ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 8672

2489 HJ SB 346

2/8

Fairbanks Memorial Hospital
1650 Cowles Street, Fairbanks, Alaska 99701

April 6, 1983

Dennis DeWitt
Alaska Hospital Association
319 Seward Street
Juneau, Alaska 99801

Dear Dennis,

I have reviewed the work draft that would amend the current act relating to the treatment of the mentally ill persons and have the following comments.

Much of this work draft simply cleans up the language of the current legislation. (Apparently the law is going to allow for those rare instances when a female is mentally ill!)

Several areas in the work draft propose significant content changes. In all cases these content changes would significantly improve the current legislation.

1. AS 47.30.915 (7) and AS 47.30.915 (10) change the definition of 'gravely disabled' and 'likely to cause serious harm.' The proposed changes in these definitions, if enacted, would greatly improve the ability of the legal system and providers of mental health care to intervene appropriately in situations where emergency detention is in the best interest of the patient.

2. Section 47.30.705 This proposed change allows a physician to initiate the involuntary commitment procedures. This is an essential addition to the current legislation and entirely appropriate.

3. The other content changes (dealing with the detention and commitment of minors, etc.) also upgrade the current legislation and make it more workable.

Overall there are no objections in the changes proposed by this work draft. The content changes deserve support and would markedly improve the current legislation governing the treatment of the mentally ill.

I would recommend that the Alaska Hospital Association support a bill that reflects the content and intent of the work draft.

Sincerely,

M. J. Emmert, R.N.
Director of Nursing Service

MJE:mc

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

BILL SHEFFIELD, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

February 3, 1984

DOCUMENT #84-32

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

Dear Senator Josephson:

RE: Senate Bill 346
(Suggested Amendment)

The language listed below is suggested as an amendment to Senate Bill 346 to allow persons under the age of 18 to be voluntarily hospitalized by their parents or guardians for additional 30 day periods. Under the existing statute, children and adolescents may not be voluntarily hospitalized by their parents or guardians for a period longer than 21 days even if they meet the criteria for hospitalization under A.S. 47.30.690. The amendment would rectify this oversight.

On page 4, line 3, Section 5 of Senate Bill 346, we recommend that the following subsection be included:

> "(c) Additional 30-day voluntary admissions of a minor under the age of 18 may be sought by parents or guardians if, in the opinion of the professional person in charge, the conditions under subsections (1), (2), and (3) continue to exist."

This amendment is considered especially important, even critical, in providing the necessary and appropriate level of care for this oftentimes fragile group of patients.

We will be happy to provide you or other members of the Senate Health, Education, and Social Services Committee with any additional information you may require concerning this proposed amendment as well as any questions you may have regarding our Position Paper which was submitted earlier.

Sincerely,

Robert London Smith

Robert London Smith, Ph.D.
Commissioner

06-F38LH

MSG 84-00028880 PRTY 1 03/27/84 16:24:35 ORIG: LA01 IN= 0007 OUT= 0115
FROM: KAREN, ANC LIO TO: POM - JUNEAU INFO
TARGET: LJHK SUBJ: POM

TO: ALL SENATORS

FROM: G. KENT EDWARDS
2113 DUKE DRIVE
ANCHORAGE, AK. 99508
H. 276-2664; W. 274-3576

MARGARET BROWN, 2957 EMORY, ANCHORAGE, AK. 99508
H. 272-6039 W. 272-3454

I URGE YOUR SUPPORT OF SB 346,, THE MENTAL HEALTH BILL.
SECTIONS 26 AND 27 ARE ESPECIALLY IMPORTANT SINCE CURRENT
DEFINITIONS ARE INADEQUATETO DEAL WITH MANY
MENTALLY ILL PATIENTS WHO MAY CAUSE BODILY HARM.

3/28/84, SHIRLEE ANC LIO, 29182

TO: ALL MEMBERS
ALASKA SENATE

[RECEIVED]

MAR 28 1984

Josephson.

FROM: PAT EDWARDS
2113 DUKE DRIVE
ANCHORAGE, AK 99508
(H) 276-2264 (W) 271-3735

SUBJ: SENATE BILL 346 (TREATMENT OF MENTALLY ILL PERSONS)

I URGE YOUR SUPPORT OF SENATE BILL 346, ESPECIALLY SECTION 27. PSYCHOTIC HISTORIES AND ACTS OF VIOLENCE TOWARDS PROPERTY MUST BE CONSIDERED WHEN EVALUATING MENTAL PATIENTS.

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MSG 84-00029328 PRTY 1 03/28/84 14:47:49 ORIG: LA09 IN= 0005 OUT= 0105
FROM: KIM / ANCH LIO TO: POM / JNU INFO
TARGET: LJHK SUBJ: P O M

TO: ALL SENATORS

FROM: JOHN BROWN, 1936 BEAVER PLACE, ANCHORAGE 99504
H 337-2755 W 272-3454

SB 346, TREATMENT OF MENTALLY ILL PERSONS

URGING YOUR SUPPORT, SPECIFICALLY SECTIONS 26 AND 27. MY FAMILY HAS BEEN PLAGUED BY A PARANOID SCHIZOPHRENIC. HE'S BEEN IN AND OUT OF API FOR THE PAST 8-10 YEARS. HE'S 6'4, 300 POUNDS PLUS AND I AM AN EX-STATE HEAVYWEIGHT WRESTLING CHAMP WHOM HE TOSSED AROUND LIKE A RAGDOLL LAST CHRISTMAS EVE.

FROM: LINDA THAGGARD
4701 CANTERBURY WAY
ANCHORAGE, AK. 99503Q
561-8085

I URGE YOU TO SUPPORT SB 443 BRINGING POWER LINES TO THE CASWELL LAKE AREA.

MSG 84-00030841 PRTY 1 04/03/84 09:14:09 ORIG: LF01 IN= 0003 OUT= 0027
FROM: PAULA/FKS TO: JNU INFO
TARGET: LJHK SUBJ: POM

TO: ALL MEMBERS OF THE SENATE

FROM: JEANETTE GRAFTO
SR 20x83
FAIRBANKS, AK, 99701
455-8212-H

RE: SB 34s, MENTALLY ILL

MSG: I SUPPORT SB 34s. I HAVE A MENTALLY ILL BROTHER AND I BELIEVE HIS RIGHT TO TREATMENT IS VERY IMPORTANT. CIVIL RIGHTS ARE NOT EVEN RELATIVE WHEN YOU CANNOT TAKE CARE OF YOURSELF AND PEOPLE IN THE STREET ARE TAKING ADVANTAGE OF YOU.

----------EOM

TO: ALL MEMBERS OF THE SENATE

FROM: DOROTHY STELLA
355 IDITAROD
FAIRBANKS, AK, 99701
456-1454-H 372-4265-W

RE: SB 34s, TREATMENT OF MENTALLY ILL

MSG: TO CONTINUE TO DENY TREATMENT OF THE CHRONICALLY MENTALLY ILL MIGHT HAVE SERIOUS LEGAL RAMIFICATIONS. SUPPORTING BILL 34s AS PROPOSED WOULD ELIMINATE DEPRIVATION OF MEDICAL CARE TO THESE INDIVIDUALS.

----------EOM

MSG 84-0003636 PRTY 1 04/03/84 00:45:52 ORIG: LF01 IN= 0002 OUT= 0019
FROM: PAUL+/F:S TO: JNU INFO
TARGET: IJHK OLBJ: FOM

TO: ALL MEMBERS OF THE SENATE

FROM: MR. & MRS. AARON, MEMBERS OF FKS ALLIANCE FOR THE MENTALLY ILL
P.O. BOX 74132
FAIRBANKS, AK, 99707-4132
456-4407-H

RE: JS 34.

SUM: FOR THOSE HELPLESSLY SUFFERING THE UNCONTROLLED DEPRIVATIONS OF SEVERE PSYCHOTIC DELUSIONS AND DEPRESSIONS, THE MOST URGENT CIVIL RIGHT IS THE RIGHT TO HAVE PROPER CARE AND TREATMENT, ESPECIALLY WHEN THE VICTIM IS TOO DISTURBED TO REALIZE THE NEED FOR HELP AND MAY BE STARVING FOR EXAMPLE. SEC V. JS 34.

----------EOM

MSG 84-00030851 PRTY 1 04/03/84 09:32:01 ORIG: LF01 IN= 0004 OUT= 0031
FROM: ANNIE IN FAIRBANKS TO: JUNEAU INFO.
TARGET: LJHK SUBJ: POM

TO: ALL SENATORS

FROM: PHYLLIS VAN ARISDALE
141 STEEL HEAD ROAD
FAIRBANKS 99701
HOME 479-3071

RE SB346, MENTAL ILLNESS

IT IS VITAL THAT YOU DO PASS SB346. THE MOST DIFFICULT PROBLEM IN THE MENTAL ILLNESS PROCESS IS GETTING TREATMENT WHEN A PSYCHOTIC BREAK OCCURS. THE MOST IMPORTANT CIVIL RIGHT OF MENTALLY ILL PEOPLE TODAY IS THE RIGHT TO TREATMENT. DENIAL OF TREATMENT WAS A CAUSE OF OUR SON'S DEATH.

6

----------EOM

TO: SENS RAY, ELIASON, PETTYJOHN, ZEIGLER, JOSEPHSON

FR: RICHARD H. RUSSELL
MEMBER OF FBX ALLIANCE FOR THE MENTALLY ILL
304 12TH AVE. #3
FBX, 99701
452-5661

RE: [redacted] TREATMENT OF THE MENTALLY ILL

MSG: THIS IS NECESSARY AND LONG OVERDUE LEGISLATION. WHILE OUR SON WAS AT API, I BECAME QUITE FAMILIAR WITH ALASKA'S COMMITMENT ACT. IT IS UNNECESSARILY VAGUE AND OFTEN MISLEADING. SB346 IS AN IMPORTANT ADJUSTMENT.

----------EOM

TO: TOM MINGEN
FBX MEMORIAL HOSPITAL
1650 COWLES
FBX, 99701
452-8181 EXT 305

RE: [redacted] TREATMENT OF MENTALLY ILL

MSG: URGE YOUR SUPPORT OF SB 346.

----------EOM

FROM: GERALDINE HARRINGTON
1820 CHEROKEE WAY
ANCHORAGE, AK. 99504
333-9252

SUPPORT [redacted] THE MENTAL HEALTH BILL. I'M A DIAGNOSED MANIC DEPRESSIVE, HOSPITALIZED SEVERAL TIMES DURING THE PAST 15 YEARS.

FROM A PATIENT'S VIEWPOINT, IT IS CRUCIAL THAT A TRAINED PROFESSIONAL BE IN THE POSITION TO TREAT THE INDIVIDUAL WHOSE JUDGEMENT CANNOT BE RELIED UPON AT THE MOMENT TREATMENT IS NEEDED MOST.

MSG 84-00023748 PRTY 1 03/13/04 12:28:17 ORIG: LJ01 IN= 0004 OUT= 0019
FROM: SITKA TO: JUNEAU
TARGET: LJHK SUBJ: POM

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN AND ZIEGLER

FROM: STAN LAUGHRIDGE, BARANOF MENTAL HEALTH CLINIC
BOX 1130
SITKA, AK 99835

RE: [redacted] TREATMENT OF MENTALLY ILL PERSONS

I AM A PROFESSIONAL MENTAL HEALTH WORKER AND I STRONGLY SUPPORT THE PROVISIONS OF SB 346.

##SITKA LIO, 3/13, 23748##

MSG 84-00023714 PRTY 1 03/13/84 15:05:07 ORIG: L*00 IN= 0009 OUT= 0070
FROM: TRACIE/FBX TO: JUN INFO
TARGET: LJHK SUBJ: FOM

15

TO: SENS RAY, JOSEPHSON, [illegible]ELIASON, [illegible]EGLER, PETTYJOHN, RAY, BENNETT,
FAHRENKAMP, MOSS
REPS DAVIS, BETTICWORTH, KOPONEN, RINGSTAD, M.W. MILLER

FR: JANET WHITE, IMMACULATE CONCEPTION COMMUNITY SERVICES DIRECTOR
PO BOX 81632
FBX, 99708
488-0646-H
452-4918-W

RE: [redacted]EATMENT OF THE MENTALLY ILL

MSG: FAMILIES OF THE MENTALLY ILL SUPPORT SB346. THIS BILL IS A TESTIMONY FOR THE IMPROVEMENT OF THE CONDITIONS FOR SUFFERING FAMILIES AND THEIR LOVED ONES, IE THE PATIENT.

----------EOM

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZEIGLER

FROM: RANDY HURST
BOX 4310
MT. EDGECUMBE, AK. 99835 966-2438 (W)

RE: [redacted]

I'M WRITING IN SUPPORT OF SB 346. THE LONGER TIME FRAMES, THE FOCUS ON LEAST RESTRICTIVE ENVIRONMENTS, AND ABILITY TO INITIATE PETITIONS BY MENTAL HEALTH PROFESSIONALS ARE VERY IMPORTAN INCLUSIONS. I WISH THE INITIAL TIME FRAME OF 30 DAYS COULD BE MADE LONGER, ESPECIALLY SINCE MEDICATION STABILIZATION TAKES AT LEAST THAT LONG IN MANY CASES.

----------SITKA LIO, 3-12-84----------

MSG 84-00023818 PRTY 1 03/13/84 13:39:52 ORIG: LJ01 IN= 0006 OUT= 0041
FROM: ELAINE, SITKA TO: JUNEAU
TARGET: LJHK SUBJ: POMS

TO: SENATORS JOSEPHSON, RAY, ELIASON, PETTYJOHN, AND ZIEGLER

FROM: DR. SUSAN CARLSEN
BOX 4575
MT. EDGECUMBE, AK. 99835 747-6474

RE: [redacted] MENTAL HEALTH ILLNESS

I URGE SUPPORT OF THE MENTAL HEALTH BILL, SB 346, WHICH WOULD FACILITATE MENTAL HEALTH TREATMENT LOCALLY AND ALLOW MENTAL HEALTH WORKERS IN SITKA TO WORK WITH THOSE WHO ARE IN INVOLUNTARY COMMITMENT.

----------SITKA LIO, 3-13-84 23818----------

file SB 354 - Mental Health

ATTACHMENT 1
Speaker/Speaker-Elect
Report to Reference Commi
and Board

American Psychiatric Association

GUIDELINES FOR LEGISLATION ON THE PSYCHIATRIC HOSPITALIZATION OF ADULTS[1]

These Guidelines Deal With:

Emergency Psychiatric Evaluation
Voluntary Admission
Involuntary Hospitalization
Right to Treatment
Right to Refuse Treatment
Patients' Rights
Legal Immunity for Mental Health Personnel

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[1] These Guidelines for Legislation on the Psychiatric Hospitalization of Adults have been prepared and approved by the American Psychiatric Association in order to assist psychiatrists, legislators and the public in considering possible revisions of civil commitment laws. The American Psychiatric Association believes that these Guidelines constitute a responsible set of proposals which would improve the process of psychiatric hospitalization in many states. However, because local laws, community conditions, and medical practices vary, state and local psychiatric associations and individual psychiatrists may properly support provisions which differ in many respects from these general Guidelines.

TABLE OF CONTENTS

Section 1. SHORT TITLE

These provisions governing the psychiatric hospitalization of adults may be cited as Title I of the Mental Health Code.[1]

Section 2. LEGISLATIVE PURPOSES

This Act is intended to achieve and shall be construed so as to promote these legislative purposes:

-- To make available psychiatric evaluation, care and treatment to all persons who suffer from severe mental disorders and can benefit from treatment, and to encourage voluntary rather than involuntary admission whenever hospitalization is necessary;

-- To safeguard the legal rights of patients in a manner which will advance and not impede the therapeutic and protective purposes of psychiatric hospitalization;

-- To provide workable procedures for obtaining consent to and administering medications and other treatments;

-- To provide legal immunity for reasonable, good-faith efforts to implement this Act, and legal penalties for knowing, willful efforts to subvert the processes in this Act; and

-- To provide a statutory framework for the promulgation of regulations by the Department of Mental Health.

Section 3. DEFINITIONS

As used in this Act, the terms below shall have the meanings indicated:

"aversive therapy" means any treatment or procedure which, because it is believed to be painful or physically uncomfortable to the patient, is administered in order

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[1] These Guidelines deal only with persons who may be hospitalized for psychiatric care and treatment under the civil commitment process; they do not deal with persons who may be confined for forensic evaluation or other purposes under the criminal justice process.

to reduce the frequency or intensity of a behavior; except that aversive therapy does not refer to verbal therapies, seclusion or physical restraints used in conformity with Section 10.F., or psychotropic medications which are not used for purposes of aversive conditioning.

"consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, where treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

"court" means the court or judicial officer designated under the laws of this State for the discharge of the functions described in this Act.

"emergency situation" means a situation in which the patient exhibits substantial behavior which is self-destructive, assaultive, or threatens significant damage to the property of others, or which indicates that the patient is suffering extreme anxiety amounting to panic, or sudden exacerbation of his severe mental disorder.

"experimental treatment" means any treatment other than one which is commonly accepted for treatment of the mental disorder involved or is supported by widely accepted scientific studies, and is provided by a qualified health professional; if such treatment poses a significant risk of harm to the patient.

"informed consent to treatment" means a knowing and voluntary decision to undergo treatment, evidenced in writing, and made by a person who has the capacity to make an informed decision, after the treatment facility has explained to the person the nature and effects of the proposed treatment.

