ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 8672

2488 HJ SB 346

2488

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

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

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

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

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

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

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

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

rbic acid in schizophrenic patients has been shown by Cowan et al. (1970) and iously by Herjanic and Herjanic (1969) and VanderKamp (1966). Current ies by Pauling and Robinson and by Herjanic are reported in Chapters 2 and 14 his volume.

igh doses of ascorbic acid may occasionally cause mild diarrhea in some viduals and it may cause false positive urine tests in diabetics who use commercial e test kits. A case is also reported in which ascorbic acid shortened the pro-mbia time in a patient who was receiving a Warfarin (Coumadin®) anticoagulant senthal, 1971). In treating over 5,000 patients with 4 grams or more of ascorbic per day, however, we have not had a single instance of any serious side effects.

/e explain to patients that vitamin B6, pyridoxine, is necessary as a precursor of tinic acid. It is an intermediary step in the biotransformation of tryptophan to tinic acid where it is required for the hydroxylation of kynurenine (derived from tophan) to 3-OH-kynurenine and for the further metabolism of 3-hydroxyky-nine to 3-hydroxyanthranilic acid (immediate precursor to nicotinic acid; Gibbs Walshe, 1969). Vitamin B6 deficiency interferes with the metabolism of amino s, proteins, and biogenic amines, and causes abnormalities of nervous system vity in man, where the pathological effects of deficiency are most marked on the loping brain. Abnormalities of vitamin B6 metabolism have been associated not with schizophrenia but also with a variety of other abnormalities of the central ous system, and B6 deficiency at the subcellular level may be produced by a ber of antimetabolites (Knapp, 1966; Coursin, 1969). The antagonism between min B6 and L-dopa is a recent illustration (Duvoisin et al., 1969; Cotzias and avasilion, 1971). Pyridoxine in high doses has been used by Cott (1969) in the tment of childhood schizophrenia. The role of pyridoxine in psychiatric disorders recently been summarized by Ananth, Ban, and Lehmann (1972) in their paper tled "Potentiation of Therapeutic Effects of Nicotinic Acid by Pyridoxine in onic Schizophrenics" presented at the Canadian Psychiatric Convention in ntreal, June 8, 1972. This paper states that pyridoxine potentiates the action of tinic acid, possibly by opening up the kynurenine cycle of tryptophan metabolism thereby decreasing the formation of indoles. In their study, already referred to, doxine alone had a therapeutic effect in schizophrenics as well. In more than 0 patients we have not observed a single side effect from pyridoxine administra-of 200 mg daily.

is best to write down the medication schedule and the recommendations for p and diet on a card and give it to the patient at the initial visit. It is also advisable dicate to the pharmacist that all medications be labelled to show the name and age size. Unless this is done, there will be mistakes and many call-backs as most ents are perceptually disordered and unable to remember verbal instructions.

summary, the addition of megavitamins is inexpensive and safe, and very itively influences the long-term outcome. Side effects of a serious nature are quite

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

INVOLVEMENT OF THE PATIENT IN AN INTEGRATED COMMUNITY TREATMENT SYSTEM

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

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

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

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

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

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

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

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

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

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

PSYCHOTHERAPY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESULTS AND RESPONSE TO TREATMENT

General Problems in Evaluating Treatment Results in Schizophrenia

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

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

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

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

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

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

Practical Factors: Acceptability, Applicability, Cost, and Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Joining Schizophrenics Anonymous and taking part in the activities of the schizophrenia associations further reduces costs in that they supply specific group therapy at no cost to the patient. When the cost of treatment in the average case is prorated over a three-year period the annual cost of treatment itself will amount to only a few hundred dollars, which compares very favorably with any other available treatment system. Even in those cases where hospitalization is necessary the comparative cost is still relatively low because the average duration of hospitalization with this treatment method is only 5 weeks, and rehospitalization is seldom necessary except in a very chronic and severe case where the patient has been ill since childhood.

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

> A 34-year-old housewife developed schizophrenia postpartum. She had been hospitalized and then treated unsuccessfully for two years. When the patient applied for treatment at the clinic she was depressed and relatively immobilized, with a HOD score of 110. On a treatment regimen of megavitamins, hypoglycemic diet, phenothiazines, antidepressants, and supportive therapy, she clinically remained essentially the same, with neither symptomatic nor behavioral improvement.
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> Serial HOD testing showed, however, that the score was coming down progressively. It was not until the fourteenth month of treatment, when the HOD score got down to 30, that her symptoms finally disappeared and she resumed total functioning. Two months prior to her behavioral recovery the question of hospitalization had arisen. Because of the trend of the HOD scores, however, hospitalization was not advised, as it appeared to be only a matter of time before the HOD score would finally reach the level where recovery would occur.

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

Evaluation of Effectiveness

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

OFFICE PRACTICE

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

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

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

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

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

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

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

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

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

HOSPITAL PRACTICE

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

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

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

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

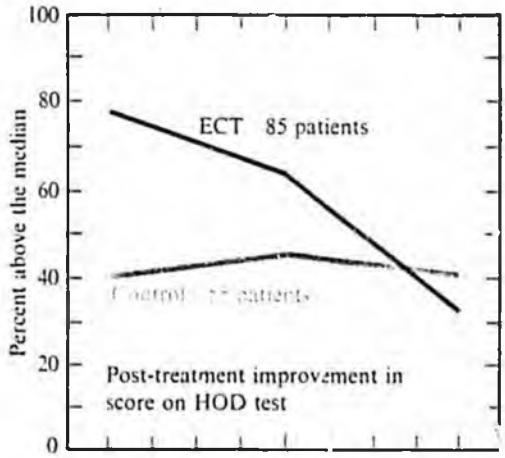

FIGURE 30-1.

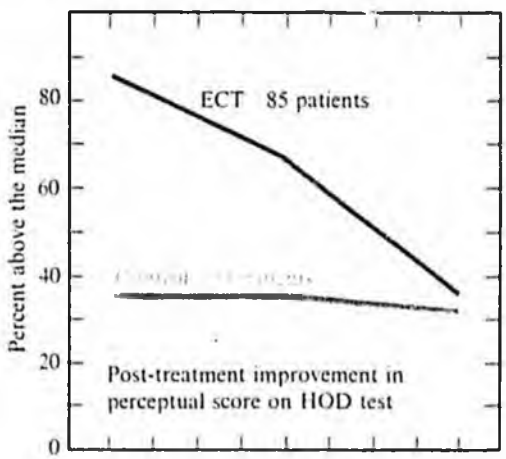

FIGURE 30-2.

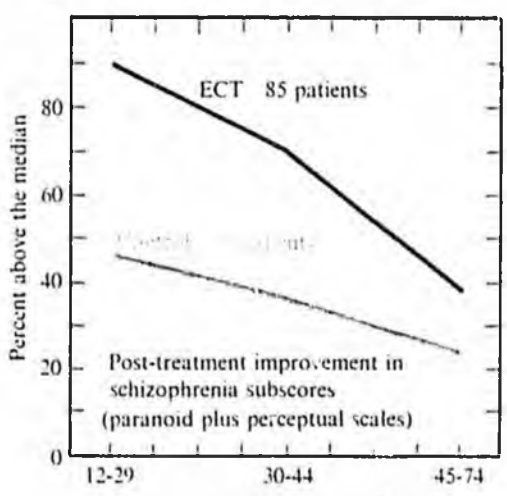

FIGURE 30-3.

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

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

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

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

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

CLINIC PRACTICE

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

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

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

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

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

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

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

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

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

> A 30-year-old chronic schizophrenic patient was brought to the clinic after having had 15 years of continuous prior treatment, including six hospitalizations where she had a full course of insulin shock treatment plus a total of 125 electroshock treatments. The family indicated that this was to be the last trial of treatment before they would reluctantly have to accept permanent state hospital placement for the patient. The family reported that she was incontinent, refused to wear her false teeth, constantly rocked, and was uncommunicative. She therefore presented a considerable nursing problem for her parents.
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> The patient was placed on an overall treatment regimen of hypoglycemic diet, megavitamins, phenothiazines, and thyroid. She responded very slowly, but by the end of two years her appearance was markedly improved, she used make-up, wore her teeth, spoke politely, had stopped rocking, and had long since been continent. The family was able to take her on social family visits, and could travel in public with her.
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> This patient was far from recovered, however, in that her affect was flat, her behavior was still moderately inappropriate, and her overall style was awkward and somewhat stilted, but her family was extremely pleased. The treatment also had been based on bi-monthly and then tri-monthly visits, which were within the family's financial capacity.

