ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 8672

2376 SHESS SB 519 - SB 528

SB
519

MEMORANDUM

TO: JOE
FROM: NANCY
RE: SB 519 - RELATING TO STATE SUPPORT FOR EDUCATION

LAST YEAR, WHEN THE LEGISLATURE PASSED HB 251, THE INTENT WAS TO FREEZE THE FOUNDATION FORMULA PENDING THE STUDY BEING COMPLETED BY THE DEPARTMENT OF EDUCATION, AND FUND SCHOOLS BY AMOUNTS SET OUT IN THE BILL APPLIED TO EACH DISTRICTS AVERAGE DAILY MEMBERSHIP.

HB 251 ONLY FROZE THE RATES FOR FY 84, AND THE STUDY WILL NOT BE COMPLETED UNTIL DECEMBER OF THIS YEAR.

THE INTENT OF SB 519 IS TO CONTINUE THE FOUNDATION FREEZE FOR FY 85, AND GRANT CPI ADJUSTMENTS FOR THE YEAR TO THE AVERAGE DAILY MEMBERSHIPS USED TO COMPUTE THE AMOUNT OF STATE AID TO EACH DISTRICT.

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 519 - State Support for education DATE March 9, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
Bill Thomson	DOE	Pouch F	465-2865
Bob Greening	AASB	326 4th St.	586-1083
Bob Conksey	NEA		586-3090

Mar. 9

Joe, Pappy, Rice

SB 579 - STATE SUPPORT FOR EDUCATION.

Bill Thomson - DOE

Sec. 10 as written in 1983 somewhat confusing in computations. No provision for FY 85. Not sure from language in Sec. 10 if they revert to F.F. or continue freeze. 515-520 million Cost for F.F. (25-27 million additional cost)

Bob Cooksey - NEA

put a minimum in funding for smaller districts to be affected if Enrollments decrease.
Bill not dealing w/ forward funding.

Bob Drane - MASB

school boards not 1 thing they need request - Bill technical only.

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: [illegible]

REQUEST

Bill/Resolution No.: SB 519
Title: Act relating to State support for education
Sponsor: Finance
Requestor: Senate HESS
Date of Request: 3/9/84

FISCAL DETAIL

Agency Affected: Education
Program Category Affected: Education
BRU, Program or Subprogram(s) Affected: K-12 Support

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
GENERAL FUND		Ø	Ø	Ø	Ø	Ø
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

Failure to amend Chapter 82, SLA 83 could result in an increase necessary to fully fund K-12 Support.

ANALYSIS: Attach a separate page for analysis

Prepared By: Alison M. Elgee [signature] Phone: 465-2800
Division: Education Date: 3/9/84

Approved by Commissioner: Harold Raynolds [signature] Date: 3/9/84
Agency: Education

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

SB
520

STAFF ANALYSIS OF CSSB 520 AND 521, AN ACT ESTABLISHING A STATE MENTAL HEALTH REHABILITATION CENTER AND MAKING A SPECIAL APPROPRIATION.

CSSB 520

SECTION 1: FINDINGS: ADDS THE NEW FINDING THAT THERE IS A NEED FOR ADDITIONAL RESIDENTIAL CARE TO SERVE THE NORTHERN REGION, THE DEVELOPMENT OF A COMMUNITY SUPPORT SYSTEM APPROACH TO DEALING WITH CHRONIC ADULT MENTAL ILLNESSES, AND A FACILITY TO SERVE THE LONG-TERM INPATIENT NEEDS OF THOSE YOUTHS WHO ARE CURRENTLY BEING SENT OUTSIDE OF THE STATE FOR MEDICAL AND EDUCATIONAL ATTENTION. FURTHER FINDS THAT THERE MAY BE A NEED FOR SEVERAL FACILITIES TO MEET THESE NEEDS. LOCATES ANY FACILITY OR FACILITIES IN FAIRBANKS.

SECTION 2: POWERS AND DUTIES OF THE DEPARTMENT: DIRECTS THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES TO CONSULT WITH LOCAL MENTAL HEALTH CARE PROVIDERS, HOSPITALS, PRIVATE CITIZENS GROUPS INVOLVED WITH MENTAL HEALTH AND THE DEPARTMENT OF EDUCATION AND DEVISE A PLAN TO MEET THE MENTAL HEALTH NEEDS OF STATE RESIDENTS. IN THE PLAN THE DEPARTMENT SHALL CONSIDER THREE NEEDS: (1) THE PROVISION OF ADDITIONAL RESIDENTIAL CARE, (2) THE PROVISION OF A COMMUNITY BASED COMPREHENSIVE SUPPORT SYSTEM TO DEAL WITH YOUNG ADULTS WHO NEITHER BELONG IN A LOCK-UP FACILITY BUT WHO CANNOT BE HELPED IN NORMAL RESIDENTIAL FACILITIES, (3) THE PROVISION OF LONG-TERM INPATIENT CARE TO ADDRESS THE LACK OF A FACILITY FOR YOUNG ADOLOSCENTS WHO ARE CURRENTLY BEING SENT OUTSIDE OF THE STATE. THE BILL ALSO DIRECTS THE DEPARTMENT TO INVESTIGATE THE FEASIBILITY OF PRIVATE AS WELL AS STATE OPERATED FACILITIES WHERE APPROPRIATE.

SECTION 3: PURPOSE OF CENTER: LISTS A STRING OF SERVICES TO BE PROVIDED BY ANY CENTER OR MIX OF CENTERS.

SECTION 4: REPORT: REQUIRES THE DEPARTMENT TO SUBMIT A REPORT TO THE LEGISLATURE ON THE 10TH DAY OF THE FIRST SESSION OF THE 14TH ALASKA LEGISLATURE INCLUDING BUDGET RECOMMENDATIONS, CAPITAL AND OPERATING, TO IMPLEMENT THE PLAN AND PROVIDE AN ANALYSIS OF THE BILL'S IMPACT ON THE MENTAL HEALTH TRUST LANDS CASE (WEISS V. STATE OF ALASKA).

CSSB 521

CHANGES THE APPROPRIATED AMOUNT FROM $30 MILLION TO $3 MILLION. RATHER THAN CONSTRUCTION, THE BILL APPROPRIATES MONIES FOR THE DEVELOPMENT OF THE DEPARTMENT'S PLAN AND FOR THE DESIGN AND ENGINEERING FOR THE CONSTRUCTION OF THE MENTAL HEALTH REHABILITATION CENTER IN FAIRBANKS. LIMITS TO $100,000 THE AMOUNT THE DEPARTMENT MAY USE IN THE DEVELOPMENT OF THEIR PLAN.

Original sponsor: Resources Committee

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

IN THE SENATE

CS FOR SENATE BILL NO. 520 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the establishment of a state mental health rehabilitation center; and providing for an effective date."

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

* Section 1. FINDINGS. The legislature finds that children and adults who suffer from chronic and debilitating psychiatric illness are among the most underserved of all of the state's citizens. These persons are unable to provide for their daily needs and require assistance to maintain themselves as functioning members of their communities. For some, acute and crisis intervention services are needed. For others, long-term maintenance care is required with on-going residential supervision and assistance, including vocational rehabilitation, continuing education, special education, psychotherapy, and opportunities for sheltered employment, in order to participate as functioning members of society. The legislature further finds that there is a need for an additional residential care facility to serve the northern region of the state, community support system facilities to provide comprehensive services to young adults [handwritten: adolescents]; and a long-term inpatient facility designed specifically to meet the medical and educational needs of young Alaskans. Therefore, the legislature finds that there is a need for a comprehensive mental health rehabilitation center or a mix of facilities to meet these needs. The facility or facilities shall be located in Fairbanks.

* Sec. 2. POWERS AND DUTIES OF THE DEPARTMENT. (a) The Department of Health and Social Services shall, in consultation with local mental health

providers, local hospitals, private citizen groups involved with mental health and the Department of Education, develop a plan to design and construct a facility or facilities to meet the mental health needs of state residents.

(b) The Department of Health and Social Services shall consider in its plan

(1) the provision of ~~additional~~ residential ~~care~~ for the chronically mentally ill adult population;

(2) the provision of ~~a~~ community-based comprehensive support ~~system~~ to deal with ~~young adults~~ who neither fit into an inpatient ~~lock-up~~ facility nor can be placed into a normal educational facility; and

(3) the provision of long-term inpatient care to address the state's lack of facilities for ~~young~~ adolescents whose needs cannot be met by private in-state institutions or by residential care facilities and who are currently being sent outside of the state to receive medical and educational attention.

(c) The Department of Health and Social Services shall investigate the feasibility of privately-operated facilities and state-operated facilities.

* Sec. 3. PURPOSE OF CENTER. The purpose of the mental health rehabilitation center is to provide residential, inpatient and outpatient, psychotherapy, vocational rehabilitation, and educational services to emotionally disabled persons in the state based upon referrals from state and private referral agencies and school districts throughout the state.

* Sec. 4. REPORT. The department shall submit a report to the legislature by the 10th day of the First Regular Session of the Fourteenth Alaska State Legislature. The report shall include specific budget recommendations to implement the plan developed under sec. 2 of this Act, including capital and operational requirements. ~~The report shall also include~~ an

1 ~~analysis of the impact of the plan on the resolution of the mental h~~ th
2 ~~trusts lands case. (Weiss v. State of Alaska)~~
3 * Sec. 5. This Act takes effect immediately in accordance with AS 01.-
4 10.070(c).
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MSG 84-00634195 PRTY 1 04/11/84 16:49:16 ORIG: LA0B IN# 0011 OUT# [illegible]
FROM: ANCHORAGE/JACKI TO: TOM/FINAL STATS
TARGET: LJHV SUBJ: (S) HESS, MENTAL HEALTH CENTERS, 4/11/84

****
LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET
****

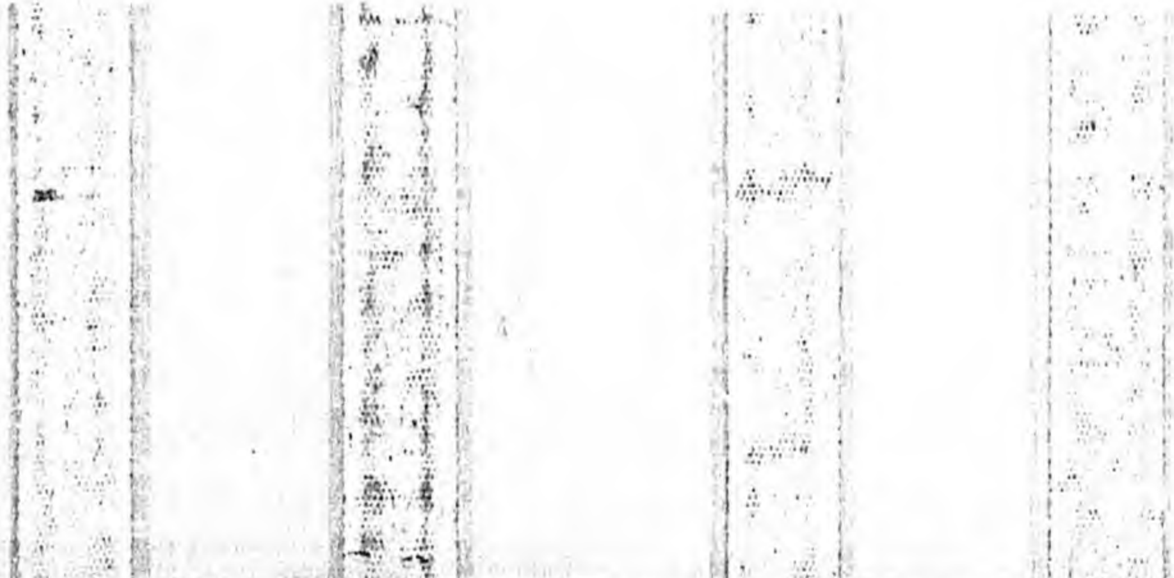
DATE:4/11/84
SITE: ANCHORAGE, LISTEN ONLY
SPONSOR/SUBJECT: (S) HESS, MENTAL HEALTH CENTERS

...0..TESTIFIED *****T/C STARTED: 3:00
...2..OBSERVED *****T/C ENDED: 4:40
...2..TOTAL

OBSERVED
****

1. KRISTI ANA BYRD, SEN. JOSEPHSON'S STAFF
2. ELIZABETH HICKERSON, SENATE ADVISORY COUNCIL

****



MSG 84-00034140 PRTY 1 04/11/84 15:47:42 ORIG: LF05 IN= 0006 OUT= 0021
FROM: PAULA/FKS TO: TOM/JNU
TARGET: LJH6 SUBJ: MENTAL HEALTH FAC/SEN HESS T/C

MARSHA SCHNEIDER WOULD LIKE TO BE CALLED ON LATER ON IN THE TELECONFERENCE AFTER SHE HAS HEARD OTHERS SPEAK.

DIANA CAMPBELL HAS A TIME CONSTRAINT, NEEDS TO SPEAK BY 4:15.

**SARRY TOM, DON'T KNOW WHAT HAPPENED TO THAT MICROPHUNE ALL OF A SUDDEN.
I HAVE SWITCHED IT.***

MSG 84-00034077 PRTY 1 04/11/84 15:12:15 ORIG: LF05 IN= 0003 OUT= 0010
FROM: LYNDA/FBX TO: TOM/JNO
TARGET: LJH6 SUBJ: SEN HESS ON MENTAL HEALTH FAC

FBX OMNI #2

TO TESTIFY (CON'T)

9. LESLEY SALISBURY
10. PAULINE BENNET, O.T.R., AK OCCUPATIONAL THERAPY ASSOC.
11. MARTI CRANOR, FBX C.M.H.C.
12. B.J. STALEY, FBX CRISIS CLINIC FOUNDATION
13. KATHY WHITZELL, FBX MEM. HOSP & F.C.M.H.C.
14. AL AARON, MEMBER F.A.M.I. (MAY OR MAY NOT WISH TO SPEAK)
15. BLANCHE BRUNK, R.C.P.C.
16. ~~PATTI KASTELIC~~
17. PHYLLIS VANAIRSDALE

PLUS ABOUT 6-8 OBSERVORS

MSG 84-00034120 PRTY 1 04/11/84 15:37:48 ORIG: LF05 IN= 0005 OUT= 0020
FROM: PAULA/FKS TO: TOM JNU
TARGET: LJH6 SUBJ: MENTAL HEALTH FAC/SEN HESS/TC

FBX

OMNI # 4

TO TESTIFY

20. GUY PATTERSON
21. TOM MOYER
22. ANN DENARDO

TO OBSERVE

12. JIM ORVIK
13. ROSE HOLLAND, FAMI
14. RUSS CUSACK, DUR

~~PS. WE HAVE RESENT OTHER OMNIS TO LAXTC~~

EOM**

MSG 84-00034064 PRTY 1 04/11/84 15:03:46 ORIG: LF05 IN= 0002 OUT= 0006
FROM: LYNDA/FBX TO: TOM/JNO
TARGET: LJH6 SUBJ: SEN HESS T/C

FORGOT TO TELL YOU I'M AT PRINTER LFH1. IF YOU COULD SEND OMNI'S HERE I'LL BE SURE TO SEE THEM. THANKS.

