTINUE TO DENY TREATMENT OF THE CRIMINALLY MENTALLY ILL RIGHT

RE: SR 349, TREATMENT OF MENTALLY ILL

453-4252-H 313-4252-H  
FAIRBANKS, AK, 99701

FROM: GOROTH STELLA

TO: ALL MEMBERS OF THE SENATE

-----EOM

ARE TAKING ADVANTAGE OF YOU.  
GELATIVE WHEN YOU CANNOT TAKE CARE OF YOURSELF AND PEOPLE IN THE STREET  
HIS RIGHT TO TREATMENT IS VERY IMPORTANT. CIVIL RIGHTS ARE NOT EVEN  
WAG: I SUPPORT SR 349. I HAVE A MENTALLY ILL BROTHER AND I BELIEVE

RE: SR 349, MENTALLY ILL

453-4252-H  
FAIRBANKS, AK, 99701  
SR 34933

FROM: JENNETTE GRATIO

TO: ALL MEMBERS OF THE SENATE

-----  
MSG 89-00030841 PRTY 1 04/02/84 09:14:09 ORIG: LFO1 31=0003 OUT=0027  
FROM: PAULA/FKS  
TARGET: LUKK SUBD: POM  
TO: JNU INFO

REC 3--00030806 PRY 1 04/03/84 08:45:57 ORIG: LFO1 IN= 0002 OUT= 0019  
FROM: PAULA/FMS TO: JMU INFO  
TARGET: LUNR SUBJ: POM

---

TO: ALL MEMBERS OF THE SENATE

FROM: MR. & MRS. AARON, MEMBERS OF FKS ALLIANCE FOR THE MENTALLY ILL  
P.O. BOX 74132  
FAIRBANKS, AK, 99707-4132  
350-4407-H

RE: CR 340

FOR THOSE HELPLESSLY SUFFERING THE UNCONTROLLED DEPRIVATIONS  
OF SEVERE PSYCHOTIC DELUSIONS AND DEPRESSIONS, THE MOST URGENT CIVIL RIGHT  
IS THE RIGHT TO HAVE PROPER CARE AND TREATMENT, ESPECIALLY WHEN THE VICTIM  
IS TOO DISTURBED TO REALIZE THE NEED FOR HELP AND MAY BE STARVING FOR EXAMPLE.  
REC TO CR 346.

-----EOM

MSG 84-00050851 PRTY 1 04/03/84 09:32:01 ORIG: LF01 IN= 0004 OUT= 0031  
FROM: ANNIE IN FAIRBANKS TO: JUNEAU INFO.  
TARGET: LJHK SUBJ: POM

---

TO: ALL SENATORS

FROM: PHYLLIS VAN ARISDALE  
141 STEEL HEAD ROAD  
FAIRBANKS 99701  
HOME 479-3271

RE: SB346, MENTAL ILLNESS

IT IS VITAL THAT YOU DO PASS SB346. THE MOST DIFFICULT PROBLEM IN THE MENTAL  
ILLNESS PROCESS IS GETTING TREATMENT WHEN A PSYCHOTIC BREAK OCCURS. THE  
MOST IMPORTANT CIVIL RIGHT OF MENTALLY ILL PEOPLE TODAY IS THE RIGHT TO  
TREATMENT. DENIAL OF TREATMENT WAS A CAUSE OF OUR SON'S DEATH.

\*\*\*\*\*

60

-----EOM

6

TO: SEN. RAY, ELIASON, PETTYJOHN, ZEIGLER, JOSEPHSON

FR: RICHARD H. RUSSELL  
MEMBER OF FBX ALLIANCE FOR THE MENTALLY ILL  
394 12TH AVE. #3  
FBX, 99701  
452-5661

RE: ~~XXXXXXXXXX~~ TREATMENT OF THE MENTALLY ILL

MSG: THIS IS NECESSARY AND LONG OVERDUE LEGISLATION. WHILE OUR SON WAS  
-T API, I BECAME QUITE FAMILIAR WITH ALASKA'S COMMITMENT ACT. IT IS  
UNNECESSARILY VAGUE AND OFTEN MISLEADING. SB346 IS AN IMPORTANT  
ADJUSTMENT.

-----EOM

FR: TOM MINGEN  
FBX MEMORIAL HOSPITAL  
1650 COULES  
FBX, 99701  
452-2181 CAT 305

RE: ~~XXXXXXXXXX~~ TREATMENT OF MENTALLY ILL

MSG: URGE YOUR SUPPORT OF SB 346.

-----EOM

FROM: GERALDINE HARRINGTON  
1320 CHEROKEE WAY  
ANCHORAGE, AK. 99504  
333-9252

SUPPORT ~~THE MENTAL HEALTH BILL~~ THE MENTAL HEALTH BILL. I'M A DIAGNOSED  
MANIC DEPRESSIVE, HOSPITALIZED SEVERAL TIMES DURING THE PAST  
15 YEARS.

FROM A PATIENT'S VIEWPOINT, IT IS CRUCIAL THAT A TRAINED  
PROFESSIONAL BE IN THE POSITION TO TREAT THE INDIVIDUAL WHOSE  
JUDGEMENT CANNOT BE RELIED UPON AT THE MOMENT TREATMENT IS  
NEEDED MOST.

MSG 84-00023748 PRTY 1 03/13/84 12:28:17 ORIG: L301 IN= 0004 OUT= 0019  
FROM: SITKA TO: JUNEAU  
TARGET: LJHK SUBJ: POM

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TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZIEGLER  
FROM: STAN LAUGHRIDGE, BARANOF MENTAL HEALTH CLINIC  
BOX 1180  
SITKA, AK 99835

RE: ~~REDACTED~~ TREATMENT OF MENTALLY ILL PERSONS

I AM A PROFESSIONAL MENTAL HEALTH WORKER AND I STRONGLY SUPPORT THE PROVISIONS OF SB 346.

##SITKA LIO, 3/13, 23748#####

MSG 84-00023714 PRY 1 03/13/84 15:05:07 ORIG: LF00 IN= 0009 OUT= 0070  
FROM: TRACIE/FBX TO: JUN INFO  
TARGET: LUHK SUBJ: POM 15

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TO: SENS RAY, JOSEPHSON, ZIEGLER, PETTYJOHN, RAY, BENNETT,  
FAHRENKAMP, HOSS  
REPS DAVIS, BETTISWORTH, KOPONEN, RINGSTAD, M.W. MILLER

FR: JANET WHITE, IMMACULATE CONCEPTION COMMUNITY SERVICES DIRECTOR  
PO BOX 81632  
FOX, 99708  
488-0046-H

450-4918-W

RE: ~~RE:~~ TREATMENT OF THE MENTALLY ILL

MSG. FAMILIES OF THE MENTALLY ILL SUPPORT SB346. THIS BILL IS A TESTIMONY  
FOR THE IMPROVEMENT OF THE CONDITIONS FOR SUFFERING FAMILIES AND THEIR  
LOVED ONES, IS THE PATIENT.

-----EDM

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZEIGLER

FROM: RANDY HURST

BOX 4310

MT. EDGECLUMBE, AK. 99835 968-2438 (W)

RE: XXXXXXXXXX

I'M WRITING IN SUPPORT OF SB 346. THE LONGER TIME FRAMES, THE FOCUS ON LEAST RESTRICTIVE ENVIRONMENTS, AND ABILITY TO INITIATE PETITIONS BY MENTAL HEALTH PROFESSIONALS ARE VERY IMPORTANT INCLUSIONS. I WISH THE INITIAL TIME FRAME OF 30 DAYS COULD BE MADE LONGER, ESPECIALLY SINCE MEDICATION STABILIZATION TAKES AT LEAST THAT LONG IN MANY CASES.

-----SITKA LIO, 3-12-84-----

MSG 84-00023818 PRTY 1 03/13/84 13:39:52 ORIG: LJO1 IN= 0006 OUT= 0041  
FROM: ELAINE, SITKA TO: JUNEAU  
TARGET: LJHK SUBJ: FOMS

---

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZIEGLER

FROM: DR. SUSAN CARLSEN  
60X 4575  
MT. EDGECUMBE, AK. 99835 747-6474

RE: ██████████ MENTAL HEALTH ILLNESS

I URGE SUPPORT OF THE MENTAL HEALTH BILL, SB 346, WHICH WOULD FACILITATE MENTAL HEALTH TREATMENT LOCALLY AND ALLOW MENTAL HEALTH WORKERS IN SITKA TO WORK WITH THOSE WHO ARE IN INVOLUNTARY COMMITMENT.

-----SITKA LIO, 3-13-84 23818-----

American Psychiatric Association

GUIDELINES FOR LEGISLATION ON  
THE PSYCHIATRIC HOSPITALIZATION OF ADULTS<sup>1</sup>

These Guidelines Deal With:

Emergency Psychiatric Evaluation  
Voluntary Admission  
Involuntary Hospitalization  
Right to Treatment  
Right to Refuse Treatment  
Patients' Rights  
Legal Immunity for Mental  
Health Personnel

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<sup>1</sup> These Guidelines for Legislation on the Psychiatric Hospitalization of Adults have been prepared and approved by the American Psychiatric Association in order to assist psychiatrists, legislators and the public in considering possible revisions of civil commitment laws. The American Psychiatric Association believes that these Guidelines constitute a responsible set of proposals which would improve the process of psychiatric hospitalization in many states. However, because local laws, community conditions, and medical practices vary, state and local psychiatric associations and individual psychiatrists may properly support provisions which differ in many respects from these general Guidelines.

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Section 1. SHORT TITLE

These provisions governing the psychiatric hospitalization of adults may be cited as Title I of the Mental Health Code.<sup>1</sup>

Section 2. LEGISLATIVE PURPOSES

This Act is intended to achieve and shall be construed so as to promote these legislative purposes:

- To make available psychiatric evaluation, care and treatment to all persons who suffer from severe mental disorders and can benefit from treatment, and to encourage voluntary rather than involuntary admission whenever hospitalization is necessary;
- To safeguard the legal rights of patients in a manner which will advance and not impede the therapeutic and protective purposes of psychiatric hospitalization;
- To provide workable procedures for obtaining consent to and administering medications and other treatments;
- To provide legal immunity for reasonable, good-faith efforts to implement this Act, and legal penalties for knowing, willful efforts to subvert the processes in this Act; and
- To provide a statutory framework for the promulgation of regulations by the Department of Mental Health.

Section 3. DEFINITIONS

As used in this Act, the terms below shall have the meanings indicated:

"aversive therapy" means any treatment or procedure which, because it is believed to be painful or physically uncomfortable to the patient, is administered in order

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<sup>1</sup> These Guidelines deal only with persons who may be hospitalized for psychiatric care and treatment under the civil commitment process; they do not deal with persons who may be confined for forensic evaluation or other purposes under the criminal justice process.

to reduce the frequency or intensity of a behavior; except that aversive therapy does not refer to verbal therapies, seclusion or physical restraints used in conformity with Section 10.F., or psychotropic medications which are not used for purposes of aversive conditioning.

"consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, where treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

"court" means the court or judicial officer designated under the laws of this State for the discharge of the functions described in this Act.

"emergency situation" means a situation in which the patient exhibits substantial behavior which is self-destructive, assaultive, or threatens significant damage to the property of others, or which indicates that the patient is suffering extreme anxiety amounting to panic, or sudden exacerbation of his severe mental disorder.

"experimental treatment" means any treatment other than one which is commonly accepted for treatment of the mental disorder involved or is supported by widely accepted scientific studies, and is provided by a qualified health professional; if such treatment poses a significant risk of harm to the patient.

"informed consent to treatment" means a knowing and voluntary decision to undergo treatment, evidenced in writing, and made by a person who has the capacity to make an informed decision, after the treatment facility has explained to the person the nature and effects of the proposed treatment.

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his mental disorder or condition, is unable despite

conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment as evidenced by inability to weigh the possible risks and benefits.

"likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.

"likely to cause harm to others" means that as evidenced by recent behavior causing, attempting or threatening such harm, a person is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person.

"patient" means any person receiving evaluation, care or treatment under this Act, except that "patient" for purposes of the rights provided in Section 10 shall refer only to persons in residential treatment programs.

"person" means for purposes of any provision of this Act authorizing the commitment or treatment of a "person," an individual aged eighteen years or more.<sup>2</sup>

"psychosurgery" means any procedure which by direct access to the brain, removes, destroys, or interrupts the continuity of brain tissue which is histologically normal (as distinguished from normal in its physiological or psychological functioning) for the primary purpose of altering behavior or treating a mental disease or disorder. Psychosurgery includes the implantation of electrodes with such an effect and

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<sup>2</sup> For provisions concerning persons under the age of eighteen, refer to the American Psychiatric Association's "Guidelines for Psychiatric Hospitalization of Minors" (1981).

for such a purpose, with or without subsequent electrocoagulation. Psychosurgery does not include neurosurgical procedures designed to treat reliably diagnosed intractable physical pain or epilepsy.

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition which (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (2) substantially impairs behavior as manifested by recent disturbed behavior.<sup>3</sup>

"treatment facility" means a community mental health facility, a general medical facility providing psychiatric services, or other psychiatric facility or program meeting applicable licensing standards, which has been approved for the provision of services under this Act by the Department of Mental Health; provided that no jail or other correctional facility shall be approved as a treatment facility for any persons other than those who could otherwise lawfully be detained there.

#### Section 4. EMERGENCY PSYCHIATRIC EVALUATION

##### 4.A. Detention by a Police Officer

1. A police officer may take a person into custody, and transport the person to a treatment facility for emergency psychiatric evaluation if and only if:

- a. the person would otherwise be subject to lawful arrest and the police officer believes that the person is in need of emergency psychiatric treatment; or
- b. the police officer has probable cause to believe that the person has attempted suicide within the last 48 hours; or
- c. the police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult under subsection

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<sup>3</sup> Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

4.C. and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others; or

- d. he is acting upon the certification of a licensed physician under subsection 4.B.

2. Any person taken into custody pursuant to this subsection shall be presented promptly to a treatment facility. Correctional facilities shall not be used as temporary shelter for such persons except for the protective custody of the person pending transportation to a treatment facility.

3. Upon or shortly after taking a person into custody, the police officer shall take reasonable precautions to safeguard and preserve the personal property of the person unless a guardian or responsible relative is able to do so. Upon presenting a person to a treatment facility the police officer shall inform the staff in writing of the facts which caused him to take the person into custody, and specifically state whether the person is otherwise subject to arrest.

#### 4.B. Certification by a Licensed Physician

A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation, when a licensed physician certifies in writing that he has examined the patient in the last 72 hours, or that he has ongoing medical responsibility for the person and has knowledge of his current condition, and on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as a result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

4.C. Petition by Any Interested Adult

Any interested adult may petition for, or present a person for, emergency psychiatric evaluation by alleging based on personal observation that he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs; and immediate hospitalization is necessary to prevent harm to the person or to others.

4.D. Treatment Facility Determination

1. Upon the presentation of a person to a treatment facility pursuant to this Section 4, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth in subparagraph 2.

2. The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

3. If the examining psychiatrist determines that there is not probable cause to believe that the person meets the criteria for emergency evaluation and treatment, the person shall be released. If a person was presented to the treatment facility by a police officer and was otherwise subject to lawful arrest, he shall continue under the custody of police officers.

4.E. Advice of Rights

The treatment facility shall advise any person admitted for emergency evaluation and treatment of the purposes and possible duration of emergency evaluation, and of his rights under this Act, as soon after admission as his medical condition permits.

4.F. Hearing on Emergency Evaluation

1. Each person who is admitted to a treatment facility shall receive a preliminary hearing before the court within five business days of admission or be discharged, unless he has, after consultation with counsel, executed a written waiver of such hearing. The hearing shall be informal and subject to such rules as the court sets consistent with fundamental fairness.

2. The court shall determine at the close of the hearing, or within five business days of the patient's admission, whether he should be discharged. A patient shall then be discharged, unless the court determines that there is probable cause to believe that he satisfies the criteria for thirty-day commitment provided in Section 6, and unless within two business days of the court's decision a petition for such commitment is filed with the court.

4.G. Duration of Emergency Evaluation  
and Treatment

The period of emergency evaluation and treatment shall in no case exceed fourteen days.

Section 5. VOLUNTARY ADMISSION

5.A. Admission

1. A treatment facility may admit a person if after examining the patient a psychiatrist [or: "a physician"]<sup>\*</sup> on the staff or with privileges at the treatment facility believes the person is mentally ill and in need of hospitalization, and if the person gives written consent to admission. Prior to such admission, the person shall be advised orally and given a written statement of his rights under this Act; provided that if his condition upon admission makes such advice infeasible and the medical reasons are entered in the record, such advice may be deferred until the patient's medical condition permits, for not more than 48 hours. Each patient shall be asked to sign an acknowledgement that he has been so advised and has consented to voluntary admission for treatment.

2. Initial consent to voluntary admission for treatment shall be valid for sixty days. Thereafter,

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\* Optional provision.

a patient may remain at the treatment facility for periods of up to one hundred eighty days each upon a signed consent executed after the patient has had an opportunity to consider with such persons as he wishes his need for continued hospitalization and treatment.

3. If the responsible psychiatrist [or: "the responsible physician"]<sup>5</sup> has substantial reason to believe that a person seeking to admit himself or to consent to further hospitalization lacks capacity to make an informed decision concerning treatment, he shall obtain in addition to the consent of the patient, the informed consent of the patient's next of kin or guardian. The responsible psychiatrist [or: "the responsible physician"]<sup>6</sup> shall renew his effort to obtain the informed consent of the patient if the patient regains the capacity to make an informed decision concerning treatment.

5.B. Discharge or Petition for  
Thirty-Day Commitment

Any patient who is voluntarily admitted to a treatment facility shall be discharged within five business days of his written request for discharge (and any patient who indicates his desire to be discharged but is unable to write shall be assisted to put his request in writing), unless a petition for thirty-day commitment is filed within that period by the treatment facility or the patient's next of kin or guardian.

5.C. Conversion from Involuntary to  
Voluntary Status

A patient who is subject to involuntary hospitalization pursuant to Sections 4, 6, or 11 of this Act may at any time convert to voluntary status if the responsible psychiatrist [or: "the responsible physician"]<sup>7</sup> agrees that such conversion is made in good faith and that the patient is an appropriate patient for voluntary hospitalization.

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<sup>5</sup> Optional provision.

<sup>6</sup> Optional provision.

<sup>7</sup> Optional provision.

Section 6. THIRTY-DAY COMMITMENT

6.A. Petition

1. Persons who are present at a treatment facility under voluntary admission but have requested discharge, and persons present at a treatment facility for emergency psychiatric evaluation, may be committed involuntarily for a period of up to thirty days upon a petition filed by the treatment facility or by the next of kin or guardian; and other persons may be so committed upon a petition filed by any interested adult. The petition shall allege that such person meets the criteria set forth in subsection 6.C. The petition shall set forth the facts supporting the allegations, and, in the case of petitions filed by a treatment facility, describe why the patient requires treatment. The petition shall be filed with the court, which shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. The copies of the petition served by the court shall be accompanied by a notice advising of the person's rights concerning the proceeding.

6.B. Summons for Evaluation;  
Psychiatric Report

1. Upon the filing of a petition for thirty-day commitment of a person who is not currently under emergency evaluation or voluntary admission, the court shall issue a summons to the person to submit to an examination (on an outpatient basis) conducted by a psychiatrist at a treatment facility or a private psychiatrist. The examining psychiatrist shall promptly prepare a report on his examination and file it with the court. The court shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. A person served with a summons to submit to a psychiatric examination may in lieu of such examination submit a report of a psychiatrist stating that he has recently examined the person, or has ongoing medical responsibility for the person and knowledge of his current condition, and that in his opinion the person does not meet the criteria for involuntary commitment. The petition for commitment may then be dismissed by the court, or continued.

6.C. Criteria for Thirty-Day Commitment<sup>1</sup>

A person may be involuntarily committed for a period of up to thirty days if, after the hearing provided in Section 6.D., the court determines, based upon clear and convincing evidence, that:

1. the person is suffering from a severe mental disorder; and
2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and
3. the person either refuses or is unable to consent to voluntary admission for treatment; and
4. the person lacks capacity to make an informed decision concerning treatment; and
5. as the result of the severe mental disorder, the person is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others.

6.D. Hearing on Thirty-Day Commitment

1. Every person as to whom a petition for thirty-day commitment has been filed shall be notified by the court sufficiently in advance to be able to prepare for the hearing, and shall receive a prompt hearing. For persons confined for emergency psychiatric evaluation, or currently under voluntary admission, this hearing shall take place within three business days of the filing of the petition.