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

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

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

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

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

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

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

> A 44-year-old man with chronic paranoid schizophrenia of 10-years duration had been given up as hopeless after many years of treatment. The family kept him home in an upstairs room where his condition was disturbed and dishevelled. He screamed obscenities at his hallucinatory enemies, refused to change clothes, refused to take any medication, and exhibited no interest in external events. The family came to the clinic, learned of the megavitamin treatment and worked out a combination of vitamins titrated with bicarbonate of soda and flavored with chicory, which was then placed surreptitiously in all of his beverages.
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> After a few months he began to respond and improve, and at that point a small dose of thioridazine in liquid form was added to his formula. By the end of the year he had become a clothes dandy, carried on a normal conversation, was no longer hallucinating, was calm, read a daily paper, watched television, and answered the telephone. Two years later he continues to do well and is planning to live on his own, which has created apprehension with the family, as they are still reluctant to inform him of their secret treatment. When they finally tried to persuade him to take megavitamins he said he didn't think he needed them as he had been doing pretty well on his own for the last few years!

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

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

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

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

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

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

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

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

GROUP AND HALFWAY HOUSE EXPERIENCE

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

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

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

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

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

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

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

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

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

SUMMARY

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

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

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

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

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

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

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

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

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

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

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

Liability of hospital for refusal to admit or treat patient. 35 ALR3d 841.

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

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

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

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

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

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

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

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

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

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

Hospital's liability for negligence in selection or appointment of staff physician or surgeon. 51 ALR3d 981.

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

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

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

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

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

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

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

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

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

Arbitration of medical malpractice claim. 84 ALR3d 375.

Malpractice in connection with electroshock treatment. 94 ALR3d 317.

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

Sec. 18.20.020. License required. No person or government unit, except the federal government, acting severally or jointly with another person or governmental unit may establish, conduct or maintain a hospital in the state without a license. (§ 40-6-3 ACLA 1949; am § 3 ch 112 SLA 1957)

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

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

If a person establishes a hospital which gives general and medical treatment and in addition provides nursing service, both aspects of hospital operation are nonetheless within the same hospital, and there is no justification for breaking up the operations of one hospital into separable units for licensing purposes; therefore, one license should be required for the entire hospital operation. 1963 Op. Att'y Gen., No. 7.

Collateral references. — Licensing and regulation of nursing or rest homes. 97 ALR2d 1187.

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

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

Sec. 18.20.045. Insurance required.

Repealed by § 40 ch 177 SLA 1978.

Editor's notes. — The repealed section derived from § 39, ch. 102, SLA 1976.

As to purpose of repealing act, see § 1, ch. 177, SLA 1978 in the 1978 Temporary and Special Acts and Resolves.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect of amendments. — The 1980 amendment substituted "90" for "75", and "10" for "25", deleted "except that in communities designated as poverty areas the ratio shall be 80 percent state money to 10 percent community money" following "community money" near the beginning of subsection (c), inserted the second sentence of subsection (e), and substituted "Review" for "Advisory" near the end of the third sentence of subsection (c).

Article 6. Mental Health Program.

Section
655. Purpose
660. Powers and duties of department

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

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

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

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

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

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

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

Editor's notes. — The parenthetical expression in the first sentence was added by the revisor of statutes pursuant to AS 01.05.031.

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

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

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

(3) administer AS 47.30.660 — 47.30.915;

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

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

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

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

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

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

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

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

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

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

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

Editor's notes. — Section 6, ch 84, SLA 1981, provided: "Except as provided in this Act, the provisions of AS 47.30.660 — 47.30.915 enacted by sec. 1 of this Act do not in themselves impair any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

Article 7. Voluntary Admission for Treatment.

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

Editor's notes. — Section 6, ch 84, SLA 1981, provided: "Except as provided in this Act, the provisions of AS 47.30.660 — 47.30.915 enacted by sec. 1 of this Act do not in themselves impair any action taken in a proceeding pending under statutes in effect before October 1, 1981, nor do they apply retroactively to terminate the detention of a person previously committed under statutes in effect before October 1, 1981. However, 90 days after October 1, 1981, the provisions of this Act apply to all persons committed under statutes in effect before October 1, 1981."

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

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

(1) notice of rights as set out in AS 47.30.825 — 47.30.895 and an explanation of any document served upon him; and

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

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

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

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

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

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

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

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

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

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

Article 8. Involuntary Admission for Treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) to present evidence on his behalf;

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

(8) to remain silent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 47.30.770. Additional 120-day commitment. (a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 120-day commitment conforming to the requirements of AS 47.30.740(a) except that all references to "24-day commitment" shall be read as "the previous 90-day commitment" and all references to "90-day commitment" shall be read as "120-day commitment".

(b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 — 47.30.760. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 120 days from the date on which the first 90-day treatment period would have expired.

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

(d) Findings of fact relating to the respondent's behavior made at a 24-day commitment hearing under AS 47.30.735, a 90-day commitment hearing under AS 47.30.755, or a previous 120-day commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings. (§ 1 ch 84 SLA 1981)

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

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

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

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

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

Sec. 47.30.795. Involuntary outpatient care for committed persons. (a) A respondent who was originally committed to involuntary inpatient care under AS 47.30.700 — 47.30.915 may be released before the expiration of his commitment period if a provider of outpatient care accepts him for specified outpatient treatment for a period of time not to exceed the duration of his commitment, and if the professional person in charge, or his professional designee, finds that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 9. Patient Rights.

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

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

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

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

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

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

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

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

(8) A patient upon discharge shall be given a discharge plan specifying the kinds and amount of care and treatment he should have after discharge and such other steps as he might take to benefit his mental health after leaving the facility. The patient shall have the right to participate, as far as practicable, in formulating his discharge plan. A copy of the plan shall be given to the patient, his guardian, the court if appropriate, and any follow-up agencies. (§ 1 ch 94 SLA 1981)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) a person authorized by a court order;

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

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

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

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

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

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

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

(1) seeking employment;

(2) resuming or continuing professional practice or previous occupation,

(3) obtaining or retaining housing;

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

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

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

Article 10. Miscellaneous Provisions.

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

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

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

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

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

Editor's notes. — This section derives from former AS 47.30.180 and was renumbered by the revisor of statutes under AS 01.05.031 to accord with the revision of the mental health statutes in Chapter 84 SLA 1981.

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

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

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

(2) a discharged indigent patient is furnished

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 47.30.915. Definitions. In AS 47.30.660 — 47.30.915

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

providing information or making allegations;

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

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

Chapter 35. Private Institutions.

Article 1. Foster Homes, Boarding Homes and Institutions.

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

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

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

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

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

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

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

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

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

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

Sec. 47.35.050. Duration of license or permit.

Repealed by § 5 ch 97 SLA 1982.

Cross references. — For present provisions covering the subject matter of the repealed section, see AS 47.35.040(b) and (c).

Editor's notes. — The repealed section derived from § 6, ch. 17, SLA 1951; § 5, ch. 42, SLA 1973; § 3, ch. 45, SLA 1977.

Sec. 47.35.055. Provisional license. (a) The department shall issue a provisional license to a new facility if the facility submits to the department an acceptable plan for operation that is in conformity with the provisions of AS 47.35.010 — 47.35.080 and the regulations adopted under AS 47.35.010 — 47.35.080. After the department determines that the new facility is operating in conformity with the provisions of AS 47.35.010 — 47.35.080 and the regulations adopted under AS 47.35.010 — 47.35.080, the department shall issue a license under AS 47.35.040 to the facility.

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

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

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

Sec. 47.35.080. Definitions. In AS 47.35.010 — 47.35.100

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

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

WITNESS REGISTER

BILL NUMBER Mental Health Commitment Laws DATE Oct. 14, 1983 (Anchorage)

NAME	REPRESENTING	ADDRESS	PHONE NUMBER
Jerry L. Schrader MD	Alaska Psychiatric Ass.	4801 Miller Dr., Anch.	561-1361
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Liz Snow	Fifth Ave Theatre		
Deborah B. Goldman, MD	Private Psychiatrist	626 F St Suite 102	338-6151
Tosef J. Par	MOA/DSS	Pouch 6-650	264 6534
D. Conrad MD	API	2900 Providence	561-1633
L. Markwood	"	"	"
David R Samson MD	ACMHC / APA	1020 F 4th 99501	276 5400
Natalie Goldstein	ACMHA	2611 Fairbanks St	276-1705
Val Vankozen	Self	1309 G Street, Anch. AK	272-0200
Linda Birch	Anch. Com. Mental Health	1577 C St- anch	278-4558
Steve Harrison	Division Mental Health Chief	3601 'C' Street Anc	561-1247
Frances Purdy	Behavioral Health Division Manager of Bur	Pouch 6-650 99502	264-4876
Jim Parsons	Behavioral Health Div. Manager of Bur.	625 C St 99501	264-4775
Judy Kleinkauf	Alaska Nat'l Ass. Social Workers		

MENTAL HEALTH COMMITMENT LAW

Senate HESS 9/23/83

Attendance: Josephson, P. Moss. Sens. V. Fischer, P. Fischer, and Halford excused.

