ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4912 HRES HB 61

484

available land near major communities and transportation corridors. If one were to reconstitute the trust exactly as it was in 1978, the pressure to dispose of the land would continue.

Finally, at present, the sale of non-renewable commodities results in a diminution of the corpus, because with Alaska's constitutional prohibition on dedicated funds, sale proceeds are not treated as part of the corpus. Unless the proceeds were immediately re-invested in land purchases, one could not have a pure land trust without having a cash account governed by cash trust principles, i.e. inflation-proofing and corpus protection.

Small, High-Value Land Trust

Arizona and Colorado have exchanged remote parcels from their land trust for high value urban and suburban acreage more suitable for active management and intensive development--either residential or commercial. In order for such a program to work in Alaska, the mental health trust would have to exchange most of its original acreage for a lesser amount of high-value, state-owned acreage around or in existing communities. The high-value acreage approach has the advantage of a much more favorable revenue-generation to management-cost ratio--assuming such acreage could be found.

Management Requirements of an All-Land Trust

In the event of any type of land trust, the legislature would also have to adopt new statutory language allowing for active management, preservation of land and cash corpus, and dedication of revenues to mental health programs--as a quid pro quo for the plaintiffs agreeing not to assert the trust's rights to lands which have left the trust but whose ownership remains in question (e.g. municipal selections and legislative designations. This is more fully discussed below.

All Cash Trust

In lieu of a land trust, the court would probably accept a cash trust. However, the legislative committee identified several factors which render this option impractical. First, the litigants disagree as to the value of the trust lands. DNR estimates that the value of the original one million acres of mental health lands exceeds $587 million in 1985 dollars, or roughly $727 per acre. Plaintiffs place the value of the original trust land at several times that figure--or several billion dollars. Resolving this issue through appraisals and/or litigation would be extremely difficult and expensive.

Secondly, a court-ordered, cash settlement award ranging from hundreds of million to several billion dollars would have serious implications for existing state programs and the state economy. Litigation costs could run into the millions of dollars, and while the courts were resolving the issues, the status of the lands in question would be indeterminate--a situation which would frustrate land management and hobble economic development.

Assuming an all cash trust reconstitution were feasible, however, cash trusts are much easier than land trusts to manage. Management costs are lower, predictable, and identifiable. Cash trusts avoid land management conflicts. Although they require inflation-proofing, under normal economic conditions, cash trusts can generate dependable revenue streams. On the other hand, cash trusts are subject to economic dislocations. Untimely, unwise, or unlucky investments could diminish the corpus' value, and catastrophic events such as depressions could render a cash trust worthless.

In order to work, a cash trust would have to be large enough to annually generate revenues sufficient to cover the necessary expenses of the mental health program and inflation-proof the corpus. As the present necessary expenses of the mental health programs are estimated to be approximately $100 million, the cash trust would probably need to be at least $2 billion. In addition to enabling legislation and appropriations, such a solution would require new statutes allowing for preservation of trust corpus and dedication of revenues (see below).

Permanent Fund Option

One cash trust option which was discussed informally was to identify part of the Alaska Permanent Fund as the mental health trust corpus. The "trust" would remain as part of the Permanent Fund corpus and continue under that fund's management. After inflation-proofing, revenues from that portion of the Permanent Fund corpus would be made available through the Undistributed Income Account to first fund the necessary expenses of the mental health program. Revenues in excess of program needs would either remain in the Undistributed Income Account or return to the Permanent Fund in order to build the corpus. By avoiding management costs and minimizing the potential for land use conflicts, such an approach returns the focus to mental health programs.

In answer to other interests seeking similar arrangements for their programs, the legislature could argue that the arrangement is based upon four conditions which must be met:

1) resolution of litigation which has the potential to disrupt the state economy and management of all state

lands
2) satisfaction federal obligations
3) of benefit to many constituencies (mental health advocates, municipalities, miners, environmentalists, recreationists, and all others having an economic interest in state lands)
4) is payment for a major contribution (one million acres) to the state general grant land base

Revenue-Stream Option

The purpose of the mental health land trust was to assure adequate funding for a comprehensive mental health program. In lieu of either a cash or land or combination land/cash trust, it might be possible to negotiate a settlement with a guaranteed revenue stream which would achieve the purpose of the original trust. In effect, such a solution would guarantee that a certain percentage of state revenues would be made available to first meet the necessary expenses of the mental health program.

As with other options, there would be difficulties, but the approach could avoid continuation of land use conflicts, management expenses, and drain upon the state's treasury.

To satisfy mental health advocates, the legislation enacting a revenue stream resolution would have to define which expenses and and services will be considered part of the mental health program. Program definition presents some thorny political problems, but without it, the restricted revenue stream has little meaning--and these political problems pale in comparison to those which might result from renewed litigation or from invading the Permanent Fund.

Furthermore, the enabling legislation should be very clear that the legislature intends to fully fund an adequate mental health program in perpetuity. To satisfy the court-ordered reconstitution, such an arrangement would have to include collateral--an identifiable, quantifiable entity--which could be redeemed by the trust in the event that the promised revenue stream failed to materialize or was somehow diverted. This might consist of a dedication of a portion of the Alaska Permanent Fund as security or some other identifiable and quantifiable state assets (real property such as buildings, lands, and transportation systems). While falling short of binding the hands of future legislatures, such a surety bond would make them always cognizant of the revenue stream legislation's original intent.

Other interests seeking similar terms from the legislature for their programs could be reminded that the revenue stream is

essentially a form of rent paid by the state to the mental health trust for the state's use of one million acres of federally granted mental health trust land.

Preferred Option: Guaranteed Revenue Stream

The recent negotiated reconstitution of the University land trust provides an example of a mixed cash and land settlement and suggests how complex a complete accounting can be--and how costly the final settlement could be for the state. The 1978 Redesignation Act also reclassified University Grant Lands as general grant lands. Although less complicated and extensive than the mental health case, a study of the University settlement is informative. (Refer to Appendix D.)

After dismissing the other alternatives as too complex or controversial, the committee focused on the revenue stream option and introduced legislation based upon it (HB 92/SB 96). With major modifications (e.g. an identifiable trust, a means of guaranteeing appropriations, etc.) the revenue stream approach might be acceptable to the Weiss litigation parties. The commission is continuing to consider this option. However, should those modifications prove politically unfeasible, or if the negotiations should bog down, then the legislature will have to reconsider all the alternatives presented above.

Negotiated/Legislated vs. Litigated Resolution

The number, complexity, and importance of the questions raised by the Weiss Opinion's trust reconstitution instructions urges a negotiated settlement.

Foremost of the issues related to trust reconstitution which the Supreme Court did not address, is the question of how to compensate the trust for actions prior to the 1978 Redesignation Act. These actions include less than fair market value transactions for the use of the lands and their resources. The Weiss decision ignored the question of lands which had not been "sold" but the legislature had designated for other purposes such as parks.

A host of trust management questions remain unresolved. Is active management to maximize trust revenue production for mental health programs required? Should the trust be compensated for "opportunity costs" as was done in the University settlement? (Refer to Appendix D.) These would include the income that the trust lands and their resources could, should, and would have produced had they been actively managed--and the income that a

trust account created from receipts from the sale of trust assets.

The inadequacy of the mental health program motivated the Weiss litigation, but programs were not an element in the litigation and the resultant decision. Although not addressed by the court, such issues will have an impact on the final resolution, and their existence underscores the necessity of pursuing a negotiated resolution. The subject of the Alaska mental health program is more fully discussed in Chapter IV, below.

