

ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 86/2

2290 HHESS SB 241 - SB 346

of background information collected. This may suggest to enlightened adoptive parents the activities to attempt or to stress.

5. Inform adoptive parents of the adoptee's rights so that there will be no surprises when the adoptee wants to find his birth parents.

-This would emphasize the importance of the adoptee's very own identity. Some adoptive parents do not tell the child he is adopted and would not give him the background information. If they knew he could get it anyway when he became 18 they would be more apt to give it to him when he really needed it, and they would be more apt to support him in a search for the birthparents. For having a background on which to build an ego will help the adoptee to become a more mature and well adjusted adult.

6. Request the adoptive parents prepare a progress report on the adopted child every few years and attach to the original birth certificate or made available by other means to the birth parents.

-Birthparents usually never forget the adoptee. This would help the birthparents cope with the tragedy and perhaps guilt of having surrendered a child to some stranger.

#### SUMMARY:

1. The present system of releasing the original birth certificate is LEGAL and we have had no problems with it.
2. An adoptee's information on his true heritage is very important to his psychological well-being.
3. A birth parent's responsibility to provide background information and to be available to the adult adoptee is more important than the birth parent's right to privacy.
4. No adoptee should have to seek permission from anyone to obtain information about himself.
5. Background information is being collected NOW and the law does not need changing regarding access to the original birth certificate. Therefore, there is no great urgency to pass this bill the way it is written now.

SO PLEASE CONSIDER THIS BILL CAREFULLY.

Over 15,000 adoptions have already taken place in Alaska. Please continue to allow ALL adoptees unconditional access to their original birth certificates. Please, leave stepping stones to the past for our adoptees, not stone walls.

4505 Dredge Lake Rd.  
Juneau, Alaska 99801  
February 17, 1984

The Honorable Milo Fritz  
The Honorable Mae Tischer  
Co-chairmen, House HESS Committee  
Alaska State Legislature  
Juneau, Alaska 99811

Dear Representatives Fritz & Tischer:

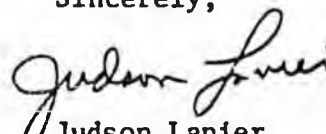
CSSSSB 241 (Jud), an act relating to adoption, seeks to amend AS 18.50.220 and thus delete the regulation 7 AAC 05.730 which now allows an adult adoptee unconditional access to his original birth certificate. The requestor of this legislation contends that privacy is promised biological parents in adoption proceedings and that is not now being honored since Vital Statistics releases the original birth certificate to the adult adoptee upon request.

After reviewing the statutes - Title 25, chapter 23 adoption and AS 18.50.210 and AS 18.50.220 New Certificate of Birth I find that:

- The statutes treat birth certificates separately from adoption proceedings. It is the adoption proceedings - court hearings and related records that are confidential as per AS 25.23.150. Birth certificates are not part of the adoption proceedings. In fact, a new certificate of birth (which names adoptive parents) is not prepared until AFTER an adoption decree becomes final. (AS.23.170)
- An adoption can take place without the issue of a substitute birth certificate because a substitute certificate is an option adoptive parents can choose. (AS 25.23.170)
- The present practice of releasing original birth certificates is legal. AS 18.50.220, New Certificate of Birth, allows regulations to be written concerning the inspection of the original birth certificate. The regulation 7 AAC 05.730 authorizes the Registrar to do so.
- The statutes and regulations also provide that records may be opened by order of the court. Thus, there exists another method by which confidentially is not assured to any party involved.

The issue of privacy is a moot point in this proposed legislation.

Sincerely,

  
Judson Lanier

Member, Alaska Bar Association

# MEMORANDUM

MAR 07 1979

TO: Ms. Joan Brooks, State Registrar  
Bureau of Vital Statistics  
Department of Health and Social  
Services

DATE: March 1, 1979

FILE NO:

TELEPHONE NO:

FROM: AVRUM M. GROSS  
ATTORNEY GENERAL

SUBJECT: Copying of Original Birth  
Certificate when a New  
Certificate has been Issued

By: Richard L. Peter *RGP*  
Assistant Attorney General

This will confirm our oral advice to you that the Bureau of Vital Statistics must provide a copy of his original birth certificate to an adopted child who has attained the age of 18 years and requested it, if the copying cost is paid. The copy should be identified however by a notice that a new certificate has been issued for the subject.

Because of some apparent inconsistencies we will recapitulate the statutes and regulations providing for inspection of records involved in an adoption.

AS 20.15.150 provides in pertinent part:

(b) All papers and records pertaining to the adoption . . . are subject to inspection only on consent of the court and all interested persons.

(c) Except as authorized in writing by the adopted child if 14 or more years of age, or by the adoptive parent . . . no person is required to disclose the name or identity of either an adoptive parent or an adopted child.

And 7 AAC 05.670 provides: "All reports of . . . adoption proceedings . . . are open to the public only under order of the Superior Court." These apparently refer to materials relating to the adoption with the exception of the original birth certificate, because while AS 20.15.080 requires that a "certified copy of the birth certificate . . . if available . . . shall be filed with the clerk" of court, AS 18.50.220(b)(1) apparently sets up a separate procedure for handling the certificate after the adoption. It provides that a new certificate shall be substituted for the original and

Thereafter the original certificate and the evidence of adoption [reported by the court] . . . are not subject to inspection except upon order of the superior court or as provided by regulation;

Ms. Joan Brooks, State Registrar  
Bureau of Vital Statistics

March 1, 1979

This is implemented by 7 AAC 05.730 which provides: "The State Registrar may open all or part of such sealed file for inspection by the person whose record it is, if of legal age."

This authority refers to inspection of such records by its language, but two sections of AS 09.25 extend the access to copying them. AS 09.25.110 provides:

Unless specifically provided otherwise, The books, records, papers, files, accounts, writings, and transactions of all agencies and departments are public records and are open to inspection by the public under reasonable rules during regular office hours. The public officer having the custody of public records shall give on request and payment of costs a certified copy of the public record.

And AS 09.25.120 provides in pertinent part:

Every public officer having custody of the records not included in the exceptions shall permit the inspection, and give on demand and on payment of the legal fees therefor a certified copy of the writing or record, and the copy shall in all cases be evidence of the original.

These sections equate copying with inspection, and impose the duty of making copies available at cost.

However, the concern you have expressed over the copying of an original birth certificate which has been -- at least temporarily -- superseded by a new certificate of birth, is reasonable, but has not been addressed by either the legislature or your department's regulations.

Therefore, we would suggest that when you copy an original birth certificate for which a new certificate has been issued, this fact should be displayed upon the face of the copy, either by typing upon the copy: "A New Certificate of Birth has Been Issued", or by duplicating such a notice by placing it on an unused portion of the document when the copy is made. This will prevent the copy being used as the only or latest evidence of birth, and keep the original clean should it be necessary to restore it to the public file on vacation of the adoption, as provided by AS 18.50.220.

Because such a procedure will affect the general public we suggest that you adopt regulations providing for it under the Alaska Administrative Code. We are prepared to assist you in drafting them so please call upon us.

RLP:vr

# Church supports rights of adoptee to find roots

The U.S. Presbyterian Church's Northern wing is the first American denomination to say adult adoptees should legally be able to learn the names of their natural parents.

The United Presbyterian Church, U.S.A., Wednesday called for an "open records policy" which would allow adopted persons, once adults, to gain access to their birth records, currently sealed at the time of adoption.

Their resolution says, "Permanent sealed records have created a mythology about adoption, which is that adopted persons have only one set of parents. The surrender paper in effect becomes a certificate attesting to the death of any relationship at any time between the original parent and child, thus creating for the child a pair of ghost parents who are not in their graves but who may live in the next town, or have hereditary illnesses

that do not surface until they are in the middle years and whose children, born later, may unknowingly risk incest with whom they attend college or work in the same work places with their half-sisters or half-brothers."

The Rev. Susan Andrews, pastor of Kitchell Memorial Presbyterian Church in East Hanover, N.J., and a sponsor of the resolution, said the church must debate moral issues involved in the debate.

She said she became interested in the issue when a parishioner unsuccessfully searched for her birth mother. "She had an issue of human rights as well as one of pastoral rights," said Ms. Andrews.

The issue of "open records" for adult adoptees has been a legal battle between adoptee rights groups and state governments, which currently seal the records.

CHRONICLE — Houston, TEXAS  
May 28, 1981

## OVERTURE 39

a resolution for open records

by The UNITED PRESBYTERIAN Church

1981

"Every great and commanding movement in the annals of the world is the triumph of enthusiasm. Nothing great was ever achieved without it." - Ralph Waldo Emerson

Once a year, 650 delegates from United Presbyterian Churches across the country meet to consider theological and social matters of importance to the church's ministry. In May, this body - the General Assembly - met in Houston, and one of the issues considered was that of supporting the rights of adult adoptees to the truth of their origins as outlined in Title V of the Model State Adoption Act.