018 Josephson convened meeting regarding mental health commitment law testimony.

093 Josephson: Our purpose today is to receive testimony on the question of mental health commitment. I think our purpose would be better served if those wishing to testify could talk to how you evaluate the existing law, what changes you would like to see, rather than to address any specific work draft as a mark-up vehicle.

120 Sonya Benson, representing Representative Niilo Koponen: I don't have any specific testimony at this time.

129 Mrs. Ann Denardo, Family of Chronically Ill Victims, Fairbanks: Our son is schizophrenic and housed at A.P.I. We've had a lot of experience of with this commitment act and we find it to be burdensome, vague, and emotional. We feel families should have a great role in commitment procedures. A broader criteria for commitment should be studied based on ability to function with thought processes.

198 Denardo: Under paragraph 7, 'gravely disabled' means a condition in which a person is a result of mental illness. We would like to add 'or is not receiving such care in mental medical treatment as is necessary for health and safety' or 'a person who thought processes, perception of reality or judgment is substantially impaired'.

230 Josephson: Has this language been used anywhere else?

273 Denardo: I've studied other acts from other states, and this language comes from a combination of law in two or three other states. We also suggest that a study be done of other commitment acts.

299 Denardo: Commitment procedures should be redefined, with a view to creating a less adversarial situation and family. Court procedures are either civil or criminal. Commitment comes under civil procedure. In civil procedure, there has to be cross-examination and rules of evidence presented. This puts family members in the position of testifying against their child. I would like to suggest that the legislature study the possibility of another procedure, not civil and not criminal, but a procedure just for mental commitments.

335 Denardo: Mentally ill patients should receive better continuity of care as they move from hospital to community. Commitment procedures should reflect this need. We feel that the courts should be better apprised to the mental health system and the whole problem of severe mental illness.

374 Josephson: What do families experience in Fairbanks, being far from API? What happens as the family member enters the system?

389 Denardo: First of all, there aren't very many involuntary commitments from Fairbanks because we do all we can to convince the patient that they should go in on a voluntary admission. It's emotionally easier because the court procedures are skipped. We then have to pay for transportation to A.P.I. I think this is a legislative oversight. When there is an involuntary commitment, the patients airfare is paid to Anchorage. We have asked for designated beds. We desperately need a psychiatric unit here in Fairbanks. There are approximately 200 chronically mental ill people in this area. We have no half-way houses or programs. The Community Mental Health Center struggles along on a few dollars. They have a small day treatment program, but it's insufficient for the needs of the community.

421 Denardo: Because of the high cost of travel, meals, hotel accommodations, rent-a-cars, etc., I am only able to visit my son once a month. We feel that the most important part of treatment for the patient is proximity to family and friends.

477 Denardo: Twenty years down the line, we will look at the neuroleptic medications as pharmaceutical labotomies. With this medication, the patients are not cured. They are put into a medicated miasthma. They can't move. Patients say that the medication makes them feel unpleasant, sick, and tired. My own son was taken off the medication because he couldn't get out of bed. This is the condition in which he returns home.

510 Josephson: For the schizophrenic, is it the only thing we have?

559 Denardo: There are no other therapies that professionals are using at this point. At this time, more than 20% of the patients don't respond to this medication. Some patients do come out of their psychotic state, but many others fall into the pharmaceutical labotomies. Eventually, all patients develop a nervous disorder, which is totally irreversable. In many cases, the liver of the patient is ruined.

601 Josephson: Do you have any anxiety that the language, 'a person whose thought processes, perception of reality or judgment is substantially impaired', could be abused by commiting people who are eccentric, etc.?

610 Denardo: No. The screening process is cumbersome and is so comprehensive that I can't see an eccentric person being committed.

621 Josephson: Is your organization part of a national group?

629 Denardo: We are part of The National Alliance for the Mentally Ill.

683 Denardo: There is inappropriate jailing of mental ill patients. People having psychotic crisis are treated as criminals. Once they get into the criminal system, it is quite hard for them to get out of it. They get on probation, they get put into A.P.I. and know that when they are released, they have to return to jail for breaking probation. They, in turn, have no incentive to be released for A.P.I.

740 End of Side A. Turned to Side B

001 Cathleen Nixer, Nurse Manager, Psychiatric Inpatient Unit, Fairbanks Memorial Hospital: Many of the problems we face with the mental health system, is based on a premise that the mental health service delivery system in Alaska is decentralized, when in fact, it is not. When the Mental Health Law was passed in 1981, there was only one in-patient treatment facility in the state, A.P.I. Today, there still remains only one designated in-patient treatment facility in the state.

103 Nixer: The easiest way for a mentally ill person to receive treatment would be through the commitment process. They at least receive care why the legal process is taking place. It's sort of a Catch-22 situation, since we encourage people to accept voluntary treatment, yet we provide no funding for this treatment.

210 Moss: What is the average number of patients in the Fairbanks facility?

216 Nixer: Our average daily count runs around 7 to 8 patients. We have an 11 bed in-patient unit, with a proposal for 1985 for 17 beds.

270 Josephson: What is the longest patient stay you've experienced?

274 Nixer: Approximately 30 days.

305 Moss: Will the 17 beds be additional beds?

308 Nixer: Yes.

318 Moss: Are you receiving any federal funding?

326 Nixer: Sometimes patients are eligible for the standard medicaid programs. We would like to see patients who may voluntarily elect to seek their treatment after a commitment process in Fairbanks, which is close to their home.

458 Maureen Phillips, Board of NARA: The designated bed problem has come up in a recent meeting with the NARA Board. The University of Alaska health coverage for mental illness does not allow for patients to be admitted to anything other than a "designated mental facility", not designated medical floor a hospital. I feel it is important that something be done about the designated bed situation here in Fairbanks.

491 Josephson: That appears to conclude the testimony this afternoon. We will make minutes of this meeting available to our colleagues who are absent today. Thank you very much for coming.

538 Meeting adjourned.

Senate Health, Education & Social Services Committee
October 14, 1983
Anchorage

TOPIC: Mental Health Commitment Bill (Work draft of "An Act relating to the treatment of mentally ill persons.")

ATTENDANCE: Senators J. Josephson (Chairman), R. Halford
Excused - P. Fischer; Absent - V. Fischer, H. Moss

The hearing was commenced at 9:15 by Chairman Josephson.

Introductory remarks by Chairman Josephson:

Previously we've heard testimony in Anchorage and recently in Fairbanks on this issue.

This new draft incorporates ideas from Department of Health and Social Services, family groups and others, particularly those who work with troubled children.

New draft incorporates these changes: involvement of correction system is reduced in terms of dealing with the mentally ill; age change from 14 to 18; time computations changed from 21-90-120 days to 30-90-180 days for commitment periods; commitment period for minors changed from 21 to 30 days; records can be made available to law enforcement agency if substantial concern over any danger to community; qualifier added to right to privacy and personal possessions - if professional in charge determines not in the best interest of patient or will pose a threat to safety, visitors and telephone calls can be denied; approval of psychologist would be added requirement for patient wanting to change from involuntary to voluntary; court proceeding would be as informal as possible; family and guardians would be notified if patient is absent without leave; form consent required of parent or guardian of patient's right relating to alternative treatments; and notification of parent or guardian of discharge plan.

Other areas you may wish to consider today; hearings for minors; equal protection of the law relating to minors; time period commitment for minors; designated facilities; involuntary outpatient commitment; use of correctional system for mentally ill; and transportation costs for voluntary committed people where costs are paid for as required by statutes.

40 Jerry L. Schraider, M.D., Alaska Psychiatric Association

Appreciate the hearing being held, general reaction to working draft is supportive.

Have often been frustrated and confused over commitment law, mental health professionals are not all legalistically minded, don't have available legal counsel when working in these situations (often crisis situation) and must proceed best we can in interest of patient. Because of confusion, believes there's been some people that should've been committed who were not.