A litigated approach would involve raising and litigating each of these issues in their turn. As some of these issues could take years to litigate, taken as a whole, a litigated resolution might consume more than a decade, clog the courts, paralyze state land management, and divert state resources from more useful applications--such as funding state programs.

Despite--or perhaps because of--the range of disagreement on nearly every issue, the representatives of all the parties to the case currently appear to be willing to attempt to reach a mutually-acceptable resolution through negotiation.

Long Term Management Recommendations

In the event that the negotiated settlement either preserves some form of a land trust or fails to materialize during the 1987 legislative session, the legislature should still act to authorize DNR to actively manage trust lands and revenues. The legislature also requested the commission to make management recommendations both for mental health trust lands and trust accounts.

Trust Land Management

DNR is the agency presently responsible for managing the vast majority of the state's land entitlement. The Alaska Statehood Act either granted, or confirmed the prior grant of, approximately 105 million acres to the State of Alaska. Section 6(k) of the Statehood act specifically confirmed and transferred to the state the 1,000,000 acre mental health land grant established pursuant to the 1956 Mental Health Enabling Act.

The department manages state land consistent with the statutory land management provisions embodied in Alaska Statue Titles 38, 41, 29 and other applicable laws. Title 38 of the Alaska Statutes is the principal land management authority guiding the state's policy for use and administration of most state land.

Title 38 has evolved since statehood to represent a collection of authorities which allow use authorizations while ensuring that the overall public interest is addressed and protected. Land disposal authorizations usually require both prior public notice and a state's "best interest" determination.

Since statehood, the legislature has enacted many AS 38 provisions which constrain the department's ability to actively manage trust lands for maximum revenue production. For example, AS 38 contains allowance for leases at no cost, veteran's discounts, senior citizen discounts, preference rights, etc. Land conveyances have been at fair market value as well as no cost conveyance for nonprofit groups and "sweat equity" (no cost) transfers under the homesite and homestead programs.

While Title 38 provides an umbrella for public and private use of state land and resources, it does not generally allow for active management of trust lands. "Active management" is defined as the administration of land and resources in a manner intended to maximize the revenue derived from land use authorizations and conveyances as well as to enhance the value of the land and resource base assets. If land is all or part of the reconstitution, it will be essential to manage trust lands in accord with revenue maximization objectives. Because the existing AS 38 statutory framework simply precludes meeting this objective, a mental health trust land management authority should be established, emphasizing active management.

The commission has obtained information related to statutory trust land management programs in several other states. In addition, the National Conference of State Legislatures has briefed the commission on alternative trust management programs. Other states with trust land management programs generally employ a dedicated trust fund to protect revenue and assets. In some cases, revenue is placed in a principal or permanent fund, with income from management of the invested fund distributed to the beneficiaries. In other states, land management revenues are used to directly programs.

Trust land management programs vary. Some states administer land through their natural resources department, or equivalent, while others use a Board of Commissioners, usually appointed by the governor. Some states employ a combination of both systems. Several western states do administer large trust bases in accord with maximum revenue yields as is implied by the public trust nature of the Alaska lands. An urban lands program has been successfully employed in Arizona, Washington and Colorado to enhance trust land revenue production.

New legislation should be enacted to allow mental health trust lands to be managed in accord with the following general principles:

1. A separate trust management regime for mental health trust lands needs to be established to assure active management;

2. Long-term revenue enhancement should be emphasized over short-term revenue production;

3. Urban lands, possessing development potential, should be retained or acquired and then development plans should be generated and implemented to enhance revenue production;

4. Long-term leasing is preferred over land sales, unless there are overriding revenue production or other trust considerations;

5. Land use authorizations shall occur at, or be based upon, fair market value appraisals, unless there are significant trust benefits otherwise unavailable (e.g. enhancement of other trust lands through the use authorization;

6. If mental health trust lands are managed by DNR, such management should be in accordance with policies and procedures approved by an independent commission or board acting as trustee;

7. The cost of trust management administration should be recovered from revenue from management.

Trust Account Management

Although the 1956 AMHEA did not specify that a mental health trust account be maintained, most other state and the University of Alaska are required by statute to maintain a permanent fund type account for investment of proceeds from management of federally granted trust lands. In establishing this commission, the legislature also created an interim special account in the general fund into which proceeds from the management of trust lands shall be deposited and from which appropriation might be made to be first applied to the necessary expenses of the mental health program. The additional responsibilities of the commission, therefore, include recommendations "relating to the management of the mental health trust account."

All of this supports the commission's recommendation that a permanent mental health trust fund be established consisting of (1) a corpus account into which would be deposited proceeds from any cash resolution of the Weiss litigation, sale of trust lands, and "inflation-proofing" from the investment management of the

corpus account; and (2) an income account into which would be deposited income (other than that from the sale of land) generated from management of the trust lands and the investment income from management of the trust fund corpus account (after retention of enough income for inflation-proofing) and from which appropriations would be made to first meet the necessary expenses of the the mental health program.

The concept of a permanent trust fund is to provide a means of preserving the corpus from being diminished. Although this is in accord with accepted trust management principles, the Attorney General and the Legislative Counsel have opined that because this constitutes a dedication of funds which is not required by federal law, it is prohibited by the Alaska Constitution and would require a constitutional amendment. Attorneys for the plaintiffs and intervenors disagree.

The provision of a means of inflation-proofing the corpus of the fund, through transfer of a portion of income, as done in the Alaska Permanent Fund, is also an important means of protecting the corpus from diminution. Active management of a money fund also requires investment strategies which will generate the highest returns (as in the case of active land trust management) consistent with observation of the "prudent investor" rule (as in the case of the Alaska Permanent Fund). In providing for the active management of the monetary trust fund, the commission recommends consideration of a management agreement with the Alaska Permanent Fund Corporation.

IV. ALASKA'S MENTAL HEALTH PROGRAM

While the Weiss litigation and subsequent Opinion of October 5, 1985, focused on reconstituting the trust, program inadequacies were the basis for the litigation in the first place. Although the status of the trust and program funding have been considered distinct issues, any negotiated settlement to the litigation involving permanent abandonment of all or part of the land trust will likely involve a reciprocal permanent commitment from the legislature to increase funding for mental health programs. In SCR 36, 1986, the legislature specifically directed the Joint Special Committee to recommend a level of appropriation adequate to provide sufficient funding for the mental health program in the future. Similarly, SB 472 (Chapter 132, SLA 1986) directed the Interim Mental Health Trust Commission to "make recommendations for amendments of the laws relating to the management of the mental health program."

Origins of the Current Program

Prior to 1956, the U.S. Department of the Interior was responsible for the territory's mental health program. The Department of Interior provided no out-patient services, and those needing hospitalization were sent to Morningside Sanitorium in Portland, Oregon. Even then, treatment was minimal: the program basically amounted to incarceration. According to the General Accounting Office's 1955 investigation, per-patient costs at Morningside were as little as one-quarter that of other states.

Early Studies

The Interior Department's program for the Territory of Alaska was one of the last to reflect the growing nationwide understanding of mental illness and its treatment. As a result, mental health professionals repeatedly criticized it. The Interior Department's own study, the 1948 Overholser Report, concluded that "there is no mental health program in Alaska." The 1954 University of Pittsburgh Graduate School of Public Health study corroborated the earlier report's findings, and the 1956 Western Interstate Commission For Higher Education (WICHE) report found that Alaska offered "practically no psychiatric care." These analyses called attention to the barbaric and archaic nature of the Alaska-Morningside approach and helped rally congressional support for reform.