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his mental disorder or condition, is unable despite

conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment as evidenced by inability to weigh the possible risks and benefits.

"likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.

"likely to cause harm to others" means that as evidenced by recent behavior causing, attempting or threatening such harm, a person is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person.

"patient" means any person receiving evaluation, care or treatment under this Act, except that "patient" for purposes of the rights provided in Section 10 shall refer only to persons in residential treatment programs.

"person" means for purposes of any provision of this Act authorizing the commitment or treatment of a "person," an individual aged eighteen years or more.[2]

"psychosurgery" means any procedure which by direct access to the brain, removes, destroys, or interrupts the continuity of brain tissue which is histologically normal (as distinguished from normal in its physiological or psychological functioning) for the primary purpose of altering behavior or treating a mental disease or disorder. Psychosurgery includes the implantation of electrodes with such an effect and

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[2] For provisions concerning persons under the age of eighteen, refer to the American Psychiatric Association's "Guidelines for Psychiatric Hospitalization of Minors" (1981).

for such a purpose, with or without subsequent electrocoagulation. Psychosurgery does not include neurosurgical procedures designed to treat reliably diagnosed intractable physical pain or epilepsy.

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition which (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (2) substantially impairs behavior as manifested by recent disturbed behavior.[3]

"treatment facility" means a community mental health facility, a general medical facility providing psychiatric services, or other psychiatric facility or program meeting applicable licensing standards, which has been approved for the provision of services under this Act by the Department of Mental Health; provided that no jail or other correctional facility shall be approved as a treatment facility for any persons other than those who could otherwise lawfully be detained there.

Section 4. EMERGENCY PSYCHIATRIC EVALUATION

4.A. Detention by a Police Officer

1. A police officer may take a person into custody, and transport the person to a treatment facility for emergency psychiatric evaluation if and only if:

a. the person would otherwise be subject to lawful arrest and the police officer believes that the person is in need of emergency psychiatric treatment; or

b. the police officer has probable cause to believe that the person has attempted suicide within the last 48 hours; or

c. the police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult under subsection

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[3] Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

4.C. and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others; or

d. he is acting upon the certification of a licensed physician under subsection 4.B.

2. Any person taken into custody pursuant to this subsection shall be presented promptly to a treatment facility. Correctional facilities shall not be used as temporary shelter for such persons except for the protective custody of the person pending transportation to a treatment facility.

3. Upon or shortly after taking a person into custody, the police officer shall take reasonable precautions to safeguard and preserve the personal property of the person unless a guardian or responsible relative is able to do so. Upon presenting a person to a treatment facility the police officer shall inform the staff in writing of the facts which caused him to take the person into custody, and specifically state whether the person is otherwise subject to arrest.

4.B. Certification by a Licensed Physician

A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation, when a licensed physician certifies in writing that he has examined the patient in the last 72 hours, or that he has ongoing medical responsibility for the person and has knowledge of his current condition, and on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as a result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

4.C. Petition by Any Interested Adult

Any interested adult may petition for, or present a person for, emergency psychiatric evaluation by alleging based on personal observation that he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he is likely to cause harm to himself or to others or is manifestly unable to care for some of his basic needs; and immediate hospitalization is necessary to prevent harm to the person or to others.

4.D. Treatment Facility Determination

1. Upon the presentation of a person to a treatment facility pursuant to this Section 4, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth in subparagraph 2.

2. The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

3. If the examining psychiatrist determines that there is not probable cause to believe that the person meets the criteria for emergency evaluation and treatment, the person shall be released. If a person was presented to the treatment facility by a police officer and was otherwise subject to lawful arrest, he shall continue under the custody of police officers.

4.E. Advice of Rights

The treatment facility shall advise any person admitted for emergency evaluation and treatment of the purposes and possible duration of emergency evaluation, and of his rights under this Act, as soon after admission as his medical condition permits.

4.F. Hearing on Emergency Evaluation

1. Each person who is admitted to a treatment facility shall receive a preliminary hearing before the court within five business days of admission or be discharged, unless he has, after consultation with counsel, executed a written waiver of such hearing. The hearing shall be informal and subject to such rules as the court sets consistent with fundamental fairness.

2. The court shall determine at the close of the hearing, or within five business days of the patient's admission, whether he should be discharged. A patient shall then be discharged, unless the court determines that there is probable cause to believe that he satisfies the criteria for thirty-day commitment provided in Section 6, and unless within two business days of the court's decision a petition for such commitment is filed with the court.

4.G. Duration of Emergency Evaluation and Treatment

The period of emergency evaluation and treatment shall in no case exceed fourteen days.

Section 5. VOLUNTARY ADMISSION

5.A. Admission

1. A treatment facility may admit a person if after examining the patient a psychiatrist [or: "a physician"]* on the staff or with privileges at the treatment facility believes the person is mentally ill and in need of hospitalization, and if the person gives written consent to admission. Prior to such admission, the person shall be advised orally and given a written statement of his rights under this Act; provided that if his condition upon admission makes such advice infeasible and the medical reasons are entered in the record, such advice may be deferred until the patient's medical condition permits, for not more than 48 hours. Each patient shall be asked to sign an acknowledgement that he has been so advised and has consented to voluntary admission for treatment.

2. Initial consent to voluntary admission for treatment shall be valid for sixty days. Thereafter,

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* Optional provision.

a patient may remain at the treatment facility for periods of up to one hundred eighty days each upon a signed consent executed after the patient has had an opportunity to consider with such persons as he wishes his need for continued hospitalization and treatment.

3. If the responsible psychiatrist [or: "the responsible physician"][5] has substantial reason to believe that a person seeking to admit himself or to consent to further hospitalization lacks capacity to make an informed decision concerning treatment, he shall obtain in addition to the consent of the patient, the informed consent of the patient's next of kin or guardian. The responsible psychiatrist [or: "the responsible physician"][6] shall renew his effort to obtain the informed consent of the patient if the patient regains the capacity to make an informed decision concerning treatment.

5.B. Discharge or Petition for Thirty-Day Commitment

Any patient who is voluntarily admitted to a treatment facility shall be discharged within five business days of his written request for discharge (and any patient who indicates his desire to be discharged but is unable to write shall be assisted to put his request in writing), unless a petition for thirty-day commitment is filed within that period by the treatment facility or the patient's next of kin or guardian.

5.C. Conversion from Involuntary to Voluntary Status

A patient who is subject to involuntary hospitalization pursuant to Sections 4, 6, or 11 of this Act may at any time convert to voluntary status if the responsible psychiatrist [or: "the responsible physician"][7] agrees that such conversion is made in good faith and that the patient is an appropriate patient for voluntary hospitalization.

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[5] Optional provision.

[6] Optional provision.

[7] Optional provision.

Section 6. THIRTY-DAY COMMITMENT

6.A. Petition

1. Persons who are present at a treatment facility under voluntary admission but have requested discharge, and persons present at a treatment facility for emergency psychiatric evaluation, may be committed involuntarily for a period of up to thirty days upon a petition filed by the treatment facility or by the next of kin or guardian; and other persons may be so committed upon a petition filed by any interested adult. The petition shall allege that such person meets the criteria set forth in subsection 6.C. The petition shall set forth the facts supporting the allegations, and, in the case of petitions filed by a treatment facility, describe why the patient requires treatment. The petition shall be filed with the court, which shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. The copies of the petition served by the court shall be accompanied by a notice advising of the person's rights concerning the proceeding.

6.B. Summons for Evaluation; Psychiatric Report

1. Upon the filing of a petition for thirty-day commitment of a person who is not currently under emergency evaluation or voluntary admission, the court shall issue a summons to the person to submit to an examination (on an outpatient basis) conducted by a psychiatrist at a treatment facility or a private psychiatrist. The examining psychiatrist shall promptly prepare a report on his examination and file it with the court. The court shall have copies promptly served upon the patient, the next of kin or guardian, and the patient's attorney if known.

2. A person served with a summons to submit to a psychiatric examination may in lieu of such examination submit a report of a psychiatrist stating that he has recently examined the person, or has ongoing medical responsibility for the person and knowledge of his current condition, and that in his opinion the person does not meet the criteria for involuntary commitment. The petition for commitment may then be dismissed by the court, or continued.

6.C. Criteria for Thirty-Day Commitment[1]

A person may be involuntarily committed for a period of up to thirty days if, after the hearing provided in Section 6.D., the court determines, based upon clear and convincing evidence, that:

1. the person is suffering from a severe mental disorder; and

2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and

3. the person either refuses or is unable to consent to voluntary admission for treatment; and

4. the person lacks capacity to make an informed decision concerning treatment; and

5. as the result of the severe mental disorder, the person is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others.

6.D. Hearing on Thirty-Day Commitment

1. Every person as to whom a petition for thirty-day commitment has been filed shall be notified by the court sufficiently in advance to be able to prepare for the hearing, and shall receive a prompt hearing. For persons confined for emergency psychiatric evaluation, or currently under voluntary admission, this hearing shall take place within three business days of the filing of the petition.

2. The respondent shall be present at the hearing unless the court finds (1) that he has knowingly and voluntarily waived such right after consulting with counsel, or (2) that because his behavior at the hearing

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[1] Refer to the Commentary for a discussion of the disposition of various types of persons who do not meet the criteria in Section 6.C.

is so disruptive, it cannot reasonably continue in his presence. Hearings shall be held in the treatment facility wherever feasible given the other functions of the court.

3. Any respondent who is unable to pay for counsel shall have the right to be provided with counsel to prepare for and represent him at the hearing. [Any respondent who is unable to pay for an examination for purposes of the hearing shall have the right to be provided with one examination by a licensed psychiatrist, at the expense of the (state or local government).][9]

4. The District Attorney or County Counsel shall represent the interests of the State at the hearing. [If the District Attorney or County Counsel fails to proceed with the commitment, the next of kin or a petitioning party may retain counsel to do so in his stead, and the reasonable costs of such counsel shall be paid by the (state or local government).][10]

5. The rules governing evidentiary and procedural matters at hearings under this Act shall be promulgated so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties. Hearsay evidence may be received, and experts and other witnesses may, consistent with law, testify to any relevant and probative facts at the discretion of the court.

6. Patients shall not have a "right to remain silent" at a psychiatric examination or hearing conducted pursuant to this Act; provided that no patient shall be held civilly or criminally liable for not speaking or testifying. Any information obtained from or disclosed by the patient during the course of evaluation or treatment is admissible in any hearing provided in this Act without regard to whether it would otherwise be privileged; provided that no disclosure made by the patient during the course of evaluation or treatment or in any proceeding conducted under this Act, and no opinion testimony based on such disclosures, may be admitted against the patient on the issue of guilt in a criminal proceeding unless he places his mental condition in issue in such proceeding, and the disclosure or opinion is relevant to such an issue raised by him.

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[9] Optional provision.

[10] Optional provision.

7. The hearing shall be closed to the public, unless the respondent requests that it be open, or the court determines for other good cause that the hearing should be open. The court shall keep a complete record, written or recorded, of every hearing.

8. At the conclusion of the hearing, or within one business day thereafter, the court shall make its findings, including specific findings as to whether the commitment is warranted because the person is (a) likely to cause harm to others, or (b) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (c) both (a) and (b). As to any person found likely to cause harm to himself or to suffer substantial mental or physical deterioration, the court shall further make findings as to whether commitment is warranted because the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will, if not treated, suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.

9. The court shall enter an order discharging the person unless it finds by clear and convincing evidence that the person satisfies all of the criteria for commitment in Section 6.C., in which event it shall enter an order committing the person for evaluation and treatment for a period of "up to thirty days." If at any time during thirty-day (or any subsequent) commitment a patient is absent without permission, the order of commitment constitutes a continuing authorization to the treatment facility and to any police officer to procure his return.

Section 7. INFORMED CONSENT TO MEDICATION OR OTHER TREATMENT -- VOLUNTARY PATIENTS

7.A. Informed Consent

Except in an emergency situation, a treatment facility shall, prior to beginning any course of medication or other treatment for a patient who is subject to voluntary admission under Section 5, obtain informed consent to treatment. If the patient does not lack

capacity to make an informed decision concerning treatment, the consent shall be his own. If he does lack such capacity, the consent shall be that of his next of kin or guardian, provided that such a patient may receive appropriate medications or other treatments, except as limited by Section 8.C., until such time as the consent or refusal to consent of such next of kin or guardian can be obtained.

7.B. Revocation of Consent

A voluntary patient (or the next of kin or guardian who consented to treatment on his behalf) may revoke consent to treatment at any time by a reasonably clear statement in writing (and patients who indicate a desire to revoke consent but are unable to write shall be assisted to put their statement in writing). If such consent is revoked, the treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.

7.C. Refusal to Consent

Except in an emergency situation, any voluntary patient (himself or through his next of kin or guardian) shall have the right to refuse any and all medications or other treatments. If appropriate medications or treatments are refused, the facility may then discharge the patient, and shall not be liable in any respect for such action.

Section 8. INFORMED CONSENT TO MEDICATION OR OTHER TREATMENT -- INVOLUNTARY PATIENTS

8.A. Consent During Emergency Evaluation

Following admission and during the period of emergency evaluation provided in Section 4, the treatment facility may administer medications or other treatments, except as limited by Section 8.C., to a patient consistent with good medical practice and without the informed consent of the patient or his next of kin or guardian. However, prior to administering any such medication or other treatment, the staff shall explain the purposes, nature, and effects of the treatment and shall request the patient's consent to it, unless the responsible

psychiatrist [or: "the responsible physician"][11] determines that the patient's condition makes doing so infeasible or harmful to him, and enters the reasons for not doing so in the record.

8.B. Consent During Thirty-Day or Subsequent Commitments

It being a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments, except as limited by Section 8.C., to such persons consistent with good medical practice without their consent. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist [or: "the responsible physician"][12] shall consult with the patient and his next of kin or guardian, and give consideration to the views they express concerning treatment and any alternatives.

8.C. Special Therapies

Notwithstanding subsections A. and B. above, a treatment facility shall not administer aversive therapy, experimental treatment, psychosurgery, or any other special therapy designated by the Department of Mental Health except as provided by law or in regulations promulgated by the Department of Mental Health.

8.D. Other Medical/Surgical Treatments

Consent for other medical/surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

Section 9. PROVISION OF TREATMENT

9.A. General Duty To Provide Treatment

Every patient shall be provided with prompt, competent and appropriate treatment, which offers him a realistic prospect of improvement. Patients shall be afforded treatment by sufficient numbers of duly qualified personnel, in facilities which meet applicable

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[11] Optional provision.

[12] Optional provision.

licensing and accreditation standards, which conform to applicable regulations of the Department of Mental Health, and which are able adequately to care for and treat the patients they serve.

9.B. Individual Treatment Plan

1. A written individual treatment plan shall be prepared, with the participation of the patient to the extent he is able, during voluntary admission or emergency psychiatric evaluation, or if a person has been subject to neither, then within seven days of a patient's thirty-day commitment. The individual treatment plan shall be approved by the responsible psychiatrist [or: "the responsible physician"],[13] and the course of treatment actually administered shall conform to the plan.

2. The patient's progress in attaining the objectives in the treatment plan shall be noted in his records and revisions in the plan shall be made as appropriate. The patient, and if the patient desires, the next of kin or guardian, shall be afforded an opportunity to participate in considering any substantial change in the treatment plan.

3. The individual treatment plan shall be available upon request to the patient, and to any other person designated by him, provided that the responsible psychiatrist [or: "the responsible physician"][14] may preclude disclosure of the individual treatment plan to the patient or others for a period not to exceed seven days from the request, if he states in writing why disclosure would be harmful to the patient.

9.C. Administration of Medications and Other Treatments

1. Medications and other treatments shall only be prescribed, ordered and administered in conformity with accepted clinical practice. Medication shall be administered only in accordance with the written order of a physician or upon a verbal order, noted in the patient's medical record and subsequently signed by the physician. Medication shall be administered only by a qualified physician, or qualified nurse, or by

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[13] Optional provision.

[14] Optional provision.

qualified other persons pursuant to procedures approved by the Department of Mental Health. The attending physician shall review regularly the drug regimen of each resident patient under his care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding thirty days thereafter, but may be renewed.

2. Medications and other treatments shall be administered in accordance with all applicable law.

3. If a patient is given any psychotropic or other medication which has an effective duration of action including the day of a court hearing, the facts concerning its administration and effects, and the patient's mental status and behavior in the absence of medication, shall be brought to the attention of the court.

9.D. Other Medical/Surgical Care

All patients shall be provided with prompt, regular and competent medical care for physical ailments under the supervision of a licensed physician. Every patient shall have a reasonably complete physical examination at appropriate intervals.

Section 10. RIGHTS OF PATIENTS

10.A. Preservation of Rights

No right of any person (including but not limited to the right to register and vote at elections; rights to acquire, use and dispose of property including contractual rights; rights to sue and be sued; rights relating to licenses, permits, privileges and benefits under law; and rights concerning domestic relations) shall be denied or reduced solely by reason of his having been evaluated, committed or treated under this Act, except as otherwise specifically provided herein or in other applicable law. A finding of lack of capacity to make an informed decision concerning treatment under Section 6 shall not alone establish lack of competence for any other purpose. A treatment facility may for clinical reasons preclude a patient who is believed to lack competence from making substantial dispositions of his property until his competence can be decided by a court.

10.B. Right to Treatment

Patients shall have a right to treatment to the extent provided in Sections 9, 10.C., and 10.D.