Will study draft further and hopes it will be submitted as legislation.

170 Ed Essa, Staff, Rep. Mae Tischer

Submitted letter addressed to Senator Josephson by Rep. Tischer stating that extensive research has suggested that nutritional deficiencies have a correlation with mental illness and that when deficiencies are identified and treated, improvements in the mental health of clients are made. Propose that the draft bill require extensive and mandatory nutritional analysis of each client be made upon admittance. This way the client is treated both mentally and physically.

190 Deborah B. Geeseman, M.D., private psychiatrist (formerly did work with children at API)

Supports most of what's in the bill. Suggested minor changes - 1) Pg 5, ln 19; instead of "21 days" should be 30 days. 2) Pg 4, ln 7; "the person" should be self.

Need a better working relationship with police force and understanding of what goes on with commitment laws.

Admission of minors - child under 14 cannot remain in hospital for evualation or treatment for no more than 21 days (under current law) without having a commitment hearing. An adult who wants to be voluntary committed may stay in hospital as long as they want or treatment facility deems necessary. Then if they want to leave hospital, it becomes a legal issue.

For children, often a good evualation cannot be made until after 3-4 weeks. Limited resources are available for treatment of children in Alaska. Only have one facility for extensive psychiatric treatment. Have some facilities for conduct and behavorial management of children (but full and have a waiting list).

260 Supports change in age from 14-18.

Pg 2, lns 23-29; not sure you need any of these three criteria, one just needs to make sure the person is mentally ill or gravely disabled. Or if it remains in #3 (pg 3, ln 1) should be "deteriorate further if" not "treated" (add not to sentance).

290 Sen. Josephson - While at API you noted that severe psychosis does not appear that often below the age of 14, correct?

Yes.

Sen. Josephson - What additional facilities do you feel Alaska needs for young children?

Difficult in state with our small population and distance from other states (where we could jointly share use of facilities). Presently we don't have a sizeable population of psychiatric young children. When we do, they will need a place, the only facility we have now is API. Would like to see other facilities that would address more extensively psychiatric needs of children.

PART II

As draft now stands, court has to get involved in 30 days, recommends 30 days be taken out, child could be a voluntary patient.

Many times children need evualation when they encounter some trauma (ex: divorce of parents). If that evualation goes beyond the time limit set, they could end up with commitment as legal statement on their record. If it remains on their record, can hamper their future.

Pg 3, Section 47.30.695; support it but has trouble with the wording. #2, lns 18-21, part (a)(b) (lns 22-29) - believes it to imply if child is dangerous, can still discharge them against medical advice. Dosen't feel its consistant. #2, ln 18; should read "treating physician," release of (should be added) "the minor" would be seriously detrimental to child's health that (should be added) "the treating physician may". (b) lns 26-29 the minor is likely to cause serious harm to self or others, or there's reason to believe the release could place the minor in immediate danger (should be added) "refuse to discharge".

60 Joseph Reum, Handicapped Services Coordinator, Municipality of Anchorage

Pg 4, ln 26 - "commitment hearing, to be held if needed", Who determines need?

Sen. Josephson - Depends whether patient is voluntary or involuntary.

80 Dr. Conrad, Superintendent, API

Submitted memorandum on admission statistics for FY'83.

Out of 1013 admissions, 500 were voluntary, 36% came involuntary under Title 47. Out of 100 involuntary patients, 73% have dropped out of involuntary channel before 72 hour limit.

Agree with Dr. Geeseman's comment on page 3 that paragraph 2a is inappropriate, not allowed that option with an adult.

Under present statute, cannot release information on history of violence to law enforcement agencies. In our judgement, release of this information (when there's concern about safety) might be helpful.

140 Patient would be better served by expeditious entry into treatment using physician's certificate. Most times used is after a suicide attempt.

150 Sen. Halford - In analysis of American Psychiatric Association guidelines, we don't allow certain types of evidence, we protect communication between patient and doctor. What kind of a problem does this bring up in involuntary commitment?

Has caused a problem by not allowing hearsay evidence at commitment hearing. Often it's highly relevant and meaningful evidence but due to rules of evidence not allowed because it's hearsay.

180 Often relatives and other people are frightened to testify for fear the person being committed will hold a grudge or seek revenge later. Also consider some people (to testify) live far away (would be expensive for transportation cost).

200 Sen. Josephson - What happens during, example a domestic conflict and people exaggerate testimony or state it falsely?

When it does occur, then don't rely on element of danger but fall back on object of evidence of mental illness. Do not proceed to commitment hearing if lacking evidence of mental illness.

210 In vast majority of cases, most do not go forward to hearing, and where there is mental illness, majority of patients accepts need for treatment. When cases do go to court, public defenders and probate masters become very involved.

240 Sen. Josephson - What is treated as confidential?

Commitment hearing itself is confidential.

260 David D. Samson, M.D., Psychiatric Supervisor, Anchorage Community Mental Health Center.

Mentally ill are more prone to be brought in for disturbing peace, public nuisance kinds of things, where their liberties are not essentially protected.

Concept of outpatient commitment should be addressed. What do you do when outpatients don't show up for their scheduled appointments?

Generally supportive of draft and comments that have also been made.

PART III

Voluntary medication on outpatient is a problem. Sometimes people are crafty enough to manipulate the system and be released (these are the dangerous ones).

30 Natelie Gottstein, Executive Director, Alaska Mental Health Association

Commends Committee for making changes, particularly inclusion of physician to be able to institute commitment procedures and redifinition of gravely disabled.

Pg 2, ln 10; concerned about definition of "timely", what's considered timely?

Dr. Conrad - Would interpret to be 8-12 hours.

70 N. Gottstein - Pg 16, ln 5; definition of mental health professional - important people working in the bush (social workers, etc) be included in this definition. A further clarification of social worker might be in order due to so many areas of social work.

90 Sen. Josephson - There's another bill on licensing of social worker and we may run into some difficulty with that.

100 Sen. Josephson - Is there an official position by Mental Health Association on this?

Not on this, but we will make recommendations before January.

Sen. Halford - What does Association think in terms of communication between doctor and patient, should be available in commitment hearings or not?

Don't have an official position. My opinion - if hearings are closed, then in very specific and well defined instances, that privilege should be opened. In individuals right to receive treatment, the doctor's opinion certainly is an important matter.

Sen. Josephson - Question of changing or relaxing rule of confidentiality, would it have the effect of causing people not to tell doctors what they would otherwise say? Or would it have a useful affect in bringing these matters out into the commitment hearing? The real danger would be if patients refused to give information to their doctors for fear it would be used against them (in court). That people shouldn't be afraid to see a psychiatrist when they have problems.

These relaxations in confidentiality need to be carefully worded, possibly be limited to psychiatric people for involuntary commitment.

Dr. Jay Verkozen, clinical psychologist (private practice)

Pg 13, lns 27-28; issue of psychosurgery, lobotomy, or other comparable forms of treatment. Not specific with other comparable forms. Consider these types of barbarisms and should be done away with. Psychosurgery has been abused.

PART IV

Sen. Josephson - (to Dr. Conrad) Has there been any record keeping in Alaska of psychosurgery or lobotomy given?

Dr. Conrad - No, the only way would be to ask all the neurosurgeons. Electroshock - no one to my knowldege at API has been administered with it.

J. Verkozen - But it does go on regularly at Providence.

Pg 14, lns 19-23; suspension of people's rights; if you're going to do something to someone, need to be clear about it with the person and if it's not in their interest to know about it, then it shouldn't be done.

You can't treat people psychologically unless you get them involved in it. If somebody might be better off with something, it dosen't mean you can force it on them.

Pg 8, ln 20 (#4) "efficient" - efficient for what? For commitment? For civil liberty?

Pg 8, ln 15 (#2); Right to view and copy all petitions - they should be given copies and helped to understand it.

Pg 12, lns 25-27; good point that family or guardian be notified on patient's absence.

Pg 11, ln 14; Disagree with 180 days for commitment, more advantageous for longer length of time.

Pg 5, ln 22; "gravely disabled" - too broad.

Pg 6, lns 4-5; replace "maximum extent possible" with absent of violence.

PART V

Dr. Conrad - Two cases of patients at API treated involuntary: 1. if violent to themself or to others; 2. severly catonic people (who don't eat or drink)

J. Verkozen - Pg 6; objects to (e)(2) and (3), lns 14-18; aren't necessary.

Pg 13, ln 9; objects to 72 hours, procedure should be speeded up rather than be long.