2. The respondent shall be present at the hearing unless the court finds (1) that he has knowingly and voluntarily waived such right after consulting with counsel, or (2) that because his behavior at the hearing

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<sup>1</sup> Refer to the Commentary for a discussion of the disposition of various types of persons who do not meet the criteria in Section 6.C.

is so disruptive, it cannot reasonably continue in his presence. Hearings shall be held in the treatment facility wherever feasible given the other functions of the court.

3. Any respondent who is unable to pay for counsel shall have the right to be provided with counsel to prepare for and represent him at the hearing. [Any respondent who is unable to pay for an examination for purposes of the hearing shall have the right to be provided with one examination by a licensed psychiatrist, at the expense of the (state or local government).]<sup>9</sup>

4. The District Attorney or County Counsel shall represent the interests of the State at the hearing. [If the District Attorney or County Counsel fails to proceed with the commitment, the next of kin or a petitioning party may retain counsel to do so in his stead, and the reasonable costs of such counsel shall be paid by the (state or local government).]<sup>10</sup>

5. The rules governing evidentiary and procedural matters at hearings under this Act shall be promulgated so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties. Hearsay evidence may be received, and experts and other witnesses may, consistent with law, testify to any relevant and probative facts at the discretion of the court.

6. Patients shall not have a "right to remain silent" at a psychiatric examination or hearing conducted pursuant to this Act; provided that no patient shall be held civilly or criminally liable for not speaking or testifying. Any information obtained from or disclosed by the patient during the course of evaluation or treatment is admissible in any hearing provided in this Act without regard to whether it would otherwise be privileged; provided that no disclosure made by the patient during the course of evaluation or treatment or in any proceeding conducted under this Act, and no opinion testimony based on such disclosures, may be admitted against the patient on the issue of guilt in a criminal proceeding unless he places his mental condition in issue in such proceeding, and the disclosure or opinion is relevant to such an issue raised by him.

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<sup>9</sup> Optional provision.

<sup>10</sup> Optional provision.

7. The hearing shall be closed to the public, unless the respondent requests that it be open, or the court determines for other good cause that the hearing should be open. The court shall keep a complete record, written or recorded, of every hearing.

8. At the conclusion of the hearing, or within one business day thereafter, the court shall make its findings, including specific findings as to whether the commitment is warranted because the person is (a) likely to cause harm to others, or (b) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (c) both (a) and (b). As to any person found likely to cause harm to himself or to suffer substantial mental or physical deterioration, the court shall further make findings as to whether commitment is warranted because the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will, if not treated, suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.

9. The court shall enter an order discharging the person unless it finds by clear and convincing evidence that the person satisfies all of the criteria for commitment in Section 6.C., in which event it shall enter an order committing the person for evaluation and treatment for a period of "up to thirty days." If at any time during thirty-day (or any subsequent) commitment a patient is absent without permission, the order of commitment constitutes a continuing authorization to the treatment facility and to any police officer to procure his return.

Section 7. INFORMED CONSENT TO MEDICATION OR  
OTHER TREATMENT -- VOLUNTARY PATIENTS

7.A. Informed Consent

Except in an emergency situation, a treatment facility shall, prior to beginning any course of medication or other treatment for a patient who is subject to voluntary admission under Section 5, obtain informed consent to treatment. If the patient does not lack

capacity to make an informed decision concerning treatment, the consent shall be his own. If he does lack such capacity, the consent shall be that of his next of kin or guardian, provided that such a patient may receive appropriate medications or other treatments, except as limited by Section 8.C., until such time as the consent or refusal to consent of such next of kin or guardian can be obtained.

#### 7.B. Revocation of Consent

A voluntary patient (or the next of kin or guardian who consented to treatment on his behalf) may revoke consent to treatment at any time by a reasonably clear statement in writing (and patients who indicate a desire to revoke consent but are unable to write shall be assisted to put their statement in writing). If such consent is revoked, the treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.

#### 7.C. Refusal to Consent

Except in an emergency situation, any voluntary patient (himself or through his next of kin or guardian) shall have the right to refuse any and all medications or other treatments. If appropriate medications or treatments are refused, the facility may then discharge the patient, and shall not be liable in any respect for such action.

### Section 8. INFORMED CONSENT TO MEDICATION OR OTHER TREATMENT -- INVOLUNTARY PATIENTS

#### 8.A. Consent During Emergency Evaluation

Following admission and during the period of emergency evaluation provided in Section 4, the treatment facility may administer medications or other treatments, except as limited by Section 8.C., to a patient consistent with good medical practice and without the informed consent of the patient or his next of kin or guardian. However, prior to administering any such medication or other treatment, the staff shall explain the purposes, nature, and effects of the treatment and shall request the patient's consent to it, unless the responsible

psychiatrist [or: "the responsible physician"]<sup>11</sup> determines that the patient's condition makes doing so infeasible or harmful to him, and enters the reasons for not doing so in the record.

8.B. Consent During Thirty-Day or Subsequent Commitments

It being a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments, except as limited by Section 8.C., to such persons consistent with good medical practice without their consent. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist [or: "the responsible physician"]<sup>12</sup> shall consult with the patient and his next of kin or guardian, and give consideration to the views they express concerning treatment and any alternatives.

8.C. Special Therapies

Notwithstanding subsections A. and B. above, a treatment facility shall not administer aversive therapy, experimental treatment, psychosurgery, or any other special therapy designated by the Department of Mental Health except as provided by law or in regulations promulgated by the Department of Mental Health.

8.D. Other Medical/Surgical Treatments

Consent for other medical/surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

Section 9. PROVISION OF TREATMENT

9.A. General Duty To Provide Treatment

Every patient shall be provided with prompt, competent and appropriate treatment, which offers him a realistic prospect of improvement. Patients shall be afforded treatment by sufficient numbers of duly qualified personnel, in facilities which meet applicable

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<sup>11</sup> Optional provision.

<sup>12</sup> Optional provision.

licensing and accreditation standards, which conform to applicable regulations of the Department of Mental Health, and which are able adequately to care for and treat the patients they serve.

9.B. Individual Treatment Plan

1. A written individual treatment plan shall be prepared, with the participation of the patient to the extent he is able, during voluntary admission or emergency psychiatric evaluation, or if a person has been subject to neither, then within seven days of a patient's thirty-day commitment. The individual treatment plan shall be approved by the responsible psychiatrist [or: "the responsible physician"],<sup>13</sup> and the course of treatment actually administered shall conform to the plan.

2. The patient's progress in attaining the objectives in the treatment plan shall be noted in his records and revisions in the plan shall be made as appropriate. The patient, and if the patient desires, the next of kin or guardian, shall be afforded an opportunity to participate in considering any substantial change in the treatment plan.

3. The individual treatment plan shall be available upon request to the patient, and to any other person designated by him, provided that the responsible psychiatrist [or: "the responsible physician"]<sup>14</sup> may preclude disclosure of the individual treatment plan to the patient or others for a period not to exceed seven days from the request, if he states in writing why disclosure would be harmful to the patient.

9.C. Administration of Medications and Other Treatments

1. Medications and other treatments shall only be prescribed, ordered and administered in conformity with accepted clinical practice. Medication shall be administered only in accordance with the written order of a physician or upon a verbal order, noted in the patient's medical record and subsequently signed by the physician. Medication shall be administered only by a qualified physician, or qualified nurse, or by

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<sup>13</sup> Optional provision.

<sup>14</sup> Optional provision.

qualified other persons pursuant to procedures approved by the Department of Mental Health. The attending physician shall review regularly the drug regimen of each resident patient under his care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding thirty days thereafter, but may be renewed.

2. Medications and other treatments shall be administered in accordance with all applicable law.

3. If a patient is given any psychotropic or other medication which has an effective duration of action including the day of a court hearing, the facts concerning its administration and effects, and the patient's mental status and behavior in the absence of medication, shall be brought to the attention of the court.

#### 9.D. Other Medical/Surgical Care

All patients shall be provided with prompt, regular and competent medical care for physical ailments under the supervision of a licensed physician. Every patient shall have a reasonably complete physical examination at appropriate intervals.

### Section 10. RIGTS OF PATIENTS

#### 10.A. Preservation of Rights

No right of any person (including but not limited to the right to register and vote at elections; rights to acquire, use and dispose of property including contractual rights; rights to sue and be sued; rights relating to licenses, permits, privileges and benefits under law; and rights concerning domestic relations) shall be denied or reduced solely by reason of his having been evaluated, committed or treated under this Act, except as otherwise specifically provided herein or in other applicable law. A finding of lack of capacity to make an informed decision concerning treatment under Section 5 shall not alone establish lack of competence for any other purpose. A treatment facility may for clinical reasons preclude a patient who is believed to lack competence from making substantial dispositions of his property until his competence can be decided by a court.

10.B. Right to Treatment

Patients shall have a right to treatment to the extent provided in Sections 9, 10.C., and 10.D.

10.C. Healthful and Humane Environment

Every patient shall have the right to a healthful and humane environment. Every treatment facility shall provide a clean, sanitary, safe and comfortable environment in a structure which complies with applicable licensing requirements governing physical facilities, nutrition, health and safety, and medical services, and for aspects of care for which there are not mandatory requirements, with generally accepted professional standards. In addition, every patient shall have a right to a humane psychological environment which protects him from harm or abuse, provides reasonable privacy, promotes personal dignity and provides opportunity for improved functioning.

10.D. Least Restrictive Alternative and Leaves of Absence

1. Every patient shall have the right to treatment consistent with the least restrictive alternative principle.

2. Leaves of absence may be granted in appropriate cases at the discretion of the treating facility. Police officers shall be authorized to and shall, at the request of a treatment facility, take into custody and return to the treatment facility any person who has been committed there and leaves without proper authorization or does not return at the end of an authorized leave of absence.

10.E. Institutional Labor

1. Patients have a right to perform labor as part of a therapeutic program.

2. Patients may not be required to perform labor, except that to the extent they are able, they may be required to perform (1) tasks necessary to care for their personal possessions, (2) routine, nondegrading housekeeping tasks necessary to maintain their living quarters, or (3) other tasks which the responsible

psychiatrist [or: "the responsible physician"]<sup>15</sup> approves and which are monitored as part of a therapeutic program for the patient. No patient shall be subjected to any loss of any right under this Act (as distinguished from a privilege which is conferred as part of a therapeutic program) because of his refusal to perform such tasks.

3. Any patient labor which confers an economic benefit upon the institution beyond merely supplementing employee performance of housekeeping tasks shall be compensated on a reasonable basis in accordance with applicable law, and the proceeds of such labor shall be paid to the patient or his designee.

#### 10.F. Restraints and Seclusion<sup>16</sup>

1. Restraints and seclusion may be of therapeutic benefit to some patients and therefore may be administered in conformity with good medical practice.

2. Every patient shall have the right to be free from unwarranted or inappropriate restraints or seclusion.

3. A patient shall be physically restrained or placed in seclusion only at the written order of a physician or upon a verbal order noted in the patient's record and subsequently signed by the physician.

4. During any period in which a patient is restrained or secluded, he shall be periodically checked and cared for properly to assure his well-being.

#### 10.G. Corporal Punishment

Every patient shall have the right to be free from corporal punishment.

#### 10.H. Nutrition

Every patient shall have the right to a nutritionally sound and medically appropriate diet.

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<sup>15</sup> Optional provision.

<sup>16</sup> These provisions establish only a basic framework for the use of restraints and seclusion. More detailed guidelines are being prepared by the American Psychiatric Association to deal with the many subtle problems which arise.

10.I. Exercise and Recreation

Every patient shall have reasonable opportunities for physical and outdoor exercise and access to recreational areas and equipment. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.J. Visitors

Every patient has the right to receive visitors of his choosing with reasonable privacy. Reasonable limitations on access of visitors may be set by general rules or, for clinical reasons, in particular cases.

10.K. Communications

1. Every patient shall have the right to send and receive mail. Reasonable rules governing inspection (but not reading) of incoming mail may be enforced, provided that they are necessary to substantial health care purposes and that they preserve the patient's privacy rights to the extent compatible with his clinical status.

2. Every patient shall have the right to reasonably private access to telephones, including the right to make long-distance calls to the extent he can arrange for payment for such calls.

3. A treatment facility shall provide reasonable assistance to patients in exercising their communication rights. Reasonable limitations on use of the mails and telephones may be set by general rules or, for clinical reasons, in particular cases.

10.L. Practice of Religion

Every patient shall have the right to practice or refrain from practicing religion, and pressure shall in no event be placed on those who do not wish to practice religion. The treatment facility shall provide appropriate assistance so that patients wishing to practice a religion have a reasonable opportunity to do so.

10.M. Personal Possessions

Every patient shall have the right to keep, use and store personal possessions and to maintain and use

bank accounts or other sources of personal funds, unless precluded from doing so by order of a court. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.N. Notice of Rights

As soon after admission as his medical condition permits, a patient shall be advised orally and given a written statement of his rights under this Act, and such a statement of rights shall be posted so that it is available to patients.

10.O. Non-Retaliation

No patient shall be retaliated against or subjected to any adverse change of conditions or treatment solely because of his having asserted his rights.

10.P. Access to Counsel

A patient may at any time have a telephone conversation with or be visited by his lawyer.

Section 11. SUCCESSIVE PERIODS OF COMMITMENT

11.A. Sixty-Day Re-Commitment

1. Any person who has been subject to a thirty-day commitment pursuant to Section 6, may be re-committed for up to sixty days upon a petition by the treatment facility or by the next of kin or guardian. The petition may be filed with the court at any time prior to the expiration of the thirty-day commitment. The petition shall include a statement of the treatment facility as to why the person still meets the criteria for involuntary commitment; what treatment has been provided and what progress has been made; why a further period of commitment is warranted; and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.

2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following the expiration of the thirty-day commitment, and shall have all other rights to which he was entitled at the hearing on thirty-day commitment.

3. The court shall order that the person be discharged unless it determines (a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and (b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

11.B. One Hundred Eighty-Day Re-Commitments

1. Any person who has been subject to sixty-day re-commitment pursuant to Section 11.A. may be re-committed for up to one hundred eighty days upon a petition filed with the court by the treatment facility or by the next of kin or guardian. The petition shall include a statement of the treatment facility as to why the person still meets the criteria for involuntary commitment; what treatment has been provided and what progress has been made; why a further period of commitment is warranted; and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.

2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following expiration of the operative period of commitment and shall have all other rights to which he was entitled at the hearing on thirty-day commitment.

3. The court shall order that the person be discharged unless it determines (a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and (b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

4. Additional re-commitments for periods of up to one hundred eighty days each may be ordered in accordance with Section 11.B.1-3 when warranted.

11.C. Waiver of Hearings

A patient may waive any hearing to which he is entitled under this Section 11 upon a written waiver which the court finds is knowingly and voluntarily executed by the patient.

Section 12. DISCHARGE

12.A. The responsible psychiatrist [or: "the responsible physician"]<sup>17</sup> shall review periodically whether a patient still meets the criteria for lawful commitment, and if he concludes that the patient does not, he shall undertake discharge procedures as provided herein.

12.B. As to a patient committed because he was likely to cause harm to himself or to suffer substantial mental or physical deterioration, if the responsible psychiatrist [or: "the responsible physician"]<sup>18</sup> concludes that the patient no longer meets the criteria for lawful commitment, he may discharge the patient directly.

12.C. As to a patient committed solely because, or partly because, he was likely to cause harm to others, if the responsible psychiatrist [or: "the responsible physician"]<sup>19</sup> concludes that the patient no longer meets the criteria for lawful commitment, or that the patient's treatment program has been completed or is unlikely to provide further benefits, he shall apply to the court for an order discharging or transferring the patient, as may be appropriate. The application shall set forth the relevant facts. The court may conduct an informal hearing, subject to such procedures as the court sets. Nothing in this subsection shall reduce any rights to hearings which patients have pursuant to other provisions of this Act.

12.D. Discharge of any patient may be delayed for a reasonable period of time in order to arrange transportation or lodging for the patient, or for other good cause.

12.E. A person who has been discharged from emergency evaluation, thirty-day commitment or a subsequent period of commitment may be re-committed only pursuant to the same procedures provided in this Act and upon a showing of some new circumstances warranting such commitment which were not known at the time of discharge.

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<sup>17</sup> Optional provision.

<sup>18</sup> Optional provision.

<sup>19</sup> Optional provision.

12.F. The responsible psychiatrist [or: "the responsible physician"]<sup>20</sup> may, as part of an individual treatment plan for a patient who is involuntarily committed, release such patient to outpatient treatment upon the condition that if the patient fails to follow through with or respond acceptably to such outpatient treatment, he may be returned to inpatient treatment for the remainder of the operative period of commitment.

12.G. Nothing in this Act shall limit any other legal rights or remedies concerning discharge which a patient may have or acquire pursuant to law, regulation or policy, including the right to petition for a writ of habeas corpus.

Section 13. CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

[This Section adopts the American Psychiatric Association's "Model Law on Confidentiality of Health and Social Service Records."]

Section 14. REPRESENTATION OF PATIENTS

14.A. Right to Counsel at Hearings

Every patient shall have a right to counsel to represent him at court hearings under this Act, except that a patient need not be provided with counsel for the preliminary hearing on emergency evaluation provided in Section 4.F.

14.B. Resolution of Grievances in Treatment Facilities

Every treatment facility shall establish a fundamentally fair procedure for the assertion, resolution, and redress of patients' grievances, and shall have a patients' representative or similar person who shall hear patients' grievances, attempt to resolve problems, and protect patients' interests.

14.C. Representation by Next of Kin or Guardian

Any right of patients provided in this Act may be exercised on behalf of a patient who is unable to exercise such right by a next of kin or guardian, in accordance with State law.

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<sup>20</sup> Optional provision.

Section 15. TRANSPORTATION

Whenever a patient is to be brought to or from a treatment facility, or is to be transferred to another facility or to a home, the court may direct the sheriff, state police or other appropriate authorities to furnish suitable transportation.

Section 16. NON-DEROGATION OF PATIENTS' RIGHTS

Rights conferred upon patients by this Act shall be in addition to, and nothing in this Act shall revoke or reduce, any rights, privileges or immunities which a patient may have or acquire by law, regulation or policy.

Section 17. COSTS OF CARE

In accordance with law, indigent public patients shall receive care and treatment under this Act without charge to them. Patients committed under this Act who are able to pay may be required to pay some reasonable costs of care and treatment, and to that end treatment facilities and the State shall be authorized to recover such costs from them or their estate, their family, custodians of their property, or third parties liable for the costs of their care or treatment, in conformity with law. The liability of patients, their families, and others for the long term care of patients committed as likely to cause harm to others shall be specially limited by regulations of the Department of Mental Health.

Section 18. IMMUNITIES AND PENALTIES

18.A. Immunities

1. In the absence of willful misconduct or gross negligence, no officer, director, staff member or employee of a treatment facility shall be liable for acts or omissions within the scope of his employment related to admission, evaluation, care, treatment, nonadmission, transfer, removal of restrictions upon, or discharge of a person, pursuant to this Act.

2. No other person who, acting in good faith and with a reasonable basis, participates in any of the processes provided in this Act shall be liable for such actions.

3. Notwithstanding any other provision of this Act, no police officer, no officer, director, staff member or employee of a treatment facility, and no other person or entity performing actions pursuant to this Act, shall be liable for any action of a patient who is discharged from or is absent from a treatment facility pursuant to this Act.

4. Under no circumstances shall any person performing actions pursuant to this Act have a duty to, or be liable for failing to, notify, advise or warn anyone concerning the non-admission, transfer, removal of restrictions on, or discharge of any person.

#### 18.B. Penalties

1. Any person who knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting or interfering with the processes provided in this Act shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under law.

2. Any person who takes into custody, admits for evaluation or commitment, detains for a further period of time, discharges, or administers medication or treatment to a patient, or takes other action affecting the substantial rights of a patient, doing so knowingly and willfully in substantial violation of this Act, shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under law. This subsection shall not be invoked in cases of minor, merely technical, or otherwise justifiable breaches of the provisions of this Act.

#### Section 19. REGULATIONS

The Commissioner of Mental Health is empowered to promulgate regulations to implement this Act which are consistent with its provisions.

#### Section 20. CONSTRUCTION

##### 20.A. Gender and Number

As used in this Act, pronouns shall refer to both male and female persons equally, and articles shall refer to singular and plural references equally.

20.3. Severability

If any provision of this Act or its application to any person or circumstance is held invalid, it is the legislative intent that such invalidity not affect other provisions or applications which can be given effect apart from that which is invalidated, and to this end the provisions of this Act shall be deemed severable.

20.C. Construction Against Implied Repeal

This Act is intended as a unified, general Act covering its subject matter, and accordingly none of its provisions shall be deemed impliedly repealed by subsequent legislation if such a construction reasonably can be avoided.