Overture 39, the text of which follows, was channeled to the Social Justice and Rights of Persons Committee, and passed by that committee upon recommendation of a sub-committee which spent three hours discussing the issues with adoptees and adoptive parents present. When the Overture came up on the floor of the General Assembly, there was a thirty-minute debate, followed by a vote of approximately 600 - 25 in favor of the Overture. We are printing it for you in hopes that (a) you will be encouraged by it and (b) that you might consider submitting a similar document to your worshipping community for consideration and action. Judeo-Christian history has had a powerful impact on people the world over, and continues to do so. As religious bodies work for national and international peace, let us urge them to work on this area of peacemaking within and among persons on all sides of the adoption triangle.

OVERTURE ON RECOGNIZING THE RIGHT OF ADULT ADOPTees TO KNOWLEDGE OF THEIR ORIGINS BY ALLOWING THEM ACCESS, UPON REACHING THE AGE OF MAJORITY, TO THEIR ORIGINAL BIRTH CERTIFICATES, COURT AND AGENCY RECORDS... ALSO ON RECOGNIZING THE NEED OF ORIGINAL PARENTS OF ADULT ADOPTees TO HAVE SOME MEANS TO COMMUNICATE THEIR DESIRES FOR CONTACT WITH THEIR RELINQUISHED SON OR DAUGHTER.

Whereas God our Creator saw fit to use an adult adoptee who was well aware of the truth of his origins to deliver the Israelites from bondage to the Egyptians; and

Whereas the Psalmist acknowledged the presence of God in the creation of every individual when he said, "You created every part of me; you put me together in my mother's womb... when I was growing there in secret, you knew that I was there—you saw me before I was born"; and

Whereas Isaiah affirmed the unreliability of a mother's ability to erase the memory of a child she birthed when he said, "So the Lord answers, 'Can a woman forget her own baby and not love the child she bore?' Even if a mother should forget her child, I will never forget you"; and

Whereas Jesus said, "You will know the truth, and the truth will set you free"; and

Whereas the sealed records laws institutional in the last five decades have prevented adopted persons, ever when a contract is made in their infancy when they are helpless to participate in it, from ordinarily knowing the truth of their origins by permanently sealing original birth certificates, agency and court records pertaining to their adoption; and

Whereas any non-adopted person in the United States has the absolute right to obtain personal vital statistics for a minimal fee, an adoptee must go to court—however expensive and unsuccessful the process—to request a judge to issue a "good cause" order to know the simple truth of who gave birth to her or him; and

Whereas because of permanently sealed records, adoptees have no medical, cultural or religious history and often experience emotional anguish; and

Whereas permanently sealed records have created a mythology about adoption, which is that adopted persons have only one set of parents; the surrender paper in effect becomes a certificate attesting to the death of any relationship at any time between the original parent and child, thus creating for the child a pair of ghost parents who are not in their graves but who may live in the next town, or have hereditary illnesses which do not surface until they are in their middle years (long after any medical history taken at the time of the child's birth); and

Whereas our Lord spoke often of acceptance, forgiveness and reconciliation as qualities desirable for believers to experience daily in their human and spiritual growth; and

Whereas the Department of Health and Human Services now has before it the proposed Model State Adoption Act which includes "Title V. Records," which would grant adult adoptees the right of access to their original records to learn their identity at birth and that of their natural parents, and which would grant original parents of adult adoptees the right to ask the agency which handled the adoption to contact the adult adoptee to notify her/him that the original parent desires contact; a section supported in testimony by the National Association of Social Workers, "Not all adoptees will wish to know the birth parent, nor to find her/him, but surely the option should be there as opposed to a rigid secrecy which would leave adoptees feeling that there is some monstrous secret in their past."

Therefore, the Presbytery of Newton, The United Presbyterian Church in America, sitting in regular session on 3/10/81 in Madison, N. J., does hereby overture the 1978 General Assembly of the United Presbyterian Church in the U.S.A. meeting in Houston, Texas, May 19-25, 1981:

That it go on record as supporting the rights of adult adoptees to receive, upon request, copies of their original birth certificates, court and agency records pertaining to their adoption;

That it support Title V of the Model State Adoption Act and Procedures prepared under section 207 of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978, which would grant adult adoptees the aforementioned information, and which would grant natural parents a more limited right as explained above;

That it act through the General Assembly Mission Council... in encouraging and stimulating synods, presbyteries and local churches to take the following types of action in supporting adoptees who have reached adulthood, in their desire to know the truth of their origins;

- 1) Send letters of support of Title V of the Model State Adoption Act to congresspersons and to the President of the U.S.;
- 2) Write letters to the editors of local newspapers and national magazines expressing support of open records;
- 3) Seek to help all persons involved in the adoptive triangle—natural and adoptive parents and adoptees, who comprise 10% of our population—face the reality of their situations with honesty, openness and compassion for one another.

(b) The petitioner or his attorney shall furnish with the petition for adoption information in the possession of the petitioner necessary to prepare the adoption report. The social, welfare agency or other person concerned shall supply the court with additional information in his possession necessary to complete the report. The furnishing of the information is a prerequisite to the issuance of a final decree in the matter.

(c) Whenever an adoption decree is amended or vacated, the court shall prepare a report on a form prescribed and furnished by the bureau. The report shall include the facts necessary to identify the original adoption report and the facts amended in the adoption decree necessary to properly amend the original report, or the new certificate of birth if already established.

(d) Before the 11th day of each calendar month, the court shall forward to the bureau reports of decrees of adoption, including those vacated or amended, which were entered in the preceding month, together with the related reports the bureau requires.

(e) When the bureau receives a report of an adoption, or vacation or amendment of an adoption from a court for a person born outside the state, a copy shall be made for the bureau's files and the original shall be forwarded to the appropriate registration authority in the state of birth. (§ 17 ch 118 SLA 1960)

Am. Jur. reference. — 1 Am. Jur.,  
Adoption of Children, § 49.

Sec. 18.50.220. New certificate of birth. (a) The state registrar shall establish a new certificate of birth for a person born in the state, upon proper request that the certificate be made, and upon receipt of

(1) an adoption report as provided in § 210 of this chapter, or a certified copy of the decree of adoption from a court of competent jurisdiction in another state, together with the information necessary to identify the original certificate of birth and to establish the new certificate of birth; however, a new certificate of birth may not be established if so requested by the court decreeing the adoption, the adoptive parents, or the adopted person if he is of legal age; or

(2) the evidence required by law and regulation proving that the person has been legitimated.

(b) When a new certificate of birth is established, the actual place and date of birth shall be shown. The new certificate shall be substituted for the original certificate of birth, and

(1) thereafter, the original certificate and the evidence of adoption or legitimation are not subject to inspection except upon order of the superior court or as provided by regulation; however, the regulation shall allow inspection by an agent of the state or federal government acting in the performance of his official duties;

(2) upon receipt of a report that an adoption has been vacated, the original certificate of birth shall be restored to its place in the files and

Highways and Ferries  
Title 19

Title 20  
Infants and Incapacitated

Alaska, upon adoption or legitimation and the submission of the required documents and other necessary information as required by the State Registrar; provided that such new certificate of birth shall not be established in cases of adoption if such negative request be received from the court decreeing the adoption, the person himself if of legal age, or from the adoptive parents. (In effect before 7/28/59; am 7/25/60, Reg. 2)

Authority: AS 18.50.220  
AS 25.20.050

**7 AAC 05.710. REQUEST.** Proper request for a new certificate shall be considered a written and signed request: in the case of adoption, from the adoptive parents, or from the adopted person if of legal age; and in the case of legitimation, from one of the parents, or from the legitimated person if of legal age. The form and type of request acceptable shall be determined by the State Registrar. (In effect before 7/28/59; am 7/25/60, Reg. 2)

Authority: AS 18.50.220  
AS 25.20.050

**7 AAC 05.720. FORM OF CERTIFICATE.** The new birth certificate shall be prepared upon the same type of form, and look as much like a regular birth certificate as possible. Nothing on it shall state or refer to the fact that it is a new certificate. The actual date and place of birth shall be shown, and any question of legitimacy shall be answered in the affirmative. The name on the birth certificate shall be as ordered in the decree, if so specified; otherwise as requested by the parents. The name of the attendant or other person signing the original certificate shall be copied on the new certificate. The personal particulars shall reflect as much as possible the new situation of adoption or legitimation, and these and any other items shall be completed as specified by the State Registrar. (In effect before 7/28/59; am 7/25/60, Reg. 2)