Pg 4; notion of deputizing all physicians in state so they can commit someone. This authority should stay with the police. All physicians shouldn't have this type of power. You're just making a cosmetic change, you're still locking someone up.

Dr. Glade Birch, Acting Director, Anchorage Community Mental Health Center

It's a good document.

Balance of right of people to receive treatment and their civil liberties. That's the balance we're maintaining.

Regarding who has the authority to commit someone, remember we're talking about all Alaska (including the bush). Physician does have degree of training in recognizing mental illness, where police officer dosen't. To protect civil liberties of people, it's better for at least someone qualified in mental health to make determination of commitment.

As a neuropsychologist, be very careful before you write into statute prohibitation against treatments.

Individuals released as outpatients from API, isn't a comfortable solution to it. You may consider transitional living (intermediate type of commitment). (A transitional facility where they could receive supervision.)

Has reservations about having licensed social workers being able to commit someone (pg 4). You may get a social worker who has no actural diagnostic abilities.

Topic of confidentiality. Two solutions: 1) treatment (must maintain confidentiality in this); 2) examination with notice for commitment (person knows it is commitment, does not have to disclose information, takes away effectiveness of examination).

Sen. Josephson - What a person discloses when he wants treatment is going to be in stream of what is revealed in commitment process, no way to unlearn that material.

That's why I tried to make the distinction. The disclosure of patient's statement when presenting himself for treatment needs to be protected. If someone is going to testify at commitment proceeding, may have to be a separate examination by another person.

200 Steve Harrison, Regional Administrator for South Central Region, Division of Mental Health

Agrees with Dr. Birch in including mental health professional in emergency detention. If we use a mental health professional, we should use those with national accreditation for social workers.

Law is workable, changes are good.

240 Frances Purdy, Mental Health Program Coordinator, Behavorial Health Division, Municipality of Anchorage

Thanks for nonsexist law.

Pg 3, Part a; lns 22-25 should be deleted, they should not be able to release someone who is dangerous.

Pg 12, lns 25-27; good idea to notify parents or guardians of patient's absence. May also want to add anyone that has been threatened by patient, also may add immediate notification instead of 3 hours.

Pg 14, lns 24-27; good idea.

Consider what other states have done with mental health professional being the office of involuntary commitment. Probably more important for Anchorage than for the bush. Impractical to have officer in bush for involuntary commitment. In Anchorage, specifically we're beginning to need an area of expertise in just emergency cases. Check into Washington state statutes. They have designated person who is trained to do reading of rights, is impartial, not hired by institution or other agency.

PART VI

Jim Parsons, Manager, Behavorial Health Division, Municipality of Anchorage (former member of licensing board of psychologists)

Concurs with Purdy's opinion of release of minors when we don't do that with adults.

Most of my concerns have been covered.

Pg 16; licensing law for psychiatrist is generic rather than speciality. There are some psychologist trained in areas other than clinical who may not have expertise in mental illness at all. May be a good idea to say licensed by state with adequate clinical training or something similar rather than clinical psychologist since we don't license in that sense.

Mention of social workers appears to be too broad. Perhaps should use national accreditation with it. Too broad to say experienced in field of mental illness rather than having some type of specific training in that area.

30 Cecilia Kleinkauf, Alaska Chapter, National Association of Social Workers

Pg 16; issue of professional social work, as included in definition of "mental health professional" - just received the draft copy and will have to be reviewed by board before Assoc. takes a position on it and makes recommendations.

Admission of minors at API - the bill, as it is, would constitute age discrimination on state in regards to minors. Minor has a constitutional right to liberty equal to adults. Unconstitutional to deprive minor of right to liberty for a greater amount of time than an adult (in institutionalizing). We have repeated this point at every hearing.

One item not covered in bill is protection of court for child's right regardless of his/her parent's right. Does not provide the child the right to a court hearing which court then hears evidence as to institutionalize the child. The bill leaves the right to child's parents and to mental health professional. Sometimes parents don't act in best interest of their children.

There are a number of children institutionalized at API whom mental health professionals say these children are not probably mentally ill but "there's no place else to put them".

The previous director of State Division of Mental Health testified at Senator Parr's Committee stating it is frequently difficult, if not impossible, to make definitive diagnosis with respect to mental illness in children.

Sen. Josephson - Which is an explanation as to why we have a longer period to evualate. I don't think the Constitution requires that you cannot make classification if there is a rational basis for it.

Why is it ok to institutionalize a child without court's protection in mental illness, and in statutes of state, it's not ok to institutionalize without court's protection when it comes to delinquincy?

PART VII

Grandfathering clause on social worker - the language and amendments proposed by National Association Social Work Chapter. Only spoke to baccalaureate level of social work. Individuals will not be grandfathered at master's level of social work with training in any other field. Anyone who is grandfathered, who wishes to be called a social worker and be licensed under social work law, could at maximum, only be licenses as a baccalaureate level. Only level grandfather amendments refer to.

Meeting was adjourned by Chairman Josephson at 12:50 pm.

BARANOF MENTAL HEALTH CLINIC

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STANLEY T. LAUGHRIDGE, PH.D.
CLINICAL PSYCHOLOGIST

12-16-83

Honorable Joe Josephson
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Senator Josephson:

I have read the proposed draft bill that you are submitting to the legislature in the forth coming session. It contains precisely those very important amendments and stipulations that I have been trying to encourage for a number of years regarding mental health commitments.

If you will check the admission record of Sitka over the past six and a half years, that our clinic has been here; you will see that we have an extremely low admission rate. This is because we have treated people in our local hospitals rather than sending them to API. Often in doing so we have had great difficulty getting under the 72 hour limit before having to go into the court room. Usually within 72 hours, I am able to obtain the person's voluntary commitment but on those few cases where I am not able to do so we end up sending some to API that we could very easily have treated in our local hopitals.

Your bill will very nicely resolve that problem and should, if we in the mental health field do our part, reduce the admission rate to API dramatically.

Congratulations on your good work.

Cordial regards,

S. T. Laughridge

Stanley T. Laughridge, Ph. D.
Clinical Psychologist

cc: Joe Adelmeyer, ACSW Supervisor
Susan Will, R.N., M.S.

Give to Nancy

CORDOVA COMMUNITY HOSPITAL
MENTAL HEALTH AND ALCOHOL CLINIC

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CORDOVA, ALASKA 99574

Senator Joe Josephson
Alaska State Legislature
Senate
Pouch V.
State Capitol
Juneau, AK 99811

Oct. 27, 1983

RE: THE MENTAL HEALTH COMMITMENT LAW

Dear Senator Josephson:

We urge you to incorporate the changes proposed by the Department of Health and Social Services and the Alaska Psychiatric Association and in particular the amendment to add licensed psychologists in changing procedures for emergency detention for evaluation in Sec.47.30.705.

In our experience the present state of things in which a peace officer must be convinced that there is probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to himself or others and should be taken into custody for evaluation is highly precarious. Just recently we had a case of a possible suicide and homocide situation in which help was delayed past a critical point because the peace officier did not believe the physician and licensed psychologist who were urging intervention. When it's a matter of arranging a flight before dark every minute is crucial. It is perhaps unfair to expect a peace officer to understand the dynamics of depression or paranoia without any particular training when years of post-graduate training and supervised experience are needed for a psychologist to do so. It is time Alaska made better use of the unique qualifications that psycholcgists do provide for intervention in and prevention of tricky situations.

Sincerely,

Judy Ringenson-Knutsson.

Judy Ringenson-Knutsson, Ph.D.
Clinical Psychologist

The Cordova Community Hospital

Central Peninsula Mental Health Center
P.O. Box 4683 • Kenai, Alaska 99611 • (907) 282-7501

February 1, 1984

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

Dear Senator Josephson,

I am writing relative to Senate Bill No.346 related to certain revisions of Title 47 of the Civil Commitment Statutes.

I am strongly in favor of the revisions relative to admission of minors, changing the age from 14 to 18 years of age.

The procedure for emergency detention for evaluation is improved by allowing the mental health professional in addition to a police office to have an individual taken into custody. The procedure relative to placement or utilization of the jail for protective custody and holding prior to transportation is appropriate and is an accurate description of the need for rural areas such as Kenai.

I am also in favor of the use of a 30 day as opposed to a 21 day commitment procedure.

I sincerely appreciate the opportunity to comment on the revisions in this Statute.