The Alaska Mental Health Enabling Act

Alaska's current mental health program grew directly out of the 1956 Mental Health Enabling Act (AMHEA) which transferred responsibility for mental health care from the federal government to the territory. AMHEA provided $6.5 million for the construction of hospital facilities, and another $6 million spread over a ten year period for program start up. The Act anticipated a "comprehensive" mental health program, by which was meant both in- and out-patient care.

Although AHMEA's sponsors had originally anticipated hospitals in Southeast, Southcentral, and Interior Alaska, funds sufficed for but one--Alaska Psychiatric Institute (API)--which opened in in 1961. Unfortunately, operating funds were also grossly inadequate-- barely sufficient to cover the costs of transporting and hospitalizing patients in Morningside Sanitorium while Alaska Psychiatric Institute (API) was being constructed.

The present program basically consists of API, the in-patient facility, and a system of community mental health centers.

Alaska Psychiatric Institute

When it opened in 1961, API was considered an up-to-date mental hospital, but a quarter-century's advances in psychiatry have rendered much of the facility obsolete. In addition, in 1981 part of API was converted to a maximum security forensic unit for Alaskan prisoners formerly sent to institutions in California. This new use exacerbated crowding and compromised the treatment environment by creating a more restrictive facility than was necessary for most of the other patient populations.

The quality and quantity of services at API have varied markedly over the years. As a consequence of having to accommodate the diverse patient populations and increased demand in an inefficient facility, patients were prematurely released and the the rate of readmissions rose dramatically. While this situation has improved, the basic ingredients of past crises--diverse patient populations with conflicting needs, antiquated facilities, and shortage and turnover of qualified staff--remain.

De-institutionalization

The 1964 National Community Mental Health Centers Act reflected a growing trend toward de-institutionalization. The federal legislation eventually funded mental health centers in Ketchikan, Juneau, Anchorage, Kodiak, and Fairbanks. However, the federal legislation failed to sufficiently solicit and respond to local needs and desires.

The Alaska Community Mental Health Center Enabling Act of 1975 made great strides towards providing mental health services at the local level statewide. Within ten years it funded an additional 23 clinics within ten years. However, geographic and cultural barriers and inadequate funding continue to frustrate attempts to adequately assess and respond to local needs. As a result, many community mental health centers have long waiting lists for clients services, and many lack the resources and staff to provide a full range of out-patient services.

Status of The Current Program

Despite the significant strides since 1956, and even since 1975, Alaska's current mental health program has been judged deficient by a host of experts from both within and outside the state.

According to the National Council of State Legislatures (NCSL), the proportion of mental health program operating expenditures compared to other state operating expenditures is one fifth that of the U.S. as a whole. The NCSL has identified three particularly deficient programs (children's care, community care, and forensic (criminals) and noted that Alaska relies on hospitalization to a much greater extent than do other states. [Hospitalization is extremely costly, and this over-reliance may contribute to Alaska's high per capita expenditure ($45--nearly double that of the states whose programs NCSL rated best) for mental health.]

The 1986 State Comprehensive Mental Health Plan also notes deficiencies in services for Alaska Natives, the elderly, the seriously mentally ill, and a need for better coordination in transitioning patients between API and the community mental health centers.

It is not yet clear how much it would cost to fully address the needs of Alaska's mentally ill, but an efficient, coordinated system of mental health care might create some economies (e.g. by reducing reliance on API and reducing the current 50% rate of readmission at API. The 1986 Mental Health Plan calls for increases in annual operating expenditures of $80 million over current levels to $106.9 million, and one-time capital expenditures of $100 million over the next five years.

Although these figures amount to more than four-fold increase in funding for operational costs alone, the Alaska Alliance For The Mentally Ill has testified that even this increase may not be enough to develop the comprehensive mental health system contemplated by the Division. As the Joint Special Committee notes, actual state funding--after inflation--on mental health

has declined over the past few years--even before the 20% cutbacks of the past nine months.

Mental Health Planning

Program deficiencies partly result from an inadequate data base and management information system. Problems with the management information system stem in part from lack of resources at the community and state level. Although efforts have been made to improve data gathering, funding should be made available to fully implement improvements. Without accurate data, there's little reason to go through a prolonged planning process, and an effective and efficient mental health program depends on a good plan.

While Alaska's statutes provided for mental health program planning, planning has been infrequent and inadequate. Since 1956, there have been several studies of the state mental health program. However, the last comprehensive plan was the 1977 Five Year Plan. The purpose of program planning is to determine the needs and how to best meet them. Yet, even the needs of Alaska's seriously mentally ill can only be estimated. The nature of mental illness complicates the task of quantifying its prevalence and the corresponding need for care. The afflicted, their families and friends, may be reluctant or unable to discuss their problems. Furthermore, mental illness definitions vary significantly which adds an additional complication to the task of censusing the mentally ill. Nonetheless, some determination of mental health need must be made, if planners are going to develop a system capable of efficiently responding to that need.

The Unmet Need

The following discussion is intended to shed light on the immensity of the problems facing mental health care providers throughout the state. The data helps explain the frustration and desperation experienced by providers, clients, and mental health care advocates.

According to "Adult Mental Health In Oregon," a 1986 League of Women Voters report, 1.5% of the residents of Oregon have serious mental disorders, and 60% of those are actively in treatment. If these percentages were applicable, approximately 7,500 Alaskans are seriously mentally ill.

<u>The incidence of serious mental illness in Alaska is almost certainly several times higher than the national average.</u> In common with other northern areas, Alaska's incidences of suicide,

alcoholism, drug abuse, divorce, child abuse and other problems correlated with the incidence of emotional disorders and mental illness are well-quantified and run several times the national average. This observation is supported by special local and regional surveys and studies. For example, a University of Alaska 1984 report, the "Estimate of Six Months Prevalence Rates of The Northern Region," revealed that 4.6% of the residents of northern Alaska suffered from serious mental illness.

As the result of a planning effort begun in 1984 and an analysis called the "Boston Study" (by The Human Services Research Institute, Cambridge, Massachussetts) the Division set the number of seriously mentally ill at 1,259. The "Boston Study" predicts that only 34 seriously mentally ill in Juneau will want or seek services in any six month period. However, a report by Dr. Gary Anders which used NIMH statistics corrected for local geographic factors and population characteristics project 33 times that number in need of services, or an estimated 980 seriously mentally ill.

On the basis of the above estimates, the number of seriously mentally ill Alaskans could range from 7,500 to 25,000. In 1986, Alaska's Community Mental Health Centers served 613 clients diagnosed as seriously mentally ill. Regardless of the estimate used, only a small percentage of those in need are being served.

Recommendations

The commission has not yet had the time to make a detailed review of the Division of Mental Health and Developmental Disabilities 1986 Comprehensive Mental Health Plan. That plan's mission statement concludes:

> "Given the fact that the State of Alaska leads the nation in many of the social indicators and environmental factors which highly correlate with the presence of mental and emotional illnesses, and that Alaska still lacks an effective comprehensive mental health delivery system, the task facing the Division is indeed formidable".