ADDENDUM

This addendum contains Guidelines for states which do not wish to undertake a comprehensive revision of their civil commitment laws, but do wish to add provisions for the commitment of persons who are likely to "suffer substantial mental or physical deterioration."

\* \* \*

## DEFINITIONS

As used in this Act, the terms below shall have the meanings indicated:

\* \* \*

"consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, where treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

\* \* \*

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his mental disorder or condition, is unable despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment as evidenced by inability to weigh the possible risks and benefits.

"likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.

\* \* \*

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition which (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment or (2) substantially impairs behavior as manifested by recent disturbed behavior.<sup>1</sup>

\* \* \*

### EMERGENCY PSYCHIATRIC EVALUATION

#### Detention by a Police Officer

A police officer may take a person into custody, and transport the person to a treatment facility for emergency psychiatric evaluation if:

\* \* \*

- the police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others;
- \* \* \*

#### Certification by a Licensed Physician

A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation when a licensed physician certifies in writing that he has examined the patient

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<sup>1</sup> Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

in the last 72 hours or that he has ongoing medical responsibility for the person and has knowledge of his current condition, and on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

\* \* \*

Treatment Facility Determination

Upon the presentation of a person to a treatment facility, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth below.

The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

\* \* \*

CRITERIA FOR COMMITMENT

A person may be involuntarily committed for a period of up to ( )<sup>2</sup> days if after the hearing the court determines, based upon clear and convincing evidence, that:

1. the person is suffering from a severe mental disorder; and

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<sup>2</sup> Insert the time period under existing law.

2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and
3. the person either refuses or is unable to consent to voluntary admission for treatment; and
4. the person lacks capacity to make an informed decision concerning treatment; and
5. as the result of the severe disorder, the person is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others.

\* \* \*

INFORMED CONSENT TO MEDICATION OR  
OTHER TREATMENT -- INVOLUNTARY PATIENTS

\* \* \*

It being a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments, except special therapies which are subject to particular laws or regulations, to such persons consistent with good medical practice without their consent. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist shall consult with the patient and his next of kin or guardian, and give consideration to the views they express concerning treatment and any alternatives.

STATE OF ALASKA  
THE LEGISLATURE

POUCH V STATE CAPITOL  
JUNEAU, ALASKA 99811  
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

September 9, 1983

SUBJECT: Mental health commitment laws  
(Work Order No. 13-1516)

TO: Senator Joe Josephson  
Chairman, Senate Health, Education and  
Social Services Committee

FROM: Edward H. Hein *EHA*  
Legislative Counsel

You have asked for a comparison of the American Psychiatric Association's draft guidelines for psychiatric hospitalization of adults with Alaska's mental health commitment laws (AS 47.30.655 - 47.30.915). I have enclosed a section-by-section comparison, with the APA guidelines on the left-hand pages and the corresponding Alaska statutes on the right-hand pages. My comments follow.

In general, there are many similarities between the APA guidelines and Alaska law. Both provide for emergency or involuntary commitments, voluntary commitments, initial periods of detention followed by longer periods of extension, standards, hearings, patient rights, immunities for mental health professionals, and penalties for bad faith commitments. In most cases Alaska law appears to provide equal or better patient protections than those recommended by the APA.

The major specific differences between the guidelines and the statutes are as follows:

1. Emergency detention. Under APA section 4.A.2. a person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility, except for protective custody purposes and only while awaiting transportation to a treatment facility. Under AS 47.30.705. a correctional facility may be used as an emergency evaluation facility if a regular evaluation facility is unavailable.

2. Petition for involuntary commitment. Under APA section 4.C. any "interested adult" may petition for an emergency psychiatric evaluation of another person. The AFA does not define what "interested" means. Under AS 47.30.700 "any adult" may petition for involuntary commitment of another person.

3. Deadline for emergency examination. Under APA section 4.D.1. a treatment facility must examine a person under emergency detention "promptly" after arrival at the facility. Under AS 47.30.710 the examination and evaluation must be completed within 24 hours of arrival.

4. Advisement of rights. Under APA section 4.E. a treatment facility must notify a person admitted for emergency evaluation of the purposes and possible duration of the evaluation, as well as the person's legal rights relating to commitment. Under AS 47.30.725 there is no specific requirement of notice relating to the purposes and duration of evaluation. But the Alaska statute requires that notice be both oral and written and in a language the person understands.

5. Hearing after emergency detention. Under APA section 4.F. a person under emergency detention must receive a hearing before a court within five business days after being admitted to a facility. This right to a hearing may be waived in writing upon advice of counsel. The hearing is informal and is conducted under rules set by the court consistent with "fundamental fairness". After the hearing a person may be discharged by the court or committed for 30 days. Under AS 47.30.725 a person under emergency or involuntary detention has a right to a hearing within 72 hours of arrival at the facility. The person may not waive the right to a hearing, but may waive the 72-hour limit if the person is represented by counsel. However, the hearing must be held within seven calendar days of the person's arrival at the facility. The person has a right to communicate, immediately after arrival at the facility, with a guardian or other adult and with an attorney. At the hearing the person has a right to be represented by an attorney, to present evidence and to cross-examine witnesses. Subject to specified exceptions, the person has a right to be free of the effects of medicine or treatment before the hearing. After the hearing the person may be discharged or committed for a period of 21 days. Additional hearing rights are

specified elsewhere in the APA guidelines and the Alaska statutes.

6. Voluntary admission. Under APA section 5.A, a person believed to be mentally ill and in need of hospitalization may be admitted voluntarily if the person consents in writing, after being advised of rights. The consent is effective for 60 days, but may be renewed for an unlimited number of periods of up to 180 days each. Under AS 47.30.670 the only requirements are that the person (1) in fact be suffering from mental illness, (2) be 14 years old or older, and (3) "voluntarily" signs the admission papers. A person under 14 years of age may be "voluntarily" admitted for a period of 21 days if (1) the minor's guardian or parent signs the admission papers and (2) the senior mental health professional at the facility concludes that specified criteria are met. Presumably the minor is automatically released after 21 days unless the minor is admitted again under the same requirements as for initial admittance.

7. Discharge from voluntary admission. Under APA section 5.B, any person voluntarily admitted must be discharged within five business days after submitting a written request for discharge, unless the treatment facility or the person's guardian files a petition for 30-day commitment. Under AS 47.30.685 - 47.30.695 a person who was voluntarily admitted to a treatment facility shall be discharged immediately upon submitting a written notice of intent to leave the facility. However, the treatment facility may hold the person for 48 hours after receiving an intent to leave notice in order to initiate involuntary commitment proceedings. In that case, the facility must give the person written notice of its intent to initiate the proceedings by the time the person would otherwise be released. A person who is under 14 years of age must be discharged immediately upon the request of the parent or guardian, unless the minor, if released, is likely to cause serious harm to himself or another as a result of a mental illness.

8. Conversion of status. Under APA section 5.C, a person who was committed involuntarily may change to a voluntary admitee with a psychiatrist's approval. No comparable provision exists in Alaska law.

9. Further periods of commitment. The APA guidelines provide for 30-day, 60-day, 90-day, and 180-day commitments. Alaska law provides for 21-day, 90-day, and 120-day

commitments. Each period of commitment is to be preceded by a hearing under both the APA guidelines and the Alaska statutes. The patient's rights at the hearing vary considerably, however, under the two different schemes. The most noticeable differences are that (1) the APA guidelines allows the use of hearsay evidence so long as it is relevant, while Alaska requires the use of civil rules of evidence; (2) the APA denies a patient's Fifth Amendment right to remain silent, while Alaska law specifically recognizes it; and (3) the APA does not allow the exclusion from evidence of privileged communications between the patient and psychiatrist or physician made during the course of evaluation or treatment, whereas Alaska law recognizes such an evidentiary privilege.

10. Petitions for further periods of commitment. Under both the APA guidelines and Alaska law, all commitments are initiated by the filing of a petition. Under APA section 6.A. a petition for a 30-day commitment of a person already at a treatment facility may be filed by the facility or by the person's "next of kin" or guardian. If the person is not currently committed, any "interested adult" may file a petition for a 30-day commitment of the person. The language of the guidelines does not make clear whether additional petitions may be filed for successive commitments of 30-days each. Under APA section 11.A. a person who "has been subject to" a 30-day commitment may be recommitted for an additional 60-day period upon a petition filed by the treatment facility or the person's "next of kin" or guardian. (The drafting here is imprecise and ambiguous. The phrase "has been subject to" could mean "has ever been subject to" or it could mean "is currently under" or it could mean "has met the criteria for".) Under APA section 11.B., a person committed for any period of time and who is dangerous to himself or herself may be committed for one additional period of "up to 90 days" upon a petition filed by the treatment facility or by the person's next of kin or guardian at any time before the current period of commitment expires. Under APA section 11.C., a person who "was committed for up to 30 days and is subject to 60-day recommitment" and who is likely to harm others may be committed for successive additional periods of 180 days each upon a petition filed by the person's next of kin or guardian, or by the state "upon advice of the treatment facility". Under AS 47.30.730, a petition for a 21-day commitment must be signed by two mental health professionals who have examined the person. It is not clear who may file

the petition. Under AS 47.30.740, a petition for a 90-day commitment may be filed by "the professional person in charge" while the person is under a 21-day commitment. Under AS 47.30.770 the "professional person in charge" may file a petition for a 120-day commitment of a person who is under a 90-day commitment. Successive commitments of 120 days each are authorized.

11. Informed consent. Under APA section 7, a treatment facility must obtain a patient's informed consent before administering medicine or treatment to a voluntary admittee in a non-emergency situation, unless the person lacks capacity to consent. A voluntary admittee may revoke consent in writing at any time except in an emergency. Under APA section 8, an involuntary admittee, or a voluntary admittee in an emergency, may be treated or given medicine without informed consent. Under AS 47.30.825, every mental patient has the right to know the name, purpose and side effects of medicine to be administered. In a "true medical emergency", surgery to save the "life, physical health, eyesight, hearing or member of the patient" may be performed without the consent of the patient, guardian or court. The law specifically recognizes an adult patient's right to not be operated on if the patient knowingly withholds consent on religious grounds.

12. Special therapies. Under APA section 8.C. experimental treatments, psychosurgery, aversive therapy or other special therapy designated by the appropriate state department may not be administered, except as provided by law or regulation. AS 47.30.825 provides that a lobotomy or psychosurgery may not be performed without specific informed consent, a full due process hearing, and a court order. Electro-convulsive therapy or aversive conditioning requires informed consent or, if the patient lacks substantial capacity to give informed consent, a court order. Under AS 47.30.830 experimental treatments involving any significant risk of physical or psychological harm are prohibited.

13. Patient rights. This is one area where the APA guidelines are more thorough than Alaska law. Under both schemes patients have rights to privacy, property, civil rights such as voting, mail, access to attorneys and visitors, and treatment consistent with the "least restrictive alternative" principle. APA section 10, however, also provides a right to "nutritionally sound and medically appropriate diet", a right to exercise and recreation, a

right to perform labor, and a right to be free from corporal punishment.

14. Discharge. Under APA section 12.F. a person may, as part of an individual treatment plan, be released from commitment at a facility to outpatient treatment. The person may, however, be returned to inpatient treatment for failure to comply with the outpatient treatment program requirements. APA section 15 provides that law enforcement or other appropriate authorities shall provide transportation of patients to and from a treatment facility. Under AS 47.30.825, a person upon discharge from a facility must be given a discharge plan suggesting, but not requiring, the kinds and amounts of treatment the person should have to maintain mental health. The person has a right to participate in formulating the discharge plan. Also, under AS 47.30.890 a person is entitled to "suitable clothing" upon discharge, and if indigent, to transportation to the person's permanent residence in the state and "a reasonable amount of money to meet immediate needs". See also AS 47.30.795.

15. Confidentiality. The APA guidelines adopt by reference the "Model Law on Confidentiality of Health and Social Service Records". AS 47.30.845 provides that patient records are confidential and not public records, and specifies the persons or agencies to whom records and information may be disclosed.

16. Grievance procedures. APA section 14.B. requires that treatment facilities establish "fundamentally fair" procedures for patients' grievances. Alaska statutes have no similar provision.

17. Immunities. Under APA section 18.A. employees of a treatment facility are not liable for acts or omissions within the scope of employment, absent willful misconduct or gross negligence. Other persons who act in good faith and with a reasonable basis are not liable for actions provided for under the guidelines. The guidelines disclaim any liability for actions by a patient who is absent from a treatment facility or who has been discharged. Finally, the guidelines disclaim any liability for failure to warn or notify anyone of a patient's discharge. Immunity under Alaska law is much more limited. Under AS 47.30.815 a person is not subject to criminal or civil liability for petitioning for evaluation or treatment of another person in

Senator Joe Josephson  
Page 7  
September 9, 1983

good faith and upon actual knowledge or reliable information. Also, four classes of officials may not be held civilly or criminally liable for detaining or releasing a person "at or before the end of" the period for which the person was committed, so long as the official acted in good faith and without gross negligence.

18. Penalties. APA section 18.B. provides that a civil fine, injunctive relief and money damages may be imposed or granted if a person (1) "knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting or interfering with the processes provided in this Act" or (2) commits, detains, discharges, or treats a patient, or otherwise affects a patient's "substantial rights" knowingly and willfully in substantial violation of the guidelines. AS 47.-30.915 makes it a class C felony to willfully initiate an involuntary commitment procedure without good cause.

19. Miscellaneous provisions. The last four pages of the comparison booklet (enclosed) consist of provisions of Alaska law for which there are no corresponding provisions in the APA guidelines. Note especially AS 47.30.760, providing for placement at the closest facility; AS 47.-30.765, providing for appeal of involuntary commitment orders; AS 47.30.875, providing for handling of nonresident patients; AS 47.30.880, adopting the Interstate Compact on Mental Health; and AS 47.30.895 - 47.30.900, disposition of personal property and money of patients who die while in custody or who leave a facility without authority. Note one error: AS 47.30.795, relating to outpatient care and appearing among the miscellaneous provisions, actually corresponds with APA section 12.F. and should have appeared opposite that section.

If you have any questions or comments, feel free to contact me at your convenience.

EHH:ljb

Enclosure  
29/002

GIVEN TO PATIENTS OF ADI  
(ALSO IN A LANGUAGE UNDERSTOOD BY PATIENT)

PATIENT RIGHTS

Your legislators have tried to protect your rights to freedom and at the same time protect everyone from dangerous people and protect people who are harmful to themselves because of mental illness.

The following are your rights according to law:

1. You may join in developing your treatment plan, and you are entitled to be informed of your medical and psychological condition and prognosis.
2. You will be told the name, purpose, and side effects of any medication you are asked to take.
3. No unnecessary or excessive medication will be given to you. All medication will be given only on the order of a licensed physician.
4. Physical restraint will not be used on you unless you behave in a manner harmful to yourself or others.
5. You will not receive electroconvulsive therapy, aversive conditioning, experimental treatment or psychosurgery.
6. You will be given a discharge plan outlining the kind and amount of care and treatment you should have after discharge.
7. Your civil rights will not be impaired.
8. Your hospital record and I.D. photograph will be confidential.
9. Unless you sign a release of responsibility, your personal property will be inventoried and safe-guarded and returned to you at discharge.
10. You will have private storage space, and will be allowed to wear your own clothing, and keep certain personal possessions and a reasonable amount of your own spending money.
11. You may have visitors during visiting hours.
12. You will have access to letter writing materials and stamps, and may send and receive unopened mail.
13. You will have reasonable access to a phone and may make and receive confidential calls.
14. After discharge you may move to have all court records pertaining to your care expunged.

Under the law certain rights may be restricted by your doctor when it is necessary for the protection of yourself or others.

The following additional information will help you better understand your care here. If you still have questions, ask your nurse or social worker:

1. No matter what your legal status is, the more you want to help yourself and work with the staff in an honest, open manner, the quicker and more effective will be your recovery.
2. You do not have the right to do the following:
  - Injure or threaten others.
  - Damage property
  - Intrude on the rights of others, such as rudeness, shouting, or excessive noise that you can control.
  - Make messes for others to clean up.
  - Bring or use drugs, alcohol or weapons.
  - Do illegal acts (break the law). This includes writing threatening letters or making threatening or obscene phone calls.

If you feel you are being treated unfairly or improperly, please follow these steps:

- 1) Bring it up in the community meeting.
- 2) If you are not satisfied with the results of that action, bring it up with your nursing advisor, doctor, or any member of the treatment team.
- 3) If not satisfied, write down your problem and complaint and forward it to the Superintendent.
- 4) You always have the right to write to your attorney, the State Ombudsman, the Commissioner of the Department of Health and Social Services, or the Superior Court which may have been involved in your hospitalization.

If you feel you've been discriminated against in any way because of race, color, sex, religion, age, or national origin, you may file a complaint with the Civil Rights Commission. You can get the forms from the Administrator's Office. If you need help in filling them out, see your nurse advisor or the Hospital Administrator's Office.

/cjb/vnc

## HALOPERIDOL (Systemic)

Haloperidol (ha-loe-PER-i-dole) is used to treat nervous, mental, and emotional conditions. It is used also to control nausea and vomiting and the effects of Gilles de la Tourette's disease. Haloperidol is available only with your doctor's prescription.

### Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have any of the following medical problems:

Alcoholism	Lung disease
Blood disease	Overactive thyroid
Epilepsy	Parkinson's disease
Glaucoma	Prostate enlargement
Heart or circulation disease	Severe mental depression
Kidney disease	Stomach ulcers
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Asthma medicine
Anticonvulsants (seizure medicine)	Epinephrine
Antihypertensives (high blood pressure medicine)	Ulcer medicine

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Prescription pain medicine
Barbiturates	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)

### Proper Use of This Medicine

Use this medicine only as directed by your doctor. Do not use more of it, do not use it more often, and do not use it for a longer period of time than your doctor ordered.

If this medicine upsets your stomach, it may be taken with food or milk to lessen stomach irritation.

If you miss a dose of this medicine, take it as soon as possible unless it is within 6 hours of your next scheduled dose. Do not double doses. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

### Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

Sometimes haloperidol must be taken for several days to several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.

Do not suddenly stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). Check with your doctor before taking any of the above while you are taking this medicine.

This medicine may cause some people to become drowsy or less alert than they are normally, especially as the amount of medicine is increased. Even if you take this medicine at bedtime, you may feel drowsy or less alert on arising. Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.

Although not a problem for many patients, dizziness, light-headedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. However, if the problem continues or gets worse, check with your doctor.

### Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

#### More common

Shuffling walk	Tic-like, jerky movements of head, face, mouth, and neck
Stiffness of arms and legs	Trembling and shaking of hands and fingers

#### Less common

Difficulty in urination	Fine, worm-like movements of tongue
Dizziness, light-headedness, or fainting	Skin rash

#### Rare

Sore throat and fever	Yellowing of eyes and skin
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Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

#### More common

Blurred vision	Dry mouth
Constipation	

## TRICYCLIC ANTIDEPRESSANTS (Systemic)

Applies to:

Amitriptyline (a-mee-TRIP-ti-leen)

Desipramine (dess-IP-ra-meen)

Doxepin (DOX-e-pin)

Nortriptyline (nor-TRIP-ti-leen)

Imipramine (im-IP-ra-meen)

Does *not* apply to:

Protriptyline

This medicine belongs to the group of medicines known as tricyclic antidepressants or "mood elevators." It is used to relieve mental depression and depression that sometimes occurs with anxiety. One form of this medicine (imipramine) may be used to treat enuresis (bedwetting). Tricyclic antidepressants are available only with your doctor's prescription.

### Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have experienced an allergic reaction to other tricyclic antidepressants.

—if you have any of the following medical problems:

Alcoholism	Heart disease
Asthma (history of)	High blood pressure
Difficult urination	Liver disease
Enlarged prostate	Overactive thyroid
Glaucoma	Stomach or intestinal problems

—if you are now taking any other medicines, including over-the-counter (OTC) or nonprescription medicine, especially the following:

Allergy medicine	Other medicine for depression
Antihistamines	Pain medicine
Barbiturates	Sedatives
Blood pressure medicine	Seizure medicine
Cold remedies	Sleeping medicine
Hay fever medicine	Tranquilizers
Narcotics	

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

### Proper Use of This Medicine

*Take this medicine only as directed by your doctor.*

To lessen stomach upset, take this medicine with food, unless your doctor has told you to take it on an empty stomach.

*Sometimes this medicine must be taken for several weeks before you begin to feel better.*

*Keep this medicine out of the reach of children since overdose is especially dangerous in young children.*

If you miss a dose of this medicine, take it as soon as possible and then go back to your regular dosing schedule. However, if a once-a-day bedtime dose is missed, do not take that dose in the morning. Instead, check with your doctor.