Respectfully Submitted,

Paul E. Turner, Ph.D.
Clinical Psychologist
Program Lirector

PET/jvh

Ann DeNardo
Families of Chronically Mentally Ill
Victims
SR Box 30754
Fairbanks, Alaska 99701

Senator Joe Josephson, Chariman
Health, Education and Social Services Committee
Pouch V
Juneau, Alaska 99811

RE: Chronic Mental Ilness

Dear Senator Josephoson:

The enclosed article tells you who I am and what I am about.

During last week's teleconference with our Fairbanks legislators, I addressed short comings in Chapter 84, Laws of Alaska, relating to mentally ill persons.

1. Families should have a greater role in and be consulted with regard to commitment procedures.

2. A broader criteria for commitment should be studied, based on ability to function rather than just being a danger to self or others.

3. Commitment and guardianship procedures should be redefined with a view to creating a less adversarial situation between patient and family.

4. Mentally ill patients should receive better continuity of care as they move from hospital to community and commitment procedures should reflect this need.

In this week's teleconference we will address the glaring lack of hospital space for our chronically mentally ill relatives. While other states are grappling with problems of closed wards and community acceptance, Alaska struggles to get patients out of the corridors and into the wards! The only State facility, Alaska Psychiatric Institute, is perpetually overcrowded.

The Fairbanks Memorial Hospital is willing and able to become a designated treatment facility for psychiatric patients. I don't understand the mechanisms involved in such a designation and would appreciate your telling me. I do understand the urgent need for such a facility in the Interior.

I urge you to work toward this goal as a positive step toward a better mental health delivery system for the entire State of Alaska.

Sincerely,

Ann F. DeNardo
Families of Chronically Mentally Ill Victims

Enclosure

AD:aw

Families of CMI Victims
SR Box 30737
Fairbanks, Alaska 99701

RECOMMENDATIONS FOR AMENDMENTS TO ALASKA'S COMMITMENT ACT

The Commitment Act, Chapter No. 84, Laws of Alaska, has caused a great deal of pain to families already engulfed in an ultimate tragedy--the loss of a loved-one; loss through the ravages of a disease as old as mankind, and for which we know no cause or cure.

We are familiar with the Commitment Act on a experiential level and on paper and make the following recommendations for amendments:

1. Families should have a greater role in and be consulted with regard to commitment procedures.

2. A broader criteria for commitment should be studied, based ability to function when thought processes, perception of reality or judgement is substantially impaired.

3. Commitment procedures should be redefined with a view to creating a less adversarial situation between patient and family.

4. Mentally ill patients should receive better continuity of care as they move from hospital to community and commitment procedures should reflect this need.

5. The courts, the judiciary, should be better apprised of the mental health system.

The above five points are overall conclusions. Some specific changes by page, section, and line were given in testimony before Senators Josephson and Fisher of the Hess Committee in Anchorage on March 19, 1983.

The above five points are still pertinent and present a good summary of the attached material presented in testimony before the HESS committee on September 23, 1983, in Fairbanks, Alaska.

TESTIMONY BEFORE THE SENATE HESS COMMITTEE
Re: Mental Health Commitment Law
September 23, 1983 - Fairbanks, Alaska

The families of severely mentally ill victims have worked with the Mental Health Commitment Law for two years. We wish to convey our position regarding the bill.

Section 47.30.660. This section sets out the powers and duties of the Department of Health and Social Services. Paragraph (4) of this section calls for the Department to designate, operate and maintain treatment facilities...to provide...care and treatment for the mentally ill. A treatment facility is defined in 47.30.915(15). In spite of the directive to designate treatment facilities, the API remains Alaska's only such facility.

Section 47.30.670. This section sets out standards for voluntary admission. A patient who accepts voluntary admission can leave the hospital anytime "against medical advice," or AMA. This is why there are so many voluntary admissions as opposed to involuntary. A psychiatrist might do a screening at this point to determine a patient's ability to function and make these decisions.

Section 47.30.705. This section addresses emergency detention for evaluation. It states that a police officer"...may cause the person to be taken into custody and delivered to the nearest evaluation facility. A correctional facility may be used as an emergency evaluation facility if an evaluation facility is not available... (and) the peace officer shall...be interviewed by a mental health professional at the facility." There are no mental health professionals at the correctional facilities.

Section 47.30.710. Examination. This section states that a person so placed in a correctional facility shall be examined and evaluated within 24 hours. This puts a person in jail for 24 hours because of an illness he cannot control. There is no other illness where, due to the illness itself, a person is incarcerated!

Section 47.30.715. Acceptance of Order. In this section the court is ordered to set a date for hearing and notify the respondent's attorney. There is no directive for the attorney to make an effort to see the respondent. Often the first contact the respondent has with his attorney is in the courtroom itself, immediately preceeding the hearing.

Section 47.30.735. This section sets out the civil procedure for a 21 day commitment. These procedures should be redefined in order to create a less adversarial situation between patient and family. Families become the caretakers following hospitalization in 50-55% of the cases. It is important to understand that hospitals do not cure patients. They are only stabilized with neuroleptic medications and returned to the family with their illness in tact, and the added belief that the family has turned against them.

Judicial procedures are either civil or criminal. Commitment procedures are civil. Families feel it might be possible to create a new area within which commitments could be handled. We request the Judiciary Committee to study this concept with a view toward lessening the adversarial approach.

Section 47.30.790. This section deals with absence without leave. If a patient is absent from a treatment facility without authorization a peace officer is instructed to take the patient into custody and return him to the treatment facility. This section should include a provision that the family or guardian be notified of such absence with a specified time, say 3 hours.

Section 47.30.795. This section addresses involuntary outpatient care. Paragraph (c). It states that if it is determined that respondent needs inpatient care due to a critical condition, oral and written notice that he must return to a treatment facility within 24 hours must be given him. If the patient is experiencing thought disorder this gives him 24 hours to get out of town. This section further states a police officer shall pick up the patient if he has not complied with the notice. The respondent is not a criminal, to be served and treated as a criminal. We object to the constant posture of addressing mental disease as criminal.

Section 47.30.825. This section deals with patient rights. Paragraph (6) of this section prevents psychosurgery, lobotomy, or other form of treatment without specific, informed consent of the patient and a court order. We would like to see a provision included that would also require specific informed consent given by "an adult designated in accordance with 47.30.725". (This is an adult designated by the respondent.)

Again, paragraph (8) of this section should insure a copy of the discharge plan is given to "an adult designated in accordance with 47.30.725". Families rarely know of any discharge plan and it is the nature of the disease that patients will not follow through without help.

Section 47.30.845. This section deals with confidential records. Paragraph (2) of this section makes it possible for an individual to whom the patient has given written consent to receive records and information on the patient. This release of records should be dated within a specified time period,-say-one year. This release of records to a designated individual should not be open-ended, but lapse within a restricted time frame.

Section 47.30.870. This section deals with transportation of patient and escort to the designated facility following involuntary commitment. (In this State, of course, this means a trip to Anchorage.) There is provision authorizing the Department to pay for transportation of patient and escort the API for INVOLUNTARY commitments only. Provision should be made to authorize payment of transportation costs for VOLUNTARY commitments as well. At present the family, or the patient, must bear this cost. This creates a continuing financial burden for families trying to remain "case manager" over the years. The continuing financial burdens encourage families to give up attempts to maintain relationships beneficial to the patient.

Section 47.30.875. This section addresses nonresident patients and the return of a mentally ill resident of this state who has been placed in a facility outside of this state. Paragraph (c) of this section is the only section of this Act which mentions the importance of maintaining family relationships and encouraging visits beneficial to the patient. It is ironic that this important approach to treatment is mentioned only under such subtitle as "nonresident patients". We would like to see the encouragement of more family involvement.

Section 47.30.915. Definitions. Paragraph (7) defines "gravely disabled" and paragraph (10) defines "likely to cause serious harm". It is the contention of everyone involved with this Act that these definitions must be broadened. This is such a complicated and emotional issue that agreement is difficult. As a consequence many people who need mental health treatment desparately are not being served. Instead of waiting for a person to commit a crime, or attempt to commit a crime, we recommend the following criteria to enlarge the definition of a mentally ill person for purposes of providing treatment:

(7) "gravely disabled" means a condition in which a person, as a result of mental illness,...
(B) or is not receiving such care and mental medical treatment as is necessary for health and safety, of a person whose thought processes, perception of reality or judgement is substantially impaired.

2 or 3 other States

We would like to see a study of other states' commitment laws in reference to their criteria for commitment.

ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH
of
AMERICAN PSYCHIATRIC ASSOCIATION

February 4, 1983

Senator Joseph Josephson
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

The Alaska District Branch of the American Psychiatric Association is a professional organization which represents the majority of the physicians in Alaska who are specialist in the field of psychiatry. The membership is composed of psychiatrists who work in both the private and public sector. The members of our organization have an ongoing interest in any subject which affects the treatment of mentally ill individuals. As a result of this interest we were actively involved in the development and passage of the Alaska Statute for the Civil Commitment of the Mentally Ill (AS 47.30). Our national organization has also been very active in monitoring the subject of civil commitment and has recently developed guidelines on this subject which we recently provided you.

The Alaska District Branch supports fully the objectives of the current Alaska Statute on Civil Commitment of the Mentally Ill which became law in October of 1981. After the first year of experience with this new law and after discussion with judicial and civic leaders, we wish to recommend certain amendments to the law which we believe will assure that its worthwhile goals are more effectively achieved. These amendments are provided in the enclosed material.

The experience during the past year has indicated to us that the following refinements are needed:

1. The Definition of "Gravely Disabled" needs to be expanded to recognize that some patients, if left untreated, will needlessly lose their capacity to be self-reliant.

2. There are many instances when physicians have clearly psychotic or suicidal persons under care in an emergency setting, and need to arrange for their hospitalization at the Alaska Psychiatric Institute. The current requirement that a peace officer be called to form an independent judgement and duplicate work already accomplished is unnecessarily cumbersome. Allowing the physician the authority to arrange for emergency detention would simplify this procedure. When family and friends are willing and able to transport the patient, the peace officer would be free for more serious business.

3. The patient and society could be better served if the rules governing evidentiary and procedural matters at commitment hearings under this law were promulgated so as to facilitate a more informal and efficient presentation of all the relevant facts.

4. The definition of "likely to cause harm to self and others" has set such a rigid standard that some of the most dangerous clients have not been committed. The issue of dangerousness is a complex one and the judge must be given the opportunity to weigh both the magnitude of the risk and the magnitude of the harm. Also, the law needs to recognize that harm to others may include property.

5. An unanticipated consequence of the current law, has created an undue hardship in the care and treatment of children under the age of 14. The right to be voluntarily hospitalized and treated, which is available to everyone over the age of 14, is curtailed for children and limited to 21 days. After 21 days, even if the parents, the child, and the treating physician agree that continued treatment is needed, the law forces them to obtain an involuntary commitment.

6. Since very few persons actually require involuntary commitment, it would facilitate their care and treatment if the law recognized that patients in this group lack the necessary understanding to accept treatment voluntarily, and authorize the use of medications and other treatments under the direction of a licensed physician subject to the medical rights already guaranteed the patients in Article 9 of Section 47.30.

7. In some instances the law requires the staff of the hospital to respond "immediately" when, in practice, a "timely" response is all that is practical or needed.

As we gain experience with the new commitment statute, I am sure we will have other suggested changes. However, for the present time, we feel these changes are urgently needed to iron out some of the procedural problems and to improve the care and treatment of the mentally ill. We would be happy to provide any additional documentation you may need. We hope you will consider putting the attached amendments in bill form and submitting them to the Legislature.

Sincerely,

Carla Hellekson, M.D.
President
Alaska Psychiatric Association

CH:mm

Alaska State Legislature

REP. MAE TISCHER
CO-CHAIRMAN

REP. MILO FRITZ
CO-CHAIRMAN

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House of Representatives
HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

October 12, 1983

The Honorable Joe Josephson
Member of the Alaska State Senate
Anchorage, Alaska 99501

Dear Senator Josephson:

Thank you for your kind offer to submit a suggestion to your committee during deliberations on the "Mental Health Commitment Law," scheduled for Thursday, October 13.

I am sorry that House HESS hearings in Fairbanks prevent my discussing this matter with your committee personally; however, I have asked Ed Essa to present this letter to you for your consideration.

In recent years, medical science has come a long way in better understanding mental illness. Research has uncovered some very interesting facts. Perhaps the most intriguing discoveries relate to the effects vitamin and other nutritional deficiencies have on our mental well-being. Extensive research has suggested that nutritional deficiencies have a correlation with mental illness, and that when deficiencies are identified and treated with vitamin therapy, some startling improvements in the mental health of clients are made.

Given this information and with the knowledge that our mental health is tied intricately to our physical health, I am proposing that the draft bill you are considering be adapted to require an extensive and mandatory nutritional analysis of each client upon admittance; and that these findings be used as the basis for appropriate intensive theraputic treatment, along with other applied therapy. In this way, the <u>whole</u> client is treated -- both mentally and physically.

Your favorable consideration of this suggestion may well serve to improve the methods of treating many Alaskans who want to be healthy, while helping to induce a marked decrease in the recurrence of mental illness.

Senator Josephson, thank you for extending me the courtesy to be heard today. I join with many others in seeking a continued dialogue on this encouraging new approach to a long-standing and seemingly worsening

problem that faces our state and our nation.

Respectfully,

Mae

Mae Tischer
State Representative

MMT:wtl

End to Nancy ✓

Central Peninsula Mental Health Center

P.O. Box 4683 • Kenai, Alaska 99611 • (907) 282-7501

October 25, 1983

Senator Joe P. Josephson
1526 "F" Street
Anchorage, Alaska 99501

Dear Senator Josephson,

I am writing to you relative to recent Senate HESS Committee Hearings on the Title 47 Commitment Statute.

I am writing to request that licensed psychologists be given the same prerogatives as physicians within the Statute. For example in 47.30.705, the recommended change is that emergency detention for evaluation can be made by a police office or a physician. Generally, however, licensed psychologists are much more able in terms of training, expertise, education and practice to be able to make determinations of need for emergency detention. It would seem wise to include this independent profession in this activity. There are also other sections that are being amended in Title 47 adding the medical profession as the identified entity, for example 47.30.815(b)(4). In those instances I think that clinical psychologists should also be included.

Thank you very much for this opportunity to correspond with you relative to this issue.

Respectfully,

Paul E. Turner, Ph.D.

Paul E. Turner, Ph.D.
Clinical Psychologist
Program Director

PET/jvh

Send to H. Finance

Oliver Osborn, M.D.
Cordova Medical Clinic
Box 310
Cordova, Alaska 99574

Nov. 5, 1983

Senator Joe Josephson
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson,

I am writing in regard to the proposed changes to the Mental Health Commitment Law. My concern is that the proposed law will not allow a licensed psychologist in Alaska to initiate emergency detention for evaluation (under sec. 47.30.705).

Here in Cordova, our health team includes a licensed psychologist working in a mental health clinic which is a department of the hospital. The psychologist is often the person most immediately involved with patients who might be a danger to themselves or to others. It is imperative that this professional be allowed to initiate emergency detention for evaluation in cases with serious potential. It has been our experience that the psychologist often works closely with the local police department to defuse crisis situations in Cordova.

Thank you for your attention.

Sincerely,

Oliver S. Osborn MD

Oliver S. Osborn, M.D.
Member, Cordova City Council

COMMUNITY MENTAL HEALTH CENTER

Box 2274
Homer, Alaska 99603-2274
(907) 235- 7701

October 25, 1983

Senator Joe Josephson
1526 "F" Street
Anchorage AK 99501

Dear Senator Josephson:

It has come to my attention that the Senate Health Education and Social Services Committee is reviewing Alaska's Mental Health Commitment Law of 1981 (SP100). I am essentially in support of the changes which have been proposed.

Under Section 47.30.705 regarding emergency detention for evaluation, I would recommend the following addition to the revised statute:

> "A peace officer or a physician licensed in this state or a psychologist licensed in this state who has probable cause to believe that a person is suffering from a mental illness and is likely to cause serious harm to the person or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken in to custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while needing transportation to a treament facility. The peace officer or physician or psychologist shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility."

In addition, I would recommend that AS 47.30.815(b) (4) be further ammended to read:

> "A peace officer or physician or psychologist responsible for detaining or transporting a person under AS 47.30.700-47.30.915."

Alaska has a pool of well qualified psychologists whose competency and training have been carefully scrutinized by the Board of Psychologists and Psychological Associate Examiners as well as the Division of Occupational Licensing. Insofar as many rural mental health practitioners in the state are licensed psychologists, it would seem appropriate and expedient to include this professional group in the emergency detention clause. With regard to

familiarity with psychiatric disorders, conducting mental status evaluations, and determining the appropriateness of civil commitment, licensed psychologists are well prepared to handle the responsibilities involved in civil commitment in a professional manner.

Thank you for considering this input to the legislative process. I appreciate your consideration.