In general, the commission agrees with that conclusion and with DMH&DD's call for a major increase in mental health care funding. The commission also supports the committee's findings and recommendations relative to Alaska's Mental Health Program. In particular:

The Comprehensive Mental Health Plan should guide the legislature in program development and spending decisions. The plan should be based upon accurate data generated by a management information

system. The funding resources necessary improve the present data system should be appropriated.

As required by statute, the plan should be continually updated to meet the changing needs of Alaskans and to reflect changing treatment philosophies.

The state benefits tremendously from public involvement in the planning process, and all measures should be taken to maximize public participation in it.

The state should refine, update, and make consistent statutory definitions of mental illness.

Whether or not funds exist in a mental health trust, Alaskans' mental health needs should be met. For FY 88, the commission recommends a minimum of $27,392,200, consisting of:

a) Continued funding of $22,533,200, the Division of Mental Health and Developmental Disabilities for mental health services and administration, Community Mental Health grants, and contract services provided by native corporations. In light of the Weiss lawsuit and the unmet mental health program needs, existing mental health programs should be protected from further budget cuts.

b) Reinstatement of the $4 million cut by executive action in July, 1986: restore $550,000 to API; allocate $272,000 for adult residential care for the chronically mentally ill to restore 13 beds and add 27 new ones; restore $151,800 to the Division of Mental Health for staff to plan and deliver mental health services; restore $223,200 to the Fairbanks community mental health program; and allocate $2,828,500 to community services for the chronically mentally ill.

c) Restore the $859,000 provided to the Department in FY 87 as legislative "add-ons". This includes funds for designated beds, emergency services for the chronically mentally ill, and suicide prevention.

HB 92 should be passed; an additional $2.2 million should be appropriated to implement it.

Future funding increases must provide for significant progress toward meeting the goals of the state's comprehensive mental health plan through financing of programs and projects.

* * *

The 1986 Comprehensive Mental Health Plan for the State Of Alaska is available from the Division of Mental Health and provides a detailed analysis of the present program and unmet needs.

APPENDIX A presents a paper on program needs and mental illness definitions by commission-member Sharron Lobaugh.

The Commission contemplates presenting more specific program-related recommendations in its final report.

APPENDIX A

APPENDIX A:

POSITION PAPER
NECESSARY NEEDS OF THE MENTALLY ILL

February 21, 1987

prepared for the
Mental Health Trust Lands Commission

Sharron Lobaugh

"Will Everyone in the Class Please Rise?"

INTRODUCTION

As member of the Alliance for the mentally ill, I have long been concerned about the lack of appropriations for the seriously mentally ill. Congress' 1956 Alaska Mental Health Enabling Act transferred responsibility for mental health programs to the territory. Prior to that time, the program served only those requiring hospitalization. Before being sent to Oregon for hospitalization, these individuals were adjudicated "insane." They were considered "hopeless" then because society believed that all they could ever do was provide indefinite asylum. Today, we now know that with medication, adequate support systems, and enough help they can lead nearly normal, productive lives. I know that community support works because I have a son who suffers from schizophrenia and is doing quite well in our community.

Although Congress clearly intended that the mental health trust lands would be used to provide programs for the most seriously mentally ill, subsequent funding always fell far short of need. Lacking an organized advocacy, the needs of the seriously mentally ill were never adequately considered and consequently during the period of 1978 through 1985 for example, only .01 % of the total capitol and operating budget of the state of Alaska was spent on mental health programs. Even within this allocation, less than 10% of those receiving services from Community Mental Health Centers were those with major mental illness. This is not to lay blame on the service providers who have long recognized the need to expand services to this population but have had to meet a wide range of expectations of their community.

The following paper discusses a number of steps that should be taken to insure that the needs of the seriously mentally are better addressed without shortchanging groups with other needs. Recognizing that the state's resources are finite there must be a means of validating the numbers to be served, describing in clinically defensable terms those who are most seriously ill, and establishing a priority of service to those in greatest need.

Once these are established in law and a mechanism is developed to assure the necessary needs of the priority population are met, the State will have fulfilled its obligation to the mentally ill.

Section I

DEFINITION OF MENTAL ILLNESS

The purpose of this section is to provide persons with definitions as to what should or should not be included in the Mental Health Program. In order to do this, one must examine the definitions in present statutes, compare them with other states, and research provided by present medical evidence. The thrust of the material discussed will be to demonstrate the wide variation that exists presently in our statutes, to recommend language that will clarify the population to be served and to suggest where changes might be made to provide a statutory framework for a mental health program.

The assumptions on which this chapter rests are that: the public burden in mental health are the seriously mentally ill; this population has historically been underserved in Alaska; the intent of Congress was to provide the resources to insure that the needs of this population are served over time; and that the proceeds of the mental health trust shall primarily be used for this purpose.

The public generally has difficulty understanding mental illness. Even among professionals the issue is not clear. A good discussion of the national dilemma is contained in a publication entitled "The Seriously Mentally Ill, A Comparison of State Programs" by E.Fuller Torrey, 1986: "There are some groups for which there is good agreement that they should be included among the seriously mentally ill. Foremost among these are those persons affected with schizophrenia, a group of brain diseases which are very common and which cause symptoms such as hearing voices, delusional and fragmented thinking, social withdrawl, changes in emotion, and occasionally bizarre behavior. A related group are persons which have manic depressive psychosis, now officially called bipolar disorder, which is often similar to schizophrenia except that changes in emotion are more prominent......between the two are persons with intermediate symptoms or schizoaffective disorders... When the person's symptoms are predominantly delusions of persecution, the diagnosis may be a paranoid disorder. Other psychotic disorders which are less common include schizophreniform disorders, postpartum psychosis, brief reactive psychosis, atypical psychosis, and psychosis due to known diseases such as severe thyroid disease or brain tumors."

There are no standard agreed upon definitions of mental health, mental illness, or the mental health program. Each state must make its own determination. As a beginning step the Mental Health Trust Lands Commission examined the court order which provided an offset for the expenses of the mental health program. This task considered the time between 1978 and 1985 but still leaves undecided the program for the future.

The definition of the mental health program continues to plague the Commission. The Commission for purposes of the "setoff audit of mental health programs", used three differing sources of definition: the Alaska Statutes, DSM III, and the 1978 Mental Health Plan. Similarly, the Alaska Statutes contain a variety of conflicting and sometimes inaccurate definitions.

The program became the focus and it was determined that a mental health service or program is one that is delivered by a qualified mental health professional to prevent or relieve a disabling mental/emotional condition experienced by a child, adolescent, or an adult. For further clarification, a definition of who is considered a "disabled person due to the mental/emotional condition" is necessary.

ALASKA STATUTES:

AS 47.30.915 (12) "Mental illness means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand; mental retardation, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

(in reference to criminals:)
AS 12.47.130 (3) "Mental disease or defect means a disorder of thought or mood that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life; 'mental disease or defect' also includes mental retardation, which means a significantly below average general intellectual functioning that impairs a person's ability to adapt to or cope with the ordinary demands of life."

AS 12.47.090 (j) (1)"Mental illness means any mental condition that increases the propensity of the defendant to be dangerous to the public peace or safety; however, it is not required that the mental illness presently suffered by the defendant be the same one the defendant suffered at the time of the criminal conduct."

Alaska Compiled Laws, Annotated Cumulative supplement (3), 1958 (51-4-20a)

"'Mentally ill individual' means an individual having a psychiatric or other disease or senile changes which substantially impair his mental health or who is mentally deficient."