### Precautions While Using This Medicine

It is very important that your doctor check your progress at regular visits.

*Do not stop taking this medicine without first checking with your doctor.* Your doctor may want you to reduce gradually the amount you are using before stopping completely.

*Before having any kind of surgery (including dental surgery) or emergency treatment, tell the doctor or dentist in charge that you are using this medicine.*

This medicine will add to the sedative effects of alcohol and other medicines that slow down the nervous system such as antihistamines or medicines for hay fever, allergies, or colds; barbiturates; medicine for seizures; narcotics; other medicine for depression; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine. *Check with your doctor before taking any of the above while you are taking this medicine and also for several days after you stop taking it.*

This medicine may cause some people to become drowsy or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

*Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If this problem continues or gets worse, check with your doctor.*

### Side effects of this Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

#### More common

Blurred vision	Irregular heartbeat (pounding, racing, skipping)
Constipation	Problems in urinating

#### Less common

Eye pain	Hallucinations (seeing, hearing, or feeling things that are not there)
Fainting	Shakiness
	Unusually slow pulse

#### Rare

Seizures	Sore throat and fever
Skin rash and itching	Yellowing of eyes and skin

## LITHIUM (Systemic)

Lithium (LI-thee-um) is a medicine used in the treatment of certain mental and emotional conditions. Lithium is available only with your doctor's prescription.

### Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you are pregnant or if you intend to become pregnant while using this medicine.

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Heart disease	Severe infection
Kidney disease	Thyroid disease
Parkinson's disease	

—if you drink large amounts of coffee or tea.

—if you are on a low-salt diet.

—if you are now taking any of the following medicines or types of medicine:

Asthma medicine	Haloperidol
Caffeine	Potassium iodide
Chlorpromazine	Sodium bicarbonate
Diuretics (water pills, especially thiazide-type)	(baking soda)

### Proper Use of This Medicine

Take this medicine exactly as directed. Do not take more of it, do not take it more often, and do not take it for a longer period of time than your doctor ordered.

Sometimes this medicine must be taken for 1 to several weeks before you begin to feel better.

While taking this medicine, drink 2 or 3 quarts of water or other fluids each day, and use a normal amount of table salt in your food, unless otherwise directed by your doctor.

Take this medicine immediately after meals or with food or milk to lessen stomach upset, unless otherwise directed by your doctor.

If you miss a dose of this medicine, take it as soon as possible unless it is 2 hours or less until your next scheduled dose. Do not double doses. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

### Precautions While Using This Medicine

Your doctor should check your progress at regular visits to make sure that the medicine is working properly and that possible side effects are avoided.

This medicine may cause some people to become drowsy or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Use extra care in hot weather and during activities that cause you to sweat heavily, such as hot baths, saunas, or exercising. The loss of too much water and salt from your body may lead to serious side effects from this medicine.

Do not drink large amounts of caffeine-containing beverages, such as coffee, tea, or colas, while taking this medicine. Since lithium is lost from the body through the urine, the increased urine flow caused by caffeine may lessen the medicine's effect.

### Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

#### More common

Nausea and vomiting  
Shakiness and tremor

#### Less common

Drowsiness	Swelling of feet and lower legs
Mental confusion	Weakness
Pains in lower stomach	Slurred speech

#### Rare

Blurred vision	Jerking of arms and legs
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Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

#### More common

Decreased sexual ability	Dry mouth
Diarrhea	Increased thirst
Dizziness	Increased urination

#### Less common

Skin eruption or rash

#### Signs of low thyroid function

Coldness of fingers and toes	Menstrual changes
Constipation	Muscle aches
Dry, puffy skin	Sleepiness
Headache	Tiredness
	Unusual weight gain

## BENZTROPINE (Systemic)

Benztropine (BENZ-troe-peer) is a medicine used to treat Parkinson's disease, sometimes referred to as "shaking palsy." By improving muscle control, benztropine allows more normal movements of the body as the disease symptoms are reduced. Benztropine is available only with your doctor's prescription.

### Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have any of the following medical problems:

Asthma	High blood pressure
Bronchitis	Intestinal blockage
Difficult urination	Kidney disease
Emphysema	Liver disease
Enlarged prostate	Myasthenia gravis
Glaucoma	Overactive thyroid
Hiatal hernia	Severe ulcerative colitis

—if you are taking any of the following medicines or types of medicine:

Amantadine	Medicine for diarrhea
Antacids	
Antihistamines or medicine for hay fever, other allergies, or colds	Medicine for Parkinson's disease
Haloperidol	Medicine for sleep
Heart medicine	Nerve medicine
	Sedatives or tranquilizers
	Ulcer medicine

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranlycypromine

### Proper Use of This Medicine

*Take this medicine only as directed by your doctor*

To lessen stomach upset, take this medicine immediately after meals or with food, unless your doctor has told you to take it on an empty stomach.

If you miss a dose of this medicine, take it as soon as possible. If it is within 8 hours of your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

### Precautions While Using This Medicine

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for depression; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine. *Check with your doctor before taking any of the above while you are taking this medicine.*

Do not take this medicine within 1 hour of taking antacids or medicine for diarrhea. Taking them too close together will make benztropine less effective.

This medicine may cause your eyes to become more sensitive to light than they are normally. Wearing sunglasses may help lessen the discomfort from bright light.

This medicine may cause some people to become drowsy, dizzy, or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Benzotropine will often reduce your tolerance of heat, since it makes you sweat less, causing your body temperature to increase. *Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, as this could possibly result in heat stroke.*

Your mouth, nose, and throat may feel very dry while you are taking this medicine. *To help relieve mouth dryness, chew sugarless gum or dissolve bits of ice in your mouth.*

*Check with your doctor if you develop intestinal problems such as constipation.* This is especially important if you are taking other medicine while taking benztropine, because if the problems are not corrected serious complications may result.

### Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

*More common*  
Constipation

*Less common*  
Difficult urination

*Rare*  
Eye pain  
Skin rash

## THIOXANTHENES (Systemic)

Applies to:

Chlorprothixene (klor-proe-THIX-een)

Thiothixene (thye-oh-THIX-een)

This medicine belongs to the general family of medicines known as thioxanthenes. It is used in the treatment of nervous, mental, and emotional conditions. This medicine is available only with your doctor's prescription.

### Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have ever had any unusual reaction to other thioxanthene or phenothiazine medicines.

—if you have any of the following medical problems:

Alcoholism	Lung disease
Blood disease	Parkinson's disease
Glaucoma	Stomach ulcers
Heart or circulation disease	Prostate enlargement
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Guanethidine (high blood pressure medicine)
Anticonvulsants (seizure medicine)	Levodopa
Epinephrine	Ulcer medicine

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Sedatives, tranquilizers, or sleeping medicine
Barbiturates	Tricyclic antidepressants (medicine for depression)
Narcotics	
Prescription pain medicine	

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylepromine

### Proper Use of this Medicine

*Do not take more of this medicine or take it more often than your doctor ordered.* This is particularly important when it is given to children, since they may react very strongly to the effects of the medicine.

This medicine may be taken with food or a full glass (8 ounces) of water or milk to reduce stomach irritation.

*Sometimes this medicine must be taken for several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.*

If you miss a dose of this medicine, take it as soon as possible. If it is two hours or less until your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

### Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially during the first few weeks the medicine is being taken. Even if you take this medicine only at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

*Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If the problem continues or gets worse, check with your doctor.*

Sometimes, patients may show signs of restlessness and excitement after taking this medicine. If this occurs, stop taking the medicine and check with your doctor.

This medicine will often make you sweat less, causing your body temperature to increase. Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, since overheating could possibly result in heat stroke. Also, hot baths or saunas may make you feel dizzy or faint while you are taking this medicine.

A few people who take this medicine may become more sensitive to sunlight than they are normally. When you first begin taking this medicine, avoid too much sun or too much use of a sunlamp until you see how you react. If you have a severe reaction, check with your doctor.

Do not take this medicine within an hour of taking antacids or medicine for diarrhea. Taking them too close together may make this medicine less effective.

### Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur

## ANTIHISTAMINES (Systemic)

### Applies to:

Asatadine (a-ZA-ta-deen)  
Bromodiphenhydramine (broe-moe-dye-fen-HYE-dra-meen)  
Brompheniramine (brome-fen-EER-a-meen)  
Carbinoxamine (kar-bi-NOX-a-meen)  
Chlorpheniramine (klor-fen-EER-a-meen)  
Dexchlorpheniramine (dex-klor-fen-EER-a-meen)  
Dimethindene (dye-meth-IN-deen)  
Diphenylpyraline (dye-fen-il-PEER-a-leen)  
Doxylamine (doxc-ILL-a-meen)  
Pyrilamine (peer-ILL-a-meen)  
Tripeleminamine (tri-pel-ENN-a-meen)  
Triprolidine (trye-PROE-li-deen)

### Does not apply to:

Cyproheptadine  
Dimenhydrinate  
Diphenhydramine  
Hydroxyzine  
Promethazine  
Trimeprazine

Antihistamines are used to relieve or prevent the symptoms of hay fever and other types of allergy. Certain antihistamine preparations are available only with your doctor's prescription. Others are available without a prescription; however, your doctor may have special instructions on the proper dose of the medicine for your medical condition.

### Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

- if you are breast-feeding an infant.
- if you have any of the following medical problems:

Enlarged prostate	Overactive thyroid
Heart disease	Stomach ulcer
High blood pressure	Urinary tract blockage
Increased eye pressure	
- if you are now taking any central nervous system (CNS) depressants such as:

Barbiturates	Prescription pain medicine
Medicine for seizures	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)
Other antihistamines or medicine for hay fever or colic	

- if you are now taking or have taken within the past two weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

### Proper Use of This Medicine

Antihistamines are used to relieve or prevent the symptoms of your medical problem. Take them only as directed. Do not take more of them or take them more often than your doctor ordered.

Take this medicine with food or a glass of water or milk to lessen stomach irritation.

If you are taking the long-acting tablet form of this medicine, the tablets are to be swallowed whole. Do not break, crush, or chew before swallowing.

Do not give this medicine to premature or newborn infants, unless otherwise directed by your doctor.

### Precautions While Using This Medicine

Antihistamines will add to the effects of alcohol and other medicines that slow down the nervous system, such as anesthetics, including dental anesthetics; tranquilizers; medicine for depression; narcotics; prescription pain medicine; medicine for seizures; sleeping medicine; sedatives; or medicine for hay fever, other allergies, or colds. *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally. Even if taken at bedtime, it may cause some people to feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive or do other jobs that require you to be alert.*

### Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. The following side effects may go away during treatment as your body adjusts to the medicine; however, check with your doctor if they continue or are bothersome:

#### More common

Dizziness	Upset stomach or stomach pain
Drowsiness	
Thickening of the bronchial secretions	

#### Less common or rare

Blurred vision	Nervousness, restlessness, or trouble in sleeping (especially in children)
Difficult or painful urination	Skin rash
Dryness of mouth, nose, and throat	Unusual increase in sweating
Headache	Unusually fast heartbeat
Loss of appetite	

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

## PHENOTHIAZINES (Systemic)

### Applies to:

Acetophenazine (a-set-oh-FEN-a-zeen)  
Butaperazine (byoo-ta-PAIR-a-zeen)  
Carphenazine (kar-FEN-a-zeen)  
Chlorpromazine (klor-PROE-ma-zeen)  
Fluphenazine (floo-FEN-a-zeen)  
Perphenazine (per-FEN-a-zeen)  
Piperacetazine (pi-per-a-SET-a-zeen)  
Prochlorperazine (proe-klor-PAIR-a-zeen)  
Promazine (PROE-ma-zeen)  
Thioridazine (thye-oh-RID-a-zeen)  
Trifluoperazine (trye-floo-oh-PAIR-a-zeen)  
Triflupromazine (trye-floo-PROE-ma-zeen)

### Does *not* apply to:

Ethopropazine  
Methdilazine  
Methotrimeprazine  
Promethazine  
Propiomazine  
Thiethylperazine  
Thiopropazate  
Trimeprazine

Phenothiazines (fee-noe-THYE-a-zeens) are a family of medicines used to treat nervous, mental, and emotional conditions; some are used also to control anxiety, nausea and vomiting, and severe hiccups. Phenothiazines are available only with your doctor's prescription.

### Before Using this Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have ever had any unusual reaction to any of the phenothiazine medicines.

—if you are pregnant or if you intend to become pregnant while using this medicine.

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Alcoholism	Lung Disease
Blood disease	Parkinson's disease
Glaucoma	Prostate enlargement
Heart or circulation disease	Stomach ulcers
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Guanethidine (high blood pressure medicine)
Anticonvulsants (seizure medicine)	Levodopa
Asthma medicine	Ulcer medicine
Epinephrine	central nervous system

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Prescription pain medicine
Barbiturates	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)

—if you are now taking or have taken within the past two weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

### Proper Use of This Medicine

*Do not take more of this medicine or take it more often than your doctor ordered.* This is particularly important when it is given to children, since they may react very strongly to the effects of the medicine.

*Sometimes this medicine must be taken for several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.*

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

If you miss a dose of this medicine and your dosing schedule is one dose to be taken:

Once a day— Take the missed dose as soon as possible. Then go back to your regular dosing schedule. But if you do not remember the missed dose until the next day, do not take it at all and do not double the next one. Instead, go back to your regular dosing schedule.

Two times a day—Take the missed dose as soon as possible. Then go back to your regular dosing schedule. However, if it is almost time for your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.

More than two times a day— If you remember within an hour or so of the missed dose, take it right away. Then go back to your regular dosing schedule. But if you do not remember until later, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.

If you have any questions about this, check with your doctor.

### Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system

such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially during the first few weeks the medicine is being taken. Even if you take this medicine only at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

*Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If the problem continues or gets worse, check with your doctor.*

Sometimes, patients may show signs of restlessness and excitement after taking this medicine. If this occurs, stop taking the medicine and check with your doctor.

This medicine will often make you sweat less, causing your body temperature to increase. *Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, since overheating could possibly result in heat stroke. Also, hot baths or saunas may make you feel dizzy or faint while you are taking this medicine.*

A few people who take this medicine may become more sensitive to sunlight than they are normally. When you first begin taking this medicine, avoid too much sun or too much use of a sunlamp until you see how you react. If you have a severe reaction, check with your doctor.

#### Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

##### *More common (occurring with increase of dosage)*

Muscle spasms, especially of neck and back	Tic-like (jerky) movements of head, face, mouth, and neck
Restlessness	Trembling and shaking of hands and fingers
Shuffling walk	

##### *Less common*

Fainting	Skin rashes
Fine, worm-like movements of tongue	

##### *Rare*

Eye problems	Yellowing of eyes and skin
Sore throat and fever	

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the

medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

##### *More common*

Blurred vision	Dry mouth
Constipation	Increased sensitivity of skin to sun
Decreased sweating	Nasal congestion
Dizziness	Unusually fast heartbeat
Drowsiness	

##### *Less common*

Changes in menstrual period	Difficult urination
Decreased sexual ability	Swelling of breasts

This medicine may cause the urine to turn pinkish red to red or reddish brown; this is harmless and may be expected. If you have questions about this, ask your doctor or pharmacist.

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

#### ADDITIONAL INFORMATION

For patients taking this medicine by mouth

This medicine may be taken with food or a full glass (8 ounces) of water or milk to reduce stomach irritation.

Do not take this medicine within an hour of taking antacids or medicine for diarrhea. Taking them too close together may make this medicine less effective.

*If you are taking a liquid form of this medicine, try to avoid getting it on your skin or clothing because it may cause a skin rash or other irritation.*

*If your medicine comes in a dropper bottle, it must be diluted before you take it. Just before taking, measure each dose with the specially marked dropper and dilute it in  $\frac{1}{4}$  glass (4 ounces) of tomato or fruit juice, water, soup, coffee, tea, milk, or carbonated beverage.*

For patients taking the extended-release tablet form of this medicine

The extended-release tablets or capsules are to be swallowed whole. Do not break, crush, or chew before swallowing.

For patients using the suppository form of this medicine

How to insert suppository: First remove the foil wrapper and moisten the suppository with water. Lie down on side and push the suppository well up into the rectum with finger.

If the suppository is too soft to insert because of storage in a warm place, before removing the foil wrapper chill the suppository in the refrigerator for 30 minutes or run cold water over it.

For patients receiving this medicine by injection

The effects of the long-acting injection form of this medicine may last for up to 6 weeks. The precautions and side effects information for this medicine applies during this period of time.

## Article 9. Patient Rights.

Section	Section
825 Patient rights: Medical	845 Confidential records
830 Prohibition of experimental treatments	850 Expungement of records
845 Civil rights not impaired	855 Posting of rights
840 Right to privacy and personal possessions	860 Notices in languages other than English
	865 Discrimination prohibited

Sec. 47.30.825. Patient rights: Medical. Each patient who is receiving services under AS 47.30.660 — 47.30.915 has the following rights:

(1) A patient, or his counsel, guardian, or the adult designated in accordance with AS 47.30.725 if the patient is mentally incapable of participation, is entitled to participate in formulating his individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in his treatment program, and being informed as to his present medical and psychological condition and prognosis. The treating physician may not withhold any of this information from the patient.

(2) A patient has the right to know the name of medication that he is asked to take, what its purpose, and what side effects may occur with this medication. If the patient is incapable of understanding the purpose and side effects of the medication, the treating physician or mental health professional shall explain it to the patient's counsel or guardian or, if there is no guardian, the adult designated in accordance with AS 47.30.725.

(3) A locked quiet room, or other form of physical restraint, may not be used, except as provided in this paragraph, unless a patient is likely to physically harm himself or others unless restrained. The form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to his preference among forms of adequate, medically advisable restraints including medication, and his preference shall be considered. Nothing in this section is intended to limit the right of staff to use a quiet room at the patient's request or with his knowing concurrence when considered in the best interests of the patient. Patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good medical practice so indicates. Patients in a quiet room must be visited by a staff member at least once every hour and must be given adequate food and drink and access to bathroom facilities. At no time may a patient be kept in a quiet room or other form of physical restraint against his will longer than necessary to accomplish the purposes set out in this paragraph. All uses of a quiet room or other restraint shall be recorded in the patient's medical record, the information including but not limited to the reasons for its use, the duration of use, and the results of the use.

(4) A patient has the right to be free from unnecessary or excessive medication. Psychotropic medication shall be administered only on the order of a licensed physician when the physician determines that such medication is in the best interest of the patient or will prevent serious harm to others.

(5) A patient capable of giving informed consent has the absolute right to accept or refuse electroconvulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given such therapy or conditioning without a court order.

(6) In no event may treatment include psychosurgery, lobotomy, or other comparable form of treatment without specific informed consent of the patient, including a minor unless he is clearly too young or disabled to give an informed consent in which case the consent of his legal guardian is required. In addition, such treatment may not be given without a court order after hearing compatible with full due process.

(7) When, in the written opinion of a patient's attending physician, a true medical emergency exists and a surgical operation is necessary to save the life, physical health, eyesight, hearing or member of the patient, the professional person in charge, or his professional designee, may give consent to the surgical operation if time will not permit obtaining the consent of the proper relatives or guardian or appropriate judicial authority. However, an operation may not be authorized if the patient is not a minor and knowingly withholds consent on religious grounds.

(8) A patient upon discharge shall be given a discharge plan specifying the kinds and amount of care and treatment he should have after discharge and such other steps as he might take to benefit his mental health after leaving the facility. The patient shall have the right to participate, as far as practicable, in formulating his discharge plan. A copy of the plan shall be given to the patient, his guardian, the court if appropriate, and any follow-up agencies. (S 1 ch 84 SLA 1981)

Sec. 47.30.830. Prohibition of experimental treatments. (a) Experimental treatments involving any significant risk of physical or psychological harm may not be administered to a patient.

(b) If the personnel of an evaluation or treatment facility are uncertain as to whether a proposed treatment is experimental or is experimental as applied to a particular patient or would involve a significant risk of mental or physical harm to the patient, the matter may be referred to the commissioner for a determination. The patient, his attorney, his guardian, if any, and an adult designated by the patient, shall, simultaneously with the referral to the commissioner, be provided with copies of all the documents by which the referral is made and shall have the opportunity to provide evidence to the commissioner on the question.

(c) A determination by the commissioner that a treatment is experimental and entails significant risks of mental or physical harm is binding upon all persons involved in the administration of treatment to a patient. (S 1 ch 84 SLA 1981)

**Sec. 47.30.835. Civil rights not impaired.** (a) A person may not deny to a person who is undergoing evaluation or treatment under AS 47.30.660 - 47.30.915 a civil right, including but not limited to, the right to free exercise of religion and the right to dispose of property, sue and be sued, enter into contractual relationships, and marry. A person who violates this subsection commits the crime of interference with constitutional rights under AS 11.76.110.