Authority: AS 18.50.220  
AS 25.20.050

**7 AAC 05.730. FILING OF CERTIFICATE.** When the new certificate of birth has been established, it shall be substituted in place of the original certificate. All references to the original certificate shall be removed or deleted from the regular indexes, and from any other source to which the public might have access. The original

certificate, any attachments thereto, and all correspondence, decrees, adjudications, or other reference to the adoption or legitimation shall be sealed away from any inspection except upon order of a superior court; provided that the State Registrar may open all or part of such sealed file for inspection by the person whose record it is, if of legal age; by an agent of the state or federal government acting in the performance of official duties; or for any necessary administrative purpose within the bureau. (In effect before 7/28/59; am 7/25/60, Reg. 2)

Authority: AS 18.50.220  
AS 25.20.050

**7 AAC 05.740. PROCEDURE ON ADOPTION.** Upon receipt of a report that an adoption has been vacated, the original certificate of birth shall be restored to its place in the files; and the new certificate together with all evidence and related material shall be sealed away from inspection except upon order of a superior court, or for administrative inspection by the State Registrar. (In effect before 7/28/59; am 7/25/60, Reg. 2)

Authority: AS 18.50.220  
AS 25.20.050

**7 AAC 05.750. NEW ORIGINAL CERTIFICATE.** If no certificate of birth is on file for the person for whom a new certificate is to be established, an original certificate must be prepared and registered in accordance with the provision of the Vital Statistics Act, these regulations, and the instructions of the State Registrar before a new certificate of birth may be established. (In effect before 7/28/59; am 7/25/60, Reg. 2)

Authority: AS 18.50.220  
AS 25.20.050

**7 AAC 05.760. SEALING OF COPIES.** When a new certificate of birth is established in the bureau, the State Registrar shall direct that any local copies of the original record in the custody of local recorders be sealed away from inspection except upon order of a superior court or demand of the State Registrar. Upon the vacation of any adoption, the State Registrar shall direct the proper disposition of any pertinent local records. The State Registrar may supply a copy of the new certificate to the same local recorder to substitute in place of the

visions of Section 9 hereof before becoming absolute. This decree so entered shall contain an order granting custody of the child to the adoptive parent or parents, and, if same has been requested, the issuance and filing of a substitute birth certificate as hereinafter provided.

#### SECTION 9. FINAL DECREE ABSOLUTE, WHEN.

Within six months after the entry of the final decree any parent who has not received actual notice of the adoption proceeding in time to appear or object thereto may move to vacate the decree, and for an award of the custody of the adopted child to him; providing, that such motion shall not be entertained unless accompanied by an affidavit disclosing good grounds for objection to the adoption. If it appears to the satisfaction of the Court that there are good grounds and sufficient reasons for setting aside the adoption if the allegations of the affidavit are true, the Court may order a hearing upon said motion, fix a time and place therefor, specify the parties to be notified which shall include all interested parties present at the original proceeding with ample time for their appearance, and upon such hearing the Court may deny the motion or grant the same by setting aside the adoption and make a re-determination of who shall have the custody of said child. No such motion shall be granted unless the person filing the same is a fit and proper person and otherwise entitled to the exclusive custody of such child as shown by the evidence at such hearing. Appeal may be taken as from a final decree.

#### SECTION 10. SUBSTITUTE BIRTH CERTIFICATE.

(a) Whenever six months has expired after a final decree of adoption and change of name has been entered in any Court of competent jurisdiction within the Territory of Alaska and no proceedings have been started to set same aside, or if the adoption is otherwise finally sustained, said Court shall, upon request by a proper party, send a certified copy of said decree to the Registrar

of Vital Statistics who shall, upon receipt thereof, prepare and issue a substitute certificate of birth of the child so adopted. This certificate shall contain all of the information required in an original certificate of birth, except that it shall show the new name of the child so adopted instead of the old, although the true date of the child's birth shall be retained, and shall give the statistical particulars of the foster parents in the place and in the stead of the natural parents and shall make no reference to the natural parents of the said child, and the statement pertaining to legitimacy shall in all such cases be shown in the affirmative. The Registrar shall strike out the words, "Attendant's Own Signature" on the substitute record and insert in their stead the words, "Territorial Registrar" and sign as such, and all dates of recording are to be left as on the original.

Form of  
certificate.

(b) The Registrar of Vital Statistics immediately upon completion of such substitute certificate shall seal his original record of the birth, and file in its stead the substitute birth certificate, and thereafter said original record so sealed may be opened by the Registrar only upon demand of the child so adopted upon his having attained his majority, or upon order of any Court of competent jurisdiction. Thereupon the Registrar shall send a certified copy of the substitute birth certificate to the Commissioner and/or recorder having on file the adopted child's original certificate of birth. Such recording officer shall forthwith enter the substitute copy in his files in the place and stead of the original copy on file. Upon such filing of the substitute birth certificate, said officer shall seal the original birth certificate and it may thereafter be opened only upon the same conditions as hereinabove prescribed for the Registrar.

Sealing of  
records.

(c) Upon request for issuance of a certified copy of a birth certificate after substitute certificate has been filed, the Commissioner, Recorder or Registrar, as the case may be, shall, as a matter of course, issue a certified copy of

Certified copies  
issued.

Offered: 1/26/84  
Referred: Rules

Original sponsors: Kerttula, Rodey,  
Ray, et al

1 IN THE SENATE BY THE JUDICIARY COMMITTEE  
2 CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 241 (Judiciary)  
3 IN THE LEGISLATURE OF THE STATE OF ALASKA  
4 THIRTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to adoption; and providing for an  
7 effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 \* Section 1. AS 18.50.220(b)(1) is amended to read:

10 (1) thereafter, the original certificate and the evidence  
11 of adoption or legitimation are not subject to inspection except upon  
12 order of the superior court; ~~however, the state registrar [OR AS PRO-~~  
13 ~~OR OLDER & HIS/HER DESCENDANTS AGE 18 OR OLDER AND~~  
14 ~~VIDED BY REGULATION, HOWEVER, THE REGULATION]~~ shall allow inspection  
15 by an agent of the state or federal government acting in the perfor-  
16 mance of the agent's [HIS] official duties;

16 \* Sec. 2. AS 18.50 is amended by adding new sections to read:

17 ARTICLE 5. ACCESS TO ADOPTION INFORMATION.

18 Sec. 18.50.500. ACCESS TO ADOPTION INFORMATION. (a) Upon  
19 receipt by ~~the state registrar of a request by an adopted person 18~~  
20 ~~years or older for information identifying the adopted person's bio-~~  
21 ~~logical parents, the state registrar shall give notice of the request~~  
22 ~~to the biological parents by certified mail, deliverable to the ad-~~  
23 ~~dresssee only. Information identifying a biological parent shall be~~  
24 ~~disclosed to an adopted person 18 years or older if certified mail~~  
25 ~~sent to a biological parent is returned to the state registrar unde-~~  
26 ~~livered or if the state registrar has not received a written objection~~  
27 ~~from a biological parent under this section.~~

28 (b) If a written objection by a biological parent is received by  
29 the state registrar within 30 days of the notice required under (a) of

18.50.500 (a) A BIOLOGICAL PARENT NAMED ON THE  
ORIGINAL BIRTH CERTIFICATE -1- MAY FILE WITH C555B 241(Jud)  
THE STATE REGISTRAR A STATEMENT AS TO WHETHER  
HE/SHE WOULD WELCOME CONTACT WITH THE ADOPTED  
PERSON AGE 18 OR OLDER.

(b) THE STATE REGISTRAR SHALL DISCLOSE INFORMATION IDENTIFYING THE BIOLOGICAL PARENTS OF AN ADOPTED PERSON WHO IS 18 YEARS OLD OR OLDER AND THE STATEMENTS OF THE BIOLOGICAL PARENTS AS DESCRIBED IN (a) OF THIS SECTION.