(51-4-20b) "The Department...is hereby authorized and directed to administer a complete and comprehensive program for the prevention of mental illness and the care and treatment of persons who are mentally ill, including in-patient and out-patient care and treatment of such persons, and to take such actions and undertake such obligations as may be necessary to participate in any Federal grant-in-aid program and to accept Federal or other financial aid...for the study, examination, care, and treatment of the mentally ill..."

As noted in the October 24,1986 legislative audit report, (page 2) "there is not a quantifiable definition of mental health nor is there a definition of the State's Mental Health Program that is widely accepted by all professionals, or State and Federal officials."

Compared to other states, some Alaska Statutes reflect more reliance on recent medical information. The 1984 revision of the commitment law AS 47.30.915 - 47.30.915, which broadened the statute to include a category: "gravely disabled" has enabled many more persons needing treatment to be helped.

However statutes containing outdated assumptions should be changed. For example, in reference to the statute outlined on page 5 which refers to criminals states: "mental illness....increases the propensity of the defendant to be dangerous to the public peace or safety." Research exists that the mentally ill are no more dangerous than the general population. "Mental Illness" should be defined by cross referencing a statute which does conform to diagnostic criteria. Also, this same statute includes the "mentally deficient" as "mental ill" which is inconsistent with other statutes which exclude developmentally disabled persons from the class of mentally ill and unnecessarily stigmatizes this population.

Because it is important that the laws reflect the most recent information available for program implementation, there are a number of areas which should be strengthened in order to assure that state supported programs meet the needs of the most seriously ill.

RECOMMENDED STATUTORY CHANGES:

a. Terms such as "acute", "seriously mentally ill", "mentally ill children" and "mental health program should be defined. and functional descriptors added to appropriate codes.

b. Priorities of populations to be served should be set into statute.

FUNCTIONAL DEFINITIONS OF MENTAL ILLNESS:

The American Psychiatric Glossary defines: "Mental Illness or Disorder" as "an illness with psychologic or behavioral manifestations and/or impairment in functioning due to a social, psychologic, genetic, physical/chemical or biologic disturbance. The disorder is not limited to relations between the person and society. The illness is characterized by symptoms and/or impairment in functioning."
A functional definition which is now the standard for eligibility for social security benefits is included in the Federal Register of August 28, 1985. (See Appendix)

Ms. Patricia Owens, director of the National Social Security System explained the rationale behind the development of these new regulations for social security eligibility in an address before the National Alliance for the Mentally ill in March 1985 in Washington D.C. "Early in the Reagan Administration, we had a tendency to take a 'snap shot' picture of recipients and if they looked 'O.K.' they were disallowed, now we know they look their best when they are functioning because of medications and appropriate program support...Medical evidence needed to be established to determine who was too sick to work and we prepared these regulations based on objective medical findings which are described as 'listings' and if medical evidence shows they are clinically within these categories, they are automatically within the entitlements."

Finally, eligibility criteria for community support programs by the National Institute of Mental Health contains the following definition:

NIMH OPERATIONAL DEFINITION OF THE COMMUNITY SUPPORT PROGRAM POPULATION:

1. Severe disability resulting from mental illness

   Client typically meets at least one of the following criteria:

   has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (emergency services, alternative home care, partial hospitalization).

   has experienced a single episode of continuous, structured supportive residential care other than hospitalization for a duration of at least two months.

2. Impaired Role Functioning:

   In addition such individuals typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

   Is unemployed, or is employed in sheltered setting;

   Has markedly limited skills and a poor work history;

   Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help;

   Shows severe inability to establish or maintain a personal social support system;

Requires help in basic living skills;

Exhibits inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system.

"People who meet these program criteria and who do not appropriately require long term full-time, skilled or semi-skilled care in a medical or nursing facility should be conceptually included regardless of where they may be residing at a particular time."

One might assume that there are subtle but insignificant differences between the functional definitions and Alaska's present statutes or that a change in statute is not warrented. However, if one examines the regulations implementing the Community Mental Health Center Act: [AS 47.30.530 and AS 47.30.540]-[7AAC 71.135.] the following are listed as undefined priorities:

> TYPES OF SERVICES AND POPULATIONS TO BE SERVED. (A) A center must serve, to the extent that mental health services are not available to them from other providers, the following populations in prioritized order:
>
> (1) acutely disturbed persons;
>
> (2) chronically, severely disturbed persons;
>
> (3) children and adolescents;
>
> (4) other persons or agencies requiring direct mental health intervention and
>
> (5) other persons or agencies requiring non-direct mental health services such as consultation or education.

(1) Acute

As a result of a lack of specific definition, most resources are devoted to whatever any clinician deems as "acute."

Persons presently in the system under long term care are considered 'acute' and persons whose situation is a result of substance or family abuse are often seen as psychiatric emergencies. There is no question the latter are crisis situations which must be handled within the social service delivery system, but they are not due to mental illnesses as such and should not be the responsibility of the mental health program.

A means to clarify this would be to define 'acute' as the State of Washington has:

"a condition which is limited to a short-term severe crisis episode of (a) A mental disorder as defined in RCW 71.05.020(2); (b) being gravely disabled as defined in RCW 71.05.020(1); or presenting a likelihood of serious harm as defined in RCW 71.05.020 (3)."

A clearer and narrower definition of "acute" will allow for the wisest use of limited public money, is necessary for determining priorities, and conforms to the intent of Congress for purposes of trust benefits.

(2) Chronically, severely disturbed persons;

Although the regulations as noted above give persons in the chronically (severely) disturbed persons category the second highest priority, addicional information would clarify this statement. Mental illness when narrowly defined as it is in the Alaska Standards for Community Support Systems has the effect of limiting the number of persons to specific diagnosis. This standard has the advantage of transcending age and cultural distinctions. This standard should be adopted in statute. A separate piece of legislation addressing the program needs of this population is needed. The standard reads:

"A severely mentally ill person means a person who is 18 years of age or older and who satisfies both of the following criteria:

> Must be diagnosed as having a Schizophrenic, Major Affective or Paranoid Disorder (DSM III diagnosis of 295.1,2,3,4,6,7,9; 296.2,3,4,5,6,;or 297.1.3) or other severe mental disorder with a documented history of persistent psychotic symptoms other than those caused by substance abuse; and
>
> Impaired role functioning, consisting of at least two of the following:
>
> a. social role: an inability to function independently in the role of worker, student, or homemaker.
>
> b. daily living skills: an inability to engage independently in personal care (grooming, personal hygiene, etc.) or community living activities (handling money, using community resources, performing household chores etc.,): or
>
> c. social acceptability; an inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

A more problematic situation exists in defining children who are severely emotionally disturbed. The term severely emotionally disturbed is a Federal NIMH descriptor that includes youngsters whose problems are severe and persistent and based on functional disabilities.

The Federal guidelines do not establish as precise a definition for emotionally disturbed children as for adults but provide parameters such as:

1. Target population includes children under 18 years of age.

2. Children should have a multiagency need based on social functioning criteria.

3. Children should have a mental illness diagnosable under DSM III or state criteria.

4. A disability of at least one year or substantial disability of long term duration.

Many states have adopted behavioral indicators in their definitions because they are more meaningful for laymen and persons from other agencies than standard DSM III diagnostic categories.