10.C. Healthful and Humane Environment

Every patient shall have the right to a healthful and humane environment. Every treatment facility shall provide a clean, sanitary, safe and comfortable environment in a structure which complies with applicable licensing requirements governing physical facilities, nutrition, health and safety, and medical services, and for aspects of care for which there are not mandatory requirements, with generally accepted professional standards. In addition, every patient shall have a right to a humane psychological environment which protects him from harm or abuse, provides reasonable privacy, promotes personal dignity and provides opportunity for improved functioning.

10.D. Least Restrictive Alternative and Leaves of Absence

1. Every patient shall have the right to treatment consistent with the least restrictive alternative principle.

2. Leaves of absence may be granted in appropriate cases at the discretion of the treating facility. Police officers shall be authorized to and shall, at the request of a treatment facility, take into custody and return to the treatment facility any person who has been committed there and leaves without proper authorization or does not return at the end of an authorized leave of absence.

10.E. Institutional Labor

1. Patients have a right to perform labor as part of a therapeutic program.

2. Patients may not be required to perform labor, except that to the extent they are able, they may be required to perform (1) tasks necessary to care for their personal possessions, (2) routine, nondegrading housekeeping tasks necessary to maintain their living quarters, or (3) other tasks which the responsible

psychiatrist [or: "the responsible physician"][15] approves and which are monitored as part of a therapeutic program for the patient. No patient shall be subjected to any loss of any right under this Act (as distinguished from a privilege which is conferred as part of a therapeutic program) because of his refusal to perform such tasks.

3. Any patient labor which confers an economic benefit upon the institution beyond merely supplementing employee performance of housekeeping tasks shall be compensated on a reasonable basis in accordance with applicable law, and the proceeds of such labor shall be paid to the patient or his designee.

10.F. Restraints and Seclusion[16]

1. Restraints and seclusion may be of therapeutic benefit to some patients and therefore may be administered in conformity with good medical practice.

2. Every patient shall have the right to be free from unwarranted or inappropriate restraints or seclusion.

3. A patient shall be physically restrained or placed in seclusion only at the written order of a physician or upon a verbal order noted in the patient's record and subsequently signed by the physician.

4. During any period in which a patient is restrained or secluded, he shall be periodically checked and cared for properly to assure his well-being.

10.G. Corporal Punishment

Every patient shall have the right to be free from corporal punishment.

10.H. Nutrition

Every patient shall have the right to a nutritionally sound and medically appropriate diet.

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[15] Optional provision.

[16] These provisions establish only a basic framework for the use of restraints and seclusion. More detailed guidelines are being prepared by the American Psychiatric Association to deal with the many subtle problems which arise.

10.I. Exercise and Recreation

Every patient shall have reasonable opportunities for physical and outdoor exercise and access to recreational areas and equipment. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.J. Visitors

Every patient has the right to receive visitors of his choosing with reasonable privacy. Reasonable limitations on access of visitors may be set by general rules or, for clinical reasons, in particular cases.

10.K. Communications

1. Every patient shall have the right to send and receive mail. Reasonable rules governing inspection (but not reading) of incoming mail may be enforced, provided that they are necessary to substantial health care purposes and that they preserve the patient's privacy rights to the extent compatible with his clinical status.

2. Every patient shall have the right to reasonably private access to telephones, including the right to make long-distance calls to the extent he can arrange for payment for such calls.

3. A treatment facility shall provide reasonable assistance to patients in exercising their communication rights. Reasonable limitations on use of the mails and telephones may be set by general rules or, for clinical reasons, in particular cases.

10.L. Practice of Religion

Every patient shall have the right to practice or refrain from practicing religion, and pressure shall in no event be placed on those who do not wish to practice religion. The treatment facility shall provide appropriate assistance so that patients wishing to practice a religion have a reasonable opportunity to do so.

10.M. Personal Possessions

Every patient shall have the right to keep, use and store personal possessions and to maintain and use

bank accounts or other sources of personal funds, unless precluded from doing so by order of a court. Reasonable limitations may be set by general rules or, for clinical reasons, in particular cases.

10.N. Notice of Rights

As soon after admission as his medical condition permits, a patient shall be advised orally and given a written statement of his rights under this Act, and such a statement of rights shall be posted so that it is available to patients.

10.O. Non-Retaliation

No patient shall be retaliated against or subjected to any adverse change of conditions or treatment solely because of his having asserted his rights.

10.P. Access to Counsel

A patient may at any time have a telephone conversation with or be visited by his lawyer.

Section 11. SUCCESSIVE PERIODS OF COMMITMENT

11.A. Sixty-Day Re-Commitment

1. Any person who has been subject to a thirty-day commitment pursuant to Section 6, may be re-committed for up to sixty days upon a petition by the treatment facility or by the next of kin or guardian. The petition may be filed with the court at any time prior to the expiration of the thirty-day commitment. The petition shall include a statement of the treatment facility as to why the person still meets the criteria for involuntary commitment; what treatment has been provided and what progress has been made; why a further period of commitment is warranted; and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.

2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following the expiration of the thirty-day commitment, and shall have all other rights to which he was entitled at the hearing on thirty-day commitment.

3. The court shall order that the person be discharged unless it determines (a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and (b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

11.B. One Hundred Eighty-Day Re-Commitments

1. Any person who has been subject to sixty-day re-commitment pursuant to Section 11.A. may be re-committed for up to one hundred eighty days upon a petition filed with the court by the treatment facility or by the next of kin or guardian. The petition shall include a statement of the treatment facility as to why the person still meets the criteria for involuntary commitment; what treatment has been provided and what progress has been made; why a further period of commitment is warranted; and the identity of the person who has knowledge concerning the case. The petition shall be promptly served by the court on the patient, the next of kin or guardian, and the patient's attorney.

2. The patient shall be entitled to a hearing before the court on the petition on or before the first business day following expiration of the operative period of commitment and shall have all other rights to which he was entitled at the hearing on thirty-day commitment.

3. The court shall order that the person be discharged unless it determines (a) by clear and convincing evidence that the person still satisfies the criteria for involuntary commitment, and (b) that there is a reasonable prospect that a substantial therapeutic purpose would be served by a further period of commitment.

4. Additional re-commitments for periods of up to one hundred eighty days each may be ordered in accordance with Section 11.B.1-3 when warranted.

11.C. Waiver of Hearings

A patient may waive any hearing to which he is entitled under this Section 11 upon a written waiver which the court finds is knowingly and voluntarily executed by the patient.

Section 12. DISCHARGE

12.A. The responsible psychiatrist [or: "the responsible physician"][17] shall review periodically whether a patient still meets the criteria for lawful commitment, and if he concludes that the patient does not, he shall undertake discharge procedures as provided herein.

12.B. As to a patient committed because he was likely to cause harm to himself or to suffer substantial mental or physical deterioration, if the responsible psychiatrist [or: "the responsible physician"][18] concludes that the patient no longer meets the criteria for lawful commitment, he may discharge the patient directly.

12.C. As to a patient committed solely because, or partly because, he was likely to cause harm to others, if the responsible psychiatrist [or: "the responsible physician"][19] concludes that the patient no longer meets the criteria for lawful commitment, or that the patient's treatment program has been completed or is unlikely to provide further benefits, he shall apply to the court for an order discharging or transferring the patient, as may be appropriate. The application shall set forth the relevant facts. The court may conduct an informal hearing, subject to such procedures as the court sets. Nothing in this subsection shall reduce any rights to hearings which patients have pursuant to other provisions of this Act.

12.D. Discharge of any patient may be delayed for a reasonable period of time in order to arrange transportation or lodging for the patient, or for other good cause.

12.E. A person who has been discharged from emergency evaluation, thirty-day commitment or a subsequent period of commitment may be re-committed only pursuant to the same procedures provided in this Act and upon a showing of some new circumstances warranting such commitment which were not known at the time of discharge.

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[17] Optional provision.

[18] Optional provision.

[19] Optional provision.

12.F. The responsible psychiatrist [or: "the responsible physician"][28] may, as part of an individual treatment plan for a patient who is involuntarily committed, release such patient to outpatient treatment upon the condition that if the patient fails to follow through with or respond acceptably to such outpatient treatment, he may be returned to inpatient treatment for the remainder of the operative period of commitment.

12.G. Nothing in this Act shall limit any other legal rights or remedies concerning discharge which a patient may have or acquire pursuant to law, regulation or policy, including the right to petition for a writ of habeas corpus.

Section 13. CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

[This Section adopts the American Psychiatric Association's "Model Law on Confidentiality of Health and Social Service Records."]

Section 14. REPRESENTATION OF PATIENTS

14.A. Right to Counsel at Hearings

Every patient shall have a right to counsel to represent him at court hearings under this Act, except that a patient need not be provided with counsel for the preliminary hearing on emergency evaluation provided in Section 4.F.

14.B. Resolution of Grievances in Treatment Facilities

Every treatment facility shall establish a fundamentally fair procedure for the assertion, resolution, and redress of patients' grievances, and shall have a patients' representative or similar person who shall hear patients' grievances, attempt to resolve problems, and protect patients' interests.

14.C. Representation by Next of Kin or Guardian

Any right of patients provided in this Act may be exercised on behalf of a patient who is unable to exercise such right by a next of kin or guardian, in accordance with State law.

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[28] Optional provision.

Section 15. TRANSPORTATION

Whenever a patient is to be brought to or from a treatment facility, or is to be transferred to another facility or to a home, the court may direct the sheriff, state police or other appropriate authorities to furnish suitable transportation.

Section 16. NON-DEROGATION OF PATIENTS' RIGHTS

Rights conferred upon patients by this Act shall be in addition to, and nothing in this Act shall revoke or reduce, any rights, privileges or immunities which a patient may have or acquire by law, regulation or policy.

Section 17. COSTS OF CARE

In accordance with law, indigent public patients shall receive care and treatment under this Act without charge to them. Patients committed under this Act who are able to pay may be required to pay some reasonable costs of care and treatment, and to that end treatment facilities and the State shall be authorized to recover such costs from them or their estate, their family, custodians of their property, or third parties liable for the costs of their care or treatment, in conformity with law. The liability of patients, their families, and others for the long term care of patients committed as likely to cause harm to others shall be specially limited by regulations of the Department of Mental Health.

Section 18. IMMUNITIES AND PENALTIES

18.A. Immunities

1. In the absence of willful misconduct or gross negligence, no officer, director, staff member or employee of a treatment facility shall be liable for acts or omissions within the scope of his employment related to admission, evaluation, care, treatment, nonadmission, transfer, removal of restrictions upon, or discharge of a person, pursuant to this Act.

2. No other person who, acting in good faith and with a reasonable basis, participates in any of the processes provided in this Act shall be liable for such actions.

3. Notwithstanding any other provision of this Act, no police officer, no officer, director, staff member or employee of a treatment facility, and no other person or entity performing actions pursuant to this Act, shall be liable for any action of a patient who is discharged from or is absent from a treatment facility pursuant to this Act.

4. Under no circumstances shall any person performing actions pursuant to this Act have a duty to, or be liable for failing to, notify, advise or warn anyone concerning the non-admission, transfer, removal of restrictions on, or discharge of any person.

18.B. Penalties

1. Any person who knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting or interfering with the processes provided in this Act shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under law.

2. Any person who takes into custody, admits for evaluation or commitment, detains for a further period of time, discharges, or administers medication or treatment to a patient, or takes other action affecting the substantial rights of a patient, doing so knowingly and willfully in substantial violation of this Act, shall be subject to a civil fine, and shall be liable for injunctive relief and money damages, in addition to any other liability under law. This subsection shall not be invoked in cases of minor, merely technical, or otherwise justifiable breaches of the provisions of this Act.

Section 19. REGULATIONS

The Commissioner of Mental Health is empowered to promulgate regulations to implement this Act which are consistent with its provisions.

Section 20. CONSTRUCTION

20.A. Gender and Number

As used in this Act, pronouns shall refer to both male and female persons equally, and articles shall refer to singular and plural references equally.

20.B. Severability

If any provision of this Act or its application to any person or circumstance is held invalid, it is the legislative intent that such invalidity not affect other provisions or applications which can be given effect apart from that which is invalidated, and to this end the provisions of this Act shall be deemed severable.

20.C. Construction Against Implied Repeal

This Act is intended as a unified, general Act covering its subject matter, and accordingly none of its provisions shall be deemed impliedly repealed by subsequent legislation if such a construction reasonably can be avoided.

ADDENDUM

This addendum contains Guidelines for states which do not wish to undertake a comprehensive revision of their civil commitment laws, but do wish to add provisions for the commitment of persons who are likely to "suffer substantial mental or physical deterioration."

* * *

DEFINITIONS

As used in this Act, the terms below shall have the meanings indicated:

* * *

"consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, where treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.

* * *

"lacks capacity to make an informed decision concerning treatment" means that the person, by reason of his mental disorder or condition, is unable despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment as evidenced by inability to weigh the possible risks and benefits.

"likely to cause harm to himself or to suffer substantial mental or physical deterioration" means that as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.

* * *

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition which (1) substantially impairs the person's thought, perception of reality, emotional process, or judgment or (2) substantially impairs behavior as manifested by recent disturbed behavior.[1]

* * *

EMERGENCY PSYCHIATRIC EVALUATION

Detention by a Police Officer

A police officer may take a person into custody, and transport the person to a treatment facility for emergency psychiatric evaluation if:

* * *

-- the police officer has probable cause to believe, based on his personal observation and investigation, or based on the petition of any interested adult and such corroboration as the police officer deems necessary in the circumstances, that the person is suffering from a severe mental disorder as a result of which he is likely to cause harm to himself or others or is manifestly unable to care for some of his basic needs, and that immediate hospitalization is necessary to prevent harm to the person or to others;

* * *

Certification by a Licensed Physician

A person may be taken into custody by a police officer, or accepted by an ambulance service, and transported and presented to a treatment facility for emergency psychiatric evaluation when a licensed physician certifies in writing that he has examined the patient

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[1] Mental retardation, epilepsy, or other developmental disabilities do not, in themselves, constitute a severe mental disorder. States may wish to provide by other provisions of law for persons whose use of or addiction to intoxicating substances warrants hospitalization.

in the last 72 hours or that he has ongoing medical responsibility for the person and has knowledge of his current condition, and on such basis he has probable cause to believe that such person is suffering from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioriation, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

* * *

Treatment Facility Determination

Upon the presentation of a person to a treatment facility, the facility shall accept the person and shall promptly examine him to determine whether he meets the criteria for emergency evaluation and treatment set forth below.

The person shall be admitted for emergency evaluation and treatment only if the examining psychiatrist determines that there is probable cause to believe that the person suffers from a severe mental disorder as the result of which: he lacks capacity to make an informed decision concerning treatment; and he is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others; and immediate hospitalization is necessary to prevent such harm.

* * *

CRITERIA FOR COMMITMENT

A person may be involuntarily committed for a period of up to ( )[2] days if after the hearing the court determines, based upon clear and convincing evidence, that:

1. the person is suffering from a severe mental disorder; and

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[2] Insert the time period under existing law.

2. there is a reasonable prospect that his disorder is treatable at or through the facility to which he is to be committed, and such commitment would be consistent with the least restrictive alternative principle; and

3. the person either refuses or is unable to consent to voluntary admission for treatment; and

4. the person lacks capacity to make an informed decision concerning treatment; and

5. as the result of the severe disorder, the person is (1) likely to cause harm to himself or to suffer substantial mental or physical deterioration, or (2) likely to cause harm to others.

* * *

INFORMED CONSENT TO MEDICATION OR OTHER TREATMENT -- INVOLUNTARY PATIENTS

* * *

It being a prerequisite to involuntary commitment that the person lacks capacity to make an informed decision concerning treatment, the treatment facility shall be authorized to administer medications or other treatments, except special therapies which are subject to particular laws or regulations, to such persons consistent with good medical practice without their consent. Although consent to treatment is not required, during the course of treatment the responsible psychiatrist shall consult with the patient and his next of kin or guardian, and give consideration to the views they express concerning treatment and any alternatives.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM September 9, 1983

SUBJECT: Mental health commitment laws
(Work Order No. 13-1516)

TO: Senator Joe Josephson
Chairman, Senate Health, Education and
Social Services Committee

FROM: Edward H. Hein EHA
Legislative Counsel

You have asked for a comparison of the American Psychiatric Association's draft guidelines for psychiatric hospitalization of adults with Alaska's mental health commitment laws (AS 47.30.655 - 47.30.915). I have enclosed a section-by-section comparison, with the APA guidelines on the left-hand pages and the corresponding Alaska statutes on the right-hand pages. My comments follow.

In general, there are many similarities between the APA guidelines and Alaska law. Both provide for emergency or involuntary commitments, voluntary commitments, initial periods of detention followed by longer periods of extension, standards, hearings, patient rights, immunities for mental health professionals, and penalties for bad faith commitments. In most cases Alaska law appears to provide equal or better patient protections than those recommended by the APA.

The major specific differences between the guidelines and the statutes are as follows:

1. Emergency detention. Under APA section 4.A.2. a person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility, except for protective custody purposes and only while awaiting transportation to a treatment facility. Under AS 47.30.705. a correctional facility may be used as an emergency evaluation facility if a regular evaluation facility is unavailable.

2. Petition for involuntary commitment. Under APA section 4.C. any "interested adult" may petition for an emergency psychiatric evaluation of another person. The APA does not define what "interested" means. Under AS 47.30.700 "any adult" may petition for involuntary commitment of another person.