(b) Court-ordered evaluation or treatment under AS 47.30.660 - 47.30.915 is not a determination of legal incapacity under AS 13.26.005 - 13.26.330. (S 1 ch 84 SLA 1981)

**Sec. 47.30.840. Right to privacy and personal possessions.** A person undergoing evaluation or treatment under AS 47.30.660 - 47.30.915 shall

(1) not be photographed without his consent and that of his guardian if a minor, except that he may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or his designee unless a court orders otherwise;

(2) at the time of admission to an evaluation or treatment facility, have reasonable precautions taken by the staff to inventory and safeguard his personal property; a copy of the inventory signed by the staff member making it shall be given to the patient and made available to his attorney and any other person authorized by the patient to inspect the document;

(3) have access to an individual storage space for his private use while undergoing evaluation or treatment;

(4) be permitted to wear his own clothing, to keep and use his own personal possessions including his toilet articles if they are not considered unsafe for him or other patients who might have access to them, and to keep and be allowed to spend a reasonable sum of his own money for his own needs and comfort;

(5) be allowed to have visitors at reasonable times;

(6) have ready access to letter writing materials, including stamps, and have the right to send and receive unopened mail;

(7) have reasonable access to a telephone, both to make and receive confidential calls. (S 1 ch 84 SLA 1981)

**Sec. 47.30.845. Confidential records.** Information and records obtained in the course of a screening investigation, evaluation, examination, or treatment are confidential and are not public records, except to the requirements of a hearing under AS 47.30.660 - 47.30.915 may

necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to

(1) a physician or a provider of health, mental health, or social and welfare services involved in caring for, treating, or rehabilitating the patient;

(2) the patient or an individual to whom the patient has given written consent to have information disclosed;

(3) a person authorized by a court order;

(4) a person doing research or maintaining health statistics, if the anonymity of the patient is assured, and the facility recognizes the project as a bona fide research or statistical undertaking;

(5) the division of corrections in a case in which a prisoner confined to the state prison is a patient in the state hospital on authorized transfer either by voluntary admission or by court order;

(6) a governmental or law enforcement agency when necessary to secure the return of a patient who is on unauthorized absence from a facility where the patient was undergoing evaluation or treatment. (S 1 ch 84 SLA 1981)

**Sec. 47.30.850. Expungement of records.** Following the discharge of a respondent from a treatment facility or the issuance of a court order denying a petition for commitment, the respondent may at any time move to have all court records pertaining to the proceedings expunged on condition that he file a full release of all claims of whatever nature arising out of the proceedings; and the statements and actions of persons and facilities in connection with the proceedings. (S 1 ch 84 SLA 1981)

**Sec. 47.30.855. Posting of rights.** The rights set out in AS 47.30.825 - 47.30.855 shall be prominently posted in all treatment facilities in places accessible to all patients. A patient who does not understand English shall have his rights explained to him in a language he understands. (S 1 ch 84 SLA 1981)

**Sec. 47.30.860. Notices in languages other than English.** When practicable all documents and notices required by AS 47.30.660 - 47.30.915 to be served on a respondent, or on his parents, guardian or adult designee, shall be explained in a language the person understands if he is not competent in English. (S 1 ch 84 SLA 1981)

**Sec. 47.30.905. Discrimination prohibited.** (a) The fact that a person is or has been evaluated or treated for mental illness may not be a basis for discrimination in

(1) seeking employment;

(2) resuming or continuing professional practice or previous occupation.

- (3) obtaining or retaining housing;
- (4) obtaining or retaining licenses or permits, including but not limited to a motor vehicle license, motor vehicle operator's and chauffeur's license, and a professional or occupational license.
- (b) Applications for positions, licenses, and housing may not contain requests for information concerning evaluation or treatment experiences.
- (c) It is unlawful for a person to aid, abet, incite, compel, or coerce the doing of an act forbidden under this section or to attempt to do so. (§ 1 ch 84 SLA 1981)

Article 10. Miscellaneous Provisions.

Section	Section
870. Transportation	900. Disposition of money and personal property subject to claim
875. Nonresident patients	905. Fees and expenses for judicial proceedings
880. Interstate compact	910. Liability for expense of placement in a treatment facility
885. Rights outside state	915. Definitives
890. Provision for personal needs upon discharge	
895. Disposition of personal property and unclaimed money	

**Sec. 47.30.870. Transportation.** When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person's necessary transportation to the designated facility accompanied by appropriate persons and if necessary by a peace officer. The department shall pay return transportation of a person, his escorts, and if necessary a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715. When advisable, one or more relatives or friends shall be permitted to accompany the person. The department may pay necessary travel, housing, and meal expenses incurred by one relative or friend in accompanying the person if the department determines that the person's best interests require that he be accompanied by the relative or friend and the relative or friend is indigent. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.875. Nonresident patients.** (a) The admission papers of a person who is admitted to a treatment facility under AS 47.30.660 — 47.30.915 shall include a statement as to his residence. The department may return a patient who is not a resident of the state to the state of his residence with court approval if the person has been committed. If the state in which he has residence does not accept him as a patient, the person shall be treated as a resident of this state under the provisions of AS 47.30.660 — 47.30.915.

(b) To facilitate the return of nonresident patients the department may enter into a reciprocal agreement or compact with another state providing for the prompt return under appropriate supervision of residents of that state who are mentally ill. A mentally ill resident of this state who has been placed in a facility outside this state may be admitted with the approval of the department to a treatment facility in the state designated by the department. The department may enter into reciprocal agreements or contracts with another state providing for custody, care or treatment, or return of mentally ill residents of this state by the other state and for the custody and care or treatment of mentally ill residents of that state by this state on a reimbursable basis. A resident of this state who has been committed in another state and is returned in accordance with this section shall, within 72 hours of his admission to the designated facility, be examined. After examination the mental health professional in charge shall release him or shall petition for involuntary commitment as prescribed in AS 47.30.710.

(c) In taking action under (a) and (b) of this section, consideration shall be given to the best interests of the patient, particularly to the relationship of the patient to his family, legal guardian, or friends to maintain relationships and encourage visits beneficial to the patient. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.880. Interstate compact.** This state ratifies and adopts by reference "The Interstate Compact on Mental Health" consisting of 11 articles approved on September 30, 1955, by the Northeast State Governments Conference on Mental Health. The department is designated as compact administrator with full power to carry out the purpose of the compact and to make all necessary regulations to implement the compact. (§ 119(c) ch 87 SLA 1957; added by § 11 ch 127 SLA 1959; AS 47.30.180)

*Editor's notes: — The section derives under AS 01.05.031 in accord with the four former AS 47.30.190 and was revision of the mental health statutes in renumbered by the revision of statutes Chapter 84, SLA 1981.*

**Sec. 47.30.885. Rights outside state.** Nothing in AS 47.30.660 — 47.30.915 alters or impairs the application or availability to a patient, while hospitalized in another state under contractual arrangements entered in accordance with AS 47.30.660 — 47.30.915, of the rights, remedies or safeguards provided by the laws of this state. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.890. Provision for personal needs upon discharge.** The department shall insure that

- (1) a patient is not discharged from a treatment facility without suitable clothing; and

(d) The petition required in (a) of this section shall allege that the respondent is reasonably believed to present a likelihood of serious harm to himself or others or is gravely disabled as a result of mental illness and shall specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.705. Emergency detention for evaluation.** A peace officer who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to himself or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available. Upon arrival at the evaluation facility, the peace officer shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.710. Examination.** (a) A respondent who is delivered under AS 47.30.700 to 47.30.705 for emergency examination and treatment to an evaluation facility shall be examined and evaluated as to his mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to himself or others, and (2) is in need of care or treatment, the mental health professional may hospitalize him, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation. (§ 1 ch 84 SLA 1981)

**Editor's notes.** The word (b) by the revision of statutes pursuant to respondent" was substituted for the word AS 01 05 031 "person" in the first sentence of subsection

**Sec. 47.30.715. Acceptance of order.** When a facility receives a proper order for evaluation, it must accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time and place for a 24 day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, his attorney, and the prosecuting attorney of the hearing

arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.720. Release before expiration of 72-hour period.** If at any time in the course of the 72-hour period the mental health professionals conducting the evaluation determine that the respondent does not meet the standards for commitment specified in AS 47.30.700, the respondent shall be discharged from the facility or the place of evaluation by evaluation personnel and the petitioner and the court so notified. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.725. Commitment proceeding rights; notification.** (a) When a respondent is detained for evaluation under AS 47.30.660 - 47.30.915, he shall be immediately notified orally and in writing of his rights under this section. Notification shall be in a language understood by the respondent. His guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

(b) Unless a respondent is released or voluntarily admits himself for treatment within 72 hours of his arrival at the facility or, if he is evaluated by evaluation personnel, within 72 hours from the beginning of his meeting with evaluation personnel, he is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause to detain him after the 72 hours have expired for up to an additional 21 days on the grounds that he is gravely disabled or mentally ill and as a result presents a likelihood of serious harm to himself or others. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS 47.30.700 - 47.30.820.

(c) The respondent has a right to communicate immediately, at the department's expense, with his guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice.

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against him at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 24 day commitment hearing; however, the facility or evaluation personnel may treat him with medication under prescription by a licensed physician or by a less restrictive alternative of his preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to

(1) prevent bodily harm to the respondent or others;

(2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable him to recover; or

(3) allow the respondent to prepare for and participate in the proceedings.

(4) A respondent, if he is represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 21-day commitment hearing and have the hearing set for a date no more than seven calendar days after his arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.730. Procedure for 21-day commitment; petition for commitment.** (a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

(1) allege that the respondent is mentally ill and as a result is likely to cause harm to himself or others or is gravely disabled;

(2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;

(3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;

(4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;

(5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 21 days;

(6) list the prospective witnesses who will testify in support of commitment or involuntary treatment;

(7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, his attorney, and his guardian, if any, before the 21-day commitment hearing. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.735. 21-day commitment.** (a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS 47.30.715.

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the

respondent, within practical limits. At the hearing, in addition to other rights specified in AS 47.30.660 — 47.30.915, the respondent has the right

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to his mental or physical health;

(2) to view and copy all petitions and reports in the court file of his case;

(3) to have the hearing open or closed to the public as he elects;

(4) to be proceeded against according to the rules of evidence applicable to civil proceedings;

(5) to have an interpreter if he does not understand English;

(6) to present evidence on his behalf;

(7) to cross-examine witnesses who testify against him;

(8) to remain silent.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 21 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to himself or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 21 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give him written notice, that if commitment or other involuntary treatment beyond the 21 days is to be sought, the respondent shall have the right to a full hearing or jury trial. (§ 1 ch 84 SLA 1981)

**Sec. 47.30.740. Procedure for 90-day commitment following 21-day commitment.** (a) At any time during the respondent's 21-day commitment, the professional person in charge, or his professional designee, may file with the court a petition for a 90-day commitment of that respondent. The petition must include all material required under AS 47.30.730(a) except that references to "21 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to injure or has inflicted serious bodily harm upon himself or another since his acceptance for evaluation, or that he was committed initially as a result of conduct in which he attempted or inflicted serious bodily harm upon himself or another, or that he continues to be gravely disabled, or that he demonstrates a current intent to carry out plans of serious harm to himself or another.

(2) allege that the respondent has received appropriate and adequate care and treatment during his 21-day commitment;

(3) be verified by the professional person in charge, or his professional designee, during the 21-day commitment.

(b) The court shall have copies of the petition for 90-day commitment served upon the respondent, his attorney, and his guardian, if any. The petition for 90-day commitment and proofs of service shall be filed with the clerk of the court, and a date for hearing shall be set, by the end of the next judicial day, for not later than five judicial days from the date of filing of the petition. The clerk shall notify the respondent, his attorney, and the petitioner of the hearing date at least three judicial days in advance of the hearing.

(c) Findings of fact relating to the respondent's behavior made at a 21-day commitment hearing under AS 47.30.735 shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. (S. 1 ch 84 S.L.A. 1981)

**Sec. 47.30.745. 90-day commitment hearing rights.** (a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in AS 47.30.350 — 47.30.915, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent, his attorney, his guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to insure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language he understands.

(b) Unless the respondent is released or voluntarily admits himself following the filing of a petition and before the hearing, he is entitled to a judicial hearing within five judicial days of filing of the petition as set out in AS 47.30.740(b) to determine if he is mentally ill and as a result is likely to cause harm to himself or others, or if he is gravely disabled. If the respondent voluntarily admits himself following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.785. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written notice of intent to leave, the professional person in charge may file with the court a petition for 120-day commitment of the respondent under AS 47.30.770. The 120-day commitment hearing shall be scheduled for a date not earlier than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be

continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine him and to testify on his behalf. Upon request by an indigent respondent, the court shall appoint an independent licensed physician or other mental health professional to examine him and testify on his behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional. A motion for the appointment may be filed to court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS 47.30.700 — 47.30.915, the rules of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If no decision has been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, he shall be released. (S. 1 ch 84 S.L.A. 1981)

**Sec. 47.30.750. Conduct of hearing.** The hearing under AS 47.30.745 shall be conducted in the same manner, and with the same rights for the respondent, as set out in AS 47.30.735(b). (S. 1 ch 84 S.L.A. 1981)

Editor's notes: The word "under AS" by the revisor of statutes pursuant to AS 47.30.15 was added following "hearing" 01/05/03.

**Sec. 47.30.755. Court order.** (a) After the hearing and within the time limit specified in AS 47.30.745, the court may commit the respondent to a treatment facility for no more than 90 days if the court or jury finds by clear and convincing evidence that the respondent is mentally ill and as a result is likely to cause harm to himself or others, or is gravely disabled.

(b) If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days. (S. 1 ch 84 S.L.A. 1981)

**Sec. 47.30.760. Placement at closest facility.** Treatment shall always be available at a state-operated hospital; however, if space in

(5) that patients be informed of their legal rights and be informed of and allowed to participate in their treatment program as much as possible;

(6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition. (S 1 ch 81 SLA 1981)

Editor's notes. — The parenthetical by the revisor of statutes pursuant to AS expression in the first sentence was added. (10/05/94)

**Sec. 47.30.660. Powers and duties of department.** The department is the mental health authority of the state and shall

(1) administer a comprehensive program for the prevention of mental illness and the care and treatment of the mentally ill, including inpatient and outpatient care and treatment and the procurement of services of specialists or other persons on a contractual or other basis;

(2) take the actions and undertake the obligations which are necessary to participate in federal grants-in-aid programs and accept federal or other financial aid from whatever sources for the study, examination, care, and treatment of the mentally ill;

(3) administer AS 47.30.660 — 47.30.915;

(4) designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for the mentally ill;

(5) provide for the placement of mentally ill patients in designated treatment facilities;

(6) enter into arrangements with governmental agencies for the care or treatment of the mentally ill in facilities of the governmental agencies in the state or in another state;

(7) enter into contracts with treatment facilities for the custody and care or treatment of the mentally ill;

(8) enter into contracts which incorporate safeguards consistent with AS 47.30.660 — 47.30.915 and the preservation of the civil rights of the patients with another state for the custody and care or treatment of patients previously committed from this state under 48 U.S.C., sec. 46 et seq., and P.L. 830, 81st Congress, 2nd Session, 70 Stat. 709;

(9) prescribe the form of applications, records, reports, requests for release, and consents to medical or psychological treatment required by AS 47.30.660 — 47.30.915;

(10) require reports from the head of a treatment facility concerning the care of patients;

(11) visit each treatment facility at least annually to review methods of care or treatment for patients;

(12) investigate complaints made by a patient or an interested party on behalf of a patient;

(13) delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed upon it by AS 47.30.660 — 47.30.915; and

(14) adopt regulations to implement the provisions of AS 47.30.660 — 47.30.915. (S 1 ch 84 SLA 1981)

Editor's notes. Section 6, ch 84, SLA 1981, provided "Except as provided in this Act, the provisions of AS 47.30.660 — 47.30.915 enacted by sec. 1 of this Act do not in themselves upon any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

**Article 7. Voluntary Admission for Treatment.**

Section	Section
670 Standards for voluntary admission	690 Admission of minors under 14 years of age
675 Notice of rights	695 Notice of request for release of minors under 14 years of age from detention and commitment
680 Discharge of voluntary patients	
685 Notice of intent to leave facility, commitment	

Editor's notes. Section 6, ch 84, SLA 1981, provided "Except as provided in this Act, the provisions of AS 47.30.670 — 47.30.825 enacted by sec. 1 of this Act do not in themselves upon any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

**Sec. 47.30.670. Standards for voluntary admission.** A person 14 years of age or older may be voluntarily admitted to a treatment facility if he is suffering from mental illness and he voluntarily signs the admission papers. (S 1 ch 84 SLA 1981)

**Sec. 47.30.675. Notice of rights.** (a) Upon the application of a person for voluntary admission, or at the time a person admitted under AS 47.30.690 reaches the age of 14, he shall be given a copy of the following documents which shall be explained to him as necessary:

(1) notice of rights as set out in AS 47.30.825 — 47.30.865 and an explanation of any document served upon him; and

(2) notice that should he desire to leave at a time when the treatment facility determines that he is mentally ill and as a result is likely to cause serious harm to himself or others or is gravely disabled, the facility could initiate commitment proceedings against him.

(b) If an applicant for voluntary admission does not understand English, the explanation shall be given in a language he understands. (S 1 ch 81 SLA 1981)

**Sec. 47.30.680. Discharge of voluntary patients.** A patient who no longer meets the standards established in AS 47.30.670 shall be discharged from the treatment facility. (S 1 ch 81 SLA 1981)

**Sec. 47.30.685. Notice of intent to leave facility; commitment.** A voluntary patient who is 14 years of age or older and who desires to leave a treatment facility must submit to the facility a written notice of intent to leave on a form provided to him by the facility. Upon immediate investigation, the patient shall be evaluated in writing and discharged immediately or given written notice that involuntary commitment proceedings will be initiated against him. The treatment facility may detain the patient for no more than 48 hours after receipt of the patient's notice of intent to leave in order to initiate involuntary commitment proceedings. (S 1 ch 81 SLA 1981)

**Sec. 47.30.690. Admission of minors under 14 years of age.** (a) A minor under the age of 14 may be admitted for 21 days evaluation, diagnosis, and treatment at a designated treatment facility if his parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,

(1) he is gravely disabled or is suffering from mental illness and as a result he is likely to cause serious harm to himself or others;

(2) there is no less restrictive alternative available for his treatment; and

(3) there is reason to believe that the patient's mental condition could be improved by the course of treatment.

(b) The minor may be released by the treatment facility at any time during the 21 day period if the professional person in charge or his designated mental health professional determines the minor would no longer benefit from continued hospitalization and the minor is not dangerous. The minor's parents or his guardian must be notified by the facility of the contemplated release and that, unless they initiate involuntary commitment proceedings, the minor will be released. (S 1 ch 81 SLA 1981)

**Sec. 47.30.695. Notice of request for release of minors under 14 years of age from detention and commitment.** The parent or guardian of a minor who is less than 14 years of age may request and obtain immediate release of the minor at any time, unless as the result of mental illness, the minor is likely to cause serious harm to himself or others. (S 1 ch 81 SLA 1981)

**Article 8. Involuntary Admission for Treatment.**

Section	Section
700 Initiation of involuntary commitment proceedings	760 Placement at closest facility
705 Emergency detention for evaluation	765 Appeal
710 Examination	770 Additional 120 day commitment
715 Acceptance of order	775 Commitment of minors
720 Release before expiration of 72 hour period	780 Early discharge
725 Commitment proceeding rights; notification	785 Authorized absences
730 Procedure for 21 day commitment; petition for commitment	790 Return from unauthorized absence
735 21 day commitment	795 Involuntary outpatient care for committed persons
740 Procedure for 90 day commitment following 21 day commitment	800 Conversion of involuntary outpatient treatment to inpatient commitment
745 90 day commitment hearing rights	805 Computing periods of time
750 Conduct of hearing	810 Habeas corpus
755 Court order	815 Limitation of liability, penalty for false application

Editor's notes: Section 6 ch 81, SLA 1981, provided "Except as provided in this Act, the provisions of AS 47.30.680 - 47.30.695 enacted by sec. 1 of this Act do not in themselves impact any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they

apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

**Sec. 47.30.700. Initiation of involuntary commitment procedures.** (a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520

(b) 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to himself or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to himself or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody or deliver him to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

outpatient basis because he is likely to cause harm to himself or others or is gravely disabled, the provider shall give the respondent oral and written notice that he must return to the treatment facility within 24 hours, with copies to the respondent's attorney, his guardian, if any, the court, and the inpatient treatment facility. If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport him to the facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

(d) If the provider of outpatient care determines that the respondent will require continued outpatient care after the expiration of his commitment period, the provider may initiate further commitment proceedings as if he were the professional person in charge, and the provisions of AS 47.30.660 — 47.30.915 apply, except that provisions relating to inpatient treatment shall be read as applicable to outpatient treatment. (S 1 ch 84 SLA 1981)

**Sec. 47.30.800. Conversion of involuntary outpatient treatment to inpatient commitment.** (a) A respondent ordered by the court under the provisions of AS 47.30.700 — 47.30.915 to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of outpatient care finds that (1) the respondent is mentally ill and is likely to cause serious harm to himself or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates that he now needs inpatient treatment to protect himself or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate to the respondent's need which will accept him as a patient. Treatment for these respondents shall be available at state-operated hospitals at all times.