The most recent State Plan, contains a definition which could be adopted in statute:

"A severely emotionally disturbed child or adolescent is one who:

1. Is under the age of 18, or under the age of 21 and has been receiving services prior to the age of 18 that must be continued for maximum therapeutic benefits;

2. Exhibits severe behavioral, emotional, or social disabilities that consequently disrupt the child's or adolescent's academic and developmental progress, family and or interpersonal relationships, often to the point that the child or adolescent is at risk for out-of-home placement or is placed out-of-home.

3. Has disabilities that have continued for an extended period of time, or on the basis of specific diagnosis by a qualified mental health professional is judged likely to continue for an extended period;

4. Frequently requires intensive well coordinated treatment delivered by an interdisciplinary team involving the family, courts, education, mental health, and other family service agencies.

5. The behaviors have been judged sufficiently disruptive to lead to exclusion from home, school or therapeutic setting.

6. The behaviors shall be sufficiently intense or severe or be considered seriously detrimental to the child's growth or safety and welfare of others.

As funds diminish States are moving toward inclusion of more specific or functional definitions in their statutes.

Washington State statute describes catagories on a continuum of severity:

1. Acute dysfunctional,
2. Prolonged dysfunctional(more than one year)
3. Disturbed functioning,
4. Vulnerable and independent.

Other States use multiple catagories. Some states cross categories with other disabilities providing for multiple handicapped functional disabilities.

By statutorily defining mental illness for both adults and children, Alaska would follow many other states in clarifying the target population.

A discussion of what is considered seriously mentally ill should also include what is generally "not" considered "SMI." A clear comparison is given by Dr. Jerrold S. Maxmen in The New Psychiatry: "Psychiatrist often hear people claim that what's called mental illness isn't really an illness, but a 'problem in living'...to equate them is false and naive, and in my view an inadvertent insult to the mentally ill.....Problems in living usually connotes things like dealing with a lousy boss, overcoming feelings of inferiority, fearing parental criticism, keeping ahead of the bill collector, and being lonely...mental illness involves symptoms, problems in living do not. A mentally ill patient may be certain a television is 'zapping' his spleen with x-rays or that skeletons are dancing in his closet, his dead grandmother's voice may be telling him to kill himself, or he may think he's Christ."

"These are delusions and hallucinations....symptoms, and to equate the diseases that provoke these symptoms with problems in living is to err in categorization and to trivialize the experience of the mentally ill...Patients with problems in living are symptom free; they seek therapy to deal with issues: 'I can't get along with authority figures' or 'I'm bored with my job.' Patients with mental disorders have symptoms and issues."

Other categories within DSM III are not included in the definition of seriously mentally ill. All categories in the "V" codes of DSM III which refers to adjustment disorders and are referred to as "maladaptive reactions to psychosocial stressors" are not considered serious mental illness. Persons suffering from these disorders would not have been adjudicated "insane" under the conditions described in the 1956 Mental Health Enabeling Act nor sent to Morningside. Persons with conditions in these categories are more likely: 1) to be able to be served in the private sector, 2) have health insurance, 3) have a greater recovery rate, 4) are most likely to return to productive employment. Similarly, the developmentally disabled and persons suffering from alcoholism do not constitute seriously mentally ill.

Section II

PRIORITY POPULATION

In addition to problems with lack of definitions, the Division has had difficulty implementing services for the priority population. This problem was identified by the Division of Legislative Audit in the June 20, 1985 "Special report on the Department of Health and Social Services Division of Mental Health and Developmental Disabilities":

Recommendation No.1
The Division of Mental Health and Developmental Disabilities (MHDD) should assert their authority over and take more responsibility for the effective use of State Funds.

As long as the Division views the system as being decentralized with the State playing a limited role, the system cannot change. The report further identifies problems in data gathering, monitoring, evaluation, planning, and lack of equitable system for allocating funds as barriers to improving service delivery.

One problem which the Division has identified is that of the Mission Statement of the Mental Health Program. According to a statute which has existed since 1958, the mission of the division has not changed from one of a "general" and "all encompasing" nature. There needs to be a reexamination of this statute to enable the division in times of limited resources to prioritize its services and assist those in greatest need.

Finally in considering, what, if any, changes in statute are needed to assure that the mentally ill receive priority, examination of the Omnibus Reconciliation Act of Oregon serves as a good model. Passed in 1981, (HB 2404) was the result of two years of study by a specially appointed Governor's task force essentially establishing treatment for the mentally ill according to a priority system. The three priorities were defined as providing these services:

Priority #1
For those persons who are in immediate risk of hospitalization...or in need of continuing services to avoid hospitalization...or pose a hazard to the health and safety of themselves or others

Priority #2
For those persons who are least capable of obtaining assistance from the public sector;

Priority #3
For those persons who are experiencing mental or emotional disturbances but will not require hospitalization in the foreseeable future.

[In addition, the services to be provided by the community mental health programs were changed and provided 100% State funding for these programs. Another feature of this act requires persons committed to the care of the Division should be appropriately tested and evaluated to identify any organic diseases or conditions that could cause or exacerbate the psychiatric symptoms.]

The benefits of restructuring the priorities in this way are:

1. serious mental illness occurs in all age groups and a change would eliminate arbitrary categories such as "youth", "elderly," and "native":

2. serious mental illness has both residual and acute phases a change would allow services to be provided to these persons in a supportive way to reduce the number of times the acute phase develops.

3. Persons who are experiencing problems with 'living' or under situational distress would be referred unless there are no other private providers in their service area or they do not have the capacity to pay for their treatment.

4. Community mental health centers will be encouraged to restructure their programs to meet the needs of the most seriously ill.

5. There would be greater incentive to develop community programs and subsequently reduce hospitalization costs.

6. The greatest benefit would be to the client who would be provided better local services, more complete diagnosis, and have a greater likelihood of maximizing their potential.

Section III

DETERMINATION OF NEED

At the present time, the Division has produced five complete and separate drafts of a 1986 Comprehensive Mental Health Plan. As the plan has developed, there has been some public input but a minimum of public involvement. The process for public involvement should be clarified in statutes. The most obvious means of assuring public involvement is to restructure the Governor's Advisory Board giving it the authority and responsibility to approve the annual plan of service. A primary change would be in title: to Alaska Mental Health Board (or Board of Trustees). Seats on the board should be designated in such a way that assures a balance between professionals and members of the public who represent the mentally ill. Persons with financial conflicts of interest should be restricted.

None of the drafts to date (Jan. 21, 1987) has produced an implementation plan phased over time with incremental funding based on the priorities set forth in statute. Such a format is essential in order to objectively determine need and prioritize funding. Mental Health care providers would be encouraged to redirect their programs to serve the needs of the seriously ill if the plan were implemented in a sequential manner; funding were tied to a formula which weighted services to the target population; and program eligibility were based on objective medical diagnosis. A formula would have the added benefit of preventing legislative "end runs" by certain communities to obtain services without going through the process established by law. More importantly, this would benefit the clients because of increased requirements for adequate evaluation, testing, and diagnosis.

Without additional statutory safeguards, accurate data regarding numbers to be served, or clear programatic priorities, the plan in its present form lacks sufficient information for the legislature to determine what the "necessary needs" of the mentally ill are or will be in the near future.

The original date for completion of the Mental Health Plan was January 1986. A fifth, final draft was released in January 1987. Reasons for the delay include: 1)there has been a lack of personnel in the Division of Mental Health 2) continual pressure of budget reduction exercizes, 3) inadequate time necessary for developing accurate data, and 4) the responsibility for development was divided among existing staff rather than contracting a mental health planner. The Division received a National Instititute of Mental Health Planning grant of $125,000 for this task. A system of care as presented in the mental health plan will significantly improve mental health care especially for the seriously mentally ill of all ages, however, it may take up to ten years to accomplish and cost 80 million annually.