3. Deadline for emergency examination. Under APA section 4.D.1. a treatment facility must examine a person under emergency detention "promptly" after arrival at the facility. Under AS 47.30.710 the examination and evaluation must be completed within 24 hours of arrival.

4. Advisement of rights. Under APA section 4.E. a treatment facility must notify a person admitted for emergency evaluation of the purposes and possible duration of the evaluation, as well as the person's legal rights relating to commitment. Under AS 47.30.725 there is no specific requirement of notice relating to the purposes and duration of evaluation. But the Alaska statute requires that notice be both oral and written and in a language the person understands.

5. Hearing after emergency detention. Under APA section 4.F. a person under emergency detention must receive a hearing before a court within five business days after being admitted to a facility. This right to a hearing may be waived in writing upon advice of counsel. The hearing is informal and is conducted under rules set by the court consistent with "fundamental fairness". After the hearing a person may be discharged by the court or committed for 30 days. Under AS 47.30.725 a person under emergency or involuntary detention has a right to a hearing within 72 hours of arrival at the facility. The person may not waive the right to a hearing, but may waive the 72-hour limit if the person is represented by counsel. However, the hearing must be held within seven calendar days of the person's arrival at the facility. The person has a right to communicate, immediately after arrival at the facility, with a guardian or other adult and with an attorney. At the hearing the person has a right to be represented by an attorney, to present evidence and to cross-examine witnesses. Subject to specified exceptions, the person has a right to be free of the effects of medicine or treatment before the hearing. After the hearing the person may be discharged or committed for a period of 21 days. Additional hearing rights are

specified elsewhere in the APA guidelines and the Alaska statutes.

6. Voluntary admission. Under APA section 5.A. a person believed to be mentally ill and in need of hospitalization may be admitted voluntarily if the person consents in writing after being advised of rights. The consent is effective for 60 days, but may be renewed for an unlimited number of periods of up to 180 days each. Under AS 47.30.670 the only requirements are that the person (1) in fact be suffering from mental illness, (2) be 14 years old or older, and (3) "voluntarily" signs the admission papers. A person under 14 years of age may be "voluntarily" admitted for a period of 21 days if (1) the minor's guardian or parent signs the admission papers and (2) the senior mental health professional at the facility concludes that specified criteria are met. Presumably the minor is automatically released after 21 days unless the minor is admitted again under the same requirements as for initial admittance.

7. Discharge from voluntary admission. Under APA section 5.B. any person voluntarily admitted must be discharged within five business days after submitting a written request for discharge, unless the treatment facility or the person's guardian files a petition for 30-day commitment. Under AS 47.30.685 - 47.30.695 a person who was voluntarily admitted to a treatment facility shall be discharged immediately upon submitting a written notice of intent to leave the facility. However, the treatment facility may hold the person for 48 hours after receiving an intent to leave notice in order to initiate involuntary commitment proceedings. In that case, the facility must give the person written notice of its intent to initiate the proceedings by the time the person would otherwise be released. A person who is under 14 years of age must be discharged immediately upon the request of the parent or guardian, unless the minor, if released, is likely to cause serious harm to himself or another as a result of a mental illness.

8. Conversion of status. Under APA section 5.C. a person who was committed involuntarily may change to a voluntary admitee with a psychiatrist's approval. No comparable provision exists in Alaska law.

9. Further periods of commitment. The APA guidelines provide for 30-day, 60-day, 90-day, and 180-day commitments. Alaska law provides for 21-day, 90-day, and 120-day

commitments. Each period of commitment is to be preceded by a hearing under both the APA guidelines and the Alaska statutes. The patient's rights at the hearing vary considerably, however, under the two different schemes. The most noticeable differences are that (1) the APA guidelines allows the use of hearsay evidence so long as it is relevant, while Alaska requires the use of civil rules of evidence; (2) the APA denies a patient's Fifth Amendment right to remain silent, while Alaska law specifically recognizes it; and (3) the APA does not allow the exclusion from evidence of privileged communications between the patient and psychiatrist or physician made during the course of evaluation or treatment, whereas Alaska law recognizes such an evidentiary privilege.

10. Petitions for further periods of commitment. Under both the APA guidelines and Alaska law, all commitments are initiated by the filing of a petition. Under APA section 6.A. a petition for a 30-day commitment of a person already at a treatment facility may be filed by the facility or by the person's "next of kin" or guardian. If the person is not currently committed, any "interested adult" may file a petition for a 30-day commitment of the person. The language of the guidelines does not make clear whether additional petitions may be filed for successive commitments of 30-days each. Under APA section 11.A. a person who "has been subject to" a 30-day commitment may be recommitted for an additional 60-day period upon a petition filed by the treatment facility or the person's "next of kin" or guardian. (The drafting here is imprecise and ambiguous. The phrase "has been subject to" could mean "has ever been subject to" or it could mean "is currently under" or it could mean "has met the criteria for".) Under APA section 11.B., a person committed for any period of time and who is dangerous to himself or herself may be committed for one additional period of "up to 90 days" upon a petition filed by the treatment facility or by the person's next of kin or guardian at any time before the current period of commitment expires. Under APA section 11.C., a person who "was committed for up to 30 days and is subject to 60-day recommitment" and who is likely to harm others may be committed for successive additional periods of 180 days each upon a petition filed by the person's next of kin or guardian, or by the state "upon advice of the treatment facility". Under AS 47.30.730, a petition for a 21-day commitment must be signed by two mental health professionals who have examined the person. It is not clear who may file

the petition. Under AS 47.30.740, a petition for a 90-day commitment may be filed by "the professional person in charge" while the person is under a 21-day commitment. Under AS 47.30.770 the "professional person in charge" may file a petition for a 120-day commitment of a person who is under a 90-day commitment. Successive commitments of 120 days each are authorized.

11. Informed consent. Under APA section 7, a treatment facility must obtain a patient's informed consent before administering medicine or treatment to a voluntary admitee in a non-emergency situation, unless the person lacks capacity to consent. A voluntary admitee may revoke consent in writing at any time except in an emergency. Under APA section 8, an involuntary admitee, or a voluntary admitee in an emergency, may be treated or given medicine without informed consent. Under AS 47.30.825, every mental patient has the right to know the name, purpose and side effects of medicine to be administered. In a "true medical emergency", surgery to save the "life, physical health, eyesight, hearing or member of the patient" may be performed without the consent of the patient, guardian or court. The law specifically recognizes an adult patient's right to not be operated on if the patient knowingly withholds consent on religious grounds.

12. Special therapies. Under APA section 8.C. experimental treatments, psychosurgery, aversive therapy or other special therapy designated by the appropriate state department may not be administered, except as provided by law or regulation. AS 47.30.825 provides that a lobotomy or psychosurgery may not be performed without specific informed consent, a full due process hearing, and a court order. Electro-convulsive therapy or aversive conditioning requires informed consent or, if the patient lacks substantial capacity to give informed consent, a court order. Under AS 47.30.830 experimental treatments involving any significant risk of physical or psychological harm are prohibited.

13. Patient rights. This is one area where the APA guidelines are more thorough than Alaska law. Under both schemes patients have rights to privacy, property, civil rights such as voting, mail, access to attorneys and visitors, and treatment consistent with the "least restrictive alternative" principle. APA section 10, however, also provides a right to "nutritionally sound and medically appropriate diet", a right to exercise and recreation, a

right to perform labor, and a right to be free from corporal punishment.

14. Discharge. Under APA section 12.F. a person may, as part of an individual treatment plan, be released from commitment at a facility to outpatient treatment. The person may, however, be returned to inpatient treatment for failure to comply with the outpatient treatment program requirements. APA section 15 provides that law enforcement or other appropriate authorities shall provide transportation of patients to and from a treatment facility. Under AS 47.30.825, a person upon discharge from a facility must be given a discharge plan suggesting, but not requiring, the kinds and amounts of treatment the person should have to maintain mental health. The person has a right to participate in formulating the discharge plan. Also, under AS 47.30.890 a person is entitled to "suitable clothing" upon discharge, and if indigent, to transportation to the person's permanent residence in the state and "a reasonable amount of money to meet immediate needs". See also AS 47.30.795.

15. Confidentiality. The APA guidelines adopt by reference the "Model Law on Confidentiality of Health and Social Service Records". AS 47.30.845 provides that patient records are confidential and not public records, and specifies the persons or agencies to whom records and information may be disclosed.

16. Grievance procedures. APA section 14.B. requires that treatment facilities establish "fundamentally fair" procedures for patients' grievances. Alaska statutes have no similar provision.

17. Immunities. Under APA section 18.A. employees of a treatment facility are not liable for acts or omissions within the scope of employment, absent willful misconduct or gross negligence. Other persons who act in good faith and with a reasonable basis are not liable for actions provided for under the guidelines. The guidelines disclaim any liability for actions by a patient who is absent from a treatment facility or who has been discharged. Finally, the guidelines disclaim any liability for failure to warn or notify anyone of a patient's discharge. Immunity under Alaska law is much more limited. Under AS 47.30.815 a person is not subject to criminal or civil liability for petitioning for evaluation or treatment of another person in

good faith and upon actual knowledge or reliable information. Also, four classes of officials may not be held civilly or criminally liable for detaining or releasing a person "at or before the end of" the period for which the person was committed, so long as the official acted in good faith and without gross negligence.

18. Penalties. APA section 18.B. provides that a civil fine, injunctive relief and money damages may be imposed or granted if a person (1) "knowingly and willfully gives substantial, false information or takes other wrongful action for the purpose of distorting, corrupting or interfering with the processes provided in this Act" or (2) commits, detains, discharges, or treats a patient, or otherwise affects a patient's "substantial rights" knowingly and willfully in substantial violation of the guidelines. AS 47.30.815 makes it a class C felony to willfully initiate an involuntary commitment procedure without good cause.

19. Miscellaneous provisions. The last four pages of the comparison booklet (enclosed) consist of provisions of Alaska law for which there are no corresponding provisions in the APA guidelines. Note especially AS 47.30.760, providing for placement at the closest facility; AS 47.30.765, providing for appeal of involuntary commitment orders; AS 47.30.875, providing for handling of nonresident patients; AS 47.30.880, adopting the Interstate Compact on Mental Health; and AS 47.30.895 - 47.30.900, disposition of personal property and money of patients who die while in custody or who leave a facility without authority. Note one error: AS 47.30.795, relating to outpatient care and appearing among the miscellaneous provisions, actually corresponds with APA section 12.F. and should have appeared opposite that section.

If you have any questions or comments, feel free to contact me at your convenience.

EHH:ljb

Enclosure
29/002

GIVEN TO PATIENTS AT API
(ALSO IN A LANGUAGE UNDERSTOOD BY PATIENT)

PATIENTS' RIGHTS

Your legislators have tried to protect your rights to freedom and at the same time protect everyone from dangerous people and protect people who are harmful to themselves because of mental illness.

The following are your rights according to law:

1. You may join in developing your treatment plan, and you are entitled to be informed of your medical and psychological condition and prognosis.

2. You will be told the name, purpose, and side effects of any medication you are asked to take.

3. No unnecessary or excessive medication will be given to you. All medication will be given only on the order of a licensed physician.

4. Physical restraint will not be used on you unless you behave in a manner harmful to yourself or others.

5. You will not receive electroconvulsive therapy, aversive conditioning, experimental treatment or psychosurgery.

6. You will be given a discharge plan outlining the kind and amount of care and treatment you should have after discharge.

7. Your civil rights will not be impaired.

8. Your hospital record and I.D. photograph will be confidential.

9. Unless you sign a release of responsibility, your personal property will be inventoried and safe-guarded and returned to you at discharge.

10. You will have private storage space, and will be allowed to wear your own clothing, and keep certain personal possessions and a reasonable amount of your own spending money.

11. You may have visitors during visiting hours.

12. You will have access to letter writing materials and stamps, and may send and receive unopened mail.

13. You will have reasonable access to a phone and may make and receive confidential calls.

14. After discharge you may move to have all court records pertaining to your care expunged.

Under the law certain rights may be restricted by your doctor when it is necessary for the protection of yourself or others.

The following additional information will help you better understand your care here. If you still have questions, ask your nurse or social worker:

1. No matter what your legal status is, the more you want to help yourself and work with the staff in an honest, open manner, the quicker and more effective will be your recovery.

2. You do not have the right to do the following:

   - Injure or threaten others.

   - Damage property

   - Intrude on the rights of others, such as rudeness, shouting, or excessive noise that you can control.

   - Make messes for others to clean up.

   - Bring or use drugs, alcohol or weapons.

   - Do illegal acts (break the law). This includes writing threatening letters or making threatening or obscene phone calls.

If you feel you are being treated unfairly or improperly, please follow these steps:

1) Bring it up in the community meeting.

2) If you are not satisifed with the results of that action, bring it up with your nursing advisor, doctor, or any member of the treatment team.

3) If not satisfied, write down your problem and complaint and forward it to the Superintendent.

4) You always have the right to write to your attorney, the State Ombudsman, the Commissioner of the Department of Health and Social Services, or the Superior Court which may have been involved in your hospitalization.

If you feel you've been discriminated against in any way because of race, color, sex, religion, age, or national origin, you may file a complaint with the Civil Rights Commission. You can get the forms from the Administrator's Office. If you need help in filling them out, see your nurse advisor or the Hospital Administrator's Office.

/ojb/vnc

HALOPERIDOL (Systemic)

Haloperidol (ha-loe-PER-i-dole) is used to treat nervous, mental, and emotional conditions. It is used also to control nausea and vomiting and the effects of Gilles de la Tourette's disease. Haloperidol is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have any of the following medical problems:

- Alcoholism
- Blood disease
- Epilepsy
- Glaucoma
- Heart or circulation disease
- Kidney disease
- Liver disease
- Lung disease
- Overactive thyroid
- Parkinson's disease
- Prostate enlargement
- Severe mental depression
- Stomach ulcers
- Urination problems

—if you are now taking any of the following medicines or types of medicine:

- Amphetamines
- Anticonvulsants (seizure medicine)
- Antihypertensives (high blood pressure medicine)
- Asthma medicine
- Epinephrine
- Ulcer medicine

—if you are now taking central nervous system (CNS) depressants such as:

- Antihistamines or medicine for hay fever, other allergies, or colds
- Barbiturates
- Narcotics
- Prescription pain medicine
- Sedatives, tranquilizers, or sleeping medicine
- Tricyclic antidepressants (medicine for depression)

Proper Use of This Medicine

Use this medicine only as directed by your doctor. Do not use more of it, do not use it more often, and do not use it for a longer period of time than your doctor ordered.

If this medicine upsets your stomach, it may be taken with food or milk to lessen stomach irritation.

If you miss a dose of this medicine, take it as soon as possible unless it is within 6 hours of your next scheduled dose. Do not double doses. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

Sometimes haloperidol must be taken for several days to several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.

Do not suddenly stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). ***Check with your doctor before taking any of the above while you are taking this medicine.***

This medicine may cause some people to become drowsy or less alert than they are normally, especially as the amount of medicine is increased. Even if you take this medicine at bedtime, you may feel drowsy or less alert on arising. ***Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.***

Although not a problem for many patients, dizziness, light-headedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. However, if the problem continues or gets worse, check with your doctor.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

- Shuffling walk
- Stiffness of arms and legs
- Tic-like, jerky movements of head, face, mouth, and neck
- Trembling and shaking of hands and fingers

Less common

- Difficulty in urination
- Dizziness, lightheadedness, or fainting
- Fine, worm-like movements of tongue
- Skin rash

Rare

- Sore throat and fever
- Yellowing of eyes and skin

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common

- Blurred vision
- Constipation
- Dry mouth

TRICYCLIC ANTIDEPRESSANTS (Systemic)

Applies to:
Amitriptyline (a-mee-TRIP-ti-leen)
Desipramine (dess-IP-ra-meen)
Doxepin (DOX-e-pin)
Nortriptyline (nor-TRIP-ti-leen)
Imipramine (im-IP-ra-meen)

Does *not* apply to:
Protriptyline

This medicine belongs to the group of medicines known as tricyclic antidepressants or "mood elevators." It is used to relieve mental depression and depression that sometimes occurs with anxiety. One form of this medicine (imipramine) may be used to treat enuresis (bedwetting). Tricyclic antidepressants are available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have experienced an allergic reaction to other tricyclic antidepressants.

—if you have any of the following medical problems:

Alcoholism	Heart disease
Asthma (history of)	High blood pressure
Difficult urination	Liver disease
Enlarged prostate	Overactive thyroid
Glaucoma	Stomach or intestinal problems

—if you are now taking any other medicines, including over-the-counter (OTC) or nonprescription medicine, especially the following:

Allergy medicine	Other medicine for depression
Antihistamines	Pain medicine
Barbiturates	Sedatives
Blood pressure medicine	Seizure medicine
Cold remedies	Sleeping medicine
Hay fever medicine	Tranquilizers
Narcotics	

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Take this medicine only as directed by your doctor.

To lessen stomach upset, take this medicine with food, unless your doctor has told you to take it on an empty stomach.

Sometimes this medicine must be taken for several weeks before you begin to feel better.

Keep this medicine out of the reach of children since overdose is especially dangerous in young children.

If you miss a dose of this medicine, take it as soon as possible and then go back to your regular dosing schedule. However, if a once-a-day bedtime dose is missed, do not take that dose in the morning. Instead, check with your doctor.

Precautions While Using This Medicine

It is very important that your doctor check your progress at regular visits.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are using before stopping completely.

Before having any kind of surgery (including dental surgery) or emergency treatment, tell the doctor or dentist in charge that you are using this medicine.