(b) Upon making the findings specified in (a) of this section, the provisions of AS 47.30.795(b) relating to notice and AS 47.30.715 relating to hearing apply. (S 1 ch 84 SLA 1981)

**Sec. 47.30.805. Computing periods of time.** (a) Except as provided in (b) of this section,

(1) computations of a 72-hour evaluation period do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility;

(2) a 24-day commitment period expires at the end of the 24th day after the 72 hours following initial acceptance;

(3) a 90-day commitment period expires at the end of the 90th day after the expiration of a 24-day period of treatment;

(4) a 120-day commitment period expires at the end of the 120th day, after the expiration of a 90-day period of treatment or previous 120-day period, whichever is applicable.

(b) When a respondent has failed to appear or absented himself contrary to any order properly made or entered under AS 47.30.660 — 47.30.915, the relevant commitment period shall be extended for a period of time equal to the respondent's absence if written notice of absence is promptly provided to the respondent's attorney and his guardian, if there is one, and if, within 24 hours after the respondent has returned to the evaluation or treatment facility, written notice of the corresponding extension and the reason for it is given to the respondent, his attorney, his guardian, if any, and to the court. (S 1 ch 84 SLA 1981)

**Sec. 47.30.810. Habeas corpus.** Nothing in AS 47.30.660 — 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus. (S 1 ch 84 SLA 1981)

**Sec. 47.30.815. Limitation of liability; penalty for false application.** (a) A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS 47.30.700 — 47.30.915 is not subject to civil or criminal liability.

(b) The following persons may not be held civilly or criminally liable for detaining a person under AS 47.30.700 — 47.30.915 or for releasing a person under AS 47.30.700 — 47.30.915 at or before the end of the period for which the person was admitted or committed for evaluation or treatment if the persons have performed their duties in good faith and without gross negligence:

(1) any officer of a public or private agency;

(2) the superintendent, the professional person in charge, the professional designee of the professional person in charge, and the attending staff of a public or private agency;

(3) a public official performing functions necessary to the administration of AS 47.30.700 — 47.30.915;

(4) a peace officer responsible for detaining a person under AS 47.30.700 — 47.30.915.

(c) A person who willfully initiates an involuntary commitment procedure under AS 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to himself or others, is guilty of a felony. (S 1 ch 84 SLA 1981)

# Detaining the Insane

## Detention Hospitals, Mental Health, and Frontier Politics in Alaska, 1910-1915

Thomas G. Smith

The strong interest in social history during the last decade has produced several studies on the care and treatment of disadvantaged, dependent, and deviant persons. Significant general works have been undertaken, but local, state, and institutional studies, especially ones set in the 20th century, are lacking. This essay explores the efforts of Alaskans to establish detention hospitals for the mentally ill between 1910 and 1915. Although students of Alaskan history point to poor treatment of the insane as evidence of the federal government's neglect of and indifference toward Alaska, the study reveals that Alaskans themselves must share the blame. In addition, the essay provides insights into mental health policy, Alaskan politics, and federal-territorial relations during the period.<sup>1</sup>

By the turn of the century, the prevalence of mental illness was a growing concern among many Alaskans. As the population surged due to the gold rushes of the 1890s, so did the number of insane. The arduous journey, excruciating work, harsh climate, loneliness, and dashed hopes sometimes proved more than pioneers could endure. In 1900 nine Alaskans were adjudged insane. By 1910 the number had climbed to 130, and a decade later the figure reached 217. Responding to pleas for assistance from Alaskans, the federal government provided for the care of the mentally ill in the civil government bill of 1900. That measure made insanity a criminal offense. The person accused in a written complaint was arrested by the marshal, brought before a district commissioner, and tried by a six-man jury. If found guilty, he was committed to an asylum. Since Alaska had no mental hospital, the governor was empowered to contract with the lowest-bidding institution west of the Rocky Mountains for the care of the insane. From 1904 to 1956 the Morningside Sanitarium (formerly Mount Tabor), near Portland, Oregon, held the contract.<sup>2</sup>

The contract system came under severe attack by residents of Alaska. They complained that it was an archaic and inhumane practice not followed by any other American state or territory. Noncontiguous dependencies such as Hawaii, Puerto Rico, and the Philippines all had

asylums that were built and maintained at local or territorial expense. Not until 1912, however, did Alaska win territorial status and its own government; in the meantime, it had to rely on the federal government to care for the insane.<sup>3</sup>

Alaskans also decried the practice of incarcerating the afflicted in jails until they could be transported to Oregon. In interior Alaska the mentally ill often had to spend as long as six months in jail until weather conditions permitted transportation to the "outside." An Alaska asylum was the solution, but Congress rejected the proposal for such an institution because of cost (\$75,000 for the building alone). Alaskans next implored the government to establish small hospitals in which the mentally afflicted could be temporarily detained pending removal to Morningside.<sup>4</sup>

1. See, for example, Gerald Grob, *Mental Institutions in America* (New York, 1973); Blake McKelvey, *American Prisons* (Montclair, N.J., 1977); David Rothman, *The Discovery of the Asylum* (Boston, 1971), and *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980). For criticisms of the way the federal government dealt with Alaska's insane, see *Alaska Daily Empire* (Juneau), Nov. 6, Dec. 6, 30, 1912; Ernest Gruening, *The State of Alaska* (New York, 1968), 200.

2. For the early treatment of Alaska's insane, see Thomas G. Smith, "The Treatment of the Mentally Ill in Alaska, 1884-1912: A Territorial Study," *PNQ*, Vol. 65 (1974), 17-28. Also see Claus-M. Naske, "Bob Bartlett and the Alaska Mental Health Act," *ibid.*, Vol. 71 (1980), 31-39.

3. Apparently Alaskans were not troubled by assigning criminal status to the insane, indigent sick, elderly, etc.; lacking asylums, almshouses, old folks homes, and local charities, they classified social dependents as criminals in order to assure them of government care. The federal government also maintained Indians who were mentally ill (a government asylum was established in 1898 at Canton, S.F.). Canada, like Alaska, transported its insane from remote and sparsely populated areas to provincial hospitals rather than build mental institutions in the Yukon and Northwest Territories. See Henry Hurd, ed., *The Institutional Care of the Insane in the United States and Canada*, 4 vols. (Baltimore, 1916-17), III, 630-32, 871-80; IV, 2-25, 228-36.

4. For introduction of these two measures, see *Congressional Record*, 61st Cong., 2d Sess., 1910, pp. 1498 (H.R. 20111), 5243 (H.R. 24833); for the texts of these bills, *ibid.*, 6853, and 61st Cong., 2d Sess., House Document 637, p. 2 (Serial 5836).

The need for some type of "holding tank" or detention center seemed obvious to the residents of interior Alaska. Detailed descriptions of mental breakdowns appeared frequently in the press. "DANGEROUS LUNATIC NOW AT LARGE" ran a Nome *Nugget* headline in October 1908. The escaped "lunatic" threatened to kill the district judge, marshal, and commissioner. In Fairbanks, a "crazed" woman shot to death the police chief in 1908. A year later in the same city a "madman" tried to kill the proprietor of the Pioneer Hotel by hurling a boulder through the window, and a knife-wielding, "blood-seeking headhunter" went berserk in Dempsey Lewis's saloon before being telled by a pool cue. In Fairbanks, the roster of persons taken into custody included the president of the Washington-Alaska Bank, an Indian woman, a prospector who repeatedly tried to commit suicide, a sourdough who imagined he was being run over by automobiles, and a woodchopper from Fox City who broke down when fire destroyed 12 cords of firewood. The Fairbanks *Daily News-Miner* pointed out that the number of insane in that community in 1909 had doubled over the previous year.<sup>5</sup>

Alarmed by the increasing frequency of insanity, Fairbanksans called for proper detention facilities for the afflicted. The federal jail lacked sufficient space to accommodate both prisoners and mental patients. Attempts to integrate criminals and the insane resulted in "pandemonium." On one occasion an insane man "kept everyone awake . . . by praying loudly and the noise was well calculated to make the rest of the prisoners nervous." The *News-Miner* noted that the number of insane was increasing at such a rapid rate that "separate quarters must necessarily be provided for them." The grand jury of the fourth judicial division at Fairbanks concurred.<sup>6</sup>

James Wickersham, Alaska's delegate to Congress, also advocated proper facilities for the care of the insane. Wickersham was a fiery progressive from Fairbanks who had served as a federal district judge at Eagle, Nome, and Fairbanks before being elected delegate in 1908. In February 1910, he tried to convince Congress to appropriate money for a permanent insane asylum in southeast-



James Wickersham, who wrote the defective hospitals bill, blamed others for the delay in construction. (Whalen Collection, University of Alaska Archives, Fairbanks)

ern Alaska (HR 20111). When that effort failed, he introduced new legislation in April calling for an appropriation of \$50,000 to build detention hospitals at Fairbanks and Nome for the temporary care of the insane (HR 24833). The House Committee on Territories recommended passage of the measure, declaring that the mentally afflicted "are entitled to the most scrupulous care, and should not be subjected to commitment in an ordinary jail." With an eye for economy, however, the committee recommended \$25,000 instead of \$50,000 for the project. The Senate Committee on Territories also approved the measure. Despite stiff opposition from some economy-minded congressmen, the bill was passed into law "In the interest of humanity."<sup>7</sup>

Specifically, the measure called for the establishment of a detention hospital in the second judicial division at Nome and in the fourth judicial division at Fairbanks. Insane persons would receive temporary care in a detention center until trails and waterways thawed sufficiently to permit the U.S. marshal to transport them to the Morningside Sanitarium in Oregon. Each hospital was to

cost no more than \$12,500. The marshal, the governor of Alaska, and the U.S. district judge, acting as a board of governors, would call for bids and award a contract for construction. Once completed, the detention houses would be administered and maintained by the Department of Justice.<sup>8</sup>

From the beginning, the detention hospitals project encountered difficulties. Although the bill became law on June 25, 1910, the summer expired without any attempt to implement it. Pressed for an explanation by the *Alaska Citizen*, Governor Walter E. Clark stated that, after reading the measure carefully, he had discovered a shortcoming which made it "practically inoperative." According to the governor, the law was defective because it failed to provide for the acquisition of sites on which to build the hospitals. John Rustgard, U.S. district attorney at Juneau, supported the governor's interpretation of the bill and advised him not to proceed without instructions from the Justice Department. Judicial officers from Nome expressed similar views.<sup>9</sup>

But U.S. District Judge Peter D. Overfield of Fairbanks voiced a different opinion. He favored prompt implementation of

5. Nome *Nugget*, July 17, Oct. 21, Nov. 2, 1908, Fairbanks *Daily News-Miner*, April 12 (headhunter), 14, May 4, Oct. 29, 1909 (hereafter cited as *News-Miner* with appropriate date).

6. *News-Miner*, Aug. 6, 1909.

7. 61st Cong., 2d Sess., 1910, House Report 1238, p. 2 (first quotation) (Serial 5593); *Congressional Record*, (1st Cong., 2d Sess., 1910, pp. 6053-58 (8856, just quotation), *Care of the Insane in Alaska: Statements of Hon. James Wickersham, Delegate from Alaska, Hon. W. R. Ellis, M.C., Mr. George Coe, Stanfield, Oregon, March 4 and April 1, 6, and 20, 1910. House Committee on the Territories* (Washington, D.C., 1910), 19, 26-28, 31-32.

8. 36 Stat. 852 (1910). In 1910 Alaska was divided into four judicial divisions: in the second and fourth, waterways froze and land routes were virtually impassable for seven or eight months of the year.

9. *Alaska Citizen* (Fairbanks), July 10, 1910; John Rustgard to Walter E. Clark, Oct. 3, 1910; Clark to Peter D. Overfield, Oct. 8, 1910; Overfield to Clark, Oct. 8, 1910, Box 564, File 4-7-2-1, Record, Group 129, Department of Justice (DJ), National Archives.

the law and accused Clark and Rustgard of pettiness and needless delay. Although Wickersham had failed to provide for hospital sites when he drafted the bill, the oversight could be remedied, Overfield held, by securing donated land. Residents of Fairbanks were eager to have a detention hospital and would furnish land to the government free of charge. Nome residents would probably follow suit. Clark rejected Overfield's suggestion because he doubted the legality of accepting land as a gift on behalf of the federal government.<sup>10</sup>

Pointing out that on several occasions in the past the federal government had accepted "gratuitous deeds of lands for public purposes," Overfield urged the governor to seek the advice of the U.S. attorney general; if land donation proved unacceptable, Congress might be asked to remedy the problem by authorizing the acquisition of land or by permitting the hospitals to be built as additions to the Fairbanks and Nome jails.<sup>11</sup>

Although the governor agreed to consult the attorney general, he did not agree to present the case objectively. Indeed, besides underscoring the law's legal defects, Clark assured the attorney general that the detention hospitals were "entirely unnecessary" because adequate provisions had been made "for the temporary care of the insane in the modern jails erected at Nome and Fairbanks two years ago." He denounced Overfield's dogged support for the detention houses as political loyalty to Wickersham, who was responsible for the judge's appointment, and he also censured Overfield for showing disrespect for the governor's office by "his conspicuous absence without excuse from a public dinner in my honor at Fairbanks."<sup>12</sup>

In October 1910 the Justice Department declared the hospitals act defective because it lacked provision for the acquisition of land; hence, it found that Governor Clark had properly delayed construction of the hospitals. Since the federal government did not own land in Fairbanks and Nome appropriate for hospital sites, the attorney general recommended referring "the matter back to Congress for a further expression of its wishes." Inexplicably, he failed to rule

on whether the federal government could accept hospital sites as a gift from the residents of Fairbanks and Nome.<sup>13</sup>

Governor Clark's objections to the detention hospital law were guided by political as well as legal considerations. Clark and Wickersham were bitter political enemies despite being members of the Republican party. Republicans in Alaska and around the nation were divided into regular and progressive factions. Clark and Lewis W. Shackelford, Alaska's Republican national committeeman, headed the regulars; Wickersham, the progressives.

Disturbed by his independence, GOP regulars referred to Wickersham as a "political harlot" and in the delegate race of 1910 nominated Edward S. Orr, a businessman from Fairbanks, to oppose him. The Socialists also entered a candidate, William O'Connor, a newspaper editor from Tanana. The Democrats, a minority party in Alaska, refused to run a candidate. When the votes were counted, the incumbent, Wickersham, easily retained his seat.<sup>14</sup>

Although the detention hospitals were not an issue in that election, residents of interior Alaska were growing increasingly irritated by the lack of action on the project. In March 1911 the grand jury of the fourth judicial division reported that the federal jail at Fairbanks was "inadequate for the proper care and detention of insane persons, of whom there are several now in custody." Due to overcrowding, it was necessary to confine the sane and insane in the same room. The grand jury found that practice unacceptable from a humanitarian standpoint and urged immediate construction of a detention center.<sup>15</sup>

In May the town council of Fairbanks passed a resolution offering the federal government free of charge a parcel of land on which to erect a detention hospital. Noting that the residents of Fairbanks "are pressing me pretty hard," Governor Clark forwarded the resolution to Attorney General George Wickersham (no relation to the delegate) for an opinion. At the same time, Clark recommended that the detention center be erected as an addition to the Fairbanks jail instead of as a separate facility.<sup>16</sup>



Even as he obstructed implementation of the hospitals act, Governor Walter Clark blamed Wickersham for the delay. (Bunnell Coll., University of Alaska Archives)

10. Overfield to Clark, Oct. 14, 15, 1910, Clark to Overfield, Oct. 17, 1910, Box 564, File 4-7-2-1, RG 129, DJ; Rustgard to Clark, Oct. 17, 1910, Box 768, Alaska Governors Papers (AGP), Alaska State Archives, Juneau.

11. Overfield to Clark, Oct. 18, 1910, Box 564, File 4-7-2-1, RG 129, DJ; Overfield and Henry K. Love to Clark, Oct. 19, 1910, Box 244, File 9-1-10, Office of the Territories (OT), National Archives, Overfield to Clark, Oct. 20 (quotation), Nov. 14, 1910, Box 768, AGP.

12. Clark to George Wickersham, Oct. 4, 1910 (quotations), 1910, Box 564, File 4-7-2-1, RG 129, DJ.

13. Acting attorney general to Clark, Oct. 18, 1910 (quotation), Box 768, AGP; attorney in charge of titles to attorney general, Nov. 1, 1910, Box 564, File 4-7-2-1, RG 129, DJ.

14. Nome Nugget, June 17 (harlot), July 13, Aug. 3, 1910; Fairbanks Sunday Times, Oct. 22, 1911; Evangeline Atwood, *Frontier Politics: Alaska's James Wickersham* (Portland, 1979), 225-34, 300.

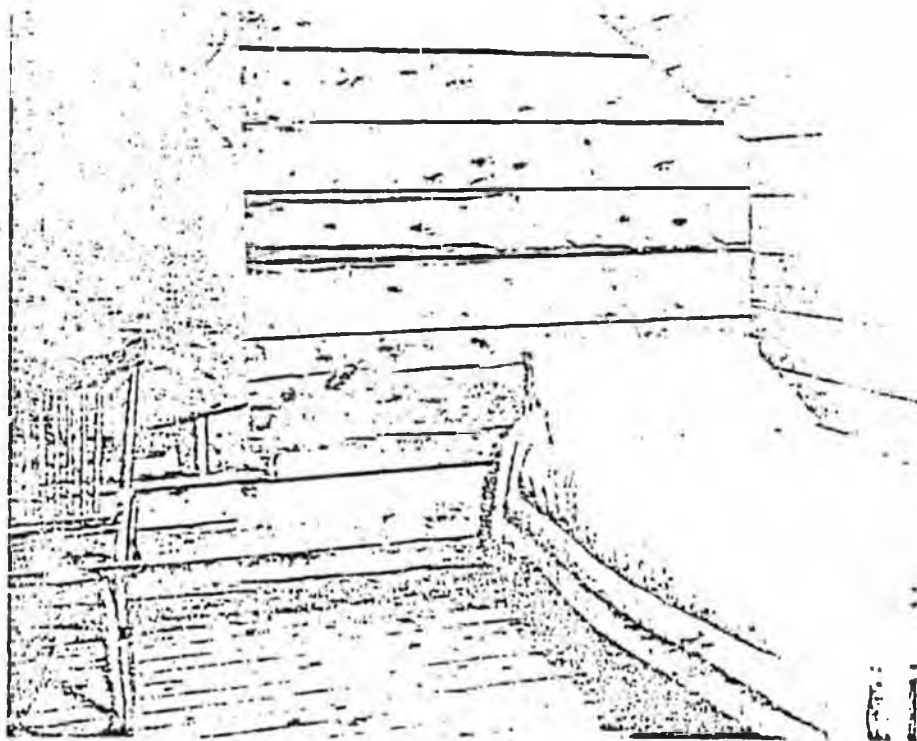
15. Overfield to Clark, Jan. 7, 1911, Box 768, AGP; grand jury of the fourth division to Overfield, March 23, 1911, Box 244, File 9-1-10, OT; News-Miner, Jan. 6, 1911.

16. Fairbanks town council to Clark, May 5, 1911, F. S. Gordon to Clark, June 3, 1911, Clark to attorney general, June 21, 1911, Box 768, AGP.