<u>The Division must be commended in moving forward to describe a mental health system which will guide the state to achieving a quality mental health program.</u>

Section IV

INCIDENCE OF MENTAL ILLNESS

The Legislative Affairs Agency report of 1985, outlines the Division of Mental Health's data gathering shortcomings. Some of these shortcomings were uncovered in preparation of this report. Additionally, the recommended administrative changes from the Legislative Affairs Agency report should be implemented in order to improve the validity of the management information system.

The Division recently completed its first statewide study of the incidence of serious mental illness which is entitled; "Alaska Resource Allocation Modeling Project," more popularly known as the "Boston Study." The Human Services Research Institute of Cambridge,

Massachusettes contracted this service and developed a computerized model for service delivery based on functional levels. An Alaskan task force working with the consultants included representatives of several agencies: Alaska Psychiatric Institute, Southcentral Counseling Center, the Division of Mental Health and Division of Family and Youth Services. Unfortunately, there were no public members on the task force and the report has never been subject to public review.

The definition of seriously mentally ill persons which is the program standard used by the Division (pg 9) was used as the criteria for eligibility in this study. The number of clients was determined by a survey of providers in the public sector plus a sampling technique of new clients who arrived for service at local community mental health centers over a two week period.

The task force identified the services which are required for a system of care, grouping 24 specific mental health services into four major categories: residential services, treatment services, support services, and rehabilitative services.

The task force determined the amount of service individuals with specific functional levels would need. Although there are inherent weaknesses, this methodology serves as a beginning for a model of service delivery for the State of Alaska. A goal of the program would be to assure a quality of care leading to a better quality of life for the mentally ill with specific concern for relevant cultural placement in a theraputic environment.

When the system is in place, the revolving door of repeated commitments to A.P.I. can be broken and thus reduce the long term hospitalization costs.

The task force on the Boston study provided for client movement between various levels of functioning and determined probabilities which can be used to predict over time the financial impacts of such movement. The Division of Mental Health's report: "Boston Study Summary and Comparison to Dann API Study" (The Dann Associates Study is a facilities expansion and need assessment for improvement of Alaska Psychiatric Institute completed in 1986) discusses the variables and how an increase in community programs would reduce the need for hospitalized care.

This conclusion assumes however, that a <u>total system</u> would be implemented all at once rather than a more practical approach which would be to implement comprehensive service packages to selective sites and expand the program in subsequent years.

Of particular importance, this report notes that "<u>if the present system continues, the current level of services will result in a regression of the clients' functional level</u>". The report also notes that Alaska's system relies more its institution than other systems do. For example, Alaska is using hospital bed days at 46 times the rate of Denver, Colorado.

Because of many considerations (such as the need for confidentiality of records, the resistance of some persons with mental illness to seek treatment, and the problems of the Management Information System,) the methodology and assumptions used to determine the incidence of mental illness in Alaska are questionable in the Boston Study. Even though the Division has indicated repeatedly in its plans, that there is a higher probability of mental illness in Alaska due to a number of variables such as higher incidence of abuse and neglect, suicide, and lower economic status of Alaskan Native people, and greater social service demands in related areas, <u>the Division projects less than one-third as many seriously mentally ill as Oregon</u>.

The Boston Study used a figure of incidence at .5% of the total population. This figure is regarded as the number of persons who are <u>likely to want and utilize the services</u> as opposed to the more global incidence of true need. There are many reasons persons do not seek service and one of the most obvious is that there have never been many programs. Given that there are 500,000 persons in Alaska, the number in need was determined to be 2,500.

In 1977 NIMH began the most extensive study ever, involving 10,000 persons who were interviewed over a several year period and another 10,000 who were included in a follow up sample. This study revealed that 19% of <u>all</u> adults in the United States suffer from at least one mental disorder during a six month period. About 8% suffer from anxiety disorders; 6% from alcohol disorders, 6% from major depression or manic depressive disorders and about 1% suffer from schizophrenia.

A 1984 NIMH study determined that the incidence of schizophrenia alone in three major population centers to be: 1.9% in New Haven, 1.65% in Baltimore, and 1.0% in St. Louis."

Dr. Gary Anders of the University of Alaska recently analyzed the socioeconomic factors of Juneau as they related to the NIMH studies of Baltimore, New Haven and St. Louis. Dr. Anders determined that in Juneau, the incidence of schizophrenia would be about 260 persons. When persons suffering from other serious disorders are added to this number, the probable number of seriously mentally ill raises to 980. This number indicates an average of lifetime prevalance at the rate of 4.6%. (this number compares favorably with the Northern Region Study of 1984) A survey of Bartlett Memorial Hospital psychiatric emergencies that same at year yielded 220 patients. The Department of Law reported 55 involuntary commitments to API for the same period. From the Division of Mental Health's "Report of Community Mental Health Center Caseloads for year end 1985 by Diagnosis," the Juneau clinic reported 38 of 483 cases in categories of serious mental illness. By comparison, however, the Boston Study estimates the number seeking services in Juneau of all seriously mentally ill at only 34.

The Juneau example clearly demonstrate the variation of numbers resulting from a range of .015% as determined the Boston Study to the 1% factor who actually received emergency psychiatric services in the local hospital, to a probable number based on national data of 4.6%.

Additional information is needed from the private sector. In Anchorage, Providence Hospital opened an 11 bed psychiatric unit in 1978. Since that time, annual admissions have grown from 325 to 450. In 1984 they began emergency room service with diagnostic and treatment backup. In the first year of this program 260 patients were seen; 101 were discharged with follow-up, 85 were admitted to the Psychiatric unit, 51 were discharged to the South Central Counseling Center or other agencies; and 23 were admitted to A.P.I.

In the State of Oregon, 1.5% of the population have been identified as seriously mentally ill. In a report from the League of Women Voters of Oregon entitled; "Adult Mental Health in Oregon," a determination was made that of the nearly 2 million Oregonians there are 29,433 who are classified as seriously mentally ill. Almost 60 percent of those persons are presently receiving services. According to their priority system, additional data reveals that no more than 10% who were receiving services are considered moderately ill (priority #2) and only 1% considered mildly ill (priority #3).

Considering Alaska's more Northern location and younger population, there is further evidence that the projections in the Boston Study are too low. Dr. E.Fuller Torrey in "Surviving Schizophrenia, A Family Manual", discusses research from other countries showing that there are higher percentages of mental illness in Northern countries.

In a study of the Northern Alaska region, "Estimate of Six Months Prevelance Rates of the Northern Region," conducted by the University of Alaska and reported to the Legislature in 1984, the incidence of serious mental illness is 4.6%.

Applying the Oregon percentage of 1.5% to the Alaskan population yields a potential of 7,500 seriously mentally ill persons. Presently identified in Alaska according to the "Boston Study" are 1,259 Alaskans. During 1985 Community Mental Health centers in Alaska reported persons served with serious mental illness represented 613 (adults) of the 6,255 persons receiving care according to calculations from "Admissions to CMHC Fiscal Year 1985 by Principal Diagnosis" from the Division of Mental Health. A different picture emerges in the Mental Health Plan, (page 22 draft four) as the number reported seen by Community Mental Health Centers in 1985 is 8,286 clients. This is between 8 to 10% of the population served in CMHC's. (There is no explanation for the variation between reports of 2,000 persons, however, if the larger number is the accurate number, there is a probability that they are not seriously mentally ill.)