This medicine will add to the sedative effects of alcohol and other medicines that slow down the nervous system such as antihistamines or medicines for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; other medicine for depression; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine. *Check with your doctor before taking any of the above while you are taking this medicine and also for several days after you stop taking it.*

This medicine may cause some people to become drowsy or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If this problem continues or gets worse, check with your doctor.

Side effects of this Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

Blurred vision	Irregular heartbeat (pounding, racing, skipping)
Constipation	Problems in urinating

Less common

Eye pain	Hallucinations (seeing, hearing, or feeling things that are not there)
Fainting	Shakiness
	Unusually slow pulse

Rare

Seizures	Sore throat and fever
Skin rash and itching	Yellowing of eyes and skin

LITHIUM (Systemic)

Lithium (LI-thee-um) is a medicine used in the treatment of certain mental and emotional conditions. Lithium is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you are pregnant or if you intend to become pregnant while using this medicine.

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Heart disease	Severe infection
Kidney disease	Thyroid disease
Parkinson's disease	

—if you drink large amounts of coffee or tea.

—if you are on a low-salt diet.

—if you are now taking any of the following medicines or types of medicine:

Asthma medicine	Haloperidol
Caffeine	Potassium iodide
Chlorpromazine	Sodium bicarbonate (baking soda)
Diuretics (water pills, especially thiazide-type)	

Proper Use of This Medicine

Take this medicine exactly as directed. Do not take more of it, do not take it more often, and do not take it for a longer period of time than your doctor ordered.

Sometimes this medicine must be taken for 1 to several weeks before you begin to feel better.

While taking this medicine, *drink 2 or 3 quarts of water or other fluids each day*, and use a normal amount of table salt in your food, unless otherwise directed by your doctor.

Take this medicine immediately after meals or with food or milk to lessen stomach upset, unless otherwise directed by your doctor.

If you miss a dose of this medicine, take it as soon as possible unless it is 2 hours or less until your next scheduled dose. Do not double doses. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits to make sure that the medicine is working properly and that possible side effects are avoided.

This medicine may cause some people to become drowsy or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Use extra care in hot weather and during activities that cause you to sweat heavily, such as hot baths, saunas, or exercising. The loss of too much water and salt from your body may lead to serious side effects from this medicine.

Do not drink large amounts of caffeine-containing beverages, such as coffee, tea, or colas, while taking this medicine. Since lithium is lost from the body through the urine, the increased urine flow caused by caffeine may lessen the medicine's effect.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

Nausea and vomiting
Shakiness and tremor

Less common

Drowsiness	Swelling of feet and lower legs
Mental confusion	Weakness
Pains in lower Stomach	Slurred speech

Rare

Blurred vision	Jerking of arms and legs

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common

Decreased sexual ability	Dry mouth
Diarrhea	Increased thirst
Dizziness	Increased urination

Less common

Skin eruption or rash

Signs of low thyroid function

Coldness of fingers and toes	Menstrual changes
Constipation	Muscle aches
Dry, puffy skin	Sleepiness
Headache	Tiredness
	Unusual weight gain

BENZTROPINE (Systemic)

Benztropine (BENZ-troe-peen) is a medicine used to treat Parkinson's disease, sometimes referred to as "shaking palsy." By improving muscle control, benztropine allows more normal movements of the body as the disease symptoms are reduced. Benztropine is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have any of the following medical problems:

Asthma	High blood pressure
Bronchitis	Intestinal blockage
Difficult urination	Kidney disease
Emphysema	Liver disease
Enlarged prostate	Myasthenia gravis
Glaucoma	Overactive thyroid
Hiatal hernia	Severe ulcerative colitis

—if you are taking any of the following medicines or types of medicine:

Amantadine	Medicine for diarrhea
Antacids	Medicine for Parkinson's disease
Antihistamines or medicine for hay fever, other allergies, or colds	Medicine for sleep
Haloperidol	Nerve medicine
Heart medicine	Sedatives or tranquilizers
	Ulcer medicine

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Take this medicine only as directed by your doctor To lessen stomach upset, take this medicine immediately after meals or with food, unless your doctor has told you to take it on an empty stomach.

If you miss a dose of this medicine, take it as soon as possible. If it is within 8 hours of your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for depression; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine. *Check with your doctor before taking any of the above while you are taking this medicine.*

Do not take this medicine within 1 hour of taking antacids or medicine for diarrhea. Taking them too close together will make benztropine less effective.

This medicine may cause your eyes to become more sensitive to light than they are normally. Wearing sunglasses may help lessen the discomfort from bright light.

This medicine may cause some people to become drowsy, dizzy, or less alert than they are normally. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Benztropine will often reduce your tolerance of heat, since it makes you sweat less, causing your body temperature to increase. *Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, as this could possibly result in heat stroke.*

Your mouth, nose, and throat may feel very dry while you are taking this medicine. *To help relieve mouth dryness, chew sugarless gum or dissolve bits of ice in your mouth.*

Check with your doctor if you develop intestinal problems such as constipation. This is especially important if you are taking other medicine while taking benztropine, because if the problems are not corrected serious complications may result.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common

Constipation

Less common

Difficult urination

Rare

Eye pain
Skin rash

THIOXANTHENES *(Systemic)*

Applies to:
Chlorprothixene (klor-proe-THIX-een)
Thiothixene (thye-oh-THIX-een)

This medicine belongs to the general family of medicines known as thioxanthenes. It is used in the treatment of nervous, mental, and emotional conditions. This medicine is available only with your doctor's prescription.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have ever had any unusual reaction to other thioxanthene or phenothiazine medicines.

—if you have any of the following medical problems:

Alcoholism	Lung disease
Blood disease	Parkinson's disease
Glaucoma	Stomach ulcers
Heart or circulation disease	Prostate enlargement
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Guanethidine (high blood pressure medicine)
Anticonvulsants (seizure medicine)	Levodopa
Epinephrine	Ulcer medicine

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Sedatives, tranquilizers, or sleeping medicine
Barbiturates	Tricyclic antidepressants (medicine for depression)
Narcotics	
Prescription pain medicine	

—if you are now taking or have taken within the past 2 weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of this Medicine

Do not take more of this medicine or take it more often than your doctor ordered. This is particularly important when it is given to children, since they may react very strongly to the effects of the medicine.

This medicine may be taken with food or a full glass (8 ounces) of water or milk to reduce stomach irritation.

Sometimes this medicine must be taken for several weeks before its full effect is reached in the treatment certain mental and emotional conditions.

If you miss a dose of this medicine, take it as soon as possible. If it is two hours or less until your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule. If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially during the first few weeks the medicine is being taken. Even if you take this medicine only at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If the problem continues or gets worse, check with your doctor.

Sometimes, patients may show signs of restlessness and excitement after taking this medicine. If this occurs, stop taking the medicine and check with your doctor.

This medicine will often make you sweat less, causing your body temperature to increase. Use extra care not to become overheated during exercise or hot weather while you are taking this medicine, since overheating could possibly result in heat stroke. Also, hot baths or saunas may make you feel dizzy or faint while you are taking this medicine.

A few people who take this medicine may become more sensitive to sunlight than they are normally. When you first begin taking this medicine, avoid too much sun or too much use of a sunlamp until you see how you react. If you have a severe reaction, check with your doctor.

Do not take this medicine within an hour of taking antacids or medicine for diarrhea. Taking them too close together may make this medicine less effective.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur

ANTIHISTAMINES (Systemic)

Applies to:
Azatadine (a-ZA-ta-deen)
Bromodiphenhydramine (broe-moe-dye-fen-HYE-dra-meen)
Brompheniramine (brome-fen-EER-a-meen)
Carbinoxamine (kar-bi-NOX-a-ameen)
Chlorpheniramine (klor-fen-EER-a-meen)
Dexchlorpheniramine (dex-klor-fen-EER-a-meen)
Dimethindene (dye-meth-IN-deen)
Diphenylpyraline (dye-fen-il-PEER-a-leen)
Doxylamine (doxe-ILL-a-meen)
Pyrilamine (peer-ILL-a-meen)
Tripelennamine (tri-pel-ENN-a-meen)
Triprolidine (trye-PROE-li-deen)

Does not apply to:
Cyproheptadine
Dimenhydrinate
Diphenhydramine
Hydroxyzine
Promethazine
Trimeprazine

Antihistamines are used to relieve or prevent the symptoms of hay fever and other types of allergy. Certain antihistamine preparations are available only with your doctor's prescription. Others are available without a prescription; however, your doctor may have special instructions on the proper dose of the medicine for your medical condition.

Before Using This Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

- Enlarged prostate
- Heart disease
- High blood pressure
- Increased eye pressure
- Overactive thyroid
- Stomach ulcer
- Urinary tract blockage

—if you are now taking any central nervous system (CNS) depressants such as:

- Barbiturates
- Medicine for seizures
- Narcotics
- Other antihistamines or medicine for hay or colds
- Prescription pain medicine
- Sedatives, tranquilizers, or sleeping medicine
- Tricyclic antidepressants (medicine for depression)

—if you are now taking or have taken within the past two weeks monoamine oxidase (MAO) inhibitors such as:

- Isocarboxazid
- Pargyline
- Phenelzine
- Tranylcypromine

Proper Use of This Medicine

Antihistamines are used to relieve or prevent the symptoms of your medical problem. Take them only as directed. Do not take more of them or take them more often than your doctor ordered.

Take this medicine with food or a glass of water or milk to lessen stomach irritation.

If you are taking the long-acting tablet form of this medicine, the tablets are to be swallowed whole. Do not break, crush, or chew before swallowing.

Do not give this medicine to premature or newborn infants, unless otherwise directed by your doctor.

Precautions While Using This Medicine

Antihistamines will add to the effects of alcohol and other medicines that slow down the nervous system, such as anesthetics, including dental anesthetics; tranquilizers; medicine for depression; narcotics; prescription pain medicine; medicine for seizures; sleeping medicine; sedatives; or medicine for hay fever, other allergies, or colds. *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally. Even if taken at bedtime, it may cause some people to feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive or do other jobs that require you to be alert.*

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. The following side effects may go away during treatment as your body adjusts to the medicine; however, check with your doctor if they continue or are bothersome:

More common

- Dizziness
- Drowsiness
- Thickening of the bronchial secretions
- Upset stomach or stomach pain

Less common or rare

- Blurred vision
- Difficult or painful urination
- Dryness of mouth, nose, and throat
- Headache
- Loss of appetite
- Nervousness, restlessness, or trouble in sleeping(especially in children)
- Skin rash
- Unusual increase in sweating
- Unusually fast heartbeat

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

PHENOTHIAZINES (Systemic)

Applies to:
Acetophenazine (a-set-oh-FEN-a-zeen)
Butaperazine (byoo-ta-PAIR-a-zeen)
Carphenazine (kar-FEN-a-zeen)
Chlorpromazine (klor-PROE-ma-zeen)
Fluphenazine (floo-FEN-a-zeen)
Perphenazine (per-FEN-a-zeen)
Piperacetazine (pi-per-a-SET-a-zeen)
Prochlorperazine (proe-klor-PAIR-a-zeen)
Promazine (PROE-ma-zeen)
Thioridazine (thye-oh-RID-a-zeen)
Trifluoperazine (trye-floo-oh-PAIR-a-zeen)
Triflupromazine (trye-floo-PROE-ma-zeen)

Does *not* apply to:
Ethopropazine
Methdilazine
Methotrimeprazine
Promethazine
Propiomazine
Thiethylperazine
Thiopropazate
Trimeprazine

Phenothiazines (fee-noe-THYE-a-zeens) are a family of medicines used to treat nervous, mental, and emotional conditions; some are used also to control anxiety, nausea and vomiting, and severe hiccups. Phenothiazines are available only with your doctor's prescription.

Before Using this Medicine

In order to decide on the best treatment for your medical problem, your doctor should be told:

—if you have ever had any unusual reaction to any of the phenothiazine medicines.

—if you are pregnant or if you intend to become pregnant while using this medicine.

—if you are breast-feeding an infant.

—if you have any of the following medical problems:

Alcoholism	Lung Disease
Blood disease	Parkinson's disease
Glaucoma	Prostate enlargement
Heart or circulation disease	Stomach ulcers
Liver disease	Urination problems

—if you are now taking any of the following medicines or types of medicine:

Amphetamines	Guanethidine (high blood pressure medicine)
Anticonvulsants (seizure medicine)	Levodopa
Asthma medicine	Ulcer medicine
Epinephrine	

—if you are now taking central nervous system (CNS) depressants such as:

Antihistamines or medicine for hay fever, other allergies, or colds	Prescription pain medicine
Barbiturates	Sedatives, tranquilizers, or sleeping medicine
Narcotics	Tricyclic antidepressants (medicine for depression)

—if you are now taking or have taken within the past two weeks monoamine oxidase (MAO) inhibitors such as:

Isocarboxazid	Phenelzine
Pargyline	Tranylcypromine

Proper Use of This Medicine

Do not take more of this medicine or take it more often than your doctor ordered. This is particularly important when it is given to children, since they may react very strongly to the effects of the medicine.

Sometimes this medicine must be taken for several weeks before its full effect is reached in the treatment of certain mental and emotional conditions.

Do not stop taking this medicine without first checking with your doctor. Your doctor may want you to reduce gradually the amount you are taking before stopping completely.

If you miss a dose of this medicine and your dosing schedule is one dose to be taken:

Once a day— Take the missed dose as soon as possible. Then go back to your regular dosing schedule. But if you do not remember the missed dose until the next day, do not take it at all and do not double the next one. Instead, go back to your regular dosing schedule.

Two times a day— Take the missed dose as soon as possible. Then go back to your regular dosing schedule. However, if it is almost time for your next dose, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.

More than two times a day— If you remember within an hour or so of the missed dose, take it right away. Then go back to your regular dosing schedule. But if you do not remember until later, do not take the missed dose at all and do not double the next one. Instead, go back to your regular dosing schedule.

If you have any questions about this, check with your doctor.

Precautions While Using This Medicine

Your doctor should check your progress at regular visits, especially for the first few months you take this medicine.

This medicine will add to the effects of alcohol and other medicines that slow down the nervous system

such as: antihistamines or medicine for hay fever, other allergies, or colds; barbiturates; medicine for seizures; narcotics; prescription pain medicine; sedatives, tranquilizers, or sleeping medicine; or tricyclic antidepressants (medicine for depression). *Check with your doctor before taking any of the above while you are taking this medicine.*

This medicine may cause some people to become drowsy or less alert than they are normally, especially during the first few weeks the medicine is being taken. Even if you take this medicine only at bedtime, you may feel drowsy or less alert on arising. *Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert.*

Dizziness, lightheadedness, or fainting may occur, especially when getting up from a lying or sitting position. Getting up slowly may help. If the problem continues or gets worse, check with your doctor.

Sometimes, patients may show signs of restlessness and excitement after taking this medicine. If this occurs, stop taking the medicine and check with your doctor.

This medicine will often make you sweat less, causing your body temperature to increase. *Use extra care not to become overheated during exercise or hot weather while you are taking this medicine,* since overheating could possibly result in heat stroke. Also, hot baths or saunas may make you feel dizzy or faint while you are taking this medicine.

A few people who take this medicine may become more sensitive to sunlight than they are normally. When you first begin taking this medicine, avoid too much sun or too much use of a sunlamp until you see how you react. If you have a severe reaction, check with your doctor.

Side Effects of This Medicine

Along with its needed effects, a medicine may cause some unwanted effects. Although not all of these side effects appear very often, when they do occur they may require medical attention. Check with your doctor if any of the following side effects occur:

More common (occurring with increase of dosage)

Muscle spasms, especially of neck and back	Tic-like (jerky) movements of head, face, mouth, and neck
Restlessness	Trembling and shaking of hands and fingers
Shuffling walk	

Less common

Fainting	Skin rashes
Fine, worm-like movements of tongue	

Rare

Eye problems	Yellowing of eyes and skin
Sore throat and fever	

Other side effects may occur which usually do not require medical attention. These side effects may go away during treatment as your body adjusts to the medicine. However, check with your doctor if any of the following side effects continue or are bothersome:

More common

Blurred vision	Dry mouth
Constipation	Increased sensitivity of skin to sun
Decreased sweating	Nasal congestion
Dizziness	Unusually fast heartbeat
Drowsiness	

Less common

Changes in menstrual period	Difficult urination
Decreased sexual ability	Swelling of breasts

This medicine may cause the urine to turn pinkish red to red or reddish brown; this is harmless and may be expected. If you have questions about this, ask your doctor or pharmacist.

Other side effects not listed above may also occur in some patients. If you notice any other effects, check with your doctor.

ADDITIONAL INFORMATION

For patients taking this medicine by mouth

This medicine may be taken with food or a full glass (8 ounces) of water or milk to reduce stomach irritation.

Do not take this medicine within an hour of taking antacids or medicine for diarrhea. Taking them too close together may make this medicine less effective.

If you are taking a liquid form of this medicine, try to avoid getting it on your skin or clothing because it may cause a skin rash or other irritation.

If your medicine comes in a dropper bottle, it must be diluted before you take it. Just before taking, measure each dose with the specially marked dropper and dilute it in ½ glass (4 ounces) of tomato or fruit juice, water, soup, coffee, tea, milk, or carbonated beverage.

For patients taking the extended-release tablet form of this medicine

The extended-release tablets or capsules are to be swallowed whole. Do not break, crush, or chew before swallowing.

For patients using the suppository form of this medicine

How to insert suppository: First remove the foil wrapper and moisten the suppository with water. Lie down on side and push the suppository well up into the rectum with finger.