TO TESTIFY:

1. SHERRY MCWHORTER, NO AK HEALTH RESOURCES ASSOC.
2. KAYE CORY BAKER PAINFUL - COSTLY —
3. MARSHA SCHNEIDER, AK CHAPTER NAT'L ASSOC OF SOCIAL WORKERS will not speak
4. NORMA LARSEN / "res - Special ED
5. RIKI SIPE, AK IC ALLIANCE
6. ALICE SIBBITT F.N.S.B. SCHOOL, SPEC ED.
7. RUTH LISTER, WICCA
8. TOM MINGEN, ABX HOSPITAL FOUNDATION

------------------------------MORE IN A MINUTE

MSG 84-00034091 PRTY 1 04/11/84 15:17:59 ORIG: LF05 IN= 0004 OUT= 0017
FROM: PAULA/FKS TO: TOM/JNU
TARGET: LJH6 SUBJ: MENTAL HEALTH FACILITY - SEN HESS T/C

OMNI # 3

TO TESTIFY:

18. ~~DIANA CAMPBELL~~
19. MARTON WUBBOLD

TO OBSERVE:

1. JAN WHITE, CAMI, ICC COMMUNITY SVS
2. COLLEEN BOHEN, FAMI
3. JACQUELINE FAGON, FAMI
4. ANNE SPINK, FKS MEMORIAL HOSP
5. RALPH MATHEWS, SELF
6. KATHY WHITZELL, FKS MEMORIAL HOSP
7. TERI LYNN COLEMAN
8. MARY MATHIS
9. DANIEL MATHIS
10. AL AARON, FAMI
11. RANDY BROWN

PROFILES OF THE CHILDREN AND YOUTH
PRESENTLY RESIDING IN RESIDENTIAL CARE FACILITIES
OUTSIDE OF ALASKA

March 16, 1984

Male, 17 years - in custody for si ears; abandonment by parents; placement in Alaska failed; haracter disorder, poor behavioral controls; school unable to control; aggressive and sexual acting out towards women.

Male, 15 years - long history of residential treatment; conduct disorder, unsocialized aggressive; attention deficit disorder with hyperactivity; mixed specific developmental disorder; mild mental retardation.

Male, 18 years - delinquent; substance abuser; diagnosed psychotic and requires medication to maintain stability; bizarre ideation.

Male, 12 years - foster and residential care in Alaska were unable to handle his problems. Hyperactive, injurious to self; bed-wetting; destruction of property; stealing; lying; cruelty to animals; sexual acting out.

Female, 15 years - major seizure disorder; mild mental retardation; nonaggressive conduct disorder, characterized by chronic running away and extremely poor judgment.

Female, 12 years - from a family where adult males were alcoholic and violent; sexually abused by grandfather; developed a pattern of lying, stealing, acting out sexually and self-destructive behavior.

Female, 13 years - six failed foster placements in a year and a half; problems with lying, stealing, fire-setting; chronic runaway; inability to relate to peers or adults.

Female, 17 years - sexually abused by father; chronic runaway; sexually acting out; suicide and homicide threats.

Female, 14 years - two institutions in Alaska failed in making any charges; sexual abuse by stepfather; lying; stealing; troubled peer relationships; physically and verbally threatening; depressive; running away.

Female, 17 years - delinquent, in McLaughlin for 11 months; out of control; alcohol abuse; truant; rebellious; conduct disorder; self-mutilation.

Female, 17 years - physically and verbally assaultive; extreme oppositionalism; stealing; chronic runaway; lying; very poor interpersonal relationships.

Female, 17 years - failed in two Alaska residential placements and in foster home; pathological lying regarding sexual abuse; multiple runaways; severe alcoholism; hostility to authority; acute anxiety and suicidal feelings.

Female, 13 years - sexually molested by father; had two residential placements and four foster home placements in Alaska; uncontrolled behavior; fighting; stealing; running; physical assaults on peers and a suicide attempt.

Male, 15 years - stealing; verbal threats of harm; suicide attempts; chronic runaway; drug abuse; conduct disorder.

Female, 13 years, sister to above - sexually abused by father; drug and alcohol abuse; chronic runaway; sexual acting out.

Male, 15 years - delinquent; theft; tortured a five year old girl with cerebral palsy; pre-psychotic.

Male, 15 years - violent, uncontrolled rages; destruction of property; drug and alcohol abuse; stealing.

Male, 16 years - delinquent; criminal mischief and burglary; emotionally disturbed; chronic substance abuser of gasoline, marijuana and alcohol; assaultive behavior.

Male, 15 years - runaway; fire setter; damaged property; drugs; sexual molestation of young children.

Male, 9 years - violent destructive behavior (destroying property, furniture, defacing walls); incontinent; attacking animals; fighting with other children.

Male, 8 years - fire setting; runaway; stealing; assaultive; hyperactive; probably brain damaged.

Male, 16 years - sexual acting out; stealing; fire setting; danger to others.

Male, 17 years - sexually abused by stepfather; running away; suicide attempts; drug and alcohol abuse.

FAMI
SR Box 30754
Fairbanks, Alaska 99701
452-3733

April 9, 1984

Senator Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenhamp:

The Fairbanks Alliance for the Mentally Ill (FAMI) supports the concept of a habilitation center, with a living component, for the Northern Region, to be built in Fairbanks. The quiet catastrophy of premature discharge from the Alaska Psychiatric Institute (API) into an unprepared community has created a social disaster. Without basic life support systems, the patient's survival in the community is marginal at best.

The need for long-term treatment exceeds the service capacity of Alaska's mental health system. In concert with this we seek an adequate long-term living facility, the entire concept to be developed toward quality care. Emphasis should be placed on patients' rights and family rights, with families being viewed as an integral part of the treatment process and not as obstacles to effective treatment.

Sitting in meetings on discharge planning at the API one understands the planner's dilemna: too few resources; too fragmented; and worst of all, no part of the system takes ultimate responsibility for discharged patients. That unsought role is assumed by the family, who quickly recognizes the comforting discharge plans bear only an accidental relationship to reality. The present reality of a non-system further discourages the patient into an eventual acceptance of a role as "an outsider".

The following conditions are of unquestioned value in promoting mental health. They constitute the basic components of an effective program.

1) A continuum of housing with proper supervision and support.

2) A constructive day activity (low-stress job, or training, or a supportive day program.)

3) Medical care

4) Crisis intervention

5) A social network

6) Income

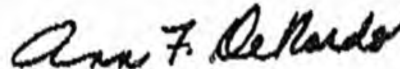
7) A core service agency that takes the ultimate responsibility when any of these six components fall apart or when the client has a relapse or disappears from sight.

We view the Greater Fairbanks Community Hospital Foundation's proposal as addressing the need for a core service agency. It should do what parents typically do until they die: be the place where the buck stops; the place that assumes full responsibility when anything goes wrong. It is not a 9 to 5 job. It would mean that once a client comes into their system, the agency retains life-long responsibility for that client. Alumni groups would assure that ex-residents could come back for varying levels of support. Follow-up outreach should be created including, when necessary, a mobile treatment team that carries treatment to the client wherever he/she is.

We would look for the core service agency to work much more closely with families which now are performing the core service role. An effective volunteer program would draw from the community, thus integrating and educating the two communities (facility and public).

With accountability and monitoring procedures built into its program, we view the proposal of the Fairbanks Community Hospital Foundation as a commitment to this ultimate responsibility to the long-term living problems and rehabilitation possibilities of our chronically mentally ill citizens.

Sincerely,



A..n F. DeNardo
Chairperson, FAMI

northern alaska health resources association, inc.

March 03, 1984

Mark Boyer, Aide
c/o The Honorable Bettye Fahrenkamp
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Mark:

In accordance with your request, attached is a copy of the material that we have pieced together regarding mental health service needs for the northern region. Although necessarily a very hastily constructed report, the paper represents the consensus of the majority of the mental health service providers in Fairbanks.

You will notice that the proposed service components are somewhat different from those originally outlined by Fairbanks Memorial Hospital. The experience of the providers indicated that this shift is appropriate. The bed needs by component also reflect the experience and expertise of the service providers, as well as their philosophy of normalization and appropriate treatment modalities.

We are all eager to see appropriate service development in the northern region of the nature outlined here. Everyone has basically three overriding concerns:

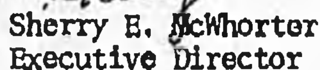
1. That services be developed which fit the needs of the people within acceptable treatment modalities and milieus and which do not create an "over-bedded" situation.

2. That maximum coordination occur with existing community programs and facilities to heighten quality and continuity of care while saving operating costs.

3. That the State ensure that long-range operating funds will be available to allow high staff-to-client ratios and other provisions essential to true treatment and rehabilitation (as opposed to custodial) services.

Please call if we can be of further assistance.

Sincerely,



Sherry E. McWhorter
Executive Director

SEM:flr

Enclosure

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

MENTAL HEALTH TREATMENT NEEDS

I. APPROPRIATE/NECESSARY COMPONENTS FOR THE NORTHERN REGION

A. Children and youth

1. Child guidance center, including family therapy, with inpatient short-term diagnostic capabilities.

2. Acute care/short-stay beds for children (short-stay for children is defined as four months or less).

3. Adolescent residential treatment unit(s).

4. Adolescent transitional care (structured group home).

5. Respite care capabilities.

B. Adults (chronically mentally ill)

1. Transitional supervised care (apartment-type and group home settings), with counseling and rehabilitation services. (Some of these adults may need day treatment and/or sheltered workshop services.)

2. Custodial long-term care with close supervision, medications monitoring, and sheltered workshop.

3. Outpatient services, day treatment, crisis intervention.

4. Respite care capabilities.

II. UNDERLYING PREMISES

A. To be effective, the facilities must include well-qualified, well-paid staff with high staff-to-client ratios.

B. Group homes, apartments, and other transitional facilities must be physically separated from any inpatient facility, ideally scattered throughout the community.

C. The bill (SB 520) or other appropriate mechanism should require the State to develop standards and regulations concerning types and ratios of staff, quality of care, etc. Regulations should include provisions for a broad-based community board and for close interactions with community-based service providers.

D. Residential services for children and youth must include provisions for schooling and must involve the Fairbanks North Star Borough School District in planning.

E. Residential facilities for all age groups should include provisions for recreation; however, the programs should not duplicate major community facilities but rather should make maximum use of these facilities (e.g., swimming pools, ice rinks, ball fields, etc.).

F. Adults, children, and youth should be physically separated from each other.

G. Acute inpatient services for adults should continue to be housed within Fairbanks Memorial Hospital proper (a 20-bed unit is now under construction in the new tower to replace the existing 11-bed unit.

H. Operating costs are a major concern. Some provision must be made by the State to cover these costs.

III. PERSONS WHO MIGHT RECEIVE SERVICES AT THE PROPOSED CENTER

A. Chronically mentally ill adults - persons aged 18 and over with a history of repeated admissions to Alaska Psychiatric Institute or other inpatient settings and who are unable to cope effectively with normal activities of daily living without some degree of supervision because of psychiatric disturbance.

B. Psychotic children and youth.

C. Children and adolescents with severe behavior disorders.

D. Children and youth with severe symptoms who are in need of diagnostic assessments.

IV. BED NEEDS BY TYPE

A. Children and youth

1. Child guidance center - beds for diagnostic stays and respite care - 5-bed unit.

2. Pre-adolescent structured group home or residential treatment unit - 5 beds.

3. Adolescent facility - 15 beds needed; arrangement of structured group home/residential treatment units to be determined.

Total - 25 beds, sufficient for average annual occupancy not to exceed 80% through 1990.

B. Chronically mentally ill adults

1. Chronic, custodial care unit with respite care capabilities - 12 beds (assuming 2 reserved for respite care).

2. Transitional care -
   supervised group homes - 2 6-bed cottages
   supervised apartments - 20 2-bed apartments.

3. Acute hospital unit - to be taken care of through Fairbanks Memorial Hospital's 20-bed unit which is under construction in the new tower.

Total - 64 beds, sufficient for occupancy not to exceed 80% by 1990.

Note: This figure assumes close-out of a separate apartment program by the Fairbanks Community Mental Health Center.

V. RESIDENTIAL FACILITY/TREATMENT BEDS ALREADY IN NORTHERN ALASKA

A. Fairbanks Community Mental Health Center Apartment Program - 8 beds

B. Presbyterian Hospitality House - 24 beds

C. North Star Children's Home, Dot Lake - 8 beds

D. Kotzebue Youth Group Home - 8 beds

E. Fairbanks Memorial Hospital Psychiatric Unit (under construction) - 20 beds

F. Fairbanks Youth Facility Detention Center - 8 beds

G. Fairbanks Youth Facility Treatment Program - 12 beds

VI. AGENCIES/ORGANIZATIONS WHO SHOULD BE INVOLVED IN PLANNING

A. Fairbanks Community Mental Health Center.

B. Tanana Chiefs Mental Health Program.

C. Fairbanks Memorial Hospital.

D. Fairbanks Rehabilitation Association.

E. Women in Crisis - Counseling and Assistance.

F. Resource Center for Parents and Children.

G. Fairbanks Counseling and Adoption.

H. Governor's Council for the Handicapped and Gifted.

I. Northern Alaska Health Resources Association.

J. Private psychiatrists and psychologists.

K. University of Alaska Health and Counseling Center.

L. Alaska Native Health Center, Fairbanks.

M. Presbyterian Hospitality House.

N. Fairbanks North Star Borough School District.

O. Fairbanks Youth Facility Detention Center and Treatment Center.

P. Juvenile Probation Office, Fourth Judicial District.

Q. Fairbanks Health Center.

R. Alaska Division of Family and Youth Services, Northern Region.

S. Alaska Division of Mental Health and Developmental Disabilities, Northern Region.

T. Family Focus/Fairbanks Native Association.

U. Fairbanks Alliance for the Mentally Ill.

V. Fairbanks Crisis Line.

W. Fairbanks North Star Borough Department of Parks and Recreation.

X. Maniilaq Association.

Y. North Slope Borough Health and Social Services Agency.

Z. McGrath-Anvik Community and Family Services.

AA. Upper Yukon Behavioral Health, Fort Yukon.

BB. Tok Area Mental Health Center.

CC. Yukon Tanana Mental Health Program, Tanana.

DD. Yukon Koyukuk Mental Health Program, Galena.

POSITION PAPER

Senate Bill 520

"An Act relating to the establishment of a statewide mental health rehabilitation center; and providing for an effective date."

The apparent purpose of Senate Bill 520 is to create the statutory authority for a state-funded and state-operated residential facility for chronically mentally ill adults and children that require a variety of on-going social, educational, vocational, and health services in order to prevent their involuntary hospitalization at Alaska Psychiatric Institute as a result of recurring episodes of acute mental illness. This purpose is certainly commendable and is supported by the Division of Mental Health and Developmental Disabilities in the Department of Health and Social Services.

In developing the position of the Department of Health and Social Services on this bill, it has been necessary to examine its impact on the two categories of targeted patients separately as it is not programmatically possible to mix mentally ill adults with emotionally disturbed children in a way that will prove successful. The first section will be about adult residential care for the chronically mentally ill adult who requires residential care in order to remain free from the need of involuntary psychiatric hospitalization at the Alaska Psychiatric Institute. The second section in this position paper will be about the need for acute/chronic child or adolescent residential care for the emotionally disturbed, conduct disordered, substance abusing, or acting-out juvenile who is either in the custody of the Division of Family and Youth Services as a child in need of aid, or a delinquent child, or at risk of being in their custody as a result of these behaviors These must be considered separately for purposes of understanding Sena[illegible] Bill 520 and its potential effects on the Department of Health and Social Services.

Adult Residential Care

The adult residential care component of this proposal for a statewide mental health rehabilitation center is envisioned as a non-acute care facility for the chronically mentally ill adult who would benefit from out-of-home residential care and treatment. This is seen as a resource that would improve the quality of life for this group of persons, as well as possibly reducing the need for their periodic involuntary hospitalization at Alaska Psychiatric Institute as a result of episodes of acute psychiatric illness.