Nearly two months elapsed without a decision. Numerous Fairbanksans seethed over the delay and sought scapegoats. Some considered the lack of progress another example of federal indifference toward Alaska. Others, particularly the Republican press in Fairbanks, faulted Wickersham for having drafted a defective bill. In an editorial entitled "Our Detained Hospital," the Fairbanks *Daily Times* criticized the delegate for failing to follow the "businesslike course" of admitting his mistake and introducing legislation to rectify it. Had he introduced corrective legislation, the community "would have a detention hospital built and running today." Wickersham had rejected that course of action, the editor opined, because as a politician he was concerned mainly with retaining office. "He is making political capital out of the fact that the hospital is not built," the newspaper charged. "Such political capital is worth more to him than the hospital would be, so he has deliberately failed to remedy the matter."<sup>17</sup>

Wickersham himself blamed the delay on Governor Clark and District Attorney Rustgard. The delegate claimed that he had purposely omitted provision for the purchase of land sites in the bill because he planned to build the centers on public land. The public domain, he stated, had been utilized in the past for jails, courthouses, and telegraph offices. It could also be used for detention centers. "It would have been considered silly," he explained to the Fairbanks Commercial Club, "for the United States to appropriate money out of its own treasury to buy its own land in Alaska for a United States hospital. Nobody but Governor Clark and Mr. John Rustgard would have ever thought of such a foolish proposition, and they would not have thought of it except for the fact that they wished to make the law a failure."<sup>18</sup>

Pro-Wickersham newspapers such as the *Alaska Citizen* echoed the delegate's charges. The *Citizen* held that there was "no one to blame for the delay" but Clark, who had advanced "the ridiculous proposition that the government could not accept a donated site." That view, the paper continued, was based on Clark's "bitter opposition to the delegate, and his determination that Wickersham shall



*The federal jail at Fairbanks housed both prisoners and the insane; the women slept in this 12-by-14-foot room with a sloping ceiling and one window. (National Archives)*

get nothing for the territory that could in any way enhance his prestige."<sup>19</sup>

Nonetheless, the argument in defense of the law was weak. If the hospitals were to be erected on public land, the act should have so specified. Moreover, its author should have realized that public land was unavailable in Fairbanks and Nome: once a patent is granted for a townsite, the land is no longer public. Instead of introducing corrective legislation, Wickersham stubbornly defended a defective law and blamed his political enemies for sabotaging the hospitals. As the Fairbanks *Daily Times* remarked, "the delegate overlooked an important detail in his bill, and in trying to cover it up is attempting to unload upon the governor whatever blame exists."<sup>20</sup>

In August 1911 the attorney general instructed Governor Clark to proceed with the construction of the Fairbanks hospital. Instead of being constructed on a donated site, the facility would be erected on top of the federal jail. Such a plan would minimize delay and save expense

by using the same personnel to operate both institutions.<sup>21</sup>

But the instructions sparked a heated protest from Wickersham. Addressing the Fairbanks Commercial Club on September 28, he ridiculed the idea of housing "poor crazy people" above the "dirty old rotten jail." His plan, he reminded the town's businessmen, was to build the hospitals on public land. Appealing to their booster spirit, he informed his listeners that the Fairbanks detention facility was part of a larger plan to secure a permanent insane asylum in the town. That larger effort would be stymied, he warned, unless Alaskans insisted upon

17. Fairbanks *Daily Times*, Oct. 28, 1911 (hereafter cited as *Times* with appropriate date).

18. *Ibid.*, July 15, 1911.

19. *Alaska Citizen*, July 10 (quotations), 17, 1911.

20. *Times*, July 15, 1911.

21. C. H. McClasmm to attorney general, June 20, Aug. 7, 1911, Box 564, File 4-7-2-1, RG 129, DJ; attorney general to Clark, Aug. 6, 1911, Box 768, AGP.

construction of detention centers separate from the jails at Fairbanks and Nome.<sup>22</sup>

Urged on by Wickersham, the commercial club branded the Justice Department's plan to build the hospital as an addition to the jail "unsafe, unsanitary, and undesirable generally." It forwarded to Washington a petition signed by more than 900 residents protesting the proposal as "an act of injustice." The petitioners demanded a separate facility for the temporary care of the mentally ill.<sup>23</sup>

Other Fairbanks civic groups joined the protest. The Tanana Valley Democratic Club unanimously adopted a resolution condemning the governor for concocting a scheme whereby the "prisoners will be a nuisance to the sick, and the insane a nuisance to the prisoners." Moreover, the town council of Fairbanks announced its displeasure with the proposal by passing an ordinance forbidding the detention of the insane "upon the upper, second or higher story" of any wooden building. The Fairbanks press also lambasted the plan, calling it a "sorry makeshift." To accept a portion of the appropriation and build the hospital above the jail, said the *Daily Times*, would qualify Fairbanksans "to become the first inmates of such a hospital." The

editor of the *Daily Times* urged the governor to build a hospital on a donated site and worry later about the legal consequences. Such a move, he declared, "would be worthy [of] the red blood of the pioneer."<sup>24</sup>

The strong protest from Fairbanks brought results. In October 1911, the Justice Department decided to "suspend action" on the construction of the hospital as an upper story to the jail. More than a year passed without further developments.<sup>25</sup>

Meanwhile, the issue continued to provoke controversy between Clark and Wickersham. The delegate repeatedly blamed the absence of a detention center on "one petty man, with a wooden nutmeg heart." Appealing to the emotions of a Fairbanks audience, Wickersham pointed out that if one's mother or wife were arrested because she was mentally ill, she would be confined in a "dirty jail" because the governor was so "spiteful" he refused to spend the money Congress had appropriated for a modern detention facility.<sup>26</sup>

Predictably, Clark denied Wickersham's charges. He reiterated the fact that his position was based not on politics but on his interpretation of the law, an interpretation supported by the Justice Department. It would be foolish, he stated, to proceed with the construction of the hospital on a donated site without prior approval from the federal government. What contractor, he asked, would build a

hospital without official authorization? Neither Clark nor Wickersham explained why he did not push for an official decision on the legality of building on a donated site.<sup>27</sup>

Wickersham's opponents used the defective hospitals act against him in the delegate election of 1912 but without effect. Indeed, his successful efforts to obtain for Alaska an elective territorial government more than offset any loss of votes caused by his mishandling of the detention hospitals affair. Running as an independent "Bull Moser," he was reelected, defeating a regular Republican, a Socialist, and two Democrats.<sup>28</sup>

On the national level, the Republican party, split between regulars and progressives, lost the White House to Woodrow Wilson. Although he was disappointed that Theodore Roosevelt, his idol, had lost, Wickersham was confident that he would be able to cooperate with the new president. And he was encouraged when Wilson's secretary of the interior, Franklin K. Lane, invited his opinions on Alaskan issues, including the appointment of a new governor.<sup>29</sup>

Created in August 1912, Alaska's first territorial legislature took the lead in securing construction of the detention centers, though prohibited by law from dealing with the insane. The territorial government act had left to the federal government responsibility for the care of the mentally ill, which meant that vic-

This cartoon depicts the Fairbanks view of Governor Strong's arrival in Alaska—a long-awaited hospital under each arm. (*Alaska Citizen*, Aug. 4, 1913)



22. *Alaska Citizen*, Oct. 2, 1911.

23. Fairbanks Commercial Club to attorney general, Oct. 4, 1911 (injustice), Box 564, File 4-7-2-1, RG 129, D); *Times*, Sept. 20 (first quotation), Oct. 5, 1911.

24. *Times*, Sept. 30 (last three quotations), Oct. 1 (nuisance), 8 (second quotation), 1911.

25. *News-Miner*, Oct. 5, 1911.

26. *Fairbanks Sunday Times*, Oct. 22, 1911.

27. *Times*, Jan. 24, 1912; *Alaska Citizen*, Feb. 5, 1912; Clark to secretary of the interior, Dec. 22, 1911, Box 564, File 4-7-2-1, RG 129, D).

28. *News-Miner*, Oct. 8, 1912; *Alaska Citizen*, Aug. 12, 1912.

29. Atwood, 247-65, 271.

tins would continue to be farmed out to Morningside Sanitarium and that patients in interior Alaska would be held in jails until detention facilities were constructed. But in April 1913, Alaskan legislators forwarded to Congress a joint memorial protesting the practice of detaining the insane in jails and requesting an appropriation of \$4,000 to buy land on which to build two detention houses. The memorial went unheeded.<sup>30</sup>

Despite the lack of congressional action, supporters of the detention hospitals were encouraged when President Wilson named John F. A. Strong to succeed Walter Clark as governor of Alaska. Born in New Brunswick in 1859, Strong had been in Alaska since 1897. He had engaged briefly in mining, then entered the newspaper business, and was editor of the Democratic Juneau *Daily Empire* at the time of his appointment.<sup>31</sup>

In June 1913, the new governor and Wickersham met with Secretary of the Interior Lane to discuss the detention hospitals. Sympathetic, Lane agreed to build the hospitals promptly if Strong could secure donated land. Within three months, the governor had obtained the sites, and Lane had authorized him to advertise for construction bids. Strong's success convinced some Alaskans that the previous delay had been "for political and personal reasons only." It also showed that Washington could be moved to action when Alaskans put aside politics and united behind a project.<sup>32</sup>

Construction of both hospitals began in September and concluded in December 1913. After a delay of more than three years, then, the communities of Fairbanks and Nome possessed detention hospitals. The Fairbanks facility was a 2-story wooden building, 42 feet square, located on 1.25 acres of land at the corner of Turner Street and Tenth Avenue. It had a porch that ran along the full front of the first floor and a large second-story balcony. The first story contained a kitchen, oak-paneled dining room, seven rooms, a bath, and a padded cell. On the second floor were four rooms, one ward, a shower-bath, and two padded cells. The facility had electric lights and steam heat and could accommodate 15 male and 5 female patients. Local residents described the building as "a thing of



Within six months of assuming office, J. F. A. Strong had delivered the Nome and Fairbanks hospitals; opening them was the next step. (Bunnell Coll., Univ. of Alaska Archives)

beauty" that was "equipped with all modern conveniences." The Nome hospital was similarly appointed, though lacking the large front porch and balcony. The Nome *Nugget* described it as a "monument" to the builder. In Juneau, the *Alaska Daily Empire* editorialized that the "construction of these institutions marks a step forward in caring for unfortunate men and women of the Territory."<sup>33</sup>

Financial considerations, however, prompted Washington to reevaluate its decision to open the hospitals. The money to maintain the centers was to come from an appropriation of \$500,000 for support of prisoners in all the states and territories. Marshal Emmet R. Jordan of Nome informed the Justice Department in early 1914 that it would cost \$17,500 a year to maintain each of the detention hospitals. The attorney general balked at spending \$35,000 yearly to provide temporary care for a handful of patients. It cost only twice that amount, including transportation, to maintain 150 Alaska patients at the Morningside Sanitarium in Oregon.<sup>34</sup>

Marshal Lewis T. Erwin of Fairbanks, who had replaced Henry Love in 1913, took issue with Jordan's figures. Erwin estimated that operation of the Fairbanks hospital would cost only \$7,500 per year. Because the two estimates differed so significantly, the Justice Department refused to open the facilities until accurate figures had been secured. On the recommendation of the U.S. superintendent of prisons, the attorney general sent an inspector to Alaska to determine the cost of running the hospitals and the necessity of opening them.<sup>35</sup>

Proud of their new facilities, residents of Fairbanks and Nome were distressed to learn that neither structure might be utilized. "Loss of the detention hospital" would "be a serious blow" to the community, declared the Fairbanks *Daily Times*: "It means that we will be right back where we were before the building of the hospital was authorized, except that we have the structure to remind us of the long fight made to secure the hospital." There was a pressing need for the centers, according to that paper, and townspeople "have every reason to expect the terms of the bill to be carried out, for, after all, the cost of maintenance is a question which should have been investigated before the money for the building was appropriated."<sup>36</sup>

30. [Alaska] Senate Joint Memorial Number 17 to Congress, April 11, 1913, Box 244, File 9-1-10, OT; *Times*, May 2, 1913.

31. *Juneau Daily Empire*, July 29, 1929 (obituary); Gruening, 166.

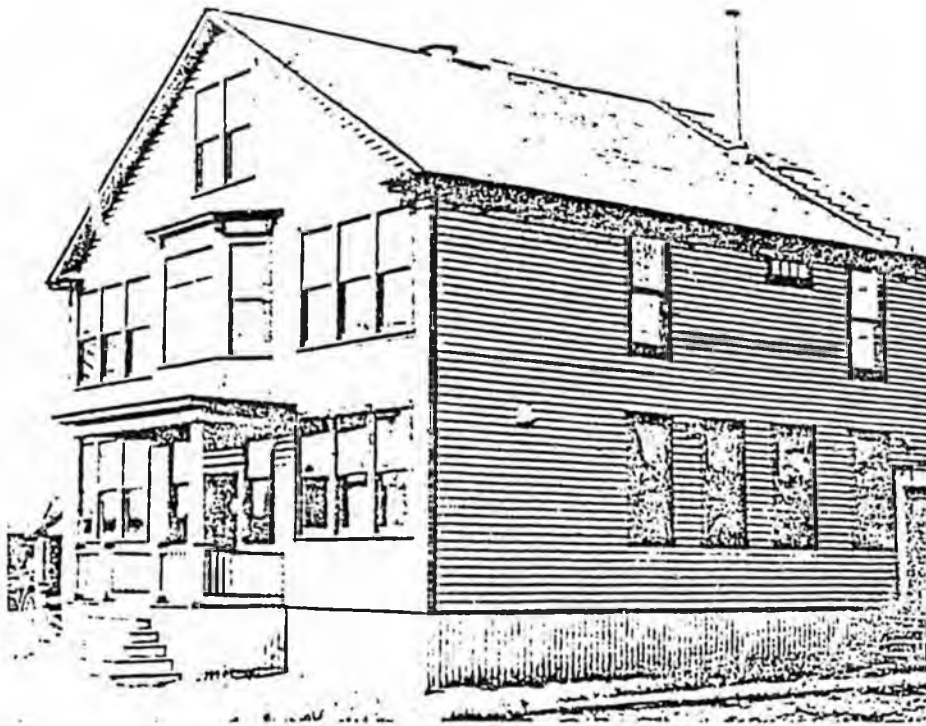
32. J. F. A. Strong to secretary of the interior, June 11, 12, 16, Aug. 5, 1913, secretary of the interior to Strong, June 12, 1913, Box 244, File 9-1-10, OT; *Alaska Citizen*, July 28, 1913 (quotation).

33. *News-Miner*, June 17, Sept. 3, Nov. 17, 1913; *Times*, Aug. 7, Sept. 3, Dec. 27 (quotations), 1913; *Alaska Daily Empire*, Nov. 21, 1913, *Nome Nugget*, Sept. 12, 15, Nov. 5 (quotation), 25, 26, 1913.

34. Superintendent of prisons to attorney general, April 1, 1914, Box 565, File 4-7-2-1, RG 129, DJ.

35. *Ibid.*; L. T. Erwin to assistant attorney general, Feb. 20, 1914, Box 564, File 4-7-2-1, RG 129, DJ.

36. *Times*, Dec. 13, 1913; *Alaska Citizen*, Dec. 15, 1913.



*Equipped with electric lights, steam heat, and other conveniences, the Nome facility was hailed as a step forward in the care of the insane. (National Archives)*

Meanwhile, Governor Strong, Delegate Wickersham, and Marshal Erwin of Fairbanks pushed Attorney General T. W. Gregory to open the detention hospitals. Erwin was especially insistent. On March 5, he had wired the Justice Department: "Have now three insane, jail not proper place." Four days later he had telegraphed: "Have just taken into custody insane woman in addition to three insane men reported. Hospital much needed." On June 2 he sent yet another message informing the attorney general that he had 14 prisoners in the jail, including two women. One of the women was insane. "No place to keep women except jail attic. Roof covered with tin. Fear women cannot live in such quarters during warmest summer weather. No toilet except men's department. Women taken ladies toilet courthouse. Makes it bad handling raving maniac. Condition insane woman requires three matrons eight-hour shifts." The marshal asked permission to transfer both women to the detention hospital where they could receive proper care. The attorney general

refused the request and advised the marshal to install toilet facilities in the jail, fix the roof, and transport the insane woman to Morningside.<sup>37</sup>

That same month, R. J. W. Brewster, the Justice Department's investigator, arrived to inspect the hospitals. After examining the facilities, he recommended against opening them. His reason: expense. He estimated that the yearly operating costs of each institution, including heat, light, food, guards, a cook, repairs, and sundry expenses, would exceed \$7,000.

The number of insane in interior Alaska was not large enough to justify the expense of operating two detention centers, Brewster advised. At Nome only three people were adjudged insane during fiscal year 1913-14, and these victims were housed in the jail for a total of 45 days; since the hospital would stand empty most of each year, Brewster recommended that the building be transferred to another government department and put to better use. At Fairbanks he found that 21 individuals had been adjudged insane in fiscal year 1913. "This hospital," he declared, "should never have been built, and although there is more reason for its opening than there is for

the opening of the Nome institution, I do not see the *real* necessity which would warrant the expense of operation." To those who argued that modern mental health care practice called for separate facilities for the sane and insane, he replied that the "theory may be beautiful but would be expensive to carry out."<sup>38</sup>

The delay over opening the detention hospitals became a campaign issue in the delegate election of 1914. Running as a "Woodrow Wilson Progressive," Wickersham sought his fourth term as delegate. He was opposed by John M. Brooks, a Socialist from Jack Wade Creek, and Charles E. Bunnell, a Democrat from Valdez who had the support of the Wilson administration. Alaska Republicans did not nominate a candidate.<sup>39</sup>

Throughout the campaign Wickersham reminded his constituents of his past accomplishments, including passage of the territorial government act, the Alaska railway bill, and the detention hospitals measure. That the hospitals remained closed, he asserted, was the fault of Marshal Erwin, a Democrat and political enemy. Wickersham accused Erwin of obstructing efforts to open the hospitals, and he asked Alaskans to consider the "inhumanity of an officer who keeps a sick prisoner in the attic of that dirty, filthy jail when you have a fine detention hospital where she should be kept."<sup>40</sup>

Wickersham's charges against Erwin were unwarranted. The Justice Department advised the marshal to issue a statement "disclaiming all responsibility for the failure to open and occupy the de-

37. Quoted in *Times*, Feb. 11, 1915.

38. Superintendent of prisons to attorney general, July 11, 31, Oct. 14, 1914, and R. J. W. Brewster to attorney general, Sept. 19, 1914 (quotations), Boxes 564, 565, File 4-7-2-1, RG 129, D; *News-Miner*, July 27, Aug. 1, 1914. The Justice Department was also reluctant to go to the expense of opening the Nome hospital because the population of that town had declined steadily since the boom days of the early 1900s.

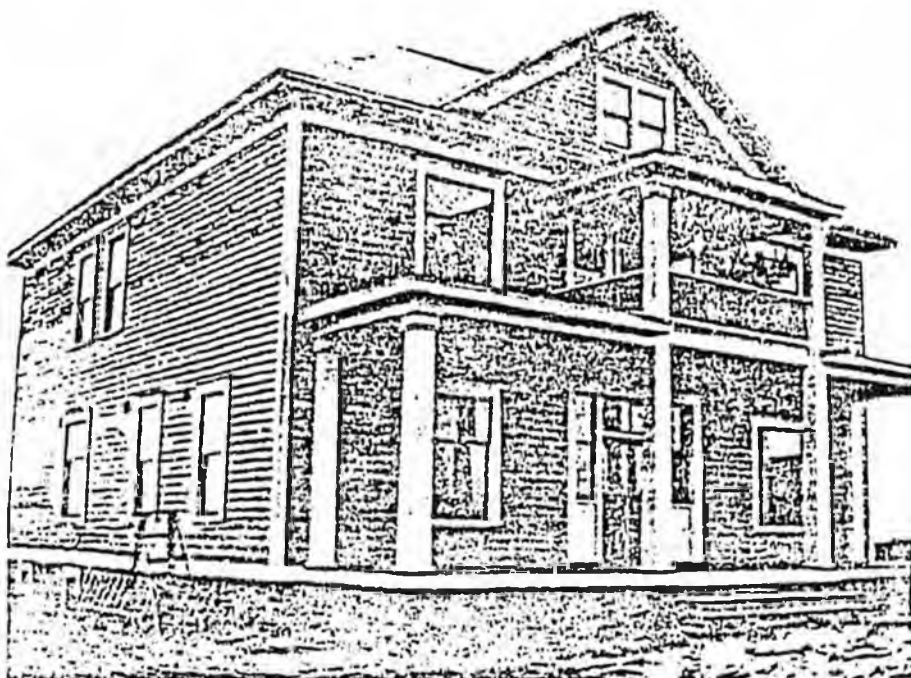
39. Atwood, 277-87.