If the suppository is too soft to insert because of storage in a warm place, before removing the foil wrapper chill the suppository in the refrigerator for 30 minutes or run cold water over it.

For patients receiving this medicine by injection

The effects of the long-acting injection form of this medicine may last for up to 6 weeks. The precautions and side effects information for this medicine applies during this period of time.

Article 9. Patient Rights.

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

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

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

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

(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 84 SLA 1981)

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 47.30.845. Confidential records. Information and records obtained in the course of a screening investigation, evaluation, examination, or treatment are confidential and are not public records, except as the requirements of a hearing under AS 47.30.660 — 47.30.915 may necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to

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

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

(3) a person authorized by a court order;

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

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

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

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

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

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

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

(1) seeking employment;

(2) 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 11 articles approved on September 30, 1955, by the Northeast State Governments Conference on Mental Health. The department is designated as compact administrator with full power to carry out the purpose of the compact and to make all necessary regulations to implement the compact. (§ 119(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

(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 he 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 (a) 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 word "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

(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

670 Standards for voluntary admission
675 Notice of rights
680 Discharge of voluntary patients
685 Notice of intent to leave facility; commitment
690 Admission of minors under 14 years of age
695 Notice of request for release of minors under 14 years of age from detention and 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 — 47.30.865 and an explanation of any document served upon him; and

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

(b) If an applicant for voluntary admission does not understand English, the explanation shall be given in a language he understands. (§ 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 1 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 — 47.30.670 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.

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)

Detaining the Insane

Detention Hospitals, Mental Health, and Frontier Politics in Alaska, 1910-1915

Thomas G. Smith

The strong interest in social history during the last decade has produced several studies on the care and treatment of disadvantaged, dependent, and deviant persons. Significant general works have been undertaken, but local, state, and institutional studies, especially ones set in the 20th century, are lacking. This essay explores the efforts of Alaskans to establish detention hospitals for the mentally ill between 1910 and 1915. Although students of Alaskan history point to poor treatment of the insane as evidence of the federal government's neglect of and indifference toward Alaska, the study reveals that Alaskans themselves must share the blame. In addition, the essay provides insights into mental health policy, Alaskan politics, and federal-territorial relations during the period.[1]

By the turn of the century, the prevalence of mental illness was a growing concern among many Alaskans. As the population surged due to the gold rushes of the 1890s, so did the number of insane. The arduous journey, excruciating work, harsh climate, loneliness, and dashed hopes sometimes proved more than pioneers could endure. In 1900 nine Alaskans were adjudged insane. By 1910 the number had climbed to 130, and a decade later the figure reached 217. Responding to pleas for assistance from Alaskans, the federal government provided for the care of the mentally ill in the civil government bill of 1900. That measure made insanity a criminal offense. The person accused in a written complaint was arrested by the marshal, brought before a district commissioner, and tried by a six-man jury. If found guilty, he was committed to an asylum. Since Alaska had no mental hospital, the governor was empowered to contract with the lowest-bidding institution west of the Rocky Mountains for the care of the insane. From 1904 to 1956 the Morningside Sanitarium (formerly Mount Tabor), near Portland, Oregon, held the contract.[2]

The contract system came under severe attack by residents of Alaska. They complained that it was an archaic and inhumane practice not followed by any other American state or territory. Noncontiguous dependencies such as Hawaii, Puerto Rico, and the Philippines all had asylums that were built and maintained at local or territorial expense. Not until 1912, however, did Alaska win territorial status and its own government; in the meantime, it had to rely on the federal government to care for the insane.[3]

Alaskans also decried the practice of incarcerating the afflicted in jails until they could be transported to Oregon. In interior Alaska the mentally ill often had to spend as long as six months in jail until weather conditions permitted transportation to the "outside." An Alaska asylum was the solution, but Congress rejected the proposal for such an institution because of cost ($75,000 for the building alone). Alaskans next implored the government to establish small hospitals in which the mentally afflicted could be temporarily detained pending removal to Morningside.[4]

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1. See, for example, Gerald Grob, *Mental Institutions in America* (New York, 1973); Blake McKelvey, *American Prisons* (Montclair, N.J., 1977); David Rothman, *The Discovery of the Asylum* (Boston, 1971), and *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980). For criticisms of the way the federal government dealt with Alaska's insane, see *Alaska Daily Empire* (Juneau), Nov. 6, Dec. 6, 30, 1912; Ernest Gruening, *The State of Alaska* (New York, 1968), 280.

2. For the early treatment of Alaska's insane, see Thomas G. Smith, "The Treatment of the Mentally Ill in Alaska, 1884-1912: A Territorial Study," *PNQ*, Vol. 65 (1974), 17-20. Also see Claus-M. Naske, "Bob Bartlett and the Alaska Mental Health Act," *ibid.*, Vol 71 (1980), 31-39.

3. Apparently Alaskans were not troubled by assigning criminal status to the insane, indigent sick, elderly, etc.; lacking asylums, almshouses, old folks homes, and local charities, they classified social dependents as criminals in order to assure them of government care. The federal government also maintained Indians who were mentally ill (a government asylum was established in 1898 at Canton, S.D.). Canada, like Alaska, transported its insane from remote and sparsely populated areas to provincial hospitals rather than build mental institutions in the Yukon and Northwest Territories. See Henry Hurd, ed., *The Institutional Care of the Insane in the United States and Canada*, 4 vols. (Baltimore, 1916-17), III, 630-32, 871-90; IV, 2-25, 228-36.

4. For introduction of these two measures, see *Congressional Record*, 61st Cong., 2d Sess., 1910, pp. 1498 (H.R. 20111), 5243 (H.R. 24833); for the texts of these bills, *ibid.*, 6853, and 61st Cong., 2d Sess., House Document 637, p. 2 (Serial 5836).

The need for some type of "holding tank" or detention center seemed obvious to the residents of interior Alaska. Detailed descriptions of mental breakdowns appeared frequently in the press. "DANGEROUS LUNATIC NOW AT LARGE" ran a Nome *Nugget* headline in October 1908. The escaped "lunatic" threatened to kill the district judge, marshal, and commissioner. In Fairbanks, a "crazed" woman shot to death the police chief in 1908. A year later in the same city a "madman" tried to kill the proprietor of the Pioneer Hotel by hurling a boulder through the window, and a knife-wielding, "blood-seeking headhunter" went berserk in Dempsey Lewis's saloon before being felled by a pool cue. In Fairbanks, the roster of persons taken into custody included the president of the Washington-Alaska Bank, an Indian woman, a prospector who repeatedly tried to commit suicide, a sourdough who imagined he was being run over by automobiles, and a woodchopper from Fox City who broke down when fire destroyed 12 cords of firewood. The Fairbanks *Daily News-Miner* pointed out that the number of insane in that community in 1909 had doubled over the previous year.[5]

Alarmed by the increasing frequency of insanity, Fairbanksans called for proper detention facilities for the afflicted. The federal jail lacked sufficient space to accommodate both prisoners and mental patients. Attempts to integrate criminals and the insane resulted in "pandemonium." On one occasion an insane man "kept everyone awake . . . by praying loudly and the noise was well calculated to make the rest of the prisoners nervous." The *News-Miner* noted that the number of insane was increasing at such a rapid rate that "separate quarters must necessarily be provided for them." The grand jury of the fourth judicial division at Fairbanks concurred.[6]

James Wickersham, Alaska's delegate to Congress, also advocated proper facilities for the care of the insane. Wickersham was a fiery progressive from Fairbanks who had served as a federal district judge at Eagle, Nome, and Fairbanks before being elected delegate in 1908. In February 1910, he tried to convince Congress to appropriate money for a permanent insane asylum in southeastern Alaska (HR 20111). When that effort failed, he introduced new legislation in April calling for an appropriation of $50,000 to build detention hospitals at Fairbanks and Nome for the temporary care of the insane (HR 24833). The House Committee on Territories recommended passage of the measure, declaring that the mentally afflicted "are entitled to the most scrupulous care, and should not be subjected to commitment in an ordinary jail." With an eye for economy, however, the committee recommended $25,000 instead of $50,000 for the project. The Senate Committee on Territories also approved the measure. Despite stiff opposition from some economy-minded congressmen, the bill was passed into law "In the interest of humanity."[7]

James Wickersham, who wrote the defective hospitals bill, blamed others for the delay in construction. (Whalen Collection, University of Alaska Archives, Fairbanks)

Specifically, the measure called for the establishment of a detention hospital in the second judicial division at Nome and in the fourth judicial division at Fairbanks. Insane persons would receive temporary care in a detention center until trails and waterways thawed sufficiently to permit the U.S. marshal to transport them to the Morningside Sanitarium in Oregon. Each hospital was to cost no more than $12,500. The marshal, the governor of Alaska, and the U.S. district judge, acting as a board of governors, would call for bids and award a contract for construction. Once completed, the detention houses would be administered and maintained by the Department of Justice.[8]

From the beginning, the detention hospitals project encountered difficulties. Although the bill became law on June 25, 1910, the summer expired without any attempt to implement it. Pressed for an explanation by the *Alaska Citizen*, Governor Walter E. Clark stated that, after reading the measure carefully, he had discovered a shortcoming which made it "practically inoperative." According to the governor, the law was defective because it failed to provide for the acquisition of sites on which to build the hospitals. John Rustgard, U.S. district attorney at Juneau, supported the governor's interpretation of the bill and advised him not to proceed without instructions from the Justice Department. Judicial officers from Nome expressed similar views.[9]

But U.S. District Judge Peter D. Overfield of Fairbanks voiced a different opinion. He favored prompt implementation of

5. Nome *Nugget*, July 17, Oct. 21, Nov. 2, 1908, Fairbanks *Daily News-Miner*, April 12 (headhunter), 14, May 4, Oct. 29, 1909 (hereafter cited as *News-Miner* with appropriate date).

6. *News-Miner*, Aug. 6, 1909.

7. 61st Cong., 2d Sess., 1910, House Report 1238, p. 2 (first quotation) (Serial 5593); *Congressional Record*, 61st Cong., 2d Sess., 1910, pp. 6853-58 (6856, last quotation); *Care of the Insane in Alaska: Statements of Hon. James Wickersham, Delegate from Alaska, Hon. W. R. Ellis, M.C., Mr. George Coe, Stanfield, Oregon, March 4 and April *, 6, and 20, 1910*. House Committee on the Territories (Washington, D.C., 1910), 19, 26-28, 31-32.

8. 36 Stat. 852 (1910). In 1910 Alaska was divided into four judicial divisions. In the second and fourth, waterways froze and land routes were virtually impassable for seven or eight months of the year.

9. *Alaska Citizen* (Fairbanks), July 10, 1910; John Rustgard to Walter E. Clark, Oct. 3, 1910, Clark to Peter D. Overfield, Oct. 8, 1910, Overfield to Clark, Oct. 8, 1910, Box 564, File 4-7-2-1, Record Group 129, Department of Justice (DJ), National Archives.

the law and accused Clark and Rustgard of pettiness and needless delay. Although Wickersham had failed to provide for hospital sites when he drafted the bill, the oversight could be remedied. Overfield held, by securing donated land. Residents of Fairbanks were eager to have a detention hospital and would furnish land to the government free of charge. Nome residents would probably follow suit. Clark rejected Overfield's suggestion because he doubted the legality of accepting land as a gift on behalf of the federal government.[10]

Pointing out that on several occasions in the past the federal government had accepted "gratuitous deeds of lands for public purposes," Overfield urged the governor to seek the advice of the U.S. attorney general; if land donation proved unacceptable, Congress might be asked to remedy the problem by authorizing the acquisition of land or by permitting the hospitals to be built as additions to the Fairbanks and Nome jails.[11]

Although the governor agreed to consult the attorney general, he did not agree to present the case objectively. Indeed, besides underscoring the law's legal defects, Clark assured the attorney general that the detention hospitals were "entirely unnecessary" because adequate provisions had been made "for the temporary care of the insane in the modern jails erected at Nome and Fairbanks two years ago." He denounced Overfield's dogged support for the detention houses as political loyalty to Wickersham, who was responsible for the judge's appointment, and he also censured Overfield for showing disrespect for the governor's office by "his conspicuous absence without excuse from a public dinner in my honor at Fairbanks."[12]

In October 1910 the Justice Department declared the hospitals act defective because it lacked provision for the acquisition of land; hence, it found that Governor Clark had properly delayed construction of the hospitals. Since the federal government did not own land in Fairbanks and Nome appropriate for hospital sites, the attorney general recommended referring "the matter back to Congress for a further expression of its wishes." Inexplicably, he failed to rule on whether the federal government could accept hospital sites as a gift from the residents of Fairbanks and Nome.[13]

Governor Clark's objections to the detention hospital law were guided by political as well as legal considerations. Clark and Wickersham were bitter political enemies despite being members of the Republican party. Republicans in Alaska and around the nation were divided into regular and progressive factions. Clark and Lewis W. Shackleford, Alaska's Republican national committeeman, headed the regulars; Wickersham, the progressives.

Disturbed by his independence, GOP regulars referred to Wickersham as a "political harlot" and in the delegate race of 1910 nominated Edward S. Orr, a businessman from Fairbanks, to oppose him. The Socialists also entered a candidate, William O'Connor, a newspaper editor from Tanana. The Democrats, a minority party in Alaska, refused to run a candidate. When the votes were counted, the incumbent, Wickersham, easily retained his seat.[14]

Although the detention hospitals were not an issue in that election, residents of interior Alaska were growing increasingly irritated by the lack of action on the project. In March 1911 the grand jury of the fourth judicial division reported that the federal jail at Fairbanks was "inadequate for the proper care and detention of insane persons, of whom there are several now in custody." Due to overcrowding, it was necessary to confine the sane and insane in the same room. The grand jury found that practice unacceptable from a humanitarian standpoint and urged immediate construction of a detention center.[15]

In May the town council of Fairbanks passed a resolution offering the federal government free of charge a parcel of land on which to erect a detention hospital. Noting that the residents of Fairbanks "are pressing me pretty hard," Governor Clark forwarded the resolution to Attorney General George Wickersham (no relation to the delegate) for an opinion. At the same time, Clark recommended that the detention center be erected as an addition to the Fairbanks jail instead of as a separate facility.[16]

Even as he obstructed implementation of the hospitals act, Governor Walter Clark blamed Wickersham for the delay. (Bunnell Coll., University of Alaska Archives)

10. Overfield to Clark, Oct. 14, 15, 1910, Clark to Overfield, Oct. 17, 1910, Box 564, File 4-7-2-1, RG 129, DJ; Rustgard to Clark, Oct. 17, 1910, Box 768, Alaska Governors Papers (AGP), Alaska State Archives, Juneau.

11. Overfield to Clark, Oct. 18, 1910, Box 564, File 4-7-2-1, RG 129, DJ; Overfield and Henry K. Love to Clark, Oct. 19, 1910, Box 244, File 9-1-10, Office of the Territories (OT), National Archives; Overfield to Clark, Oct. 20 (quotation), Nov. 14, 1910, Box 768, AGP.

12. Clark to George Wickersham, Oct. 4, 19 (quotations), 1910, Box 564, File 4-7-2-1, RG 129, DJ.

13. Acting attorney general to Clark, Oct. 18, 1910 (quotation), Box 768, AGP; attorney in charge of titles to attorney general, Nov. 1, 1910, Box 564, File 4-7-2-1, RG 129, DJ.

14. *Nome Nugget*, June 17 (harlot), July 13, Aug. 4, 1910; Fairbanks *Sunday Times*, Oct. 22, 1911; Evangeline Atwood, *Frontier Politics: Alaska's James Wickersham* (Portland, 1979), 225-34, 300.

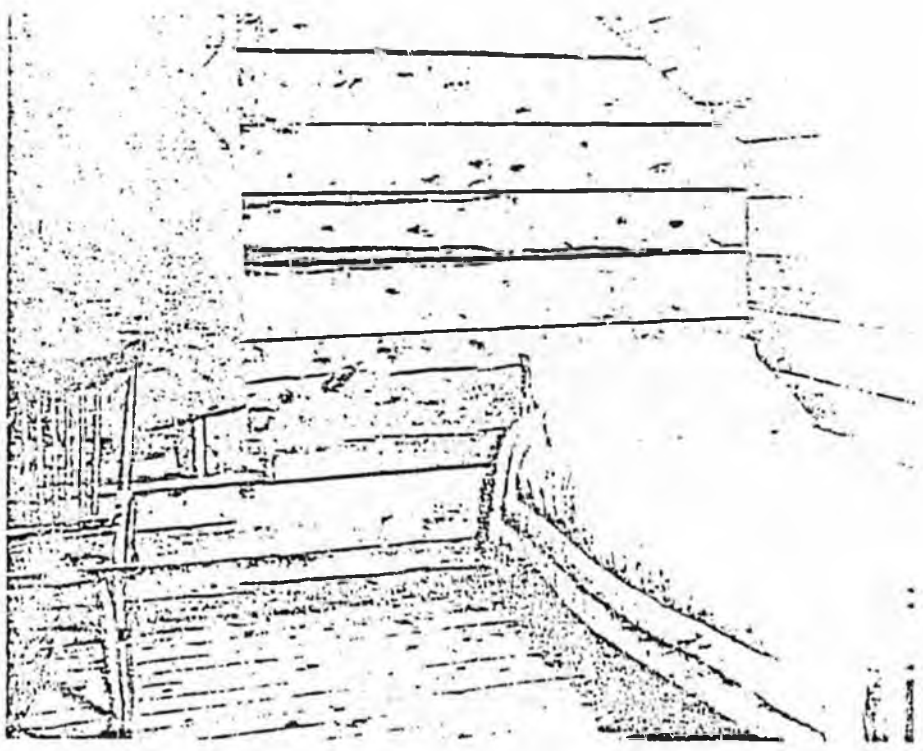
15. Overfield to Clark, Jan. 7, 1911, Box 768, AGP; grand jury of the fourth division to Overfield, March 23, 1911, Box 244, File 9-1-10, OT; *News-Miner*, Jan. 6, 1911.