This may be especially effective if the statutes relating to involuntary outpatient commitment under A.S 47.30.655-915 can be modified to make them more compatible with the need for a reduced standard of dangerousness to self or others for outpatient commitment of the mentally ill. Our experience has shown that by using the same standard for involuntary inpatient and outpatient commitment of the mentally ill, it is not practical to expect a community based, non-secure program to be able to accept and effectively treat the mentally ill persons under involuntary conditions. Frankly, they are simply

too sick to be able to cooperate with their treatment plan in an outpatient setting and present too great a risk of harm to themselves or others under the standard of dangerousness required for involuntary commitment.

By reducing the standard for involuntary outpatient commitment it would be possible to commit certain patients to this facility for residential care and treatment in an environment that is less restrictive than Alaska Psychiatric Institute.

In providing services for the chronically mental ill patient, the degree of illness and resulting danger to self or others varies over time. The amount and type of treatment that we are able to make available to these persons depends on the nature and extent of our statutory authority and the availability of our resources. The greater our ability to monitor and control the behaviors of these patients, the greater the chance of preventing episodes of acute distress and hospitalization.

Additionally, the facility will be available as a residential care center for the chronic mentally ill that voluntarily seeks placement. Such a facility as described in Senate Bill 520 would be capable of providing a comprehensive system of care, treatment, education, and training on a long term basis.

The concept of "community support systems" or "community case management" for the chronic patients is known to be an effective method of serving these patients. This bill would help to fill the extensive gap in that service system and will result in a greatly improved quality of life for the chronic mentally ill person and his family.

Acute/Chronic Child or Adolescent-Residential Care

The facility for the emotionally disturbed children and adolescents would have to be completely separate from the adult residential facility housing the chronically mentally ill. The facility for children and adolescents should be divided into two units. The first should be a short-term unit that would provide intensive mental health care for the acutely mentally ill child or adolescent. The second unit should be a residential or longer-term unit for those emotionally disturbed children and adolescents who require a supervised residential/educational program in a structured setting.

The children and adolescents referred to these programs may be in the custody of the Division of Family and Youth Services as a child in need of aid or a delinquent child or they may be referred by their parents or guardian or some other agency such as a school district or court if the youth is involuntarily committed.

The long-term residential capacity of this facility will allow the approximately 40 children and adolescents currently in out-of-state facilities to be returned to Alaska for continued residential care and treatment closer to home. These children and adolescents have been sent out-of-state by the Department of Education for special education purposes and the Division of Family and Youth Services as delinquent children or children in need of aid. Most of these children are suffering from emotional disturbance and

require specialized resources for their care. They would be provided at this facility.

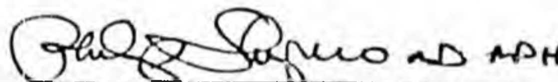
The following description of these children and their treatment is excepted from the "Management and Treatment Philosophy on the Adolescent Unit" at Alaska Psychiatric Institute:

> "Essentially, conduct disorder refers to youth who are acting out in a profound manner. The ordinary healthy and expected rebelliousness of adolescent years has turned to a severity that is obviously dangerous and inherently self and other destructive. The parents and family have lost control of their conduct disordered child in a major and agonizing way. Depression, anger, guilt, and fear have been released and are running rampant in the hearts of both child and parent. Such youngsters are generally using drugs and or alcohol, involved in sexual promiscuity, running away, and criminal behaviors. They are aggressive, violent, angry, frequently assaultive or homicidal, depressed and possibly suicidal. Some are living in the streets. Some are engaged in prostitution or pornography. Sexual molesting and fire setting behaviors are occasionally part of the picture.
>
> Since most of these children are utilizing the defenses of projection, denial, and blaming, and are therefore unable to admit themselves to the hospital on a voluntary basis, the Alaska State mental health commitment law must be instituted in order for the hospital staff to be given the right to contain these youths in a locked setting-a critical component in their care in the initial stages of treatment since running escapist behavior is a keystone of this syndrome. Since these children are either homicidal, suicidal, or gravely disabled or some combination of these, it is not difficult to get a commitment. Nor is it difficult to convince a judge that the child's life was in grave danger, that the parent's had lost control, and that the hospital would serve the purpose of temporary parent until the patient had obtained sufficient self knowledge to regain control and therefore security and safety. Indeed, inpatient treatment for behaviorally disordered teenagers represents one of society's last lines of defense against repeated failures of the community to hold youngsters long and safely enough until they can achieve mastery over the conflicts which beset them. Often, children arrive after having lost their place at home, in school, in group and foster care, and their

choices are limited to hospital, jail, or streets. The first step then in the successful treatment of severe conduct disorder is to confine and contain the child behind a closed locked door. This serves to emphasize to the child and family that the individual is sick and is now a patient in a hospital as with any other severe life threatening illness. This is an important symbolic statement for the physician and treatment team to make as it may not be apparent to the family and patient that conduct disorder or extreme acting out is an illness and that it has a definitive treatment. In the initial interview the child is confronted with this in a clear manner not only with the and patient status in a hospital but with a verbal statement form the treatment team. The patients are told that they are ill, that the illness is severe, and that it is life threatening.

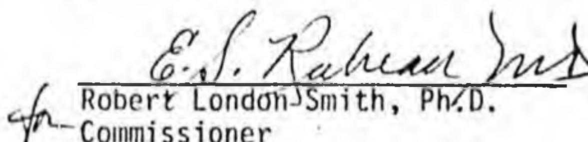
As can be seen from the description noted above, this is a group of disturbed young people that is extremely difficult to manage and treat. This is further complicated if the child or adolescent is not in the legal custody of the Department of Health and Social Services with a court order that authorizes institutional placement. In order for this facility to provide appropriate inpatient and residential care and treatment for periods longer than the 2. days currently allowed under the existing statute on a voluntary basis (A.S. 47.30.690), the law will have to be amended to permit voluntary admission on a longer term basis.

The Department of Health and Social Services supports the passage of Senate Bill 520 with the above noted recommendations.

Recommended by: 

Philip Shapiro, M.D., Director
Division of Mental Health and
Developmental Disabilities

Date: ______________________

Approved by: 

for Robert London-Smith, Ph.D.
Commissioner

Date: March 30, 1984

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 520-521 Mental Health Rehabilitation DATE April 11, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
E. S. RABEAU	HoSS	AOB Pouch H-01	3030
John Page	HSS		
Bill McGuire	DOE		

PROFILES OF THE CHILDREN AND YOUTH
PRESENTLY RESIDING IN RESIDENTIAL CARE FACILITIES
OUTSIDE OF ALASKA

March 16, 1984

Male, 17 years - in custody for six years; abandonment by parents; placement in Alaska failed; character disorder, poor behavioral controls; school unable to control; aggressive and sexual acting out towards women.

Male, 15 years - long history of residential treatment; conduct disorder, unsocialized aggressive; attention deficit disorder with hyperactivity; mixed specific developmental disorder; mild mental retardation.

Male, 18 years - delinquent; substance abuser; diagnosed psychotic and requires medication to maintain stability; bizarre ideation.

Male, 12 years - foster and residential care in Alaska were unable to handle his problems. Hyperactive, injurious to self; bed-wetting; destruction of property; stealing; lying; cruelty to animals; sexual acting out.

Female, 15 years - major seizure disorder; mild mental retardation; nonaggressive conduct disorder, characterized by chronic running away and extremely poor judgment.

Female, 12 years - from a family where adult males were alcoholic and violent; sexually abused by grandfather; developed a pattern of lying, stealing, acting out sexually and self-destructive behavior.

Female, 13 years - six failed foster placements in a year and a half; problems with lying, stealing, fire-setting; chronic runaway; inability to relate to peers or adults.

Female, 17 years - sexually abused by father; chronic runaway; sexually acting out; suicide and homicide threats.

Female, 14 years - two institutions in Alaska failed in making any changes; sexual abuse by stepfather; lying; stealing; troubled peer relationships; physically and verbally threatening; depressive; running away.

Female, 17 years - delinquent, in McLaughlin for 11 months; out of control; alcohol abuse; truant; rebellious; conduct disorder; self-mutilation.

Female, 17 years - physically and verbally assaultive; extreme oppositionalism; stealing; chronic runaway; lying; very poor interpersonal relationships.

Female, 17 years - failed in two Alaska residential placements and in foster home; pathological lying regarding sexual abuse; multiple runaways; severe alcoholism; hostility to authority; acute anxiety and suicidal feelings.

Female, 13 years - sexually molested by father; had two residential placements and four foster home placements in Alaska; uncontrolled behavior; fighting; stealing; running; physical assaults on peers and a suicide attempt.

Male, 15 years - stealing; verbal threats of harm; suicide attempts; chronic runaway; drug abuse; conduct disorder.

Female, 13 years, sister to above - sexually abused by father; drug and alcohol abuse; chronic runaway; sexual acting out.

Male, 15 years - delinquent; theft; tortured a five year old girl with cerebral palsy; pre-psychotic.

Male, 15 years - violent, uncontrolled rages; destruction of property; drug and alcohol abuse; stealing.

Male, 16 years - delinquent; criminal mischief and burglary; emotionally disturbed; chronic substance abuser of gasoline, marijuana and alcohol; assaultive behavior.

Male, 15 years - runaway; fire setter; damaged property; drugs; sexual molestation of young children.

Male, 9 years - violent destructive behavior (destroying property, furniture, defacing walls); incontinent; attacking animals; fighting with other children.

Male, 8 years - fire setting; runaway; stealing; assaultive; hyperactive; probably brain damaged.

Male, 16 years - sexual acting out; stealing; fire setting; danger to others.

Male, 17 years - sexually abused by stepfather; running away; suicide attempts; drug and alcohol abuse.

The Greater Fairbanks
Community Hospital Foundation
POST OFFICE BOX 1396
FAIRBANKS, ALASKA 99707

April 3, 1984

Dear Senator Fahrenkamp:

Enclosed you will find a proposal which we are submitting for development and implementation of a total continum of psychiatric care facilities for the interior of Alaska. The first portion of the proposal deals with an adult facility while the second portion of the proposal deals with a separate youth facility. The total cost of the two separate facilities is $29,891,000.

It is the Greater Fairbanks Community Hospital Foundation's belief that it is totally inappropriate to combine youth and adult psychiatric care into one facility. Psychiatric care is a specialized medical science which deals with a number of different diagnostic categories. In attempting to combine those categories seen in adult patients with those categories seen in youth patients, we believe it is very inappropriate from a patient standpoint. If one looks at model psychiatric facilities throughout the country, they would find that youth psychiatric care is separated from adult psychiatric care because of the different needs presented by each group. We also believe that free-standing adult facilities with inpatient, outpatient, day treatment, apartment living and chronic care can financially stand on its own while a youth facility cannot from an operations standpoint and will have to be funded directly on an ongoing basis by the State of Alaska in order to maintain its operating viability. This operating viability will be discussed further under the youth facility.

We request your serious consideration of this proposal.

Sincerely,

The Greater Fairbanks Community
Hospital Foundation

APR 5 1984

PROPOSAL TO DEVELOP

A COMPREHENSIVE MENTAL HEALTH CENTER

FOR INTERIOR ALASKA

Submitted by

The Greater Fairbanks Community Hospital Foundation

Adult Comprehensive Mental Health Center

For many years the interior region of Alaska has been faced with the problems of developing adequate adult mental health facilities as well as coordinating services offered by numerous agencies serving the mentally ill. This proposal will try to identify and meet the needs of interior Alaska residents as well as providing continuity in mental health services offered in the northern region.

At the current time the following adult mental health services are offered in the Fairbanks area by one and/or more agencies: acute care, chronic care, outpatient care, day treatment program and apartment-type living. None of the programs listed above are connected or have continuity between segments.

The Greater Fairbanks Community Hospital Foundation is proposing to build a facility to house all segments of adult mental health care, including acute care, chronic care, outpatient care, day treatment, emergency screening services and apartment living.

Organization

It is proposed that in order for the Foundation to develop such a comprehensive mental health facility that the Foundation would require a grant from the

State of Alaska. The facility constructed would be owned by the Greater Fairbanks Community Hospital Foundation, a community-based organization currently involved in acute and long-term care in the Fairbanks area. The Foundation would sign a management contract with the Lutheran Hospitals and Homes Society, which currently manages both Fairbanks Memorial Hospital and Denali Center. The Lutheran Hospitals and Homes Society would be responsible to provide the accounting, administration, housekeeping, dietary, laundry and maintenance services for the facility while at the same time hiring a physician/director. The physician/director would be responsible for the adult acute and chronic care performed in the facility. The physician/director would also be a liaison for adult outpatient services offered by the Fairbanks Community Mental Health Center and other agencies which would lease space in the facility.

The purpose of the facility would be to draw together all agencies offering mental health services to interior residents so that a total, comprehensive approach could be taken towards treatment of residents regardless of whether it be acute care, chronic care, outpatient, day treatment or apartment living.

It is expected that once the facility is built Fairbanks Memorial Hospital will give up adult acute mental health care and will move such services to the new facility. It is also expected that Denali Center, which is currently performing adult chronic mental health services, will give up those services and will move those patients to the new center. By accomplishing these transfers, it will relieve both Fairbanks Memorial Hospital and Denali Center of acute overcrowding in addition to providing better services to mental health

patients through a coordination of efforts under one roof.

Organizations such as the Community Mental Health Center, Tanana Chiefs Mental Health Services and other agencies which would participate in the facility would retain their own identity and would only lease space in the facility in order to work towards a goal of developing the continuity of care throughout the system.

The Greater Fairbanks Community Hospital Foundation and the Lutheran Hospitals and Homes Society would attempt to help facilitate the agencies located in community by working closely together for program continuity. It is projected that the facility would be configured in the following manner: (a) 20 acute care psychiatric beds; (b) 20 chronic care psychiatric beds; (c) 20 apartments and (d) 20,000 square feet of outpatient day program space.

Capital Funding

The best alternative for funding this project would be through a direct state grant of approximately $16,533,000. Listed below you will find a construction cost breakdown for the facility by area. At the present time it is projected that 20 acute care beds will require approximately 20,000 square feet and 20 chronic care beds will require approximately 15,000 square feet. It is our understanding that both the acute and chronic units will be required to be built to somewhat higher standards than the remaining parts of the facility. This should not be a significant problem since the facilities can be connected by corridors and/or walkways. It is expected the cost of building the acute and chronic care areas will be approximately $275 per square foot. In providing for 20,000 square feet of outpatient services,

we are projecting a cost of approximately $130 per square foot and for the apartments we are projecting a square footage of 600 feet per apartment, or a total of 12,000 square feet. Again, it is estimated the apartment cost will be $130 per square foot.

Program Description	Square Feet Required	Cost Per Sq. Ft.	Total Cost
20 Acute Care Beds	20,000	$275	$ 5,500,000
20 Chronic Beds	15,000	275	4,125,000
Outpatient Services	20,000	130	2,600,000
36 Apartments	21,600	130	2,808,000
Equipment and Furniture			1,500,000
Total	76,600		$16,533,000

As listed above, the total cost of the facility, including equipment and furniture, will be $16,533,000. It is projected in order to receive authorization from the State of Alaska to build such a facility, a certificate of need will be required. This has not been accomplished to date and will only be submitted should possible funding be received.

Operational Funding

The ongoing operational expenses of the facility would be funded from the following revenues:

a. Adult acute care would be funded directly through private patient billings, third party billing or government agency billings for the services rendered.

b. Adult chronic care would again be funded through patient billings, third-party billings and government billings.

c. It is expected the apartment living would be funded through

renting apartments to prospective clients for a fixed rate per month.

d. The outpatient space would be leased out to different community agencies interested in obtaining space in an adult comprehensive mental health center. These agencies would include the Community Mental Health Center, the Tanana Chiefs Mental Health Center, Vocational Rehabilitation, Fairbanks Rehabilitation, Crisis Line, Adult Protective Services and the Resource Center for Parents and Children.

It is projected that through these different operational funding mechanisms the facility would break even given the fact that no debt service would be required on the building.