1 ~~this section, the state registrar may not disclose the identifying~~  
2 ~~information on that biological parent to an adopted person unless~~  
3 ~~disclosure is ordered by the court under AS 25.23.150.~~

4 (c) The state registrar shall provide the adoptive parents of a  
5 person adopted after January 1, 1985, and an adopted person who is 18  
6 years of age or older after January 1, 1985, the following nonidenti-  
7 fying information on a standard form prepared by the commissioner  
8 regarding each biological parent named on the original certificate of  
9 birth if the information is available:

10 (1) the age of the biological parent at the birth of the  
11 adopted person but not the birth date of the biological parent;

12 (2) the heritage of the biological parent, including:

13 (A) national origin;

14 (B) ethnic background; and

15 (C) race and tribal membership;

16 (3) the health history of the biological parent and of  
17 blood relatives of the biological parent;

18 (4) education, which is the number of years of school com-  
19 pleted by the biological parent at the time of the birth of the adopt-  
20 ed person;

21 (5) general physical appearance of the biological parent at  
22 the time of the birth of the adopted person in terms of height,  
23 weight, color of hair, eyes, skin, and other information of a similar  
24 nature;

25 (6) the existence of another child or children of the  
26 biological parent;

27 (7) whether the biological parents were alive at the time  
28 of adoption;

29 (8) the religion of the biological parent;

(10) OCCUPATION

(11) HOBBIES, TALENTS, SPECIAL INTERESTS

1 (9) whether the adopted person was legitimate at the time  
2 of adoption.

3 (d) The state registrar shall, on the request of an adopted  
4 person over the age of 18 years, attach to the original birth certifi-  
5 cate of the adopted person the current address and name of the adopted  
6 person. The information provided under this subsection may be releas-  
7 ed to the biological parent of the adopted person.

8 (e) The state registrar shall, on the request of a biological  
9 parent, attach to the original birth certificate of the child of the  
10 biological parent the current address and name of the biological  
11 parent. The information provided under this subsection may be releas-  
12 ed to the child of the biological parent.

13 Sec. 18.50.510. MAINTENANCE OF RECORDS. (a) The commissioner,  
14 a child adoption agency, and a person authorized by law or regulation  
15 to place a person for adoption shall furnish the state registrar the  
16 information concerning biological parents required under AS 18.50.-  
17 500(c) for all adoptions that occur after January 1, 1985. If the  
18 information concerning biological parents required under AS 18.50.-  
19 500(c) is requested but is not available for adoptions that occurred  
20 before January 1, 1985, the state registrar shall request the commis-  
21 sioner to attempt to obtain the required information from the child  
22 adoption agency, records of the commissioner, or court adoption re-  
23 cords, or a person authorized by law or regulation to place a person  
24 for adoption.

25 (b) A child adoption agency licensed under AS 47.35.100 and a  
26 person authorized by law or regulation to place a person for adoption  
27 shall maintain records required under AS 18.50.500(c) and by the  
28 regulations of the commissioner. If a child adoption agency or a  
29 person authorized by law or regulation to place a person for adoption

1 ceases to place persons for adoption, it shall transfer its records to  
2 the commissioner.

3 Sec. 18.50.520. DEFINITIONS. In AS 18.50.500 - 18.50.520

4 (1) "adoptive parent" means a parent who adopted a person  
5 under AS 25.23;

6 (2) "biological parent" means a birth parent who is named  
7 on the original certificate of birth of an adopted person;

8 (3) "child adoption agency" means a child adoption agency  
9 licensed under AS 47.35.100;

10 (4) "commissioner" means the commissioner of health and  
11 social services;

12 (5) "state registrar" means the state registrar appointed  
13 under AS 18.50.030.

14 \* Sec. 3. AS 25.23.060(a) is amended to read:

15 (a) The required consent to adoption shall be executed at any  
16 time after the birth of the child in the presence of the court or in  
17 the presence of a person authorized to take acknowledgements. The  
18 consent is not valid unless

19 (1) the consent form states that the person required to  
20 consent to adoption under AS 25.23.040 has the right to withdraw that  
21 consent as provided in AS 25.23.070(b); and

22 (2) the person signing the consent is provided with a copy  
23 of the consent.

24 \* Sec. 4. AS 25.23.080(c) is amended to read:

25 (c) A certified copy of the birth certificate or verification of  
26 the birth record of the person to be adopted, if available, the non-  
27 identifying information specified in AS 18.50.500(c), if available,  
28 and the required consents, relinquishments, and termination orders  
29 shall be filed with the clerk.

1 \* Sec. 5. AS 25.23.150(b) is repealed and reenacted to read:

2 (b) The papers and records relating to the adoption that are a  
3 part of the permanent record of the court are subject to inspection  
4 only upon consent of the court. The papers or records relating to the  
5 adoption that are in a file in the department or in an agency are  
6 subject to inspection only with consent of all interested persons or  
7 by order of the court for good cause shown. Except as provided in  
8 this section, adoption records of the Bureau of Vital Statistics  
9 established under AS 18.50 are subject to inspection under the pro-  
10 visions of AS 18.50.

11 \* Sec. 6. AS 25.23.150(c) is amended to read:

12 (c) Except as authorized in writing by the adopted child if 14  
13 or more years of age, or by the adoptive parent, or upon order of the  
14 court for good cause shown [IN EXCEPTIONAL CASES], a [NO] person may  
15 not [IS REQUIRED TO] disclose the name or identity of either an adop-  
16 tive parent or an adopted child.

17 \* Sec. 7. AS 25.23 is amended by adding a new section to read:

18 Sec. 25.23.185. RECORDS AND INFORMATION. (a) A person or  
19 agency petitioning for adoption, the department, or a person placing a  
20 child for adoption shall obtain from each known biological parent of  
21 the adopted person for the state registrar

22 (1) the information listed in AS 18.50.500(c) on a form  
23 prepared by the department;

24 (2) a statement <sup>AS TO WHETHER THE BIOLOGICAL PARENT</sup> ~~that the biological parent is aware of the~~  
25 ~~procedure set out in AS 18.50.500(a) and (b);~~ <sup>WISHES TO HAVE CONTACT WITH THE ADOPTED PERSON WHEN THE</sup>  
<sup>ADOPTEE IS AGE 18 OR</sup>  
<sup>OLDER.</sup>

26 (3) a statement that indicates the biological parent has  
27 been informed that the state registrar must attach the biological  
28 parent's current name and address to the original birth certificate at  
29 any time the biological parent wishes to have a current address

1 attached.

2 (b) The statement and the information provided by a biological  
3 parent under (a) of this section shall be attached to the original  
4 birth certificate of the adopted person.

5 (c) The biological parent shall be given a copy of a statement  
6 provided under (a)(2) of this section.

7 \* Sec. 8. This Act takes effect January 1, 1985.

(d) THE BIOLOGICAL PARENT MAY CHANGE A  
STATEMENT FILED UNDER (a)(2) OF THIS SECTION  
AND MAY UPDATE FACTS FILED UNDER (a)(1) OF THIS  
SECTION AT ANY TIME AND THIS OPTION OF THE  
BIOLOGICAL PARENT SHALL BE STATED ON THE  
COPY OF THE STATEMENT PROVIDED TO THE  
BIOLOGICAL PARENT UNDER (c) OF THIS SECTION.

(e) THE ADOPTIVE PARENTS SHALL BE ADVISED  
IN WRITING ON A FORM PROVIDED BY THE  
COMMISSIONER THAT THE ADOPTEE AT AGE 18  
MAY OBTAIN A COPY OF THE ORIGINAL BIRTH  
CERTIFICATE ALONG WITH THE BACKGROUND INFORMATION  
DESCRIBED UNDER (a)(1) OF THIS SECTION  
AND THE STATEMENTS OF THE BIOLOGICAL PARENTS  
DESCRIBED IN (a)(2) OF THIS SECTION

(f) THE COMMISSIONER SHALL REQUEST ON A PERIODIC  
BASIS THAT THE ADOPTIVE PARENTS PROVIDE TO THE DEPARTMENT  
A PROGRESS REPORT ON THE CHILD'S HEALTH, SOCIAL & PHYSICAL  
DEVELOPMENT. THE REPORT SHALL BE ATTACHED TO THE ORIGINAL BIRTH  
CERTIFICATE & SHALL BE AVAILABLE TO THE BIOLOGICAL PARENTS  
UPON REQUEST.

January 17, 1984

M E M O R A N D U M

TO: Senator Bill Ray, Chairman  
Senate Judiciary Committee  
Senator Joe Josephson  
Senator Richard Eliason  
Senator Fritz Pettyjohn  
Senator Robert Ziegler, Sr.

FROM: Karla Forsythe <sup>KF</sup>  
General Counsel  
Alaska Court System

SUBJECT: SS for SB 241, an act relating to adoption.

The Alaska Court System appreciates this opportunity to bring to your attention court-related concerns about SS for SB 241, an act relating to adoption.

Under section six of the proposed legislation, the clerk of the superior court, the department of health and social services, or the person placing a child for adoption is required to obtain from each known biological parent a variety of nonidentifying information, as well as statements about access to identifying information. It is the position of the court system that the reference to the clerk of the superior court should be deleted.