16. Fairbanks town council to Clark, May 5, 1911, F. S. Gordon to Clark, June 3, 1911, Clark to attorney general, June 21, 1911, Box 768, AGP.

Nearly two months elapsed without a decision. Numerous Fairbanksans seethed over the delay and sought scapegoats. Some considered the lack of progress another example of federal indifference toward Alaska. Others, particularly the Republican press in Fairbanks, faulted Wickersham for having drafted a defective bill. In an editorial entitled "Our Detained Hospital," the Fairbanks *Daily Times* criticized the delegate for failing to follow the "businesslike course" of admitting his mistake and introducing legislation to rectify it. Had he introduced corrective legislation, the community "would have a detention hospital built and running today." Wickersham had rejected that course of action, the editor opined, because as a politician he was concerned mainly with retaining office. "He is making political capital out of the fact that the hospital is not built," the newspaper charged. "Such political capital is worth more to him than the hospital would be, so he has deliberately failed to remedy the matter."[17]

Wickersham himself blamed the delay on Governor Clark and District Attorney Rustgard. The delegate claimed that he had purposely omitted provision for the purchase of land sites in the bill because he planned to build the centers on public land. The public domain, he stated, had been utilized in the past for jails, courthouses, and telegraph offices. It could also be used for detention centers. "It would have been considered silly," he explained to the Fairbanks Commercial Club, "for the United States to appropriate money out of its own treasury to buy its own land in Alaska for a United States hospital. Nobody but Governor Clark and Mr. John Rustgard would have ever thought of such a foolish proposition, and they would not have thought of it except for the fact that they wished to make the law a failure."[18]

Pro-Wickersham newspapers such as the *Alaska Citizen* echoed the delegate's charges. The *Citizen* held that there was "no one to blame for the delay" but Clark, who had advanced "the ridiculous proposition that the government could not accept a donated site." That view, the paper continued, was based on Clark's "bitter opposition to the delegate, and his determination that Wickersham shall get nothing for the territory that could in any way enhance his prestige."[19]



The federal jail at Fairbanks housed both prisoners and the insane; the women slept in this 12-by-14-foot room with a sloping ceiling and one window. (National Archives)

Nonetheless, the argument in defense of the law was weak. If the hospitals were to be erected on public land, the act should have so specified. Moreover, its author should have realized that public land was unavailable in Fairbanks and Nome: once a patent is granted for a townsite, the land is no longer public. Instead of introducing corrective legislation, Wickersham stubbornly defended a defective law and blamed his political enemies for sabotaging the hospitals. As the Fairbanks *Daily Times* remarked, "the delegate overlooked an important detail in his bill, and in trying to cover it up is attempting to unload upon the governor whatever blame exists."[20]

In August 1911 the attorney general instructed Governor Clark to proceed with the construction of the Fairbanks hospital. Instead of being constructed on a donated site, the facility would be erected on top of the federal jail. Such a plan would minimize delay and save expense by using the same personnel to operate both institutions.[21]

But the instructions sparked a heated protest from Wickersham. Addressing the Fairbanks Commercial Club on September 28, he ridiculed the idea of housing "poor crazy people" above the "dirty old rotten jail." His plan, he reminded the town's businessmen, was to build the hospitals on public land. Appealing to their booster spirit, he informed his listeners that the Fairbanks detention facility was part of a larger plan to secure a permanent insane asylum in the town. That larger effort would be stymied, he warned, unless Alaskans insisted upon

17. Fairbanks *Daily Times*, Oct. 28, 1911 (hereafter cited as *Times* with appropriate date).

18. *Ibid.*, July 15, 1911.

19. *Alaska Citizen*, July 10 (quotations), 17, 1911.

20. *Times*, July 15, 1911.

21. C. H. McGlasson to attorney general, June 28, Aug. 7, 1911, Box 564, File 4-7-2-1, RG 129, DJ; attorney general to Clark, Aug. 8, 1911, Box 768, AGP.

construction of detention centers separate from the jails at Fairbanks and Nome.[22]

Urged on by Wickersham, the commercial club branded the Justice Department's plan to build the hospital as an addition to the jail "unsafe, unsanitary, and undesirable generally." It forwarded to Washington a petition signed by more than 900 residents protesting the proposal as "an act of injustice." The petitioners demanded a separate facility for the temporary care of the mentally ill.[23]

Other Fairbanks civic groups joined the protest. The Tanana Valley Democratic Club unanimously adopted a resolution condemning the governor for concocting a scheme whereby the "prisoners will be a nuisance to the sick, and the insane a nuisance to the prisoners." Moreover, the town council of Fairbanks announced its displeasure with the proposal by passing an ordinance forbidding the detention of the insane "upon the upper, second or higher story" of any wooden building. The Fairbanks press also lambasted the plan, calling it a "sorry makeshift." To accept a portion of the appropriation and build the hospital above the jail, said the *Daily Times*, would qualify Fairbanksans "to become the first inmates of such a hospital." The editor of the *Daily Times* urged the governor to build a hospital on a donated site and worry later about the legal consequences. Such a move, he declared, "would be worthy [of] the red blood of the pioneer."[24]

The strong protest from Fairbanks brought results. In October 1911, the Justice Department decided to "suspend action" on the construction of the hospital as an upper story to the jail. More than a year passed without further developments.[25]

Meanwhile, the issue continued to provoke controversy between Clark and Wickersham. The delegate repeatedly blamed the absence of a detention center on "one petty man, with a wooden nutmeg heart." Appealing to the emotions of a Fairbanks audience, Wickersham pointed out that if one's mother or wife were arrested because she was mentally ill, she would be confined in a "dirty jail" because the governor was so "spiteful" he refused to spend the money Congress had appropriated for a modern detention facility.[26]

Predictably, Clark denied Wickersham's charges. He reiterated the fact that his position was based not on politics but on his interpretation of the law, an interpretation supported by the Justice Department. It would be foolish, he stated, to proceed with the construction of the hospital on a donated site without prior approval from the federal government. What contractor, he asked, would build a hospital without official authorization? Neither Clark nor Wickersham explained why he did not push for an official decision on the legality of building on a donated site.[27]

Wickersham's opponents used the defective hospitals act against him in the delegate election of 1912 but without effect. Indeed, his successful efforts to obtain for Alaska an elective territorial government more than offset any loss of votes caused by his mishandling of the detention hospitals affair. Running as an independent "Bull Mooser," he was reelected, defeating a regular Republican, a Socialist, and two Democrats.[28]

On the national level, the Republican party, split between regulars and progressives, lost the White House to Woodrow Wilson. Although he was disappointed that Theodore Roosevelt, his idol, had lost, Wickersham was confident that he would be able to cooperate with the new president. And he was encouraged when Wilson's secretary of the interior, Franklin K. Lane, invited his opinions on Alaskan issues, including the appointment of a new governor.[29]

Created in August 1912, Alaska's first territorial legislature took the lead in securing construction of the detention centers, though prohibited by law from dealing with the insane. The territorial government act had left to the federal government responsibility for the care of the mentally ill, which meant that vic-

This cartoon depicts the Fairbanks view of Governor Strong's arrival in Alaska—a long-awaited hospital under each arm. (Alaska Citizen, Aug. 4, 1913)

22. *Alaska Citizen*, Oct. 2, 1911.

23. Fairbanks Commercial Club to attorney general, Oct. 4, 1911 (injustice), Box 564, File 4-7-2-1, RG 129, DJ; *Times*, Sept. 29 (first quotation), Oct. 5, 1911.

24. *Times*, Sept. 30 (last three quotations), Oct. 1 (nuisance), 8 (second quotation), 1911.

25. *News-Miner*, Oct. 5, 1911.

26. Fairbanks *Sunday Times*, Oct. 22, 1911.

27. *Times*, Jan. 24, 1912; *Alaska Citizen*, Feb. 5, 1912; Clark to secretary of the interior, Dec. 22, 1911, Box 564, File 4-7-2-1, RG 129, DJ.

28. *News-Miner*, Oct. 8, 1912; *Alaska Citizen*, Aug. 12, 1912.

29. Atwood, 247-65, 271.

tims would continue to be farmed out to Morningside Sanitarium and that patients in interior Alaska would be held in jails until detention facilities were constructed. But in April 1913, Alaskan legislators forwarded to Congress a joint memorial protesting the practice of detaining the insane in jails and requesting an appropriation of $4,000 to buy land on which to build two detention houses. The memorial went unheeded.[30]

Despite the lack of congressional action, supporters of the detention hospitals were encouraged when President Wilson named John F. A. Strong to succeed Walter Clark as governor of Alaska. Born in New Brunswick in 1859, Strong had been in Alaska since 1897. He had engaged briefly in mining, then entered the newspaper business, and was editor of the Democratic Juneau *Daily Empire* at the time of his appointment.[31]

In June 1913, the new governor and Wickersham met with Secretary of the Interior Lane to discuss the detention hospitals. Sympathetic, Lane agreed to build the hospitals promptly if Strong could secure donated land. Within three months, the governor had obtained the sites, and Lane had authorized him to advertise for construction bids. Strong's success convinced some Alaskans that the previous delay had been "for political and personal reasons only." It also showed that Washington could be moved to action when Alaskans put aside politics and united behind a project.[32]

Construction of both hospitals began in September and concluded in December 1913. After a delay of more than three years, then, the communities of Fairbanks and Nome possessed detention hospitals. The Fairbanks facility was a 2-story wood[illegible] building, 42 feet square, located on 1.25 acres of land at the corner of Turner Street and Tenth Avenue. It had a porch that ran along the full front of the first floor and a large second-story balcony. The first story contained a kitchen, oak-paneled dining room, seven rooms, a bath, and a padded cell. On the second floor were four rooms, one ward, a shower-bath, and two padded cells. The facility had electric lights and steam heat and could accommodate 15 male and 5 female patients. Local residents described the building as "a thing of

Within six months of assuming office, J. F. A. Strong had delivered the Nome and Fairbanks hospitals; opening them was the next step. (Bunnell Coll., Univ. of Alaska Archives)

beauty" that was "equipped with all modern conveniences." The Nome hospital was similarly appointed, though lacking the large front porch and balcony. The Nome *Nugget* described it as a "monument" to the builder. In Juneau, the *Alaska Daily Empire* editorialized that the "construction of these institutions marks a step forward in caring for unfortunate men and women of the Territory."[33]

Financial considerations, however, prompted Washington to reevaluate its decision to open the hospitals. The money to maintain the centers was to come from an appropriation of $500,000 for support of prisoners in all the states and territories. Marshal Emmet R. Jordan of Nome informed the Justice Department in early 1914 that it would cost $17,500 a year to maintain each of the detention hospitals. The attorney general balked at spending $35,000 yearly to provide temporary care for a handful of patients. It cost only twice that amount, including transportation, to maintain 150 Alaska patients at the Morningside Sanitarium in Oregon.[34]

Marshal Lewis T. Erwin of Fairbanks, who had replaced Henry Love in 1913, took issue with Jordan's figures. Erwin estimated that operation of the Fairbanks hospital would cost only $7,500 per year. Because the two estimates differed so significantly, the Justice Department refused to open the facilities until accurate figures had been secured. On the recommendation of the U.S. superintendent of prisons, the attorney general sent an inspector to Alaska to determine the cost of running the hospitals and the necessity of opening them.[35]

Proud of their new facilities, residents of Fairbanks and Nome were distressed to learn that neither structure might be utilized. "Loss of the detention hospital" would "be a serious blow" to the community, declared the Fairbanks *Daily Times*; "It means that we will be right back where we were before the building of the hospital was authorized, except that we have the structure to remind us of the long fight made to secure the hospital." There was a pressing need for the centers, according to that paper, and townspeople "have every reason to expect the terms of the bill to be carried out, for, after all, the cost of maintenance is a question which should have been investigated before the money for the building was appropriated."[36]

30. (Alaska) Senate Joint Memorial Number 17 to Congress, April 11, 1913, Box 244, File 9-1-10, CT; *Times*, May 2, 1913.

31. Juneau *Daily Empire*, July 29, 1929 (obituary); Gruening, 166.

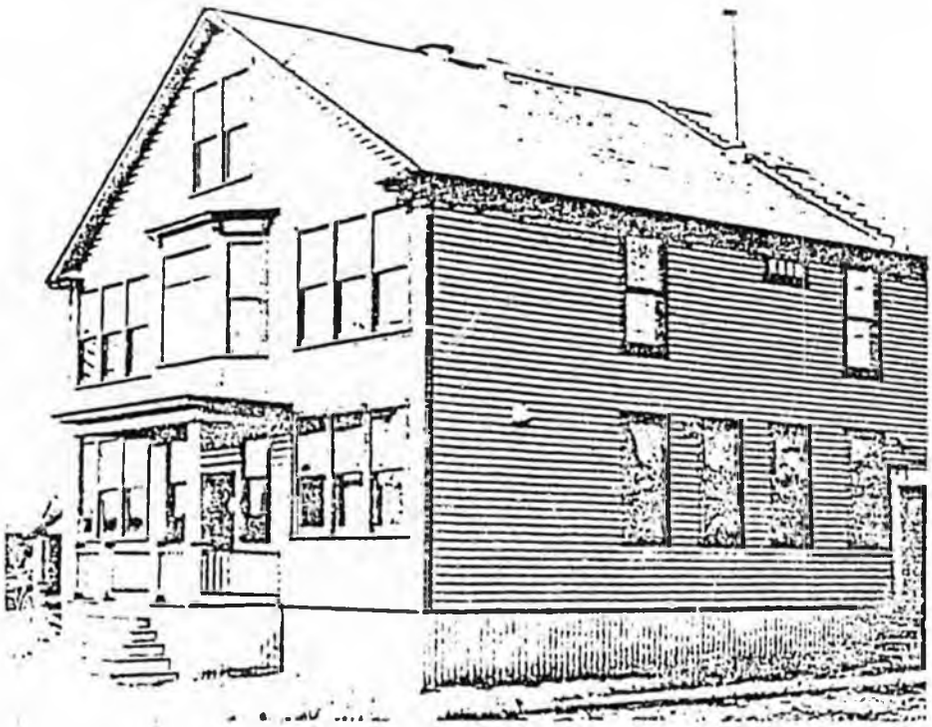
32. J. F. A. Strong to secretary of the interior, June 11, 12, 16, Aug. 5, 1913, secretary of the interior to Strong, June 12, 1913, Box 244, File 9-1-10, CT; *Alaska Citizen*, July 28, 1913 (quotation).

33. *News-Miner*, June 17, Sept. 3, Nov. 17, 1913; *Times*, Aug. 7, Sept. 3, Dec. 27 (quotations), 1913; *Alaska Daily Empire*, Nov. 21, 1913; Nome *Nugget*, Sept. 12, 15, Nov. 5 (quotation), 25, 26, 1913.

34. Superintendent of prisons to attorney general, April 1, 1914, Box 565, File 4-7-2-1, RG 129, DJ.

35. *Ibid.*; L. T. Erwin to assistant attorney general, Feb. 20, 1914, Box 564, File 4-7-2-1, RG 129, DJ.

36. *Times*, Dec. 13, 1913; *Alaska Citizen*, Dec. 15, 1913.



Equipped with electric lights, steam heat, and other conveniences, the Nome facility was hailed as a step forward in the care of the insane. (National Archives)

Meanwhile, Governor Strong, Delegate Wickersham, and Marshal Erwin of Fairbanks pushed Attorney General T. W. Gregory to open the detention hospitals. Erwin was especially insistent. On March 5, he had wired the Justice Department: "Have now three insane, jail not proper place." Four days later he had telegraphed: "Have just taken into custody insane woman in addition to three insane men reported. Hospital much needed." On June 2 he sent yet another message informing the attorney general that he had 14 prisoners in the jail, including two women. One of the women was insane. "No place to keep women except jail attic. Roof covered with tin. Fear women cannot live in such quarters during warmest summer weather. No toilet except men's department. Women taken ladies toilet courthouse. Makes it bad handling raving maniac. Condition insane woman requires three matrons eight-hour shifts." The marshal asked permission to transfer both women to the detention hospital where they could receive proper care. The attorney general refused the request and advised the marshal to install toilet facilities in the jail, fix the roof, and transport the insane woman to Morningside.[37]

That same month, R. J. W. Brewster, the Justice Department's investigator, arrived to inspect the hospitals. After examining the facilities, he recommended against opening them. His reason: expense. He estimated that the yearly operating costs of each institution, including heat, light, food, guards, a cook, repairs, and sundry expenses, would exceed $7,000.