Children and Adolescent Guidance Center

The Foundation's proposal to develop a separate youth mental health facility primarily comes from the lack of in-state resources for children and adolescents to receive appropriate care. Alaska has historically placed a significant number of children in residential facilities outside of the state. In a report prepared by Criminal Justice Planning Agency in July of 1981, it was noted that prior to 1979 the number of children placed in residential facilities outside of the state numbered nearly 100. Since then there has been a concerted effort to limit out of state placement. However, no new facilities have been developed to care for these children in state.

The majority of Alaska children who are placed in out of state programs have been categorized as severely emotionally disturbed. As of 1981 there were 39 residential facilities in the state; however, only two of those 39 accepted and provided treatment for children who had been diagnosed as severely emotionally disturbed. It is projected that the need for children and adolescents will continue to grow.

Organization

The Greater Fairbanks Community Hospital Foundation is proposing to develop a children and adolescent guidance center. In order to develop such a center the Hospital Foundation would require a grant from the State of Alaska. It is proposed the facility would be owned by the Greater Fairbanks Community Hospital Foundation, which currently is involved in the hospital and long-term care in the Fairbanks area. The Foundation would then have a management contract with the Lutheran Hospitals and Homes Society to provide the

administration, accounting, housekeeping, laundry, dietary and maintenance services for the facility. In addition, a director for the facility would be hired. The director would be responsible for all treatment occurring in the facility. It is imagined that the Foundation would recruit a physician/director who has extensive experience in the treatment of emotionally disturbed children and adolescents.

The pur[illegible] of the facility would be to draw all of the youth services together and [illegible]ovide them in a setting which would be conducive for the treatment of the youth in the interior of Alaska. It is expected the patients who are currently treated at Fairbanks Memorial, Denali Center and other places in the state such as API will be possible candidates for this center as well as Alaska residents who are currently being treated out of the state. We believe in order for this center to be successful, it will have to include office space and treatment space for other organizations which deal with emotionally disturbed youth in the community at the present time. Again, it is expected these organizations would retain their identity and would only lease space in the facility. It is projected these agencies would be combined under one roof in order to work towards a more uniform goal in continuity of care for children and adolescents.

It is projected the following services would be included in the facility: five evaluation acute psychiatric beds, ten acute children psychiatric beds and ten adolescent psychiatric beds. The total square footage would amount to approximately 20,000 square feet at $275 per square foot or approximately $5,500,000. Thirty residential beds would be provided with a square footage estimate of 15,000 square feet at $200 per square feet or $3 million. Also

outpatient day treatment and other services would be provided through lease of office space, with approximately 17,000 square feet available at $130 per square foot or a total of $2,210,000. In addition, approximately 12 group homes or apartments would be provided for adolescents under close supervision at approximately 800 square feet per apartment. This would total 9,600 square feet at $130 per square foot or $1,248,000. The total equipment for the facility, including furniture, would approximate $1,400,000 or a total for the facility of $13,358,000.

	Square Feet	Cost Per Sq. Ft.	Total Cost
Children and Adolescent Guidance Center			
Acute			
5 Evaluation)			
10 Children Treatment Beds)	20,000	$275	$ 5,500,000
10 Adolescent Treatment Beds)			
Residential Beds (30 beds)	15,000	200	3,000,000
Outpatient/Day Treatment	17,000	130	2,210,000
Group Homes (12 Apartments)	9,600	130	1,248,000
Equipment and Furniture			1,400,000
Total			$13,358,000

It is again projected that in order to receive authorization from the State of Alaska to build such a facility, a certificate of need will be required. This has not been accomplished to date and will only be submitted should possible funding be received.

Operational Funding

The operational expenses of this facility would be primarily funded from a grant from the State of Alaska on an annual basis. Only the following services will be self-funded: (a) space leased to nonprofit agencies in

the community which would be combining their talents to provide a continum of care; (b) acute treatment services which would be reimbursed through third-party insurance and Medicaid; (c) the remaining residential beds, outpatient day treatment and group homes would require funding from the state.

****

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

****

APRIL 11, 1984______:DATE
FAIRBANKS___________:SITE/LOCATION
SENATE H.E.S.S. CMTE________________:SPONSOR/SUBJECT
"SB520 & 521" MENTAL HEALTH REHAB CENTER

TESTIFIED/PARTICIPATED:

1. TOM MINGEN, FBX HOSPITAL FOUNDATION, 1650 COWLES, FBX AK 99701 #456-2283
2. SHERRY MCWHORTER, NO AK HEALTH RESOURCES ASSOC, 529 5TH AVE, FBX 99701 #456-2553
3. KATE CORY BAKER, 21 MI. RICH HWY, BOX 55459, NO.POLE,AK,99705 #488-2455
4. NORMA LARSEN, SR BOX 20062, FBX 99701 #479-6958
5. [illegible] SIRE, ARCTIC ALLIANCE, PO BOX 74711, FBX 99707 #479-7341
6. ALICE SIBBITT, F.N.S.B.SCHOOL, SPEC.ED, PO BOX 1267, FBX 99707 #452-2000
7. RUTH LISTER, WICCA, 702 10TH AVE, FBX AK 99701 #452-2293
8. LESLEY SALISBURY, BOX 90033, COLLEGE, AK 99708 #479-6449
9. DIANA CAMPBELL, 1215 KENNICOTT, FBX AK 99701 #456-2914
10. PAULINE BENNET, O.T.R., 3605 ARCTIC BLVD, ANC, AK 99503 #456-6127
11. MARTI GRANOR, FBX C.M.H.C., 209 FORTY MILE AVE, FBX 99701 #452-1575
12. D.J. STALEY, FBX CRISIS CLINIC FOUNDATION, PO BOX 832, FBX 99707 #479-0166
13. KATHY WHITTELL, FBX MEM HOSP, 1650 COWLES, FBX 99701 #452-8181
14. BLANCHE PRUNK, R.C.P.C., 807 COLLEGE, AK 99701 #456-2966
15. PHYLIS VANATERSDALE, 141 STEELHEAD, FBX 99701 #479-3271
16. MARION WUSROW, PO BOX 60773, FBX 99701 #452-7603
17. GUY PATTERSON, FAMILY FOCUS, 1531 GILLAM, FBX 99701 #452-3733
18. ANN DENARDO, SR BOX 30754, FBX 99701 #452-3733

OBSERVED:

1. MARTHA SCHNEIDER, AK CHAPTER, NAT'L ASSOC. OF SOCIAL WORKERS, PO BOX 10430, FBX AK 99710 #456-5914
2. AL AARON, [illegible] MEMBER, PO BOX 74132, FBX 99701 #--
3. PATTY CASTILLO, 4020 ANDERSON RD, FBX 99701 #479-5744
4. [illegible] WHITE, 115 NO CUSHMAN, FBX 99701 #456-4918
5. COLLEEN BOHEN, 1512 3RD AVE, FBX 99701 #452-8644
6. MADELINE FAGAN, 2415 WILSON, FBX 99701 #488-3133
7. [illegible], 555 21ST AVE #1, FBX 99701 #452-1229
8. [illegible] ERVIN, SR BOX 10359-A, FBX AK 99701 #479-6196
9. [illegible] SPINK, FBX MEMORIAL HOSP, 1650 COWLES, FBX 99701 #452-8181
10. RALPH MATHEWS, SR BOX 40575, FBX 99701 #--
11. TERRI LYNN COLEMAN, 914 COLLEGE RD, FBX 99701 #452-6177
12. MARY MATHIS, SR BOX 70660, FBX AK 99701 #488-6647
13. DANIEL MATHIS, SR BOX 70660, FBX 99701 #488-6647
14. MRS. ROSE HOLLAND, SR BOX 40282-A, FBX 99701 #456-7599
15. RUSS CUSACK, 575 7TH AVE, FBX 99701 #452-8191
16. LAWRENCE A. ROBLES, 9 MI STEESE, FBX 99701 #456-2276
17. JEANETTE GRASTO, SR BOX 20603, FBX 99701 #455-6212
18. DAVE MATHE, 201 FIRST AVE, FBX 99701 #452-2446
19. TOM MOYER, CRISIS LINE, PO BOX 832, FBX AK 99707 #452-3733

_____STATS_____

18____TESTIFY/ED *****T/C STARTED:________
19____OBSERVE/ED *****T/C ENDED:________
37____TOTAL

HEALY VOLUNTEER SITE:

OBSERVED:

1. MARY VAN BLASCOM, RAILBELT MENTAL HEALTH ASSOC, PO BOX 2, HEALY AK #683-2442
2. WALT DURHAM, , PO BOX 313, HEALY, AK #683-[illegible]
3. SHELLEY USIBELLI, FBX COMMUNITY MENTAL HEALTH, POUCH [illegible], HEALY, AK 997[illegible]
4. RAYMOND GANG, RAILBELT MENTAL HEALTH, BOX 41, HEALY 99743 #683-2651
5. B. MACFARLANE, AK COURT SYSTEM, BOX 12, HEALY, AK 99743 #683-2213

-...TESTIFIED
5...OBSERVED
5...TOTAL

Jn. Anderson
Charlotte Thickstum testified

==EOM

Healy   To observe   Dissent in FDX.

Mary Van Blarcom   Walt Durham

Shelly Usibelli

Andersen   Eileen

To speak

~~Charlotte Thickstun~~

SOURCE: From Dependence to Independence, Western Interstate Commission on Higher Education, March 1981.

3. NEEDS OF THE CHRONICALLY MENTALLY ILL ADULT: IMPLICATIONS FOR MENTAL HEALTH SERVICES

by

JAMES H. WATERS, Ph.D.
Director, Intensive Treatment Team
Mental Health Center of Boulder County, Inc.

Editor's Preface: The author identifies the basic needs of the adult mentally ill and the psychological deficits which interfere with satisfaction of these needs. Skills and functions of key staff and the necessity for a multidisciplinary team approach to respond adequately to the multiple and divergent needs of the CMI are highlighted.

A thorough analysis of service needs for the adult mentally ill must begin with the awareness that, like the general population, the mentally ill need food, shelter, clothing, money, friends, transportation, medical care, education and recreation (2, 19). As adults, they must be able either independently to obtain these needs or in some way to arrange for others to provide these to them.

FUNDAMENTAL DEFICITS OF THE CHRONICALLY MENTALLY DISABLED

Mental illness characteristically results in a great vulnerability to decompensation under stress to a psychotic state, with severely disturbed thinking, mood and behavior (17, 19). In addition, however, and usually persisting beyond the episode of actual psychosis, serious psychological deficits are found in this population; these deficits markedly impair the abilities of such patients to meet their basic needs or to arrange for others to help them meet them. These deficits can be grouped into five general categories.

Attitudinal and motivational factors

In this population, decreased drive, impersistence and passivity are common, as are dependence (due to a perception of self as helpless (17)),

and resistiveness. Many who are experienced in the care of the adult mentally ill (1, 3, 18, 21) consider such features to be just as much basic characteristics of chronic mental illness, especially schizophrenia, as periods of psychosis. These traits result in a marked withdrawal from and inability to engage society. They also lead to tremendous frustration on the part of society's caregivers and the client's family.

Problems with judgment and impulse control

Reduced ego strength is reflected in imprudence and in impulsive "acting out." Commission of minor "crimes" and social transgressions may lead to contact with the legal system (including incarceration), to social and community rejection, and to the client's wasting of his already scarce resources (especially money) (19, 20, 21).

Impaired social skills

Client's in this population have weak ego boundaries and poor object relations and poor defenses to handle anger, anxiety, sexuality, and losses (3). Impaired empathy is characteristic. Also, these clients have chronic social anxiety (21). These psychological problems lead to marked social skill deficits resulting in social withdrawal or poor social integration, difficulty establishing close personal ties (17) and lack of a stable, enduring social support system (21).

Difficulty obtaining work, poor vocational adjustment, and poor job performance

These patients not only have poor work histories due to interruption of jobs as a result of psychotic decompensation under the stress of work, but they also often have deficits in or inadequate learning of job skills, poor work habits (slowness, especially), and have minimum job-seeking skills. Problems in the vocational sphere, because of our society's emphasis on the work ethic, lead to poor self-esteem and ostracism, to poverty, and to dependence on the (usually inadequate) welfare and disability payment systems.

Severe deficits in, and a limited repertoire of, everyday instrumental or coping skills

Many experts feel it is these deficits, and not psychotic symptoms or episodes *per se*, that lead either to institutionalization or to poor quality of life outside institutions (2, 6, 18). Problems with grooming, hygiene, health care, house cleaning and maintenance, shopping, budgeting, use of the banking system, cooking, and use of public transportation are a few of the crippling deficits frequently observed (6, 17, 18, 19). In addition these clients tend to be concrete in their thinking (17). Thus, learning and

adjustment obtained in one setting may not carry over to a new one when, as is common, the client's place of residence changes, for instance, as a result of hospitalization or incarceration.

Because of the extensiveness of their needs and the severity of their deficits, certain unique problems arise for the chronically mentally ill adult. In our society, financial, medical, legal, and educational services, for example, are each provided by separate agencies. Hence the client who has multiple service needs must approach and negotiate with many different bureaucratic systems. Community assistance is also needed, including support from "significant others" (2). Yet, because of the territoriality and complexity of the bureaucracies (5), the client may find coordinating these care systems very difficult (e.g., coordinating the welfare, medicaid and medical-care systems to get medical treatment). Lack of social skills and social withdrawal lead to difficulty establishing rapport with and enlisting the assistance of caregivers in these agencies. Therapists and caseworkers "burn out" due to the enormity of these clients' needs, to the limited gains observed and the difficulty forming a stable, comfortable alliance. Poor social skills, impaired judgment, and impulsive acting out may lead not just to lack of community acceptance, but to outright rejection, harassment, or scapegoating. In sum, the chronically mentally ill adult is very poorly equipped to survive in our complex, bureaucratic, demanding society.

SERVICE NEEDS IN THE MENTAL HEALTH SYSTEM

Comprehensive and effective service to the chronically mentally ill adult in the community requires a complex, sophisticated, extensive (and expensive) service delivery network. In what follows, I will outline some essential characteristics of such a network, using the assumption that it would be based in a comprehensive community mental health center. The components of the system can be roughly sorted into three categories: direct psychiatric interventions and psychosocial rehabilitation, case management and consultation, and administrative support. Again, there is some overlap of functions and characteristics between categories. After discussion of the components, some brief comments about the overall structure will follow.

PSYCHIATRIC INTERVENTION AND PSYCHOSOCIAL REHABILITATION

Psychiatric treatment of the chronically mentally disabled adult is supportive and rehabilitative. To this date there is no widely accepted, coherent theory explaining the etiology of schizophrenia or manic depressive illness, nor do we know how to "cure" these illnesses (1, 2, 17). We only know how to improve the symptoms and functioning of those suffering from these conditions. Appropriate goals of psychiatric treatment of the chronically mentally ill include helping the client achieve control over his situation and a feeling of mastery, i.e., symptom control, increased coping and instrumental skills, organization of life, increased responsibility and independence (1, 2, 5, 7, 17, 18).

ASSESSMENT

The treatment process begins with a good assessment. This includes not just formal diagnosis (required for administration of medication (4, 15, 24) and for establishing eligibility for social services assistance (11)); it also includes identification of strengths and weaknesses in the social and instrumental skills areas mentioned above (18).

Psychiatrists and nurses in this setting must be expert in psychopharmacological intervention. The psychochemical armamentarium now includes antipsychotics, anti-depressants, lithium, and stimulants (23). Recent research, however, indicatesthat discretion in the use of medications is essential because in some cases they may not only be unnecessary but even harmful (4, 13, 14, 15). Detection and management of side effects and of long-term toxicity (e.g., tardive dyskinesia) requires the psychiatrist (and nursing staff) working with the chronically mentally ill adult to be well trained, knowledgeable, and resourceful. They must also update knowledge constantly through reviewing current research and through continuing education. The psychiatrist must also know when and how to use (and when not to use) the hospital (3, 9, 17).