The practical effect of including the court as one of the information-gathering agencies is to add a new and inappropriate clerical procedure to the work of the courts. The implication of this section is that if an agency or the

department is not involved in an adoption, the court should obtain the information. In almost all step-parent adoptions, an agency or the department is not involved, so the court would have to collect the information from the biological parent. These types of adoptions comprise a substantial portion of the court's adoption workload. Moreover, in these situations the biological parent is often difficult to contact. Therefore the court will spend a great deal of time obtaining this information, which will likely require additional staff in major court locations. This investigatory function is not compatible with the court's adjudicatory role.

An easier and more appropriate way to obtain this information in step-parent adoptions is for the person petitioning for adoption and not the court to furnish it to the registrar. If the phrase "person placing a child for adoption" is intended to include these petitioners, the court's concerns with section six can be remedied simply by deleting the reference to the clerk of the superior court. However, if petitioners in step-parent adoptions are not meant to be included in the phrase, they should be specifically mentioned. If this is the case, the court system suggests that lines 10-12, page five of the proposed bill, should read: "The person petitioning for the adoption, the department, or the person placing a child for adoption shall obtain from each known biological parent of the adopted person for the state registrar . . . ."

Deleting the reference to the court comports with the apparent intent of the legislation. Proposed section 18.50.510 requires the commissioner, an adoption agency, or a person placing an adoptee, and not the court, to provide information to the registrar. It is inconsistent to then require the court to obtain the information under the adoption provisions of title 25. Also, a reference to the court implies that inability or failure to obtain the information will affect the court's review of the adoption. However, it is clear from proposed section 18.50.500 that the missing information results not in denial of the adoption, but in nondisclosure.

In summary, the court system recommends deletion of the reference to the "clerk of the superior court" from section six.

cc: Senator Kerttula  
Senator Rodey  
Senator Sturqulewski  
Senator Fahrenkamp  
Senator Halford  
Senator P. Fischer  
Senator Moss  
Paula Scavera  
Arthur H. Snowden, II

Public opinion favors opening adoption records

By CECILIA KLEINKAUF

Throughout the winter and spring of 1980, the subject of "opening" adoption records in Alaska received a good deal of attention.

A public forum, sponsored by the League of Women Voters, the National Association of Social Workers and the Social Work Department at the University of Alaska generated much discussion and a series of resolutions supporting opening records for release of non-identifying information (i.e. — medical, racial data) and opening records for release of identifying information with the consent of the individual whose name is released. Legislation was also introduced in the 11th Alaska Legislature to amend the Alaska statutes to provide for open records but did not pass.

In order to determine the opinions of the general public regarding adoption issues, the Social Work Department at the University of Alaska agreed to undertake a research survey of public opinion and make the results available to the legislature and the public at large.

Both KIMO-TV, Channel 13, and the Anchorage Daily News provided assistance by actually publicizing the short questionnaire, thus assuring participation by the general public.

The survey asked the following questions:

1) Whether respondents believed that non-identifying information should be available to adult adoptees without a court order.

2) Whether respondents believed that identifying information (names) should be accessible to adult adoptees, adoptive and biological parents —

- a) Only with written consent of the person to be adopted;
- b) Only with a court order and the written consent of the person to be adopted;
- c) Only with a court order;
- d) Not at all;

3) Whether adoptions should be done by a licensed adoption agency or the state — except for relative or step-parent adoptions.

One hundred forty-two (142) individuals responded to the brief questionnaire. Of this number — 19 were adopted persons, 37 were adoptive parents, 22 were biological parents of a child released for adoption, 13 were professional and 46 were classified "other." Composite breakdowns of their responses are as follows:

1) Those believing that non-identifying information should be available to adult adoptees without a court order —

- Yes.....89 percent
- No.....6 percent
- Don't Know.....4 percent

2) Those believing that identifying information (names) should be accessible to adult adoptees, adoptive and biological parents —

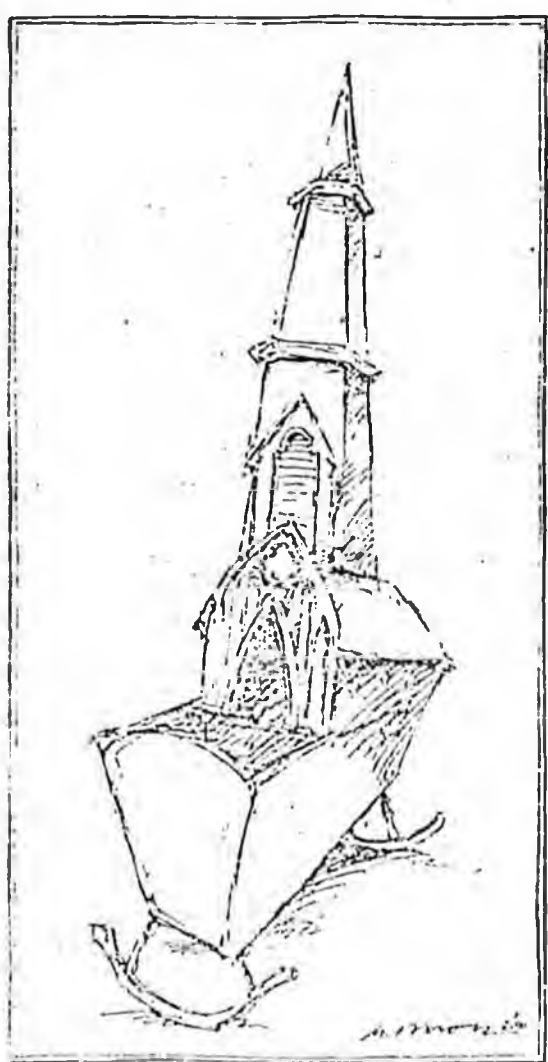
- Written consent.....77 percent
- Court order & written consent.....15 percent
- Only with court order.....2 percent
- Not at all.....4 percent
- Don't know.....1 percent

3) Those believing that adoptions should be done by a licensed adoption agency or the state — (except for relative or stepparent adoptions)

- Yes.....65 percent
- No.....17 percent
- Don't Know.....18 percent

Contrary to what might be expected, when the responses are broken down by adoptees, adoptive parents and biological parents, the support for open records remains strong within each discrete group.

Of those respondents who were ADOPTIVE PARENTS, 67 percent believed that access to identifying information should be granted with the consent of the person to be identified. Sixty-five percent believed adult adoptees should have access to non-identifying information without a court order. Fifty-one percent of



the adoptive parents believed adoptions should be done by a licensed agency or the state and 35 percent disagreed. Fourteen percent weren't sure.

Of those respondents who were the BIOLOGICAL PARENT of a child released for adoption, 82 percent believed that access to identifying information should be granted with the written consent of the person to be identified. Ninety-one percent believed adult adoptees should have access to non-identifying information without a court order. Forty-five percent of the biological parents believed adoptions should be done by a licensed agency or the state. Forty-one percent weren't sure and 14 percent disagreed.

Of the respondents who were ADOPTEES, 81 percent believed that access to identifying information should be provided with the written consent of the person to be identified. Ninety-five percent believed that access to non-identifying information should be possible without a court order, and 84 percent believed adoptions should be done by a licensed agency or the state. Eleven percent disagreed and five percent weren't sure.

Of the remaining respondents, 80 percent believed that written consent should be required for the release of identifying information, 27 percent believed that access to non-identifying information should be possible without court order and 74 percent believed a licensed agency or the state should do the adoptions.

Survey results such as these give clear indications of changing social attitudes about adoption and about "secret" adoptive records.

It is obvious that the majority of respondents in this survey believe that Alaska should "open" adoptive records. It remains to be seen whether the 12th Alaska Legislature will agree.

Cecilia "Pudje" Kleinkauf is a faculty member of the University of Alaska, Anchorage with the Department of Social Work.

## Oklahoma Law Review Summary

Attacks on the sealed record laws spread nationwide in the 1970's as activists for adoptees' rights began lobbying legislators to amend laws that prevented adopted persons from finding out the circumstances of their own adoption. Challenges to the laws began to be voiced in state and federal courts with plaintiffs claiming that such laws violated constitutional rights. Among rights adoptees assert are violated by the closure statutes are a first amendment right to receive significant personal information, a ninth amendment right to personhood and privacy, and denial of equal protection of the law under the fourteenth amendment. State courts have uniformly upheld sealed record laws against all such attacks. The U.S. Supreme court has not yet decided the constitutionality of sealed record laws.

Modern adoption procedures are primarily designed to protect the welfare of the adoptee, they simultaneously safeguard the rights of the biological and adoptive parents. Like other aspects of family law, adoption is governed by state rather than federal rules. In most jurisdictions, adoption proceedings are closed and records are sealed to protect rights of the parties involved.