The number of insane in interior Alaska was not large enough to justify the expense of operating two detention centers, Brewster advised. At Nome only three people were adjudged insane during fiscal year 1913-14, and these victims were housed in the jail for a total of 45 days; since the hospital would stand empty most of each year, Brewster recommended that the building be transferred to another government department and put to better use. At Fairbanks he found that 21 individuals had been adjudged insane in fiscal year 1913. "This hospital," he declared, "should never have been built, and although there is more reason for its opening than there is for the opening of the Nome institution, I do not see the *real* necessity which would warrant the expense of operation." To those who argued that modern mental health care practice called for separate facilities for the sane and insane, he replied that the "theory may be beautiful but would be expensive to carry out."[38]

The delay over opening the detention hospitals became a campaign issue in the delegate election of 1914. Running as a "Woodrow Wilson Progressive," Wickersham sought his fourth term as delegate. He was opposed by John M. Brooks, a Socialist from Jack Wade Creek, and Charles E. Bunnell, a Democrat from Valdez who had the support of the Wilson administration. Alaska Republicans did not nominate a candidate.[39]

Throughout the campaign Wickersham reminded his constituents of his past accomplishments, including passage of the territorial government act, the Alaska railway bill, and the detention hospitals measure. That the hospitals remained closed, he asserted, was the fault of Marshal Erwin, a Democrat and political enemy. Wickersham accused Erwin of obstructing efforts to open the hospitals, and he asked Alaskans to consider the "inhumanity of an officer who keeps a sick prisoner in the attic of that dirty, filthy jail when you have a fine detention hospital where she should be kept."[40]

Wickersham's charges against Erwin were unwarranted. The Justice Department advised the marshal to issue a statement "disclaiming all responsibility for the failure to open and occupy the de-

37. Quoted in *Times*, Feb. 11, 1915.

38. Superintendent of prisons to attorney general, July 11, 31, Oct. 14, 1914, and R. J. W. Brewster to attorney general, Sept. 19, 1914 (quotations), Boxes 564, 565, File 4-7-2-1, RG 129, DJ; *News-Miner*, July 27, Aug. 1, 1914. The Justice Department was also reluctant to go to the expense of opening the Nome hospital because the population of that town had declined steadily since the boom days of the early 1900s.

39. Atwood, 277-87.

40. Quoted in Erwin to attorney general, Nov. 14, 1914, Box 564, File 4-7-2-1, RG 129, DJ.

tention hospital." Opponents of Wickersham were probably correct when they declared that his attack on the marshal was a smokescreen to cover up his own ineptness. The Democratic Fairbanks *Daily Times* reminded readers that the law "was so clumsily drawn that the hospital never would have been built but for the efforts of Governor Strong and the Democrats of Fairbanks." Despite Wickersham's irresponsible charges, he was reelected with votes to spare.[41]

After his reelection, Wickersham continued to lash out against Erwin for failing to utilize the hospitals. In mid-November 1914, he informed the press that the marshal permitted the caretaker to use the Fairbanks institution as a "chicken coop." Producing a photograph that showed chickens hanging lifeless by their feet from a rope stretched across the hospital's balcony, Wickersham urged Fairbanksans to petition the Justice Department to use the hospital for needy mental patients not dead chickens.[42]

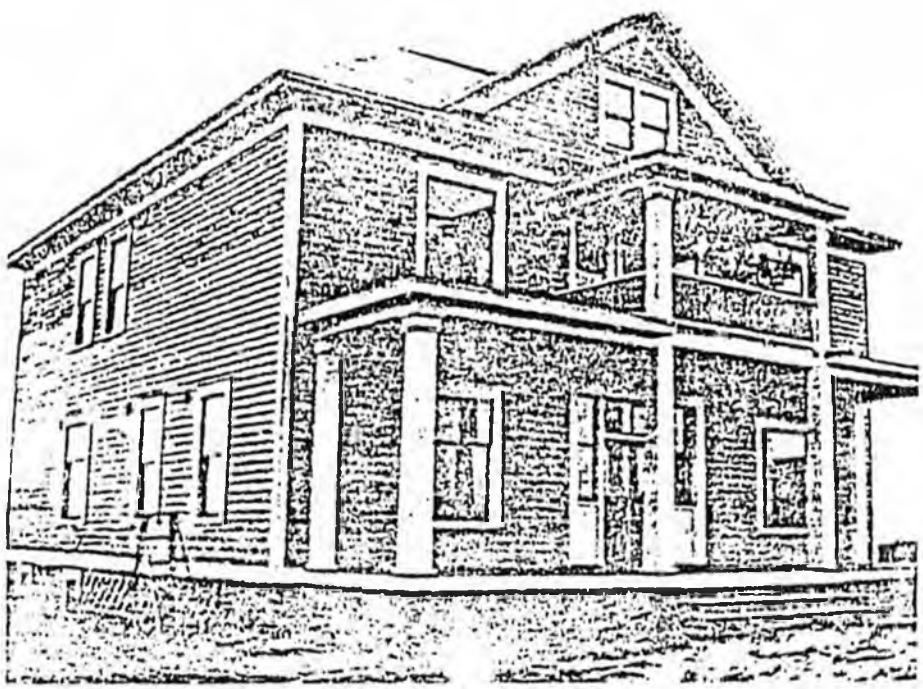
The delegate also censured the Justice Department for its indifference. He informed the Fairbanks Commercial Club on November 9 that "there is no reason in the world why the Department of Justice should not make the necessary appropriation to maintain the institution." Instead of utilizing a modern facility, he noted, the federal government is confining the insane in a "hellhole." He implored club members "to get busy, to do something to force the proper parties to open the hospital and I pledge myself to do all I can to help."[43]

Wickersham made good his promise. On January 6, 1915, he sent a long letter to the attorney general lamenting the policy of holding Alaska's insane in "dirty foul-smelling old jails." He enclosed three photographs taken by the Fairbanks health officer, Dr. J. A. Sutherland, showing the "exact condition of the room in the attic" of the Fairbanks jail where insane women were housed. "In this stinking hole the United States of America keeps the insane women who fall into their clutches," the delegate wrote. "It is a disgrace to the Department of Justice that such a condition may continue to exist." He reminded the attorney general that the detention hospitals act was intended to prevent the "vile arrangement" of housing the mentally ill in jails. Failure to open the institutions for financial reasons, he believed, was unjustified. According to section 2 of the act, the hospital expenses were to be paid "from the same fund as the expenses of the United States jails under the same marshal." Enclosing the "chicken coop" photograph, Wickersham informed the attorney general that the hospital at Fairbanks was being used to accommodate slaughtered chickens instead of mentally afflicted human beings. He exhorted the Justice Department to make proper use of the Nome and Fairbanks structures at once.[44]

Wickersham's hard-hitting letter to Washington was not entirely accurate. He had written on the photograph that the jail was a "dirty-hole," a description that was exaggerated as Erwin, Dr. Sutherland, and several newspapers pointed out. Yet the delegate's main point was on the mark—namely, that the detention hospitals and not jails should be used for the temporary confinement of the mentally afflicted and that the government, in delaying the opening of the facilities, had failed to execute the law. Responding to Wickersham's letter, the attorney general stated that the issue was "under consideration" and would be resolved soon.[45]

Actually, the Justice Department was working diligently to rid itself of both buildings, to "turn them loose" on other government departments. The Bureau of Education in the Interior Department wanted the Nome building as a medical facility for Indians. The deal fell through though when the Justice Department insisted that the Interior Department take

This photograph of the Fairbanks hospital, its balcony festooned with dead chickens, no doubt furthered the campaign to open the facility. (National Archives)



41. Assistant attorney general J. Erwin, Dec. 14, 1914, Box 565, File 4-7-2-1, RG 129, DJ; *Times*, Nov. 1, 1914.

42. *Times*, Nov. 10, 1914.

43. *Ibid.*; George C. Bruce to Wickersham, Nov. 16, 1914, Box 565, File 4-7-2-1, RG 129, DJ.

44. Wickersham to attorney general, Jan. 6, 1915, Box 564, File 4-7-2-1, RG 129, DJ.

45. *Times*, Feb. 10, 11, 12, 1915; Fairbanks *Weekly Times*, Feb. 15, 1915; assistant attorney general to Wickersham, Jan. 12, 1915, Box 565, File 4-7-2-1, RG 129, DJ.

both "white elephants"; having no use for the Fairbanks facility, the secretary of the interior refused the offer.[46]

Residents of Fairbanks were enraged when they learned of the Justice Department's attempts to unload their hospital. The mayor, marshal, district judge, and district attorney sent wires to the attorney general reminding him that the Fairbanks City Council had donated land for a "detention hospital only" and would oppose using the building and grounds for any other purpose. One Fairbanks citizen scored the federal government for being parsimonious toward a land "which has returned so much more than it cost to the government which owns it." The three local newspapers pushed hard for the cause by running editorials that supported the opening of the detention hospital.[47]

The strong protest brought results. In March 1915, nearly five years after Congress passed Wickersham's bill, the attorney general instructed Erwin to open the Fairbanks hospital immediately. That message elicited "great joy" among Alaska's territorial officials. Nomites, on the other hand, had little to cheer about: their facility remained closed. Inspired by the Fairbanks success, however, Nome residents, including the mayor, city council, Western Federation of Miners, and several fraternal organizations, petitioned Washington in June and repeatedly during the next year, but without results. In 1921 the Justice Department transferred the building to the Bureau of Education for use as a residence for teachers.[48]

In Fairbanks the triumph was short lived. Within five months of the hospital's opening, high operating costs caused the Justice Department to contemplate closing it again. Governor Strong admitted that the building required around-the-clock caretakers and that it would "always be a source of continued expense to the Government, whether occupied or not." Yet he advised against shutting down the institution because a "considerable percentage of the patients would recover, and the expense of their transportation to Morningside Sanitarium and their maintenance there would be avoided." Wickersham sided with Strong and blamed the high maintenance costs on the extravagance of Erwin, whom he accused of using the hospital as a place of residence.[49]

Wickersham's charges prompted an investigation by the Department of Justice. Asked for a response, Erwin maintained that he was making every effort to keep expenses at a minimum. He reported that from the opening of the hospital in March 1915 through August, a total of seven patients had been detained for 114 days at a cost of $2,000. Admitting that he lived at the hospital, he claimed that his presence saved the government money by obviating the need for a guard and custodian to watch the patients. He paid his own board and maintained a garden on the grounds that brought the government $625 worth of produce. He also economized by feeding the inmates fish, moose, and mountain sheep, which he provided free of charge. "I have attempted to economize and save the Government all I could at the same time rendering a good service but not a wasteful one," Erwin declared.[50]

Erwin's report convinced the Justice Department that the operation of the facility "has been economical and careful under the circumstances." Yet the paucity of inmates and high cost of their care (approximately $15 per day for each) did not seem to warrant keeping the hospital open on a permanent basis. Nonetheless, the attorney general decided to "continue its operation during the closed period of this winter in order to get a complete list of the cost of its maintenance."[51]

The Justice Department's position proved "disquieting" to Wickersham. Moreover, he continued to attack the marshal for extravagance. In December 1915, he wrote a scathing letter to the attorney general accusing Erwin of reckless spending and graft. He pointed out that for much of the year the hospital contained no patients, yet the cost of a building caretaker and electricity totaled $1,260. This money could have been saved, the delegate contended, had the facility been closed when it was unoccupied. The only reason for a caretaker, he declared, was that the marshal "wants the use of this nice, warm, new, handsome, well lighted building as a private residence: he needs the caretaker and his wife as servants, and he is annoyed that insane persons are intruded upon his privacy."[52]

Once again Wickersham's charges were groundless and probably sparked by political animosity. As most federal officials in Fairbanks realized, the hospital required the services of a permanent caretaker to protect the building and grounds from vandalism. It was necessary to heat the structure to prevent burst pipes and frost damage. Moreover, the institution might be needed at any time to detain an individual who suddenly became insane. To shut down the facility when it was unoccupied seemed senseless. Judge Charles Bunnell and District Attorney R. J. Roth both believed that the marshal's residence in the hospital re-

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46. Memorandum (from "W.C.E.") to attorney general, Nov. 12, 1914, attorney general to secretary of the interior, Nov. 12, 1914, and assistant secretary of the interior to attorney general, Dec. 9, 1914, Box 565, File 4-7-2-1, RG 129, DJ; assistant secretary of the interior to attorney general, Sept. 17, 1914, File 6—51, Bureau of Education, Hospital Service, Nome, Alaska, part 1, RG 48, National Archives (hereafter cited BE-Nome, RG 48).

47. Charles Bunnell et al to attorney general, March 10, 12, 1915, Box 565, File 4-7-2-1, RG 129, DJ; *News-Miner*, March 11 (first quotation), 12, 13 (last quotation), 1915; *Times*, March 13, 1915; *Alaska Citizen*, March 15, 1915.

48. Attorney general to Erwin, March 12, 1915, and to Wickersham, March 16, 1915, Box 565, File 4-7-2-1, RG 129, DJ; *Times*, March 16, 1915 (great joy); Nome Residents Petition for Attorney General, June 8, 1915, Box 769, AGP; *Nome Nugget*, Aug. 20, 1915, April 10, Sept. 19, 1916; assistant secretary of the interior to attorney general, Oct. 11, 1922, attorney general to secretary of the interior, Oct. 16, 1922, File 6—51, BE-Nome, RG 48.

49. Wickersham to attorney general, July 9, 1915, and Strong to attorney general, Aug. 27, 1915, Box 564, File 4-7-2-1, RG 129, DJ.

50. Attorney general to Erwin, Aug. 14, 1915, Erwin to attorney general, Sept. 22, 1915, *ibid.*

51. Assistant attorney general to attorney general (memorandum), Oct. 30, 1915 (first quotation), attorney general to Erwin, Nov. 1, 1915, and to Wickersham, Nov. 1 (last quotation), Dec. 11, 1915, *ibid.*

52. Wickersham to attorney general, Dec. 27, 1915, *ibid.*

sulted in an efficient and economical operation. To avoid the appearance of impropriety and to silence Wickersham, however, they recommended that the marshal cease living there. The attorney general agreed.[53]

To secure the permanent operation of the detention hospital, Wickersham stressed the need for humane care of the mentally ill and for following the dictates of Congress. He emphasized that in 1910 Congress passed legislation establishing detention hospitals for patients in interior Alaska who could not be promptly shipped stateside. "Now what authority has an Attorney General, the Marshal, or any one else," he asked, "to disregard and violate that law?" Will the Justice Department return to the archaic practice of keeping the mentally ill in jails? he queried. He advised the attorney general to continue the operation of the institution and to adhere to "humane methods for the care and protection of the insane sick entrusted to your care, as you are instructed to do by Congress."[54]

Wickersham's appeal proved persuasive. The detention hospital was not shut down, and it remained in operation for two decades. In the 1930s the facility served as both a detention hospital and jail until a new federal building was erected in 1933.

Although Alaskans in 1910 sought to provide humane care for the insane by maintaining them in detention centers rather than jails, they achieved modest success only after five years of delay caused by indifference and parsimony at the federal level and political factionalism within Alaska itself. When territorial officials at last united behind Governor Strong in 1913 and 1915, they got two hospitals built and one operating; the second—for lack of patients and excessive maintenance costs—never opened. The detention center episode was one of the early fights in the long crusade for mental health care in Alaska: it would take another 40 years for Alaskans to obtain a permanent asylum. □

Thomas G. Smith is associate professor of history at Nichols College, Dudley, Massachusetts. His research interests include 20th-century America, Alaska, and U.S. foreign policy. He is currently at work on a biography of the New Deal budget director and cold war ambassador Lewis W. Douglas.

53. R. J. Roth to attorney general, Jan. 7, 1916, Bunnell to attorney general, Feb. 18, 1916, and attorney general to Erwin, March 17, 1916. Box 565, File 1-7-2-1, RG 129, DJ.

54. Wickersham to attorney general, Dec. 27, 1915, *ibid.*

E. T. Barnette

E. T. Barnette: The Strange Story of the Man Who Founded Fairbanks. By TERRENCE COLE. (Anchorage: Alaska Northwest, 1981. ix, 163 pp. Illustrations, notes, selected bibliography, index. $7.95)

Terrence Cole has put flesh on a phantom. The year of Barnette's birth is uncertain. When, or where, or from what cause he died is unknown. There are, apparently, only two probable Barnette photographs. In one his face is obscured, and in the other a fur hat and a bushy moustache hide his hairline and mouth. Paradoxically, Barnette was as substantial as he was phantasmal.

Cole's study of the real Barnette is a fine historical narrative and investigation. Barnette established a trading post on the Chena River in 1901. The trading post became Fairbanks, while Barnette became a prosperous merchant, miner, and banker. He was a large man, ambitious, gregarious, and plausible. He invested much of his money in a Kentucky farm and a Mexican plantation. Affable though he was, court suits and controversy swirled around him. He throve until his bank collapsed in 1911, a few months after he had resigned its presidency and left town. The bank failure was the beginning of the end of Barnette's fortune. His Mexican property suffered from the turmoil of revolution, his wife divorced him and won a large property settlement, and his comeback attempts were ineffectual.

Such schemes and adventures call for placement in the context of western and Alaska history, yet Cole's interpretations rarely venture beyond the judgments of contemporaries. Those judgments were possibly too particularistic and severe, delivered as they were from a provincial "sourdough" perspective. For instance, Barnette's manufactured rush to Fairbanks certainly duped some gullible miners. Nevertheless, it was in the tradition of western boom-town promotionalism. Interpretive lacunae aside, Cole writes with verve. He skillfully relates Barnette to the development of Fairbanks and the Alaska-Yukon interior. His book is nicely composed, with many pertinent maps and photographs. Best of all, Cole, a widely published Alaska historian, is not yet out of his twenties. Therefore we may look forward to many more worthwhile studies from the author of *E. T. Barnette*. □

WILLIAM H. WILSON
North Texas State University