PSYCHOTHERAPY

There is a need for psychotherapy in the treatment of the chronically mentally ill. However, traditional psychotherapy training programs do not prepare therapists well to do the type of work needed. The therapist must understand his clients's pathology and dynamics and realize that the appearance of psychotic symptoms is a result of stress (5, 7, 17, 18). The attitude of the therapist must be hopeful, encouraging and supportive (12, 14, 17, 18, 21). Therapists must be comfortable with clients who are anxious or depressed, and who may show poor control over hostility and sexuality (14, 17, 18, 21). A directive, assertive approach is also necessary to counteract the client's passivity and withdrawal (18). The therapist must not be afraid to give direct advice (5, 7, 18) often thought of as taboo in traditional psychotherapy training. A primary task of the therapist is to support the client's ego functioning and increase reality contact and reality testing (5, 7, 12).

In terms of theoretical outlook, a traditional analytically-oriented approach might be of some value in understanding a client's psychodynamics, but for achieving behavior change a social learning perspective is likely to be more powerful (18, 24). Attention to and intervention in the psychosocial milieu is crucial. The therapist must use principles such as (external) social reinforcement including group support and encouragement, modeling, and coaching to change behavior. Inasmuch as the chronically mentally ill have concrete thinking and learning, interventions will have to be specific and direct. Therapists must be willing to teach basic skills rather than hoping that somehow addressing "underlying" conflicts or illness will result in general, overall improvement.

DIRECT TRAINING

For instance, vocational rehabilitation, which is crucial, requires direct training and skill-building. Clients may start learning work habits and skills in a sheltered workshop. However, as soon as feasible, placement in a regular work setting with special arrangements for continued training, encouragement, and support is advisable. Supervising staff in these placements will need to be familiar with the work to be done themselves so they can assist the clients in performing it (1). Eventually, clients may consolidate their efforts and run a business, reducing the need to work full time, which is often an unrealistic expectation. Special expertise in business management, however, will need to be taught specifically.

Group treatment is useful with this population. Participation in groups increases feelings of affiliation and mutual support, improves social skills and amount of socialization and may increase the likelihood of clients remaining in treatment (4, 13).

In view of the chronicity of deficits in this population, an ongoing, continuous model of treatment is more appropriate than a crisis or episodic model focused on "cure." Many of these clients have a lifelong disability; most follow up studies show that even when a program achieves success in improving clients' psychosocial functioning many of the gains disappear if support and involvement is not continued. Aftercare reduces recidivism (13, 18).

Treatment Settings

Therapists must balance the degree of support provided and dependence allowed against the therapeutic principle of normalization (22). The overall goal in treatment of the chronically mentally ill adult is the decrease of institutionalization (17).

Hospitals

Use of the hospital should be therefore kept to a minimum. Research indicates there is little need for hospitalization if adequate psychosocial alternatives are provided (14, 16). However, clients with organic mental impairment complicating a functional psychosis, or those with medical problems, may need hospitalization. Also, when a closed setting is needed to enforce civil involuntary commitment or to control violent behavior, hospitalization may be needed (3, 17). There is probably a residual population of clients who are not able to be placed out of hospitals due to chronic and severe behavior control deficits (public inappropriate sexuality, self-destructive behavior, aggression) and for these, hospitalization will continue to be needed. Exact numbers are difficult to estimate, but Lamb and Goertzel found fourteen such clients in a catchment area containing half a million people (9).

Use of non-hospital alternatives leads to less need of hospitalization in the future and to better psychosocial functioning. Clients treated without hospitalization are more likely to live independently, to have better jobs and more and better social relationships than matched controls (14, 16, 17).

An effective, responsive crisis intervention program, available twenty-four hours a day, is helpful in reducing need for hospitalization. Also adjustment can take place in the community if crisis work is done on an outreach, home basis, lessening the disruption of social, residential, and vocational ties and overcoming the problem of concreteness of learning (16). Nevertheless, for some clients, placement in a residential treatment facility, especially during psychotic episodes, will be necessary.

Residential Alternatives

Recommendations as to the nature of residential alternatives to inpatient care differ for recovery during acute episodes and for long-term rehabilitation of chronic clients, but in both cases attention to the psychosocial milieu is of paramount importance. Staff should be warm, nurturant, and accepting and convey positive expectations to clients that they will recover and improve (13, 14, 15, 16). For acute clients, however, small size and intensive staffing is important. Staff need to help clients limit their stimulation level. Stays of three to five months can be expected (13).

For long-term improvement chronic clients require a high degree of structure (clear guidelines for conduct, extensive daily plans) and organization and a practical, problem-solving, down-to-earth staff approach. High but realistic expectations for positive, concrete behavior change are important. Even though this may be stressful and the stress may lead at times to some shortlived decompensation and hospitalization, clients given higher expectations will eventually develop better psychosocial functions and will spend less time overall in the hospital (8, 13). A social learning approach is the most useful theoretical framework, and indefinitely long support (although not necessarily long residential placement) is necessary (2, 13, 15, 18). Emphasis on active participation in decision making by staff and clients and on cultivating a sense of autonomy is important (1. 4).

One should encourage "normalization" wherever possible. Clients should be expected to obtain work and seek recreation outside the residential setting as soon as possible and to take meals, sleep, and rise at normal hours (22). Clients should move to unsheltered residences -- not to boarding or nursing homes -- early. Sheltered residences imply a "license to be sick" (17) and discourage independence (8). Teaching of basic skills can be carried out best in a school classroom (6) or in the client's home when the skills to be learned are home skills such as cooking (18). They should not be taught in a community mental health center if other arrangements can be made. Any attempt to avoid a "total institution" atmosphere, where all needs are met in one setting, is positive (4, 17, 22).

CASE MANAGEMENT AND CONSULTATION

As noted above, the chronically mentally ill adult is likely over the course of treatment to require services from multiple agencies outside the mental health center and to be involved with more than one staff member or treatment setting within the mental health center. The task of the case manager is to tie together services to the client both within and outside the mental health center. Intake, assessment, planning, treatment, and referral to outside agencies (for housing, financial assistance, medical care, etc.) should be coordinated and systematically planned to help the client meet his needs and achieve his goals (2). If at all possible the case manager should be the client's therapist. He will need to know the client's pathology, strengths and weaknesses, and dynamics and establish an alliance (5). The case manager must also know other agencies and be able to work cooperatively with them. He must be able to communicate the client's needs, problems and characteristics effectively to these agencies, and provide consultation to them on how to help the mutual client (2, 5). Consultation to the family, including support and education, is essential for those family memebers must be able to assist their ill relatives who are at times stressful to live with due to their unpredictable, socially embarrassing, sometimes violent, or withdrawn behavior (4, 10, 13). The case manager must know how to impact the criminal justice system so that necessary treatment is continued if incarceration occurs, and so that that system is able to provide meaningful consequences for anti social, irresponsible behavior (18, 20, 21). Considerable effort is sometimes required to avert the legal system's tendency to relieve clients of their responsibilties as citizens by pressing for hospitalization for the mentally ill offenders as an "alternative" to punishment. Clients with high dependency needs (i.e., most clients) will learn to use this tendency to "arrange" hospitalization when feeling stressed, by acting out and getting arrested, if the case manager does not intervene to prevent this (18). Long jail stays for minor transgressions are not being recommended here, but a brief incarceration can increase the client's sense of responsibility.

Case management is at present a rather vaguely defined concept. Hence, other than the brief outline suggested above, it is difficult to define precisely the tasks,let alone the mix of knowledge, skills, and ability required of case managers (2).

ADMINISTRATIVE SUPPORT

Due to the size and complexity of the care delivery system, effective administration is a necessity in the modern mental health center. Of particular importance is a straightforward, informative clinical records-keeping operation to facilitate collection, communication, and availability of information about clients for clinical staff. Second, competent business management is needed to maximize collection of revenue (especially from complex systems such as state governments and Medicaid) and to minimize waste of scarce

financial resources. Finally, as civil commitment proceedings become ever more complex and strongly contested, good legal advice and administrative assistance in carrying out mental health law procedures will be increasingly essential. Mental health systems in the past have relied on the promotion of clinical staff (without administrative expertise or training) to fill administrative positions. This practice will become increasingly less defensible as administrative tasks become more complex and demand special skills and training.

OVERALL STRUCTURE OF THE SYSTEM

It is difficult to conceive of attempting to treat the chronically mentally ill adult in a community setting without using a multidisciplinary, team approach. Clearly, psychiatric expertise, behavioral techniques, knowledge of and ability to teach basic skills, ability to be comfortable with clients, awareness of laws governing treatment, and familiarity with a variety of social agencies will all be required in the case of these clients. In addition, this population is notorious for "burning out" service providers; the responsiblities and needs are great, the frustrations many, and the gains often limited and slow in coming. The multidisciplinary team allows for both pooling of specialties and for sharing of responsibility and frustrations, and for mutual support. The treatment staff of a comprehensive treatment agency will include psychiatrists, psychologists, psychiatric nurses, social workers, trained paraprofessionals, and residential care staff.

The exact nature of the skills, abilities, knowledge, and attitude mix required of particular staff in a given setting will vary according to staff arrangements, and from staff member to staff member, and across disciplines. What is essential is that the treatment team as a whole embody the skills, knowledge, abilities,and attitudes mentioned in the preceding sections. For instance, it is not necessary for the psychiatrist to be a skilled psychotherapist, providing he works closely with a primary therapist/case manager who is and providing the psychiatrist does not undermine the hopeful, directive approach of the therapist. Similarly, residential treatment shift coverage staff do not need to be familiar with the workings of the legal or social security systems, providing the case manager does or has administrative assistants who can deal with these systems. Even the number of clients a given therapist or psychiatrist can serve will vary according to the exact duties expected of the therapists and the abilities of other team members. In addititon, training and utilization of volunteers is an important way for staff to increase services to clients. The efforts of non-core agency personnel (teachers, social services and welfare workers, the medical community, law enforcement) to help the chronically mentally ill adult may best be facilitated by vigorous, knowledgeable consultation from core agency personnel.

SUMMARY

The chronically mentally ill adult has difficulty surviving (meeting

basic needs) and achieving a reasonable quality of life outside an institution due to fundamental deficits in social and instrumental coping skills, deficits which persist beyond the period of overt psychosis. Successful treatment of such clients involves long-term supportive, rehabilitative, and training efforts, using the principles of normalization and social learning to structure and intervene in the psychosocial milieu. Hospitalization should rarely be necessary if a multidisciplinary team uses a system that provides appropriately structured social settings including residential care. Case management by a therapist who understands the client's dynamics, strengths and weaknesses and who can organize efforts within the service delivery team and arrange for non-core agencies to supply needed resources, is essential. The need for effective administration is great given the size and complexity of the care delivery system. The exact mix of skills and abilities required of particular staff will depend on the overall staffing patterns; however, the mental health agency as a whole should have the general characteristics described above.

REFERENCES

1. Beard, John H. "Psychiatric Rehabilitation at Fountain House." In Rehabilitation Medicine and Psychiatry, edited by Jack Meislin, pp. 393-413. Springfield, Ill.: Charles C. Thomas, 1976.

2. Benjamin, M.L., and Ben-Dashan, T. "Case Management: Implications and Issues." Paper presented at the New Hampshire Case Management Conference, September 12, 1979.

3. Diamond, R.J. "The Role of the Hospital in Treating the Chronically Disabled." New Directions for Mental Health Services 2 (1979): 45-56.

4. Gunderson, J.G. "Drugs and Psychosocial Treatment of Schizophrenia Revisited." Journal of Continuing Education in Psychiatry (December 1977): 25-40.

5. Lamb, H.R. Discussion, April 10, 1979, at the Mental Health Center of Boulder County, Inc., Boulder, Colorado.

6. Lamb, H.R. "An Educational Model for Teaching Living Skills to Long Term Patients." Hospital and Community Psychiatry 27 (December 1976): 875-877.

7. Lamb, H.R. "Helping the Long-Term Schizophrenic." Psychiatric Annals 5 (July 1975): 44-45.

8. Lamb, H.R., and Goertzel, V. "Discharged Mental Patients--Are They Really in the Community?" Archives of General Psychiatry 24 (1971): 29-34.

9. Lamb, H.R., and Goertzel, V. "The Demise of the State Hospital--A Premature Obituary?" Archives of General Psychiatry 26 (1972): 489-495.

10. Lamb, H.R., and Oliphant, E. "Schizophrenia Through the Eyes of Families." Hospital and Community Psychiatry 29 (1978): 803-806.

11. Lindsey,D., and Ozawa, M.N. "Schizophrenia and SSI: Implications and Problems." Social Work (March 1979): 120-126.

12. Mayer, S., and Sperl, J. "Role of the Therapist." Boulder, Colo.: Mental Health Center of Boulder County, Inc., 1979.

13. Mosher, L.R., and Keith, J. "Research on the Psychosocial Treatment of Schizophrenia: A Summary Report." American Journal of Psychiatry 136 (May 1979): 623-631.

14. Mosher, L.R., and Menn, A.Z. "Community Residential Treatment of Schizophrenia: Two-Year Follow-Up." Hospital and Community Psychiatry 29 (November 1978): 715-723.

15. Paul, G.L.; Tobias, L.L.; and Holly, B.L. "Maintenance Psychotropic Drugs in the Presence of Active Treatment Programs." Archives of General Psychiatry 27 (July 1972): 106-114.

16. Polak, Paul R.; Deever S.; and Kirby, M.W. "On Treating the Insane in Sane Places." Journal of Community Psychology 5 (1977): 380-387.

17. Test, M. A., and Stein, L.E. "Community Treatment of the Chronic Patient: Research Overview." Schizophrenia Bulletin 4 (1978): 319-347.

18. Test, M.A. and Stein, L.I. "Practical Guidelines for the Community Treatment of Markedly Impaired Patients." Community Mental Health Journal 12 (1976): 72-82.

19. Turner, J., and TenHoor, W.J. "The NIMH Community Support Program: Pilot Approach to a Needed Social Reform." Schizophrenia Bulletin 4, no. 3 (1978).

20. Waters, J.H. "The Chronic Psychiatric Patient, Involuntary Psychiatric Treatment and the Criminal Justice System." Unpublished manuscript. Boulder, Colo.: Western Interstate Commission for Higher Education, 1980.

21. Whitmer, G.E. "From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill." American Journal of Orthopsychiatry 50 (January 1980): 65-75.

22. Wolfensberger, W. "The Principle of Normalization and Its Implications to Psychiatric Services." American Journal of Psychiatry 127 (1970): 291-297.

23. Wood, D.R.; Reimherr, W.F.; Wender, P.H.; et al. "Diagnosis and Treatment of Minimal Brain Dysfunction in Adults." Archives of General Psychiatry 33 (1976): 1453-1460.

24. Zusman, J., and Lamb, H.R. "In Defense of Community Mental Health." American Journal of Psychiatry 134 (August 1977): 887-890.

SB

521

General Fund $3,000,000
Other Funds -0-
$3,000,000

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 521 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for a state mental health rehabilitation center; and providing for an effective date."

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

* Section 1. The sum of $3,000,000 is appropriated from the general fund to the Department of Health and Social Services for a development plan and the design for construction of a state mental health rehabilitation center at Fairbanks.

* Sec. 2. The department may not spend more than $100,000 for a development plan for the center.

* Sec. 3. The appropriation made by this Act is for a capital project and is subject to AS 37.25.020.

* Sec. 4. This Act takes effect immediately in accordance with AS 01.10.070(c).