Paul L. Craig, Ph.D.
Psychologist, Director

PLC: cjs

ALASKA PSYCHIATRIC ASSOCIATION

ALASKA DISTRICT BRANCH
of
AMERICAN PSYCHIATRIC ASSOCIATION

February 15, 1984

The Honorable Joseph Josephson
Alaska State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Josephson:

At a recent meeting of the Executive Committee of the Alaska District Branch of the American Psychiatric Association this group voted to support your bills regarding changes in the involuntary hospitalization statutes and also the bill which you have submitted requiring parity coverage for psychiatric services by insurance companies doing business in the State of Alaska. It was the wish of the Executive Committee that I write you and notify you that we strongly support you on both these issues.

Thank you very much for introducing this much needed legislation.

Sincerely yours,

Irvin A. Rothrock, M.D.
President, Alaska District Branch
American Psychiatric Association

IAR:bw

ALASKA MENTAL HEALTH ASSOCIATION

2611 Fairbanks Street. Suite A Anchorage. Alaska 99503
Telephone 276-1705
A Division of the National Mental Health Association

March 6, 1984

RECEIVED

MAR 19 1984

Josephson,

Senator Joe Josephson
Pouch "V"
Juneau, Alaska 99811

Dear Senator Josephson:

The Alaska Mental Health Association commends the Senate HESS committee for undertaking the review of the Mental Health Commitment Statute. As you know, implementation of the current Statute which was enacted in 1981 has revealed some major problems which the current bill addresses. We wholeheartedly support this effort.

Our concern is that the mentally ill of Alaska receive the best available treatment in a timely manner, in their home community or as close as possible. We believe the procedures established by this Statute must protect individual civil/human rights AND provide for the protection of society. These goals must be accomplished in a manner that recognizes that the primary purpose of this statute is to enable individuals who are mentally ill to receive appropriate treatment. On the whole we believe the Bill does this quite well.

When we consider that mental disease is today's most common disabling condition, one of its least understood, one of its most difficult to treat and yet, the major disease group we spend the least amount of research dollars to study, we can see why the central purpose of the Statute must be to provide care and treatment.

We believe that the current Statute needed to be reviewed and improved. Before commenting specifically on the proposed changes in the Statute, we would offer the following proposal:

> Since one of the original purposes of the Statute was to provide for evaluation and treatment as close to the individual's home as possible, we suggest the Legislature conduct a study of the commitments during the past year to determine whether or not this purpose is being met. Another important purpose the Statute attempted to include was to provide for a timely judicial review and supervision of the commitment process. The study should also focus on the actual length of time required for judicial involvement.

With respect to some of the specific proposed changes, in AS 47.30.655-915 we have the following comments and suggestions:

#1 AS 47.30.690 Admissions of minors, line 12:

The limitation on the involuntary admission of a minor should be increased to 60 days. It is generally recognized that therapy with minors, when hospitalization is necessary, requires a longer average length of stay than do adults. Even this requirement will place a needless burden on the facility and the parents if they live in remote portions of Alaska.

#2 Sec. 47.30.705 Emergency detention for evaluations - Line 3:

The extension of the emergency detention's powers to all "mental health professionals" has both advantages and disadvantages. It greatly expands the numbers of people who will have the power in the bush areas. This will create the kind of flexibility that is needed to provide timely and local action. The disadvantage is that many, if not most, non-medical mental health professionals have not received training or experience in the legal and clinical issues involved in the commitment process. As a consequence, we recommend that these powers be somewhat more limited. The law should limit this power to (i) peace officers and (ii) physicians and mental health professionals who have had sufficient training to properly perform this function. In conjunction with this, we would like to see the establishment of a system to train and designate "mental health professionals" who will have the expertise to exercise this function. Although this will require an additional state expenditure, it should not be prohibitive.

#3 AS 47.30.730(b) - 30 day commitment, line 26:

The extension of the commitment to provide 30 days of treatment is recommended because it is a reasonable length of time considering the seriousness of these disorders.

#4 AS 47.30.735(b)(4):

The attorney member of our Board of Directors informs us this section does not make sense because the rules of civil procedure and evidence would not be "informal but efficient presentation of evidence" in that they are formal rules. It appears the intent is for the respondent to be given a choice between (i) the formal rules of evidence and the rules of Civil Procedure and (ii) an informal set of rules. The draft we have reviewed does not make this at all clear.

#5 AS 47.30.845(7) - Confidential Records, Line 7:

We feel that the "presumed mentally ill person" standard is (i) not defined and (ii) too broad. "Presumed" by whom? What does "presumed mentally ill" mean anyway? If the intent is to release records of former mental patients, that is what should be stated. If the intent is something else, that should be stated. In any event, the standard should be in language that is susceptible to clear interpretation and implementation.

#6 AS 47.30915 (7) - Definition of "gravely disabled":

We strongly support the passage of this amended language as many psychotic patients' symptoms prevent them from seeking the treatment which may restore them to a nearly normal state of mind.

#7 AS.47.30.915 (10) - Definition of likely to cause serious harm:

We strongly recommend the amendments to this section since, in our opinion, the former language created a "standard" which was too restrictive and led to persons being released who were actually dangerous.

Sincerely

Dr. Jerry Schrader
President

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

POUCH H 04
JUNEAU, ALASKA 99811
PHONE:

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

March 6, 1984

The Honorable Bill Sheffield
Governor
State of Alaska
Pouch A
Juneau, AK 99811

Dear Governor Sheffield:

Your Mental Health Advisory Council has been following the developments of Senate Bill Number 346 amending an Act entitled: "An act relating to the treatment of mentally ill persons." We are aware that many public hearings have occurred prior to its introduction January 11, 1984 by Senators Josephson and Halford. Additionally, individual professionals, the Alaska Psychiatric Association and the Alaska Psychological Association have had consultation and input into these revisions with strong support for these amendments. These amendments are thought to represent improvements in the treatment of adolescents and adults from the standpoint of both providers and consumers.

Your advisory Council heard today that this bill is being held "hostage" pending untold bargaining possibilities. Since these amendments would improve the quality of care and likely result in more efficiently and less cost for both the Mental Health and Judicial Divisions, it seems unfortunate to delay its enactment.

Your Mental Health Advisory Council recommends your support for the quick passage of this act. On behalf of all Council Members thank you for your consideration.

Sincerely,

Herbert G.W. Bischoff, Ph.D.
Chairperson

Council Members
David R. Samson, M.D.
Anchorage, Vice Chairperson
Ann Egrass, McGrath
Mabel Rosvold, Petersburg
Alice Wardlow, Bethel
Barbara T. Wihloborg, Fairbanks
Robert Hunter, M.D., Mt. Edgecumbe
Kevin C. Ritchie, Juneau

cc: Bill Ray, Chairman, Judiciary Committee
All Judiciary Committee Members
HGWB/dmb

06-F100LH

American Psychiatric Association

1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900
Melvin Sabshin, M.D., Medical Director

Alaska Psychiatric Association
4001 Dale Street, Suite 101
Anchorage, Alaska 99508

February 28, 1984

Senator Josephson
Pouch V
Juneau, Alaska 99801

Dear Senator Josephson:

The Legislative Committee of the Alaska Psychiatric Association has reviewed Senate Bill 346 -"An Act relating to the treatment of the mentally ill." We support the proposed amendments. We have one additional suggestion pertaining to page 18, line 24. We believe the inclusion of a period of experience for psychiatric nurses is a good idea, but we do not believe this should serve to eliminate a Masters Degree in Psychiatric Nursing from the list of mental health professionals. A simple "or" in line 24, page 18 would suffice to change this.

Thank you once again for your efforts on the behalf of the mentally ill.

Sincerely,

Jerry L. Schrader, M.D.
Legislative Representative
Alaska Psychiatric Association

JLS/saw
Enc.

MEMORANDUM State of Alaska

TO: Nancy Deitrick
Aide to Senator Josephson
Alaska State Senate

DATE: April 4, 1984

FILE NO:

TELEPHONE NO:

FROM: Jennifer Strickler
Management Analyst
Division of Occupational Licensing
Department of Commerce and Economic Development

SUBJECT: SB 303 and SB 346

This is to inform you that at a meeting held on March 13, 1984, the Board of Psychologist and Psychological Associates reviewed SB 303, "An Act relating to the practices of social work and establishing the Board of Social Worker Examiners; and providing for an effective date"; and, also, SB 346, "An Act relating to the treatment of mentally ill persons."

Determinations were made by the Board to support both SB 303 and SB 346.

JS/shA/20-3
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