40. Quoted in Erwin to attorney general, Nov. 14, 1914, Box 564, File 4-7-2-1, RG 129, D).

tention hospital." Opponents of Wickersham were probably correct when they declared that his attack on the marshal was a smokescreen to cover up his own ineptness. The Democratic Fairbanks *Daily Times* reminded readers that the law "was so clumsily drawn that the hospital never would have been built but for the efforts of Governor Strong and the Democrats of Fairbanks." Despite Wickersham's irresponsible charges, he was reelected with votes to spare.<sup>41</sup>

After his reelection, Wickersham continued to lash out against Erwin for failing to utilize the hospitals. In mid-November 1914, he informed the press that the marshal permitted the caretaker to use the Fairbanks institution as a "chicken coop." Producing a photograph that showed chickens hanging lifeless by their feet from a rope stretched across the hospital's balcony, Wickersham urged Fairbanksans to petition the Justice Department to use the hospital for needy mental patients not dead chickens.<sup>42</sup>

*This photograph of the Fairbanks hospital, its balcony festooned with dead chickens, no doubt furthered the campaign to open the facility. (National Archives)*



The delegate also censured the Justice Department for its indifference. He informed the Fairbanks Commercial Club on November 9 that "there is no reason in the world why the Department of Justice should not make the necessary appropriation to maintain the institution." Instead of utilizing a modern facility, he noted, the federal government is confining the insane in a "hellhole." He implored club members "to get busy, to do something to force the proper parties to open the hospital and I pledge myself to do all I can to help."<sup>43</sup>

Wickersham made good his promise. On January 6, 1915, he sent a long letter to the attorney general lamenting the policy of holding Alaska's insane in "dirty foul-smelling old jails." He enclosed three photographs taken by the Fairbanks health officer, Dr. J. A. Sutherland, showing the "exact condition of the room in the attic" of the Fairbanks jail where insane women were housed. "In this stinking hole the United States of America keeps the insane women who fall into their clutches," the delegate wrote. "It is a disgrace to the Department of Justice that such a condition may continue to exist." He reminded the attorney general that the detention hospitals act was intended to prevent the "vile arrangement" of housing the mentally ill in jails. Fair-

ure to open the institutions for financial reasons, he believed, was unjustified. According to section 2 of the act, the hospital expenses were to be paid "from the same fund as the expenses of the United States jails under the same marshal." Enclosing the "chicken coop" photograph, Wickersham informed the attorney general that the hospital at Fairbanks was being used to accommodate slaughtered chickens instead of mentally afflicted human beings. He exhorted the Justice Department to make proper use of the Nome and Fairbanks structures at once.<sup>44</sup>

Wickersham's hard-hitting letter to Washington was not entirely accurate. He had written on the photograph that the jail was a "dirty-hole," a description that was exaggerated, as Erwin, Dr. Sutherland, and several newspapers pointed out. Yet the delegate's main point was on the mark—namely, that the detention hospitals and not jails should be used for the temporary confinement of the mentally afflicted and that the government, in delaying the opening of the facilities, had failed to execute the law. Responding to Wickersham's letter, the attorney general stated that the issue was "under consideration" and would be resolved soon.<sup>45</sup>

Actually, the Justice Department was working diligently to rid itself of both buildings, to "turn them loose" on other government departments. The Bureau of Education in the Interior Department wanted the Nome building as a medical facility for Indians. The deal fell through though when the Justice Department insisted that the Interior Department take

41. Assistant attorney general to Erwin, Dec. 14, 1914, Box 565, File 4-7-2-1, RG 129, DJ; *Times*, Nov. 1, 1914.

42. *Times*, Nov. 10, 1914.

43. *Ibid.*; George C. Bruce to Wickersham, Nov. 16, 1914, Box 565, File 4-7-2-1, RG 129, DJ.

44. Wickersham to attorney general, Jan. 6, 1915, Box 564, File 4-7-2-1, RG 129, DJ.

45. *Times*, Feb. 10, 11, 12, 1915; Fairbanks *Weekly Times*, Feb. 15, 1915; assistant attorney general to Wickersham, Jan. 12, 1915, Box 565, File 4-7-2-1, RG 129, DJ.

both "white elephants"; having no use for the Fairbanks facility, the secretary of the interior refused the offer.<sup>46</sup>

Residents of Fairbanks were enraged when they learned of the Justice Department's attempts to unload their hospital. The mayor, marshal, district judge, and district attorney sent wires to the attorney general reminding him that the Fairbanks City Council had donated land for a "detention hospital only" and would oppose using the building and grounds for any other purpose. One Fairbanks citizen scored the federal government for being parsimonious toward a land "which has returned so much more than it cost to the government which owns it." The three local newspapers pushed hard for the cause by running editorials that supported the opening of the detention hospital.<sup>47</sup>

The strong protest brought results. In March 1915, nearly five years after Congress passed Wickersham's bill, the attorney general instructed Erwin to open the Fairbanks hospital immediately. That message elicited "great joy" among Alaska's territorial officials. Nomites, on the other hand, had little to cheer about; their facility remained closed. Inspired by the Fairbanks success, however, Nome residents, including the mayor, city council, Western Federation of Miners, and several fraternal organizations, petitioned Washington in June and repeatedly during the next year, but without results. In 1921 the Justice Department transferred the building to the Bureau of Education for use as a residence for teachers.<sup>48</sup>

In Fairbanks the triumph was short lived. Within five months of the hospital's opening, high operating costs caused the Justice Department to contemplate closing it again. Governor Strong admitted that the building required around-the-clock caretakers and that it would "always be a source of continued expense to the Government, whether occupied or not." Yet he advised against shutting down the institution because a "considerable percentage of the patients would recover, and the expense of their transportation to Morningside Sanitarium and their maintenance there would be avoided." Wicker-

sham sided with Strong and blamed the high maintenance costs on the extravagance of Erwin, whom he accused of using the hospital as a place of residence.<sup>49</sup>

Wickersham's charges prompted an investigation by the Department of Justice. Asked for a response, Erwin maintained that he was making every effort to keep expenses at a minimum. He reported that from the opening of the hospital in March 1915 through August, a total of seven patients had been detained for 114 days at a cost of \$2,000. Admitting that he lived at the hospital, he claimed that his presence saved the government money by obviating the need for a guard and custodian to watch the patients. He paid his own board and maintained a garden on the grounds that brought the government \$625 worth of produce. He also economized by feeding the inmates fish, moose, and mountain sheep, which he provided free of charge. "I have attempted to economize and save the Government all I could at the same time rendering a good service but not a wasteful one," Erwin declared.<sup>50</sup>

Erwin's report convinced the Justice Department that the operation of the facility "has been economical and careful under the circumstances." Yet the paucity of inmates and high cost of their care (approximately \$15 per day for each) did not seem to warrant keeping the hospital open on a permanent basis. Nonetheless, the attorney general decided to "continue its operation during the closed period of this winter in order to get a complete list of the cost of its maintenance."<sup>51</sup>

The Justice Department's position proved "disquieting" to Wickersham. Moreover, he continued to attack the marshal for extravagance. In December 1915, he wrote a scathing letter to the attorney general accusing Erwin of reckless spending and graft. He pointed out that for much of the year the hospital contained no patients, yet the cost of a building caretaker and electricity totaled \$1,260. This money could have been saved, the delegate contended, had the facility been closed when it was unoccupied. The only reason for a caretaker, he declared, was that the marshal "wants the use of this nice, warm, new, hand-

some, well lighted building as a private residence: he needs the caretaker and his wife as servants, and he is annoyed that insane persons are intruded upon his privacy."<sup>52</sup>

Once again Wickersham's charges were groundless and probably sparked by political animosity. As most federal officials in Fairbanks realized, the hospital required the services of a permanent caretaker to protect the building and grounds from vandalism. It was necessary to heat the structure to prevent burst pipes and frost damage. Moreover, the institution might be needed at any time to detain an individual who suddenly became insane. To shut down the facility when it was unoccupied seemed senseless. Judge Charles Bunnett and District Attorney R. J. Roth both believed that the marshal's residence in the hospital re-

46. Memorandum (from "W.C.F.") to attorney general, Nov. 12, 1914, attorney general to secretary of the interior, Nov. 12, 1914, and assistant secretary of the interior to attorney general, Dec. 9, 1914, Box 565, File 4-7-2-1, RG 129, D); assistant secretary of the interior to attorney general, Sept. 17, 1914, File 6-51, Bureau of Education, Hospital Service, Nome, Alaska, part 1, RG-48, National Archives (hereafter cited BE-Nome, RG-48).

47. Charles Bunnett et al to attorney general, March 10, 12, 1915, Box 565, File 4-7-2-1, RG 129, D); *News-Miner*, March 11 (first quotation), 12, 13 (last quotation), 1915; *Times*, March 13, 1915; *Alaska Citizen*, March 15, 1915.

48. Attorney general to Erwin, March 12, 1915, and to Wickersham, March 16, 1915, Box 565, File 4-7-2-1, RG 129, D); *Times*, March 16, 1915 (great joy); *Nome Residents Petition for Attorney General*, June 8, 1915, Box 769, AGP; *Nome Nugget*, Aug. 20, 1915, April 10, Sept. 19, 1916; assistant secretary of the interior to attorney general, Oct. 11, 1922, attorney general to secretary of the interior, Oct. 16, 1922, File 6-51, BE-Nome, RG-48.

49. Wickersham to attorney general, July 9, 1915, and Strong to attorney general, Aug. 27, 1915, Box 564, File 4-7-2-1, RG 129, D).

50. Attorney general to Erwin, Aug. 14, 1915, Erwin to attorney general, Sept. 22, 1915, *ibid*.

51. Assistant attorney general to attorney general (memorandum), Oct. 30, 1915 (first quotation), attorney general to Erwin, Nov. 1, 1915, and to Wickersham, Nov. 1 (last quotation), Dec. 11, 1915, *ibid*.

52. Wickersham to attorney general, Dec. 27, 1915, *ibid*.

sulted in an efficient and economical operation. To avoid the appearance of impropriety and to silence Wickersham, however, they recommended that the marshal cease living there. The attorney general agreed.<sup>53</sup>

To secure the permanent operation of the detention hospital, Wickersham stressed the need for humane care of the mentally ill and for following the dictates of Congress. He emphasized that in 1910 Congress passed legislation establishing detention hospitals for patients in interior Alaska who could not be promptly shipped stateside. "Now what authority has an Attorney General, the Marshal, or any one else," he asked, "to disregard and violate that law?" Will the Justice Department return to the archaic practice of keeping the mentally ill in jails? he queried. He advised the attorney general to continue the operation of the institution and to adhere to "humane methods

for the care and protection of the insane sick entrusted to your care, as you are instructed to do by Congress."<sup>54</sup>

Wickersham's appeal proved persuasive. The detention hospital was not shut down, and it remained in operation for two decades. In the 1930s the facility served as both a detention hospital and jail until a new federal building was erected in 1933.

Although Alaskans in 1910 sought to provide humane care for the insane by maintaining them in detention centers rather than jails, they achieved modest success only after five years of delay caused by indifference and parsimony at the federal level and political factionalism within Alaska itself. When territorial officials at last united behind Governor Strong in 1913 and 1915, they got two hospitals built and one operating; the second—for lack of patients and exces-

sive maintenance costs—never opened. The detention center episode was one of the early fights in the long crusade for mental health care in Alaska; it would take another 40 years for Alaskans to obtain a permanent asylum. □

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53. R. J. Roth to attorney general, Jan. 7, 1916, Bunnell to attorney general, Feb. 18, 1916, and attorney general to Erwin, March 17, 1916, Box 565, File 1-7-2-1, RG 129, DJ.

54. Wickersham to attorney general, Dec. 27, 1915, *ibid.*

**E. T. Barnette: The Strange Story of the Man Who Founded Fairbanks.** By TERRANCE COLE. (Anchorage: Alaska Northwest, 1981. ix, 163 pp. Illustrations, notes, selected bibliography, index. \$7.95)

Terrance Cole has put flesh on a phantom. The year of Barnette's birth is uncertain. When, or where, or from what cause he died is unknown. There are, apparently, only two notable Barnette photographs. In one his face is obscured, and in the other a fur hat and a bushy moustache hide his hairline and mouth. Paradoxically, Barnette was as substantial as he was phantasmal.

Cole's study of the real Barnette is a fine historical narrative and investigation. Barnette established a trading post on the Chena River in 1901. The trading post became Fairbanks, while Barnette became a prosperous merchant, miner, and banker. He was a large man, ambitious, gregarious, and plausible. He invested much of his money in a Kentucky farm and a Mexican plantation. Affable though he was, court suits and controversy swirled round him. He thrived until his bank collapsed in 1911, a few months after he had resigned its presidency and left town. The bankruptcy was the beginning of the end of Bar-

nette's fortune. His Mexican property suffered from the turmoil of revolution, his wife divorced him and won a large property settlement, and his comeback attempts were ineffectual.

Such schemes and adventures call for placement in the context of western and Alaska history, yet Cole's interpretations rarely venture beyond the judgments of contemporaries. Those judgments were possibly too particularistic and severe, delivered as they were from a provincial "sourdough" perspective. For instance, Barnette's manufactured rush to Fairbanks certainly duped some gullible miners. Nevertheless, it was in the tradition of western boom-town promotionalism. Interpretive lacunae aside, Cole writes with verve. He skillfully relates Barnette to the development of Fairbanks and the Alaska-Yukon interior. His book is nicely composed, with many pertinent maps and photographs. Best of all, Cole, a widely published Alaska historian, is not yet out of his twenties. Therefore we may look forward to many more worthwhile studies from the author of *E. T. Barnette*. □

WILLIAM H. WILSON  
North Texas State University

## E. T. Barnette

Alaska State Legislature

REP. MAE TISCHER  
CHAIRMAN



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House of Representatives  
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

M E M O R A N D U M

May 16, 1984

TO: All Members of the House HESS Committee  
Senator Joe Josephson, Sponsor, SB 346  
Senator Jan Faiks, Sponsor, SB 346  
Dr. Phil Shapiro, Director, Division of Mental  
Health and Developmental Disabilities  
All Interested Persons

FROM: Representative Mae Tischer, Chairman, House HESS *MT*

RE: Version 3, Proposed House CS for CS for Senate Bill  
346 (HESS)

Attached please find a copy of Version 3 of a proposed House HESS CS for CS for Senate Bill 346, "An Act relating to the treatment of mentally ill persons."

The amendments to the bill, indicated with blue highlighting on the attached draft, are found on the pages and lines indicated below. A brief explanation of the effect of each amendment is provided. Please note that page and line references are to Version 3, House CS for CS for Senate Bill 346 (HESS), dated May 15, 1984.

1. Page 1, line 20: This phrase was slightly reworded so as to give added emphasis to the requirement that persons be given ample opportunity to accept voluntary treatment.
2. Page 3, lines 24 - 26: This sentence was rewritten so as to accommodate a couple of substantive and technical amendments: (a) at the request of the Court System, the words "under AS 25.24.310" (circled on line 25 of the draft) were inserted in order to clarify the legal mechanics for the appointment of guardians ad litem as described in this section; (b) the words "as soon as possible" (circled on line 26 of the draft) were inserted so as to require the prompt appointment of a guardian ad litem for each minor.

3. Page 3, lines 28 and 29: As in amendment 2(a) above, the words "under AS 25.24.310" were inserted at the request of the Court System in order to clarify the legal mechanics for the appointment of guardians ad litem under this section.
4. Page 4, lines 11 - 15: This amendment would require a treatment facility to inform as soon as possible the parent or guardian of a minor under 18 years of age if the minor is detained at or admitted or committed to the treatment facility.
5. Page 13, lines 27 and 28: The catch line for AS 47.30.790 was changed so as to more accurately reflect the contents of the section.
6. Page 16, lines 4 - 16: This set of amendments would require a treatment facility to evaluate all patients present in the facility for more than 72 hours to determine if any individual patients have nutritional deficiencies. In conjunction with the original requirement that the treatment facility provide a nutritionally sound diet, this amendment further requires the facility to take appropriate steps to correct any identified deficiencies.
7. Page 20, line 11: This amendment merely returns the language in the bill to the way it appears in present law, deleting the reference to "a psychologist trained in clinical psychology."
8. Page 20, lines 17 - 18: This amendment inserts the word "substantial" before the word "experience," the effect of which would be the application of a higher standard (requiring substantial experience, instead of some possibly lesser degree of experience) when determining the kind of social worker who would be qualified to act as a "mental health professional."
9. Page 20, line 18: This amendment, meant as a purely technical amendment, changes the phrase "experience in the field of mental illness" to "experience in the field of mental health."
10. Page 20, lines 27 - 29; Page 21, lines 1 - 3: This amendment inserts temporary law requiring the division of mental health and developmental disabil-

Version 3, Proposed HCS CSSB 346 (HESS)  
May 16, 1984  
Page 3

ities to review the literature concerning orthomolecular psychiatric methods (nutritional therapy) in order to determine their potential uses in the treatment and diagnosis of mentally ill persons in the state; and to submit the report to the legislature by February 1, 1985.

Amendments 1, 2(b), 5, 7, 8 and 9 are found in Version 3 of the proposed House HESS Committee Substitute only. Amendments 2(a), 3, 4, 6 and 10 (in substance) have appeared in one or more of the earlier versions of the proposed House HESS Committee Substitute.

Please review this proposed CS and share your suggestions or comments with me as soon as possible. If there are no additional suggestions or comments, this will be the Version of the bill which we will discuss and hopefully move out during our next HESS meeting. I would appreciate receiving your response as soon as possible.

Attachment

SECTIONAL ANALYSIS OF CSSB 346 (JUD)am - AN ACT RELATING TO THE TREATMENT OF MENTALLY ILL PERSONS BY Josephson and Faiks.

NOTE: Throughout the bill, the age of majority has been changed from 14 to 18, commitment time periods have been from 21, 90 and 120 days to 30, 90, and 180 days, and neutral words have been substituted for gender pronouns.

- Section 1 Provides a word change ("every" to "reasonable") to limit the endless paperwork from patients transferring in and out of voluntary status.
- Section 2-5 Changes the age of majority under the title from 14 to 18 to make this statute consistent with others dealing with juveniles. Section 4 also changes the term "immediate" to "timely" in order to avoid the inoperable situations caused by literal interpretation of the language. Section 5(b) provides for the appointment of a guardian ad litem for each minor to monitor appropriateness of placement. Subsection (3) adds language to admission procedures to allow treatment of those minors whose condition could worsen if untreated.
- Section 6 Provides options for the release of a minor, and options to keep a minor in danger of harming self or others. (Statutory basis for procedure currently used at A.P.I.)
- Section 7 Adds "mental health professional" to current law allowing peace officers to take someone into custody for emergency evaluation. It also limits the use of a correctional facility for the mentally ill, providing only emergency protective custody while awaiting transportation to an evaluation facility.
- Section 8-9 and 10 Technical amendments concerning time computations and neutral language to comply with other sections of this bill.
- Section 11 Adds to respondents rights in a 30 day commitment hearing; that the rules of evidence and civil procedure be applied in an informal way; that experts and other witnesses may testify on the respondent's behalf.
- Section 12, 13 and 14 Time computation changes.
- Section 15 Adds a new section providing that medication and treatment may be administered to an involuntarily committed patient in compliance with patient's rights.
- Section 16 Provides new language to the statute dealing with unauthorized absences providing that a parent, guardian or a person known to have been threatened by the patient will be immediately notified.
- Section 17 Adds a new section to the statute relating to the change of status from involuntary to voluntary, providing that the physician must agree that the transfer is appropriate and must be made in good faith.

- Section 18 Provides that acceptance of order, and 48 hour detention period time computations will not include weekends and holidays.
- Section 19 Amends liability section to include a mental health professional who detains and transports a patient.
- Section 20 Provides that an adult designated as a guardian shall be provided with a copy of a patient's discharge plan.
- Section 21 Adds a new section to the law providing that a patient has the right to a nutritionally sound and medically appropriate diet.
- Section 22 Adds to the patient's rights section of law, additional rights to:  
be free of corporal punishment;  
exercise and recreation;  
at any time have a visit or phone conversation with an attorney;  
not be retaliated against for assertion of rights.
- Section 23 Allows for temporary suspension of certain patient rights (wearing personal clothing, phone calls, visitors and recreation) only after the initial evaluation period, if there is a threat to the patient or others.
- Section 24 Allows access to confidential records by a law enforcement agency if there is substantial concern over imminent danger from a presumed mentally ill person.
- Section 25 Includes federal facilities in the definition of "evaluation facility".
- Section 26 Expands the definition of "gravely disabled" to include persons who are not in imminent danger, but whose lack of treatment would cause deterioration of their condition.
- Section 27 Expands the definition of "likely to cause serious harm" beyond recent attempts to include threats and likelihood of injury in the near future.
- Section 28 Changes language relating to psychologists and psychological associates, to be consistent with their licensing statute, which indicates that they do not have a "specialty designation" but have training in clinical psychology.
- Section 29 Definition of mental illness.