No appropriated funds for design of a state mental health rehabilitation center shall be spent except upon certification from the ~~Commissioner of the Department of Health and Social~~ governor that a development plan has been completed and that pursuant to such plan the governor recommends to the legislature ~~the~~ that funds be ~~contracted~~ appropriated for construction of the center.

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 520-521 mental health rehab center DATE May 7, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
John Pugh	DHSS		465-3030

Original sponsor: Resources Committee

Funding Information

General Fund	$3,000,000
Other Funds	-0-
	$3,000,000

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

CS FOR SENATE BILL NO. 521 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTEENTH LEGISLATURE - SECOND SESSION

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For an Act entitled: "An Act making a special appropriation to the Department of Health and Social Services for a state mental health rehabilitation center; and providing for an effective date."

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* Sec. 2. The department may not spend more than $100,000 for a development plan for the center.

* Sec. 3. The appropriation made by this Act is for a capital project and is subject to AS 37.25.020. the Department may not expend the appropriation in Section 1 until the Governor has certified that the

* Sec. 4. This Act takes effect immediately in accordance with AS 01.-10.070(c).

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
H&SS	MH&DD	SB 521	Resources Committee

DEPARTMENT POSITION
The Department of Health and Social Services supports the passage of SB 521

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
Dr. Philip Shapiro	3/30/84		

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUP(S) AFFECTED BY BILL
Department of Education	Mentally ill children and adults and their families

ORGANIZATIONAL SUPPORT FOR BILL	ORGANIZATIONAL OPPOSITION TO BILL
Fairbanks Alliance for the Mentally Ill Alaska Mental Health Associations	Unknown

FISCAL IMPACT: ☐ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

This bill proposes to make a capital appropriation in the amount of $30 million in order to construct a residential facility in Fairbanks which would house approximately 33 chronically mentally ill adults and 80 acutely and chronically emotionally disturbed children and adolescents. The statutory authority for the DH&SS to operate this program is contained in a companion bill, SB 520.

ANALYSIS OF BILL/PROGRAM EFFECTS

Based upon the average cost of a hospital bed on a statewide basis of $286 per day per patient, not including ancillary cost or medical costs. The figure of $286 is considered adequate for operational costs of such a facility in Fairbanks by the DMH&DD. Thus, with a proposed total of 113 beds X $286 per day X 365 days = $11,796,070 for yearly operational costs of this new facility. Please see the attached Bill Analysis of SB 520 for additional information regarding program effects of SB 521.

AMENDMENTS PROPOSED

None recommended for SB 521

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS.

01-009 (Rev. 12/83)

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
H&SS	MH&DD	SB 520	Resources Committee

DEPARTMENT POSITION

The Department of Health and Social Services supports the passage of SB 520

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
Dr. Philip Shapiro	3/17/84		

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUP(S) AFFECTED BY BILL
Department of Education	Mentally ill children and adults and their families

ORGANIZATIONAL SUPPORT FOR BILL	ORGANIZATIONAL OPPOSITION TO BILL
Fairbanks Alliance for the Mentally Ill Alaska Mental Health Association	Unknown

FISCAL IMPACT: ☐ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

This bill will provide the statutory authority for the Department of Health and Social Services to operate a residential program for chronically mentally ill adults and children and adolescents that are emotionally disburbed and require specialized services in a residential center. Currently, these types of services for these groups of persons in Alaska are inadequate or non-existent.

ANALYSIS OF BILL/PROGRAM EFFECTS

Senate Bill 520 provides the statutory basis for the operation of a residential care facility for the chronically mentally ill adults and for a residential facility for emotionally disturbed children and adolescents. The construction of such a facility would allow the State to return emotionally disburbed children and adolescents from out-of-state placements. Additionally, it will result in a reduction in recidivism to API and an improved quality of life for the chronically mentally ill adult.

AMENDMENTS PROPOSED

The following amendments are proposed:

1. Reduce the standard for involuntary outpatient commitments.
2. Amend A.S. 47.30.690 to allow parents and guardians to voluntarily hospitalize children and adolescents for period in excess of 21 days.

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS.

POSITION PAPER

Senate Bill 520

"An Act relating to the establishment of a statewide mental health rehabilitation center; and providing for an effective date."

The apparent purpose of Senate Bill 520 is to create the statutory authority for a state-funded and state-operated residential facility for chronically mentally ill adults and children that require a variety of on-going social, educational, vocational, and health services in order to prevent their involuntary hospitalization at Alaska Psychiatric Institute as a result of recurring episodes of acute mental illness. This purpose is certainly commendable and is supported by the Division of Mental Health and Developmental Disabilities in the Department of Health and Social Services.

In developing the position of the Department of Health and Social Services on this bill, it has been necessary to examine its impact on the two categories of targeted patients separately as it is not programmatically possible to mix mentally ill adults with emotionally disturbed children in a way that will prove successful. The first section will be about adult residential care for the chronically mentally ill adult who requires residential care in order to remain free from the need of involuntary psychiatric hospitalization at the Alaska Psychiatric Institute. The second section in this position paper will be about the need for acute/chronic child or adolescent residential care for the emotionally disturbed, conduct disordered, substance abusing, or acting-out juvenile who is either in the custody of the Division of Family and Youth Services as a child in need of aid, or a delinquent child, or at risk of being in their custody as a result of these behaviors. These must be considered separately for purposes of understanding Senate Bill 520 and its potential effects on the Department of Health and Social Services.

Adult Residential Care

The adult residential care component of this proposal for a statewide mental health rehabilitation center is envisioned as a non-acute care facility for the chronically mentally ill adult who would benefit from out-of-home residential care and treatment. This is seen as a resource that would improve the quality of life for this group of persons, as well as possibly reducing the need for their periodic involuntary hospitalization at Alaska Psychiatric Institute as a result of episodes of acute psychiatric illness.

This may be especially effective if the statutes relating to involuntary outpatient commitment under A.S 47.30.655-915 can be modified to make them more compatible with the need for a reduced standard of dangerousness to self or others for outpatient commitment of the mentally ill. Our experience has shown that by using the same standard for involuntary inpatient and outpatient commitment of the mentally ill, it is not practical to expect a community based, non-secure program to be able to accept and effectively treat the mentally ill persons under involuntary conditions. Frankly, they are simply

too sick to be able to cooperate with their treatment plan in an outpatient setting and present too great a risk of harm to themselves or others under the standard of dangerousness required for involuntary commitment.

By reducing the standard for involuntary outpatient commitment it would be possible to commit certain patients to this facility for residential care and treatment in an environment that is less restrictive than Alaska Psychiatric Institute.

In providing services for the chronically mental ill patient, the degree of illness and resulting danger to self or others varies over time. The amount and type of treatment that we are able to make available to these persons depends on the nature and extent of our statutory authority and the availability of our resources. The greater our ability to monitor and control the behaviors of these patients, the greater the chance of preventing episodes of acute distress and hospitalization.

Additionally, the facility will be available as a residential care center for the chronic mentally ill that voluntarily seeks placement. Such a facility as described in Senate Bill 520 would be capable of providing a comprehensive system of care, treatment, education, and training on a long term basis.

The concept of "community support systems" or "community case management" for the chronic patients is known to be an effective method of serving these patients. This bill would help to fill the extensive gap in that service system and will result in a greatly improved quality of life for the chronic mentally ill person and his family.

Acute/Chronic Child or Adolescent-Residential Care

The facility for the emotionally disturbed children and adolescents would have to be completely separate from the adult residential facility housing the chronically mentally ill. The facility for children and adolescents should be divided into two units. The first should be a short-term unit that would provide intensive mental health care for the acutely mentally ill child or adolescent. The second unit should be a residential or longer-term unit for those emotionally disturbed children and adolescents who require a supervised residential/educational program in a structured setting.

The children and adolescents referred to these programs may be in the custody of the Division of Family and Youth Services as a child in need of aid or a delinquent child or they may be referred by their parents or guardian or some other agency such as a school district or court if the youth is involuntarily committed.

The long-term residential capacity of this facility will allow the approximately 40 children and adolescents currently in out-of-state facilities to be returned to Alaska for continued residential care and treatment closer to home. These children and adolescents have been sent out-of-state by the Department of Education for special education purposes and the Division of Family and Youth Services as delinquent children or children in need of aid. Most of these children are suffering from emotional disturbance and

require specialized resources for their care. They would be provided at this facility.

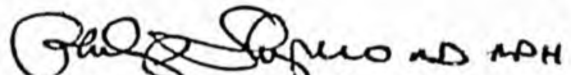
The following description of these children and their treatment is excepted from the "Management and Treatment Philosophy on the Adolescent Unit" at Alaska Psychiatric Institute:

> "Essentially, conduct disorder refers to youth who are acting out in a profound manner. The ordinary healthy and expected rebelliousness of adolescent years has turned to a severity that is obviously dangerous and inherently self and other destructive. The parents and family have lost control of their conduct disordered child in a major and agonizing way. Depression, anger, guilt, and fear have been released and are running rampant in the hearts of both child and parent. Such youngsters are generally using drugs and or alcohol, involved in sexual promiscuity, running away, and criminal behaviors. They are aggressive, violent, angry, frequently assaultive or homicidal, depressed and possibly suicidal. Some are living in the streets. Some are engaged in prostitution or pornography. Sexual molesting and fire setting behaviors are occasionally part of the picture.
>
> Since most of these children are utilizing the defenses of projection, denial, and blaming, and are therefore unable to admit themselves to the hospital on a voluntary basis, the Alaska State mental health commitment law must be instituted in order for the hospital staff to be given the right to contain these youths in a locked setting-a critical component in their care in the initial stages of treatment since running escapist behavior is a keystone of this syndrome. Since these children are either homicidal, suicidal, or gravely disabled or some combination of these, it is not difficult to get a commitment. Nor is it difficult to convince a judge that the child's life was in grave danger, that the parents had lost control, and that the hospital would serve the purpose of temporary parent until the patient had obtained sufficient self knowledge to regain control and therefore security and safety. Indeed, inpatient treatment for behaviorally disordered teenagers represents one of society's last lines of defense against repeated failures of the community to hold youngsters long and safely enough until they can achieve mastery over the conflicts which beset them. Often, children arrive after having lost their place at home, in school, in group and foster care, and their

choices are limited to hospital, jail, or streets. The first step then in the successful treatment of severe conduct disorder is to confine and contain the child behind a closed locked door. This serves to emphasize to the child and family that the individual is sick and is now a patient in a hospital as with any other severe life threatening illness. This is an important symbolic statement for the physician and treatment team to make as it may not be apparent to the family and patient that conduct disorder or extreme acting out is an illness and that it has a definitive treatment. In the initial interview the child is confronted with this in a clear manner not only with the and patient status in a hospital but with a verbal statement form the treatment team. The patients are told that they are ill, that the illness is severe, and that it is life threatening.

As can be seen from the description noted above, this is a group of disturbed young people that is extremely difficult to manage and treat. This is further complicated if the child or adolescent is not in the legal custody of the Department of Health and Social Services with a court order that authorizes institutional placement. In order for this facility to provide appropriate inpatient and residential care and treatment for periods longer than the 21 days currently allowed under the existing statute on a voluntary basis (A.S. 47.30.690), the law will have to be amended to permit voluntary admission on a longer term basis.

The Department of Health and Social Services supports the passage of Senate Bill 520 with the above noted recommendations.

Recommended by: 

Philip Shapiro, M.D., Director
Division of Mental Health and
Developmental Disabilities

Date: ____________________

Approved by: ____________________

Robert London Smith, Ph.D.
Commissioner

Date: ____________________

SB
528

DISTRICT ATTORNEY FOR BENTON COUNTY

Court House, Corvallis, Oregon 97330 — Telephone (503) 757-6815

PETER F. SANDROCK, JR.
District Attorney

KENNETH A. OSHER
Chief Deputy

JANE E. AIKEN
Deputy

CYNTHIA A. BURT
Deputy

LAURIE G. McADAM
Deputy

May 9, 1983

MAY 12 1983

Honorable Vic Fischer
Vice Chairman
Senate Committee on Health
and Social Services
Pouch V
Juneau, Alaska 99811

RE: Spousal Rape

Dear Senator Fischer:

The 1977 Session of the Oregon Legislative Assembly enacted the nation's first spousal rape law. The purpose of my letter is to describe Oregon's experience with spousal rape prosecution.

To my knowledge, there were only four spousal rape prosecutions between 1977 and late 1980. The first, of course, was the infamous Rideout case, which resulted in an acquittal.

The second case resulted in a negotiated plea to felony assault. The third resulted in rape and kidnapping convictions at trial. The fourth case, tried by my office, resulted in a conviction of the lesser-included offense of sexual abuse.

Following the Rideout spectacle, Oregon's 1979 legislature reconsidered its position; but after a public hearing before a joint session of the House and Senate Judiciary committees, declined to introduce legislation to repeal the law.

Since 1980, the number of prosecutions has increased, but not to a great extent. My office has received no reports of spousal rape since 1980, and, consequently, there have been no prosecutions.

I recently spoke with Chris Van Dyke, the Marion County District Attorney (population 240,000). He reports that his office has prosecuted five cases with reasonable success. He supports the law.

I also spoke with Mike Schrunk, the Multnomah County District Attorney (population 559,000), who stated that spousal rape cases are relatively rare and tightly screened by his office. He volunteered the opinion that Oregon's spousal rape law has not been abused.

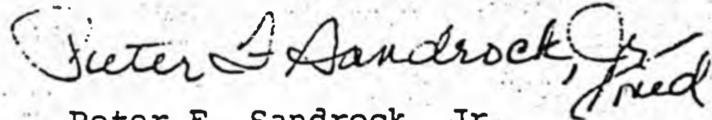
A frequently expressed concern is that spousal rape cases would not be provable. The same difficulty of proof exists, however, in virtually every rape by an acquaintance of the victim. About half of

all reported rapes are by acquaintances of the victims and a fair number of those involve relationships in which there had been some degree of sexual intimacy. Obviously the problem of weighing the evidence when deciding whether to charge rape is a difficult one, but it is the kind of problem prosecutors must deal with every day.

My discussions with rape and domestic violence counselors suggests that they receive significantly more reports of spousal rape than do Oregon prosecutors, but even the counselling centers have not been deluged with reports. Victims are apparently very reluctant to discuss sexual abuse inflicted by their husbands.

In summary, Oregon's prosecutors have not been inundated by a large number of spousal rape complaints, nor have the victims used the rape charge to extort a favorable divorce settlement.

Respectfully submitted,



Peter F. Sandrock, Jr.
District Attorney
for Benton County

PFS:med

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER SB 528 - Spousal Defense DATE March 23, 1984

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
Patty Kastelic	UAF Women's Center Women in Crisis Counseling Asst	4920 Anderson Rd	479-5744 474-6330
Carla Timpone	AK Network on Domestic Violence + Sexual Assault	110 Seward #13 Juneau	586-3650

I am here to speak in favor of SB 528.

The marital exemption to the violent crime of rape is invariably traced back to the 17th century when Mathew Hale, Chief Justice in England, pronounced,

> "But the husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual consent and contract the wife hath given up herself in this kind unto her husband which she cannot retract."

This ruling was based upon the notion that women were the property of their husbands and procreation was the sole purpose of matrimony.

Since most of us have had sexual intercourse and because our magazines, movies and now television have given so much time and attention to sexuality, it is impossible for us not to relate personally to this discussion of marital rape. When considering this legislation, I kindly request that you refrain from imagining in your mind a gallant Rhett Butler sweeping a petulant Scarlett O'Hara off her feet and up the stairs. Followed, in keeping with 1950 sense of proprieties, a fade out to the next morning -- a sun-filled room and a smiling Scarlett. I emphatically assure you that it not the situation out of which a marital rape charge could ever rise.