**\*\* Pro sealed records:** One court reasoned that sealed record laws offer assurance to a biological mother that instead of haphazardly placing the child herself, she can allow desirous and qualified persons to adopt the infant. She will be protected in the process so that no one will ever know by means of the adoption proceedings that the child was illegitimate, if such is the case. The statutes further purport to assure the adoptive parents that the child may be treated as their own and that they need not fear the adoption records will hurt the child or their relationship with the child. Sealed record laws were enacted basically to protect the adoptee from any possible stigma of illegitimacy they might bear, to allow a parent-child relationship to form in the adoptive family without the threat of interference from the biological parents, and to afford the biological mother a chance to make a new life for herself, secure in the knowledge that this phase of her life would not be revealed. Most sealed record laws were enacted in an era when illegitimacy carried a devastating legal and social stigma.

**\*\*** The sudden appearance of the child years later could be a shocking experience. Traditionally, when a parent places a child for adoption, that parent is given a promise of anonymity. Opening adoption records might be humiliating to a mother who surrendered a child years ago, and who would not want to confront a part of her life long buried in the past.

**\*\*** Adoptive parents fear that the liberalization of sealed record laws would lead to the loss of their adopted child to the biological parent, once the child and parent locate each other.

\*\* With a scarcity of babies available to adopt, many fear a powerful black market will emerge. Perhaps legislators and courts believe that statutes that deny confidentiality in adoption procedures would be another factor that might force biological parents covertly to surrender a child they cannot support.

\*\* Con sealed records: With maturation, many adoptees experience identity crises, health problems that possibly have a genetic connection, and curiosity about their biological heritage. One study of the psychological status of adults revealed that only a small portion of adoptees become well-adjusted adults. Other studies show adoptees are prone to emotional and psychological problems, all traceable to a lack of identity. One psychologist notes that one's identity has to do with immediate life involvements (the adoptive family) and a larger sense of heritage. It is in the latter category that adoptees feel identity-deficient. Without this sense of heritage, psychologist reason, adoptees have no sense of continuity, wholeness, or fidelity, all of which are important to identity formation. Thus, the conspiracy of silence against the adult adoptee prevents the development of a full self-identity. While confidentiality may serve its purposes in the adoptee's young life when the parent-child relationship is forming, it is questionable whether insistence upon such a policy remains in a adoptee's best interests once adulthood is reached, the "best interests" rationale should extend into the life of the adult adoptee.

\*\* A relationship between parent and child that has developed throughout the adoptee's young life is not easily endangered by outside persons or influences. While adoptive parents have a valid interest in keeping adoption records sealed during the adoptee's youth, that interest decreases after the parent-child relationship has blossomed. Furthermore, one commentator suggest that most adoptees experience a deeper sense of love and appreciation for the adoptive parents as a result of establishing a relationship with biological relatives. It is reasonable to believe that revealing the information sought by adoptees concerning their identity would lead to their mental health and happiness.

\*\* States must consider the mental health of those persons for whose adoptions they are responsible. Medical studies reveal that some adoptees who are denied the opportunity to seek out biological parents or genealogical history have suffered severe psychological stress. A suggestion was made that states should establish some provision in their adoption laws to help these adoptees overcome their disorder and thus keep that person from becoming a burden on the state.

\*\* Adoption laws are drafted to result in the best interests of the adoptee, in many cases, revealing information about the adoption process is in the best interest of the adoptee.

Among the avenues of constitutional argument open to an adoptee seeking access to birth records or adoption proceedings is the challenge that sealed record laws violate first amendment rights. One theory supporting the purpose of the first amendment is that it promotes a "marketplace of ideas" concept that allows the free exchange of information, enabling all person to participate knowledgeably in government and society. Sealed adoption laws that are the cause of psychological stress on adoptees arguably frustrate one of the basic premises of the first amendment. The Supreme Court has extended the first amendment beyond its literal terms. On numerous occasions, the Court has held that the amendment protects the right to receive information. It has been argued that this includes information about the adoption process, but courts have rebuffed that argument. Another court faced with a challenge to sealed record laws noted that no constitutional or personal rights were unconditional and absolute to the exclusion of the rights of all other. That court thought that the conditional limitation (the good cause requirement) of the challenged statute promoted a valid state policy of protecting privacy rights. Applying a balancing test, the court found that the adoptees' first amendment rights were outweighed by the countervailing rights of the other interested parties.

A plaintiff's attempt to invoke the right to receive information in this context would seem to be an overly broad extension of the right and an unprecedented interpretation of the first amendment. But a general conclusion that all biological and adoptive parents wish to keep adoption information confidential once the adoptee reaches adulthood should not be made. In those cases where all parties are amenable to releasing the information, the adoptee should have the right to view adoption records.

Although the Constitution does not explicitly mention a right to privacy, such a fundamental right has been found to exist in the penumbras of the first, third, fourth, fifth, and ninth amendments. The definition of privacy and the nature of the interests it encompasses have not clearly been set forth. The Supreme Court has deemed fundamental two types of privacy interests: those involving traditional family ties and decisions about control over one's own body. The privacy right limits governmental interference into individual decisions regarding those issues deemed fundamental. Adoptees allege that the right to know genealogical identity is similar to areas in which privacy has been held to apply. (extended to such areas as abortion, marriage, contraception, procreation, child rearing, and education) The privacy right arguably could encompass an adoptee's right to view birth records because the ability to make decisions involving fundamental rights is likely influenced by identity formation gained through those records. Preventing access to information about an adoptee's genetics may hamper the decision-making process concerning such things as procreation and contraception. Without such genealogical facts, the adoptee has no information upon which to base intelligent decisions. Thus, sealed record laws prevent adoptees from fully exercising fundamental rights by deterring dissemination of information needed to make decisions protected by the right to privacy. Such a governmental intrusion is forbidden

by the Constitution. One court has held that information regarding heritage and heredity, while it may be important to forming identity, is nevertheless not so intimately personal as to fall within the zones of privacy implicitly protected by the Bill of Rights penumbras. The penumbral rights that adoptees use to assert a right of access to files is the same right opponents assert to keep the files closed.

Establishing a fundamental privacy right to birth records would entitle adoptees to strict scrutiny of the closure laws. The state would have to show that a compelling interest is served by the statute and that less intrusive alternatives are unavailable. Although the purposes served by sealed record statutes are important, arguably even compelling, there are less intrusive means of achieving the goals such laws are aimed to meet. Procedures could be developed to contact birth parents through a liaison. If the parent refused to cooperate, privacy rights would still be protected and parents would be able to appear and meet with the adoptee if neither party wanted to remain silent.

#### Suggested Reforms

Under most current sealed record laws, an adoptee must make a showing of some form of good cause in order to inspect records. However, what constitutes good cause is left to the subjective discretion of the judge and is nowhere defined in most state statutes. A suggestion offered by the Superior Court of New Jersey in *Mills v. Atlantic City Department of Vital Statistics*. The court held that when an adoptee seeks access to adoption records during minority, the minor must satisfy the good cause requirement. When the adoptee reaches majority, the burden of proof shifts to the state to show an absence of good cause. If biological parents consent to disclosure, the records may be opened on demand.

A court-supervised intermediary process would offer another solution that would be consistent with the rights of all parties involved. A person appointed by the court to act as an intermediary could seek out the biological parents and inform them of the adoptee's desire to meet them.

Court and legislators should abandon the popular all or nothing approach to adoption record laws in an effort to best serve the needs of all persons involved. Courts thus far have not taken the incentive; thus it falls to the state legislatures to initiate this desirable change.

# Rewriting the Adoption Story

The Old Version Was Based on More Fiction Than Fact—the Belief that Law Could Mirror Biology. Today's Adoption Procedures Are More Realistic

*Who may adopt? Who may be adopted? How important is it to match religion or race? When is a birth parent's consent unnecessary to complete adoption? Under what circumstances can a birth mother revoke her consent after she has relinquished her child? These questions of the '60s were based on traditional thinking of adoption. Today's questions are not only based on changes in family patterns but on a new way of thinking about the concept of adoption.*

The institution of adoption was incorporated into U.S. law in 1851, when Massachusetts enacted the first American adoption statute that provided for judicial supervision over adoptions. In other states, adoption was a private legal act, like a conveyance of real estate or a commercial contractual transaction. Before 1851, other state statutes merely authenticated and made a public record of private agreements.

For the past century, our adoption laws and practices have followed the Roman legal tradition of attempting to make law mirror biology. This tradition was based on the notion that the adopted child, by physical appearance alone, could have been the birth child of the adoptive parents. The adoptive parents were supposed to be people who, by appearance and age, could have conceived the infant. Thus, adoption laws were designed to imitate nature.