Until fairly recently, our law reflected the opinion of many lawmakers that rape was a charge easily made and difficult to defend against. However, as the recently highly publicized New Bedford rape trial reaffirmed, the women victim is very much on trial as well. Her past sexual history and behaviors, her motivation, and even what she was wearing, and where she was at the time of the crime are given a thorough public scrutiny.

Through the increasing number of studies being done, we are learning that rape is a crime of violence. It rise out of a desire for conquest and domination greatly exacerbated by the media images that tell us sexual prowess is part of the definition of masculinity. As in the case of domestic

violence, sexual violence in the context of marriage exists on a continuum. The continuum extends from a non-violent marriage where sex is the result of mutual desire and consent, all the way to the opposite extreme of the rape/murder of a spouse.

As long as wife rape is condoned by our legal system many men will continue to feel that their wife has no right to refuse sex, and many women will continue to feel that they have no right to control their own bodies. By 1980, New Jersey, Oregon and Nebraska had completely abolished the marital rape exemption. It has been variously considered and debated in many other states since that time. State by state variance is so extreme that in West Virginia, a man may not be charged with first degree sexual assault if the woman has ever been a voluntary social companion of the man, even though they have never had mutually consentual sexual relations.

In arguing for SB 528 and against marital exemption, I first sight the moral and philosophical implications of the law as it presently exists. To allow marital exemption endorses the antiquated principle that women are property. Those who would argue that the charge will be made lightly and that the circumstances will be ambiguous, should take some time to familiarize themselves with the recent work of Irene Frieze, Nicholas Groth, Del Martin and Diane Russel. The case study descriptions make sobering and chilling reading.

The marital exemption has been shown to be in violation of the constitutional right to "equal protection" - both in the sense of married versus unmarried women and in the sense of wives versus husbands. Further, why in this one instance are we saying that identity and relationships of the perpetrator to the victim is relevant to our judgment of the crime. Isn't

murder always murder? Is murder less serious if you murder your wife or your child? It is a distortion of justice to rule that rape outside of marriage is a violent, heinious crime, while within the bonds of matrimony, it is allowable.

Nor does the evidence support the charge that rape is less traumatic to a women when it is done by a man with whom there has been previous mutual consent. The violation of personal trust can be deeply disturbing, and we know from case studies that marital rape frequently occurs in conjunction with life threatening violence.

To tolerate wife rape in law is to minimize the seriousness of rape in other contexts. When we codified bigotry and racial prejudice, we tacitly perpetuate that prejudice. So to with violence. Violence condoned, made glamorous in our media and entertainment, violence used as a subject of humor, violence excused by its context promotes and perpetuates violence.

To quote Diane Russel from her book, "Rape in Marriage"

> "To continue to see rape in marriage as husbands privilege is not only an insult, but a danger to all women. We must strive to stop wife rape, including working to eliminate the conditions that have given rise to it."

Patty Kastelic, Director
Women's Center
Board Member of Women in Crisis Counseling Assistance
4920 Anderson Road
Fairbanks, Alaska 99701
(907) 479-5744

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Patty Kastelic
Director Women's Center
Board member Women in Crisis Counseling Assistance

4920 Anderson Rd
Fairbanks, Alaska
99701

479-5744

Husband acquitted on charge of raping wife

By Larry Lange
and Jack Hopkins
P-I Reporters

EVERETT — Roger Braaten, charged with raping his wife, expressed relief after being acquitted by a six-man, six-woman jury yesterday, but the verdict drew fire from the head of a woman's support organizaiton.

Karen Bosley, president of the Washington Coalition of Sexual Abuse Programs, said she was "very disappointed" at the trial's outcome because it could make abused women "think more than once or twice before they report this kind of case."

Officials said many women remain reluctant to complain despite a change in Washington state law that permits wives to bring criminal charges of rape against their husbands.

"You don't hear about it until somebody reaches the end of her rope," said Rebecca Roe, senior deputy prosecutor in King County.

Members of Braaten's family cheered when the verdict was read in Snohomish County Superior Court.

"Hallelujah!" shouted Braaten's sister, Gloria Perrin, when Judge Paul Hansen relayed the jury's finding. "Praise the Lord God for everything."

Braaten's attorney, Lorne Grier, said the state's marital-rape law is "good," but said the verdict shows the jury thought Braaten, who denied the charges, "was being truthful on the witness stand."

The unanimous verdict ended a three-day trial in which Braaten, 27, was accused of first- and second-degree rape by his estranged wife, Amanda Braaten, 28.

The trial is believed to be the first in the state on a marital rape charge. The accused husband had faced up to 30 years in prison and up to $70,000 in fines.

After the verdict was announced, Braaten told reporters he was relieved, but still puzzled by his wife's charges.

"I still have a little feeling in my heart for her," he said, but he added: "I don't know if I could ever go back to her."

Amanda Braaten, who charged her husband with forcing her to commit oral and anal sex, filed for divorce last fall and has not lived with her husband since then.

ROBERT De GIULIO/P-I PHOTO

Pier to a run

By Neil Modie
P-I Olympia Bureau

OLYMPIA — Pierce C ecutive Booth Gardner wi the first candidate to plung race for governor Monda well-financed but recogniti campaign for the Democr nation.

Besides being the first candidate, Gardner, 48, has campaign war chest — quarter of a million dollar either of his potential rival also is the least known of candidates and, therefore, who most needs an early s

So little-known is Gar side Pierce County that internal memorandum by can Gov. John Spellman's director seems to have w his chances of winning th cratic nomination.

Spellman memo

"It is all but certain th Sen.) Jim McDermott will Democratic primary base results of several polls jus said the Jan. 28 memo, w Brian McCauley to other of Spellman's organization.

"We must not allow Gardner's possible presenc down our campaign agains mott," McCauley's memo s

The memo, a copy of w obtained by the Post-Inte predicts that "Booth Gard the 'Charley Royer' of 1984 more disadvantages tha had." That is a reference Mayor Royer's loss to Con Mike Lowry in the De primary race for the U.S. Se

Pierce Co quits to b

With Pierce County E Booth Gardner preparing t governor this year, She

divorce last fall and has not lived with her husband since then.

Tearful testimony

Testimony in the trial pitted her story against her husband's denials. Attorneys involved said that, as in other rape cases, the wife's credibility became a key issue in the emotion-packed trial.

In tearful testimony, she told jurors her husband had poked her with a knife and threatened her life last Sept. 7 while demanding oral sex.

She also testified that she feared for her life when her husband grabbed her by the waist, held her down and forcibly performed what she called "gross" and "disgusting" sexual acts with her Oct. 12.

Roger Braaten, who appeared equally emotional on the witness stand, denied his wife's charge, contending she willingly participated and that, in the darkness of their bedroom, he thought he was engaging in normal sex.

Braaten said that during the September incident he was using the knife to soothe his wife's fears about the instrument.

Grier conceded the claim was "bizarre," but explained it by saying Braaten has "thought processes like a little kid. He doesn't understand what's going on."

Grier emphasized that the wife had delayed reporting the September incident until after the October incident, and suggested that the criminal charges were a ploy to gain an upper hand in the couple's divorce case.

He further attacked her credibility by saying she had stayed married to her husband more than eight years despite alleging he'd threatened her with a knife within weeks after their wedding.

"She's no shrinking violet," he said, playing on jurors' doubts.

Deputy Prosecutor David Kurtz said Grier's divorce theory made no sense. He said the wife had delayed reporting the first incident because it

Roger Braaten enters the Snohomish County Courthouse in Everett shortly before announcement of his acquittal by a six-man, six-woman jury on charges that he raped his wife.

was a "shattering experience." He said she initially wanted to work out problems with her husband without going to authorities.

"Something had to be wrong for Amanda to go to these people and reveal all these embarrassing, humiliating things . . . to go through the humiliation of a public trial," Kurtz said. "Why did she want a divorce in the first place?"

Kurtz described Roger Braaten as a "fundamentally insecure man" whose male self-esteem had been damaged after major surgery had forced him to give up a job and stay home to recover.

He said Braaten's assaults on his wife were actions of a man "trying to reassert himself. The weapon he used, other than the knife, was his sex."

According to Karen Bosley, the verdict in the Braaten case reflects "a general misunderstanding" of domestic violence by members of the public who sit on juries.

"I hope this does not discourage other women who are abused by their husbands from reporting this kind of thing. Women definitely need support."

She said 16 states have laws like Washington's but many women won't bring complaints because of the embarrassment and trauma involved.

Bosley's observations were confirmed by Puget Sound-area prosecutors, who said they suspect the small number of complaints they hear is just the tip of the iceberg.

Other incidents of marital rape have come to the attention of officials, including a trial set for April in Snohomish County, said chief criminal deputy prosecutor Larry McKeeman. But a Pierce County case last summer was reported the night before the state's new law took effect, making prosecution impossible.

Deputy Prosecutor Roe said police brought in a marital rape case about two months ago but the woman refused to be interviewed by prosecutors or to press charges.

"There's tons of battering that goes on that you don't hear about and undoubtedly it's the same in marital rape," Roe said. "You just don't hear about it."

Mighty Mo could move in the spring

P-I Staff
and News Services

The Navy wants Congress to move full speed ahead on refitting the battleship USS Missouri, and will ask to move the warship this spring from Bremerton to Long Beach, Calif.

The plan had been to take the vessel under tow to Long Beach in August.

Secretary of the Navy John Lehman says he will ask Congress for permission to move the historic, 45,000-ton ship to Long Beach this spring to save 200 jobs at the Long Beach Naval Shipyard.

It would take 60-90 days to get ... ing, the small on-board museum would be removed, and the below-decks area would have to be secured and generally everything that was loose would be prepared for possibly rough seas.

Lehman's plan could save the jobs of about 200 workers due to be laid off because of a lack of work at the shipyard, said Gil Bond, director of industrial relations for the shipyard.

"We will be prepared to tow the Missouri down to Long Beach as soon as the weather permits, which at the earliest will be mid to late spring," Lehman told reporters Tuesday after meeting with the

Seattle Post-Intelligencer

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Vol. No. 121, No. 35
Published every morning, Monday through Saturday, by the Hearst Corp. 521 Wall Street

with Pierce County ... Booth Gardner preparing ... governor this year. ... Smith has resigned to ... helping out with Gardner ... duties.

However, Smith, a Re... denies that his new job as ... administrative assistant ... any hopes of heading ... Patrol should Gardner, a D... succeed in a bid for the st... post.

"I don't think that's an ... eration of his, or mine ... Smith, 58, said last night.

"I had expressed to th... executive, prior to this, my ... retire."

Smith said he plans to

ALASKA NETWORK ON DOMESTIC
VIOLENCE AND SEXUAL ASSAULT
110 SEWARD #13 JUNEAU ALASKA 99801
(907)586-3650

POSITION PAPER

SB528: An Act relating to the spousal defense to sexual assault

The Alaska Network on Domestic Violence and Sexual Assault, a non-profit corporation composed of 20 programs statewide that provide services to victims of domestic violence and sexual assault, supports SB528, which would remove the marital exemption in cases of rape.

Under current Alaskan law, in order for a woman to prosecute her husband for rape, the couple must either be living apart or the perpetrator would have had to cause serious physical injury to the victim. In the opinion of the Network, this exemption provides no protection to the married woman who is the victim of forced, not concensual, sexual contact with her husband.

The Network is especially concerned about this issue because of the proven correlation between domestic violence and marital rape. A study conducted by Morton Hunt in 1979 and reported in Family Circle magazine indicated that one-fifth of the estimated 2 million battered wives in America were "forced to have sex as part of the beating or as a sequel to it." In a survey of 930 women conducted in 1981 and reported in the Family Law Quarterly, 14% of the women indicated that they were victims of marital rape.

By passing laws which recognize spouse abuse and child sexual assault as serious crimes, the Legislature has indicated that criminal behavior is not based on the relationship of the perpetrator and victims. The Network believes that the same recognition should be afforded the crime of rape within marriage, and urges your support of this bill.

COUNCIL ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

POSITION PAPER

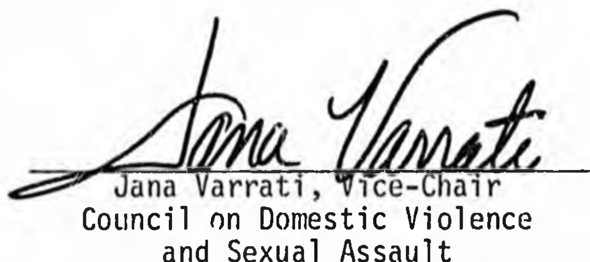
SB 528

"An Act relating to the spousal defense to sexual assault."

Marital rape, like stranger rape, is an act of power and hostility. Nicholas Groth, who has extensively studied men's motivations for rape, identifies five reasons why men rape their wifes: "to assert power and strength; to punish and degrade; to prove their virility; to overcome feelings of being unloved; and to convince themselves that all is right with the world."

Victims that are raped by their spouses often suffer devastating effects. Among the most common reactions are self-blame, reduced self-esteem, humiliation, guilt, anger and depression. Diana Russell, a San Francisco sociologist, notes that these women's intense feelings of self-blame are heightened by the knowledge that society holds them more responsible for rape than it does victims of stranger rape. Further, many of the women she interviewed confessed to overwhelming feelings of betrayal. These feelings can destroy the victim's capacity for intimacy forever.

Yet most state laws and many people condone forced sex if the victim is married to the rapist. Only sixteen states have stricken the marital rape exemption from their criminal codes and permit prosecution of husbands who rape their wives under most circumstances. The Council on Domestic Violence and Sexual Assault supports this proposed legislation to make marital rape a crime in Alaska under all circumstances.



Jana Varrati, Vice-Chair
Council on Domestic Violence
and Sexual Assault

RECEIVED
MAR 21 1984
Josephson,

Bus. 276-7279
24-hr.
Crisis 276-RAPE

March 16, 1984

Senator Joe Josephson
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Josephson,

I am writing this letter in support of Senate Bill 528. Alaska should enact this legislation to abolish its marital rape defenses. Under current law a victim is not accorded protection if she is raped by her spouse while living with him or if she has not sustained physical injury.

A rationale exists in our society that a wife consents to sexual intercourse by marrying her spouse. To accept this incredible notion indicates that an exchange of wedding vows implies the right to have sexual intercourse at any moment, even by force with one's spouse. Clearly forcing one's spouse to engage in sexual relations violates her contractual marriage agreement, but also, physically abuses her body and violates her right to privacy.

In the past emphasis has been placed on the appropriateness of using the criminal justice system in domestic disputes. The notion being that the family should solve their own problems. The victim in a domestic disturbance may be in grave danger for her safety and the crime should be treated the same as if she were assaulted by a stranger. We have recognized this by recent changes in statutes regarding child sexual assault. Indeed the violence by a husband is even more traumatic than that by a stranger because the wife has been sexually assaulted by someone she trusted.

Recently someone suggested to me that immunity from prosecution is justified because marital rape is hard to prove. Granted there are many rape cases and other crimes which are hard to prove, however no one suggests ignoring those crimes for that reason. Victims should have the same rights whether assaulted by a friend, husband or loved one.

Further there is a notion that a wife will bring false and malicious accusations of rape against her husband. Women in rape trials often feel that they are on trial, so the rationale that wives will bring malicious accusations can be discounted.

STANDING TOGETHER AGAINST RAPE
PO BOX 103356 ANCHORAGE, ALASKA 99510

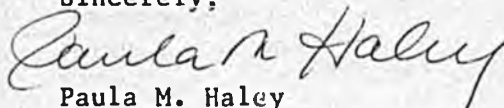
Thanks to you it works for all of us. A United Way Agency

page 2 continued:

Rape is not matrimonial misconduct. It is a violent act of abusing the victim's body, violating her right to privacy and inflicting physical, emotional and psychological harm to the victim. The legislature should abolish Alaska's marital rape defenses by enacting SB 528. Alaska could then join sixteen other states who have acknowledged the violence of rape and removed marital rape exemptions.

Should you have any questions regarding my position on SB 528 please do not hesitate to call.

Sincerely,



Paula M. Haley
Executive Director

Alaska State Legislature

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

1024 W. 6th Avenue, Suite 203
Anchorage, Alaska 99501
Phone: (907) 274-1426

SENATE ADVISORY COUNCIL

MEMORANDUM

TO: SENATOR JALMAR KERTTULA
FROM: ELIZABETH J. HICKERSON
RE: MARITAL RAPE
DATE: January 21, 1984

CURRENT LAW

Under Alaska law less protection is afforded individuals who are victims of sexual assault and abuse if the perpetrator is the victim's spouse.

For one prosecuted under AS 11.41.410 - 11.41.440 (sexual assault in the first and second degrees and sexual abuse of a minor in the first, second, third, and fourth degrees) it is an affirmative defense that, at the time of the alleged offense, the victim was the legal spouse of the defendant unless the spouses were living apart or the defendant caused physical injury to the victim.

While separate domiciles of the marriage partners at the time of the offense and physical injury to the victim trigger protection under our laws, the victim's consent to sexual assault or sexual contact is not at issue in cases of marital rape or sexual abuse. Lack of consent to sexually abusive acts is defined by the Alaska statutes at AS 11.41.470:

> "without consent" means that a person
> (A) with or without resisting, is coerced by the use of force against a person or property, or by the express or implied threat of death, imminent physical injury, or kidnapping to be inflicted on anyone; or
> (B) is incapacitated as a result of an act of the defendant.

These violent acts defined above are protected by law only if the victim and perpetrator have entered into a marriage contract.

We have no means of assessing the occurrences of rape in marriage since few are ever reported. It does exist however. According to the statistics compiled by Standing Together Against Rape, between

January 1, 1982, and December 31, 1982, one percent of the female victims seen by the staff in Anchorage were victims of marital rape. Domestic violence is on the increase in Alaska. The Abused Women's Aid in Crisis in Anchorage provided shelter for 596 battered women in 1982, a 55% increase over 1981. These victims are particularly susceptible to sexual assault and abuse in a marital relationship.

PROPOSED LEGISLATION

Attached is draft legislation that abolishes all defenses in cases of marital rape or sexual abuse. The sole issue to be considered is whether or not the victim consented to the sexual acts.

Last session the laws pertaining to sexual abuse of minor were extended to include "statutory rape" or sexual penetration and contact between consenting minors. Since marriages involving minors is sanctioned under certain conditions in this state and other jurisdictions, the draft legislation exempts these cases from prosecution under AS11.41.434 - 11.41.440 unless the victim did not consent.

TREND IN OTHER JURISDICTIONS

According to the National Center on Women and Family Law, as of November, 1983, eight states had abolished marital rape exemptions. Rape by a spouse is treated the same as rape by a stranger in the following states: Florida, Kansas, Massachusetts, North Dakota, New Jersey, Nebraska, Oregon and Wisconsin.

Eight states have partially stricken, or limited the marital rape exemption so that rape by a spouse is a crime under most circumstances: California, Connecticut, Delaware, Hawaii, Iowa, Minnesota, New Hampshire and Washington.

CONCLUSION

By retaining the affirmative defenses in marital sexual assault and abuse cases, the state of Alaska interprets the marriage license to be an absolute right of the husband to sexually assault and abuse his wife.

Marital Rape: What Happens When Women Fight Back?

by Teresa Priem

In marital rape, the wife is the victim. But occasionally, the victim strikes back, and sometimes she kills her husband.

The National Clearinghouse on Marital Rape, a new project of the Women's History Research Center in Berkeley, California (see letter in *NWT*, Mar., 1981, vol. VII, no.3), has on file eleven cases in which marital rape or sexual abuse was a known factor in causing a wife to kill her husband. Four of these women are still incarcerated under lengthy sentences.

Definition and History of Legal Marital Rape

Rape is defined in the statutes of 36 states as forced sexual relations with someone other than the "perpetrator's" wife. So, for a woman to get the State to charge her husband with raping her, marital rape has to be criminalized in her particular state. The only states that have criminalized marital rape are Nebraska, Iowa, Oregon, New Jersey, California, Minnesota, Massachusetts and Connecticut--and only within the past seven years.

A New Hampshire bill criminalizing marital rape was voted on in April (*Ed. note: at the time we went to press, the outcome of the vote was not known.*) Assemlywoman May Newberger is sponsoring a New York bill, and a bill will soon be introduced in Wisconson--letters of support are crucial now. (Letters on the Wisconson bill can be sent to Representative Barbara Ulichny of Milwaukee.)

In the six remaining states where husbands are not specifically exempted from rape charges by statutue, the district attorneys could try to prosecute, but the judges could dismiss the charges if they think the English Common Law tradition applies. (See "The Common Law Does Not Support a Marital Exemption for Forcible Rape" by Dennis Drucker in *Women's Rights Law Reporter*, vol. 5, no. 2-3, Winter/Spring, 1979)

Thus it appears that a woman can use marital rape as a defense when she is being prosecuted for killing her husband only in the eight states where marital rape is criminalized. In fact, even in Oregon, after the exemption for husbands was removed, Greta Rideout"s divorce attorney told her before the trial of her husband John for raping her, that marital rape was not a grounds for a divorce in Oregon. (From the Clearinghouse pamphlet on Greta Rideout before, during and after the trial, $2.00. After his acquital, John publically apologized, and they reconciled. However, she divorced him after he became violent.)

So even though marital rape is criminalized, it is often not taken seriously, and criminalizing it may not necessarily provide an adequate legal defense for a woman who defends herself against her husband's sexual attack.

The original comment exempting husbands from being charge with the rape of their wives was made by England's mid-17th century Chief Justice Sir Matthew Hale, who was also known for his overzealous hanging of witches. He wrote that:

> *"the husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent and contract, the wife hath given up herself in this kind unto her husband, which she cannot retract."*

200 years later, Justice Pollock in England still insisted that "a wife cannot resist her husband no matter how cruel or brutal" because she gave up her right to consent by marrying him.

300 years after Hale, his doctrine is still enforced in the 36 states which protect husbands married to their victims. Furthermore, in 13 states, it is legal for a man to rape the woman he is merely living with; and in four of these states, he can only be charged with a lesser degree of rape of a date ("voluntary social companion") with whom he

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has had previous voluntary sexual intercourse. And in West Virginia, he can be charged with a lesser degree of rape even if he has not had previous voluntary sexual contact with his date. (The breakdown by states is available from the National Center of Women and Family Law, 779 Broadway, Suite 402, New York, New York 10003)

Marital Rape as a Part of the Lives of Battered Women

Marital rape is an often unreported form of violence towards battered women. According to Dr. Lenore Walker (in a call made to the Clearinghouse in the fall of 1980), she discovered in reviewing the sample for her 1979 book, *The Battered Woman*, that 80% of the women had been raped by their husbands.

Many women do not describe their rapes as "rapes" but instead say "he forced me," "he used me," or "he took advantage of me. Saying the word rape makes the shame more acute and raises the intolerable question of how she is going to leave him.

Battered women are often raped, because they refuse to have sex or they refuse another of their husbands' orders. They are also beaten because they refuse sex. When women are beaten because they refuse sex, they sometimes submit after the beatings to prevent further beatings.

Because of this, men often say women want to be beaten as foreplay! This was John Rideout's attorney's basis for defense in the December, 1978 Oregon trial, because Greta finally submitted (after her jaw was nearly broken).

Deadly Fear as a part of the Lives of Battered Women

Many battered women have recently been accused of killing their husbands. And it's not because women are frequent killers. In the United States, the homocide rate for women is only 15% and declining. "Most women in this culture are trained to inflict their disappointments on themselves, we are taught not to become angry, but to become depressed and self-destructive...programed to commit suicide, not homicide." (from "The Lady is a Felon, the Harris Case is a New Morality Play for the Instruction of Uppity Women." by Anne Jones. *In Theses Times*, April 1-7, 1981)

According to a 1969 government report about as many wives kill their husbands as vice versa, but women are motivated by self-defense seven times as often as men (from "Battered Women--The Fight to End Wife-Beating" by Beverly Jacobson in *Civil Rights Digest*, Summer, 1977). "In many cases the homicide is an accident; the woman means merely to prevent or stop a beating, but a chance blow or hair-trigger brings death instead. But in all the battered women's cases from accident to justifiable homicide to premeditated murder, the women are impelled by deadly fear." (from "The Lady is a Felon")

According to Police Chief James Bannon, from 1971 through 1981, "all the men who were arrested in Detroit for killing their wives had previously beaten them." (from a phone call to Chief James Bannon in April, 1981 and *One Battered Woman Strikes Back, Murder or Self Defense?*" by Jane Lindsay, September, 1978)

Wives who report beatings to the police find little help or protection. A study done by Claudia McCormick in the Chicago jail shows that all the women who were there for killing their husbands had called the police at least five times. And 27% of the women said that the beatings became evem more severe after each arrest. (from *One Battered Woman Strikes Back, Murder or Self Defense?*)

Another obstacle that battered women face is that only 2% of the battering males are even prosecuted. (from "Battered Women, the Fight to End Wife-Beating." by Beverly Jacobson in *Civil Rights Digest*, Summer, 1977)

So what are the alternatives open to a battered woman? She can try to escape the situation knowing that he might eventually catch up with her, she can seek help--if it's available, she can be passive or she can fight back. According to Dr. Elaine Hilberman and Kit Munson in their study "60 Battered Wives":

"This passivity reveals an emotional state of helplessness and despair, plus feelings of incompetance, worthlessness, guilt, shame and being unlovable. The women felt they deserved the battering. The women were also trying to control their own aggressive impulses as a result of a violent encounter."

The women were also trying to control their own aggressive impulses as a result of violent encounter. "Passivity and denial of anger, then, did not imply that the battered women is adjusted or likes the situation. It is the last desparate defense against homicidal rage." (from *Victimology An International Journal*, vol. 2 [3--] 1977-1978)

So there is a fine line between being passive and fighting back. Battered, sexually abused and raped wives who fight back are of all ages and races with the common link of having abusive husbands. The accounts of some of these women will follow.

Bernadine Howard

Bernadine Howard is a marital rape victime who was convicted of the murder of her husband on November 1, 1980. She is still institutionalized. She comes from Richmond, California, which is near the location of the Clearinghouse. Bernadine is young, Black and poor. She was found guilty of second degree murder and sentenced to five to seven years in the California Youth Authority Correctional Institution in Camarillo, California, at the Ventura School. When called, Barbara Nious, Bernadines future parole officer when Bernadine is actually on parole, said that efforts to free Bernadine would be appreciated, especially since Bernadine won't be considered for parole for at least two years, and probably three.

Bernadine was only 18 when she killed her husband Lurria (Larry). The incident occurred in March, 1980, just three months after marital rape was criminalized in California. Therefore, Bernadine was able to plead self-defense since she was avoiding her husband's attempts to rape her.

According to the testimony of witnesses, Bernadine and Lurria had previously fought. Bernadine also told the police that Lurria was a karate trainee who practiced karate on her.

Her public defender, William Veale, said that the tape of her interrogation by the police was played at the trial and that she gave, "maybe five different statements to the police, totally contradicting herself." He said that her psychiatric state, as explained by psychiactric testimony showed that, "she could not tell the truth because she couldn't bear to look at what she did." Veale tried to show that Bernadine was mentally ill but not violently crazy. He believes that Bernadine is innocent and that the jury "was wrong and callous" because it judged so harshly on her mixed-up testimony to the police.

"The husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent and contract, the wife hath given herself up . . ."

On March 19, 1980, Lurria had come home around 3 a.m. after drinking at a neighbors apartment. Bernadine said that she hit him with a wine bottle four times to fend off his rape attempts. She said that they fought and then he beat her. Afterwards, Bernadine told her mother, Bessie Gilbert, that she got dressed and called Bessie from a neighbor's apartment (the same neighbor who Luria had visited). The neighbor testified at the preliminary hearing that he heard the couple arguing, then struggling, then Lurria telling Bernadine to put a knife down. He said that Bernadine came to his apartment, carrying a knife, to phone her mother. He said that Lurria staggered into the neighbor's and said, "Look, she hit me with a bottle" and then died. That was a curious thing for Lurria to say because medical testimony showed that Lurria died after being stabbed in the heart with an eight inch carving knife.

Bessie told the Clearinghouse that Bernadine called from the neighbor's apartment to say, "Larry's going to kill me!" Bernadine wanted her mother's help, but Bessie is crippled and has no car. Bessie said that she wanted to talk to Lurria, but he was yelling in the background, "It's our fight and stay out of it!"

Bessie emphasized that Bernadine, "hadn't cut him" before the phone call. When Lurria arrived at the neighbor's apartment, Lurria was in a rage and "there was no one to come to her rescue," sadly said Bessie. Bessie said her daughter told her afterwards that Bernadine shut her eyes and "stuck a knife in him in the neighbor's apartment. Bessie concluded, "She had to do it since he (Lurria) was going to kill her."

The neighbor committed suicide a month before Bernadine's trial, and Bessie is sure it is because he had guilt feelings pertaining to the incident.

"Saying the word rape makes the shame more acute and raises the intolerable question of how is she going to leave him."

Veale said that the main issue was not where the killing took place, but whether Bernadine was innocent of murder. He said that there was blood all over the Howard bedroom, and only one bleeding wound, so it was impossible to fight the physical evidence that Bernadine had stabbed him before entering the neighbor's apartment. (Bessie said that Bernadine told her that the blood found was from wounds he received from the bottle).

Prosecutor John McTigue argued at the trial that if Lurria had intended to rape his wife, he would have been found in some stage of undress. Instead, all of Lurria's clothes were fastened when he was examined. The prosecutor said that Lurria's clothes did not show any signs of the struggle that Bernadine described, and that the scratches she had received were consistent with his defending himself from her hitting him with a wine bottle. The jury was swayed by the prosecutor's arguments and found Bernadine guilty.

An employee at the Ventura School told Bessie that if Bernadine "obeys, she'll only get two more years." So Bessie has resolved herself to helplessly accept Bernadine's conviction because Bernadine is getting the education she needs and couldn't get before. In fact, Bessie said that the schooling will keep her daughter "off the streets" and out of trouble. Bernadine recently phoned Bessie saying that the authorities are "so good to her that she's really satisfied."

But Bessie has mixed feelings. She would also like to have her daughter home. Bernadine's imprisonment is a hardship for Bessie because she is unable to visit her daughter since the school is far from any bus service. Bessie doesn't know where to turn for help, nor does she have the money to pay for assistance. The Clearinghouse is trying to connect her with interested organizations. (Our sources are Barbara Nious, Bernadine's future parole officer; Bessie Gilbert, Bernadine's mother; and William Veale, Bernadine's defender - all interviewed by phone in March and April, 1981; plus the *Contra Costa Times* of November 2, 1980, and the San Francisco *Examiner* of November 4, 1980).

Juanita Davenport

Juanita Davenport, a white 48-year-old mother from Cave Junction, Oregon, pleaded no contest to the manslaughter of her husband who had sexually abused her during their thirty year marriage. Her husband, Roland, 59, was described in court testimony by their 28-year-old daughter, who had also been sexually abused by Roland, as "somewhat of a cross between Charles Manson and Hitler."

According to a call to District Attorney Bob Burrows, Roland had been impotent so he "engaged in vicarious sex" by making her have sex with others while Roland looked on. Burrows also indicated that Roland even attempted to mate her with a dog once.