Throughout history, a birth mother has had two options: she could choose the adoptive parents and relinquish her child to them—often without going to court; or she could leave the decision to a licensed private or public social service agency that would receive the child, obtain the relinquishment, and then place the child—usually with a childless couple. Most American adoptions con-

sisted of unwed mothers, whose newborn or infant children were released directly from a hospital nursery or a special short-term foster home. For an unwed mother, adoption was a socially acceptable alternative.

But times have changed. The patterns of earlier years are now the exception, not the rule. Today, adoption is usually the end of a process that began as a child neglect or abuse proceeding. While there are still some newborns being placed for adoption, the typical profile of the adoptive child in the '80s is a three-to-five-year-old youngster who has lived with his or her birth mother, then with a series of foster parents, and has lacked a permanent home for at least a year. The birth mother usually has failed to rehabilitate herself, and the most likely candidates to adopt the child are the child's foster parents.

Foster care has become a first step toward adoption. In the past, foster parents often were excluded as candidates because of the matching physical requirements and factors such as financial eligibility. Now, foster parents often are given priority because they have formed strong emotional bonds with the child. They have become the child's "psychological parents."

Government-subsidized adoption programs, which provide the financial support for children to be adopted by their foster parents, was an idea in the '60s. It became a reality in the '70s and is being implemented in the '80s.

## CHILDREN BORN OUT OF WEDLOCK

During these 20 years, there has been a great deal of litigation over the status and rights of children born out of wedlock. The U.S. Supreme Court has moved in the direction of declaring illegitimacy a suspect classification under the Equal Protection Clause of the Constitution. The legal distinction between legitimate and illegitimate

## The open records issue needs rethinking

births has been blurred, and some state statutes have eliminated the distinction altogether—stating that all children are legitimate. But the highest court in the land has not gone that far.

This new attempt to give illegitimate children the same rights as legitimate children has encouraged legislative change, particularly in the area of parental consent. For years, the child born out of wedlock was considered the child of the mother. And unless an unwed father acknowledged paternity or was declared the father through judicial proceedings, he was virtually a legal nonentity. Not only did the father have no rights to the custody of his illegitimate children, but the children had no rights to the companionship of their unwed father.

Although *Stanley v. Illinois*, 405 U.S. 645 (1972), was not an adoption case but a case of neglect and dependency, it had a major effect on adoption law. *Stanley* held that an unwed father who had sired and lived with his three children and their mother intermittently for 18 years was, upon the mother's death, entitled to a hearing before his children could be removed for reasons of neglect. Under Illinois law, Mr. Stanley was not considered a "parent" and thus was not entitled to due process of law because he was not married to his children's mother. The Supreme Court stated in a footnote that its decision also affected adoption.

This case and many that followed it, such as *Rothstein v. Lutheran Social Services*, 405 U.S. 1051 (1972), where the father's rights were considered, have had an impact on all state adoption statutes. In most instances, fathers of children born out of wedlock now must be accorded the opportunity to consent to the adoption of their biological offspring. But there are practical problems in providing this opportunity. Procedures to implement *Stanley* are still being worked out by states to ensure fairness to the biological father without jeopardizing the adoption of the child.

### OPEN ADOPTION

"Open adoption" is a concept of the 1980s that represents a new idea about adoption. It is the antithesis of the Roman ideal—it does not seek to imitate nature and makes no attempt to be a fiction. The essence of open adoption is to provide the child with the opportunity to maintain ties with his or her biological family.

Traditionally, adoption required the complete termination of the biological parent-child relationship, for both legal and practical reasons. Once adoption was decreed, the child was no longer considered the child of the birth parents. Ties with the biological family were severed, unless the child's adoptive parents chose to continue some contact, usually in intra-family adoptions.

Today, most adoptees are older children who have

memories of their earlier childhood and have some contact, if minimal, with their birth families. In cases where contact has been beneficial, but not so positive as to demand return to their birth parents, some courts have made allowances in the decree for visitation by certain members of the biological family. This is usually done only if the child desires it.

Open adoption is controversial because it challenges the basic goal of adoption—to accomplish a complete transplant of a child from the birth family to the adoptive family. Some opponents prefer that contact with the biological family be accomplished voluntarily, without decreeing it, or that guardianship be used rather than adoption.

With open adoption, the mystery of biological birth is eradicated. The price, however, is that it creates a different model for the parent-child relationship. The question is whether society is ready for it.

### LOOKING AHEAD

During the next decade, states that forbid private adoptions are likely to reexamine that policy and the roles of professionals in the adoption process. I anticipate that our legislatures will ask whether it is fair to give agencies a monopoly in the placement of children for adoption of newborns or whether birth parents should be allowed to choose a suitable family for their child.

Other questions facing us in the '80s include: In states that do not allow private adoptions, how can adoptive applicants be assured of fair treatment? Is surrogate motherhood a socially acceptable alternative to traditional adoptive placement? Should there be state regulation of this newly adapted scientific method, or should women and physicians alone be the sole decision makers?

The open records controversy will continue. The debate over whether adoptive children have the legally protected right to inspect their adoption records should prompt states to reevaluate their legislation. The open records issue is an emotional one that needs rethinking. By changing the laws to allow free access to the records by anyone in the adoption triad, we will radically alter adoption in America.

Because adoption has existed in essentially one form for over one and one-half centuries, changes that affect underlying assumptions and strongly felt social values have been, and will continue to be, slow in coming. Those involved in adoption reform must be patient.

The Family Law Section's Adoption Committee is developing a new Model Adoption Act. The Committee is trying to propose an act that takes into account what adoption of children means in the '80s and how it can be accomplished with fairness to all the participants.

In any discussion of adoption, however, we must not lose sight of its primary goal: to provide a permanent, secure, and loving home for a child whose birth parents are unable or unwilling to meet the child's needs. Throughout the process of change, we must never cease to ask the basic question: "Is it well with the child?"

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*Sanford N. Katz, professor of law at Boston College Law School, is a past chairman of the Family Law Section. He is editor-in-chief of the Family Law Quarterly and president of the International Society on Family Law.*

# Alaska State Legislature

Advisory Council Members  
Senator Kerttula, Chairman  
Senator Bennett  
Senator Vic Fischer  
Senator Fahrenkamp



Pouch V  
State Capital  
Juneau, Alaska 99811  
Phone: (907) 465-3114

## SENATE ADVISORY COUNCIL

### MEMORANDUM

TO: Senator Kerttula  
FROM: Elizabeth J. Hickerson *EJH*  
RE: Adoption Legislation  
DATE: March 14, 1983

Last year SB 399 was introduced and passed the Senate with a committee substitute out of Judiciary. This session a very similar bill has been drafted regarding the issue of non-identifying information for adoptees and their adopted parents. Also included in the bill is a procedure whereby an adoptee or the biological parents can attach information to the original birth certificate with identifying information.

The primary intent of the adoption bill is to provide vital non-identifying information to adoptees. Basically, adult adoptees have stated that they feel a void in their lives due to the fact that information regarding their biological parents is missing. Not only is access to medical history vital, but adult adoptees have stated repeatedly that additional non-identifying information is essential to knowing oneself and past roots.

This bill would provide a means of collecting non-identifying information at the time of adoption and attaching this to the birth certificate. No identifying information as to the biological parent is included.

In addition this bill provides an optional mechanism whereby either the biological parent or the adoptee upon reaching 18 years of age can provide identifying information to the other party. The bill provides that at any time a biological parent can attach identifying information (name, address, etc.) to the child's birth certificate for release. This can be revoked at any time by the biological parent. At the same time the adult adoptee can attach similar information to his/her birth certificate. This basically provides a mechanism whereby the parties can establish direct contact with one another.

Neither of these two sections permits identification of the parties being released unless they so request. The parties must take affirmative steps for identifying information to be released. The state would merely establish a registry to assist those wishing to release identifying information.

As it is today children are born, biological parental rights are terminated and adoption takes place without the benefit of background information on the biological parent being preserved. With passage of this bill, non-identifiable information will be preserved and accessible, and a mechanism will be created to aid those wishing to identify themselves.

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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/U/MS						
900 MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

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 that 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.

**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 Meach 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

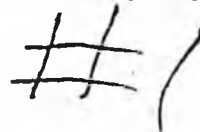
DATE: April 25, 1984

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



# ORTHOMOLECULAR PSYCHIATRY

TREATMENT OF SCHIZOPHRENIA

EDITED BY

DAVID HAWKINS and LINUS PAULING

THE NORTH NASSAU MENTAL HEALTH CENTER  
MANHASSET, NEW YORK

STANFORD UNIVERSITY  
STANFORD, CALIFORNIA



W. H. FREEMAN AND COMPANY  
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## Preface

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 psychotherapy 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 and niacinamide. The pellagra-preventing intake of about

mental and physical health of 150 patients with niacinamide 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 niacinamide per day, in divided doses over five years (Kaufman, 1955). He has treated several thousand patient-years of niacinamide for treatment of restricted niacinamide deficiency 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 niacin or niacinamide. 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

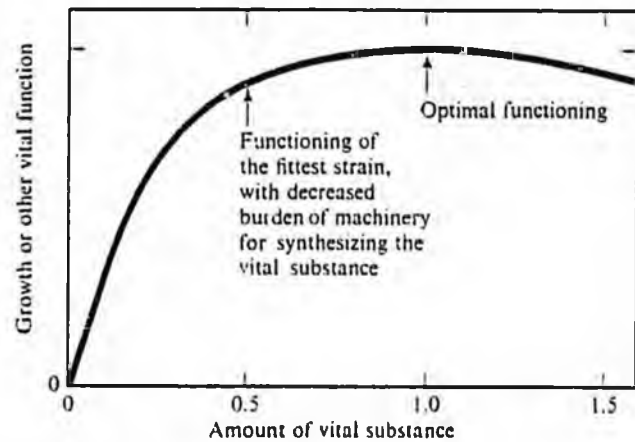


FIGURE 1-1.

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.

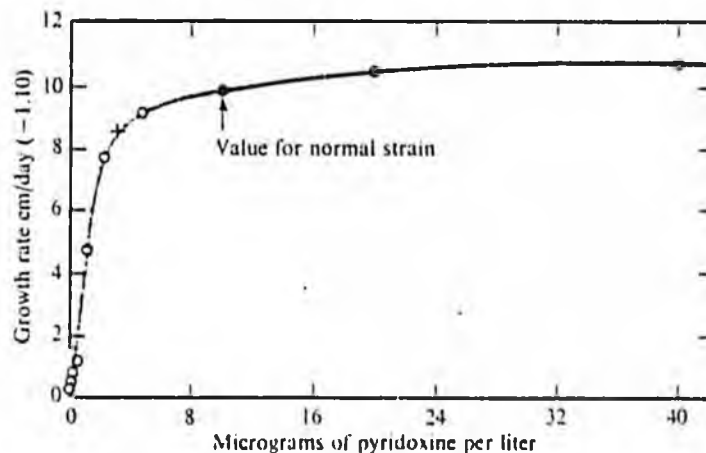


FIGURE 1-2. The observed rate of growth of a pyridoxine-requiring *Neurospora* mutant (Beadle and Tatum, 1941), as function of the concentration of pyridoxine in the medium.

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.

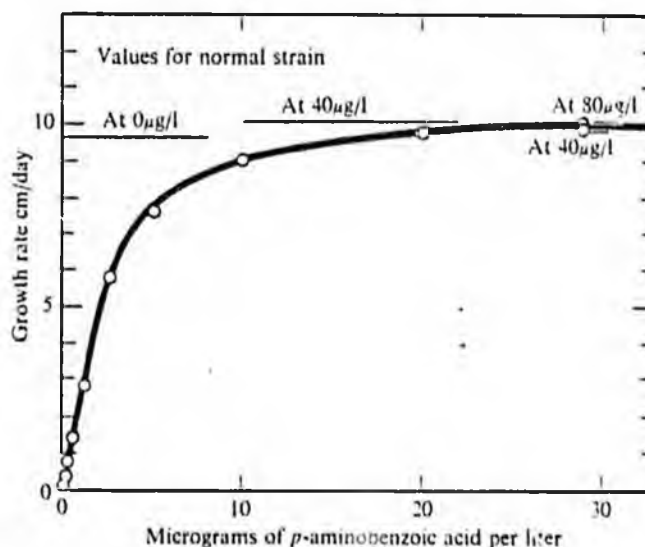


FIGURE 1-3.  
The observed rate of growth of a *p*-aminobenzoic-acid-requiring *Neurospora* mutant (Tatum and Beadle, 1942), as function of concentration of the growth substance in the medium.

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 40 micrograms per liter and for the mutant strain at 80 micrograms per liter, as indicated in Figure 1-3.

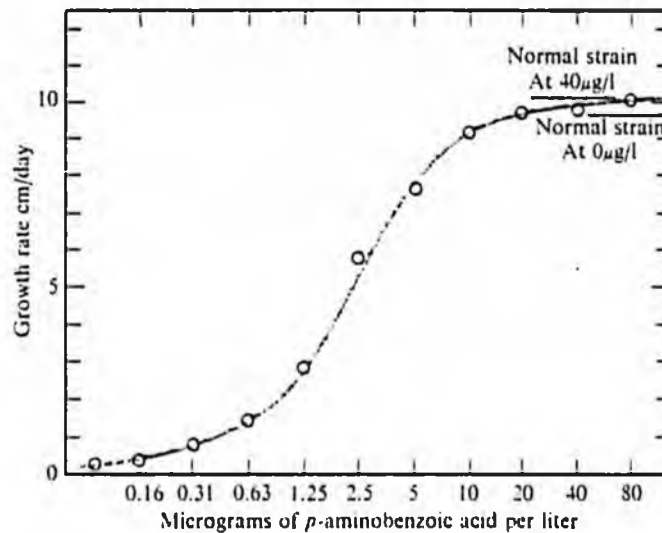


FIGURE 1-4. Observed rate of growth of a *p*-aminobenzoic-acid-requiring *Neurospora* mutant as function of the logarithm of the concentration of *p*-aminobenzoic acid.

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.

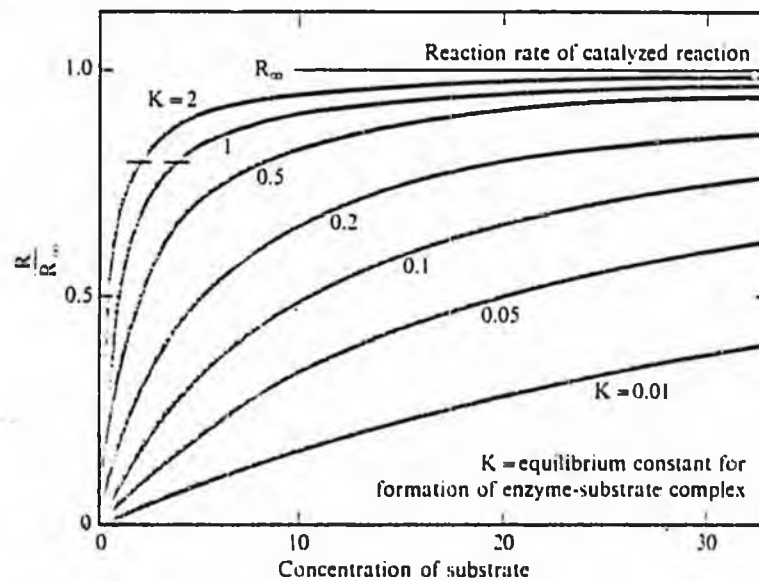


FIGURE 1-5. Curves showing calculated reaction rate  $R/R_m$  of catalyzed reaction as function of the concentration of the substrate, for different values of the equilibrium constant  $K$  for formation of the enzyme-substrate complex.

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 reaction 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 55 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

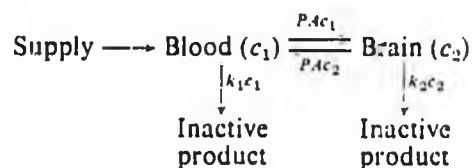
<sup>a</sup> A recent survey of the role of glutamic acid in cognitive behaviors has been published by Vogel et al. (1966). Many references to earlier work are given in this paper.

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

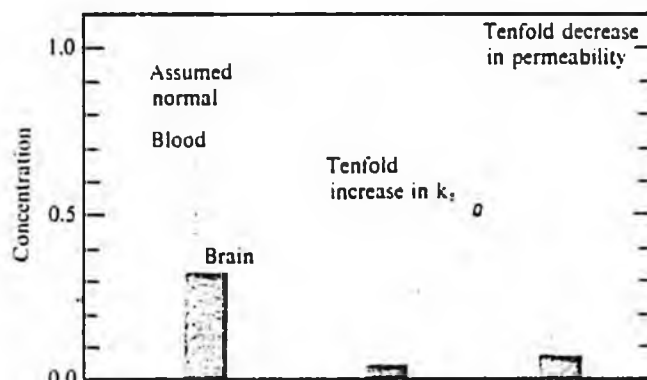


FIGURE 1-6. Values of the concentration of a vital substance in the blood and in the cerebrospinal fluid for three different assumed sets of values of blood-brain barrier permeability and rate of destruction in the cerebrospinal fluid.

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.