Although programs for the seriously mentally ill are few and scattered throughout the state, they are far more costly than present out-patient care. In Anchorage, for example these programs account

for over half of the funds spent by South Central Counseling Center. The majority of mental health clinics are limited to outpatient counseling which while it serves to monitor medication, does little to prevent recidivism.

Programs that are effective in reducing recidivism exist in Ketchikan and the Transitional Living Center in Anchorage. When completed, the programs in Fairbanks and Juneau can be expected to have a significant impact and reduce the reliance on Alaska Psychiatric Institute from these areas. A report from the Transitional Living Center issued Dec. 1984 demonstrates the relationship of the Respite Care Progam and the Rehabilitation progam on hospitalization care. For the Respite program in 1984, a projected reduction of 1320 hospital days was reported. Even more dramatic results can be expected as full systems become operational. As reported in the December, 1984, issue of Hospital and Community Psychiatry: "The data shows that programs must continue for a period of several years before the real impact becomes evident."

Clearly then, the division must reexamine its data gathering mechanisms and establish a more valid method of determining persons in need. Attention must be given to a variety of indicators. For example: In 1984, King County Mental Health Center of Seattle, Washington, received a grant to aggressively find young adult chronic mental patients, and begin a program of intensive outreach and treatment. "To identify the most severely mentally ill was the most difficult of tasks," according to Gary Johnson, a presentor at the University of Washington Medical School CSP conference in summer of 1985. "Emergency room visits were found to be the most reliable source for outreacn to seriously mentally ill persons, and the success of the program was measured primarily by the lack of, or reduction in, emergency room visits."

In Arizona, the department of health and social services is required to compile and submit a report on its chronically mentally ill to the governor, the president of the senate and speaker of the house each year which includes:

the total number of requests for publicly funded mental health services.

the number of requests for involuntary commitments;

the number of court ordered inpatient treatments;

the number of court-ordered outpatient treatments;

the number of requests for publicly funded screening and evaluation;

the number of voluntary commitments to publicly funded mental health service facilities;

the total number of persons treated in publicly funded mental health services facilities;

the number of persons treated per month in publicly funded mental health service facilities,

the length of stay in a publicly funded mental health services facility from the date of admission to the date of contact.

B. INCIDENCE OF MENTAL ILLNESS AMONG CHILDREN:

Alaska participates in the Federal CCASP project for childrens services and has determined a prevalence rate for service ten times greater than the level of need for the adult population or 20,000 children. The reasons for this greater number are due to a broader definition of childhood mental illness and the probability that the adult number is far too low. There is a need for some further clarification in order to focus the major attention on the most seriously ill children.

According to a recent study by Gould, Wunsch-Hitzig, and Dohrenwend, 1981, the national incidence of emotionally disturbed children is 1.8% of the general population or 11.8% of all children. Within this population, only 2% of all children who are emotionally disturbed manifest psychosis (excluding autism) or .023% of the general population Rutter, Tizard, Whitmore, and Longman (1970). Anxiety/affective disorders accounted for 40% of the 11.8%, (4.5% of all children); 30% of the 11.8% had conduct disorders or about 3.5% of the general population and multiple handicaps accounted for 1.%

Without complete information, there is a likelihood that the incidence in Alaska would be underestimated using national information again because of high rates for related problems such as child sexual assault and abuse. There is general agreement that the most seriously underserved in Alaska are the adolescents and teenage group. However, there have been no studies which indicate that major mental illness, such as schizophrenia can be prevented by intervention in childhood or conversely that emotionally disturbed children become mentally ill adults (except autism and childhood schizophrenia). Applying a 11.8% (all emotionally disturbed youth) incidence figure to the 130,000 plus children in Alaska under the age of 18, yields about 15,000 in need of care. Only 2,500 children received services in Community Mental Health Centers in 1984.

According to a 1986 CASSP Technical Assistance Center Report; "A System of Care of Severely Emotionally Disturbed Children and Youth" B.A. Stroul, the subset nationally that are considered seriously mentally ill children represent 5% of all children. Applying this criteria would yield 7,500 youth in need in Alaska.

It becomes apparent that it is essential to define the seriously mentally ill children in statute in order that they become part of the population to be served. The Department of Education has a mandate under P.L. 94-142 to provide an appropriate educational program in the least restrictive environment. Alaska has built in a

factor in the foundation formula for increased services for children who are receiving special education services. Emotionally disturbed children are not clearly identified in the data available and the exact number cannot be determined unless a system of data collection is developed and implemented by interagency cooperation betweem the Department of Education and the Division of Mental Health.

The most likely group to receive highest priority are those that are presently being sent out-of-State by the Departments of Health and Social Services or Division of Mental Health. According to data collected by the Division for the "Alaska Youth Initiative," a new program aimed at returning out-of-State placements, there are presently over 200 out-of-State placements at the present time. It is reasonable to assume that at least that many more are at risk without appropriate in-state services.

Unless some precise guidelines exist, all of the Mental Health Trust funds could be used for childrens services. There is no question that the type of program outlined in the State Plan is needed, however, the adults and children should not be competing for funds. Adopting the priority system used by Oregon and precisely defining those with serious mental illness regardless of age would avoid such a situation.

Section V

MENTAL HEALTH FUNDING

Since Statehood, there has been very little offered for the seriously mentally ill. The 1977 State Plan did not even discuss services to this population. This oversite is in part due to the fact that diagnosis and treatment has changed over time. Considering the same definition of "mental health program" that the commission used to determine the offset between 1978 and 1985, there was approximately $200,000,000 spent on the mental health program compared to a general operating budget during that period of time of $ 12,785,000,000.

In a report to the Legislative Committee on Mental Health Trust Lands delivered in October 1986, by the National Conference of State Legislators, Alaska was the lowest of the Western States in expenditures as a percentage of the total operating budgets, although Alaska spent the most per capita.

In Alaska, .4% of the operating budget went to mental health services compared to 2% of the U.S. States as a whole, or five times as great as Alaska's expenditure. The States rated highest by Torrey and Wolfe in the Care of the Seriously Mentally Ill, a Comparison of State Programs, (Wisconsin, Rhode Island, Colorado, Maine, and Oregon) are spending per capita over $25.00 and they depend far less on the use of hospitals than other States. According to this rating, Alaska's program was rated as 28th among States. Using seven of twelve variables, Alaska scored well on a number of conditions such as the number of highly qualified psychiatrists per population, but were adjudged as having "Major Problems Impeding Progress."

According to a study of the 1984 Final Report of Funding Sources and Expenditures NASMHPH, Alaska provided the lowest percentage of State Revenues to Mental Health programs of all States.

Even services within the Division of Mental Health are not equitable. In 1984 $403,000 were distributed to vocational programs for the developmentally disabled and only $30,000 for vocational services for the seriously mentally ill. Last year programs for the mentally ill were reduced by 12.5% while those for developmentally disabled were only reduced by 5%.

The Community Mental Health Center Directors were surveyed by the Governors Advisory Board in 1984 to determine the perception of unmet needs. According to a summary by Dr. David Samson, "The major mental disorders were felt fairly commonly to be untreatable in our mental health centers....such as acute psychosis, major affective disorders, and chronically mentally ill.....the same themes I think tend to be occurring from the various sources and this is that there are inadequate mental health services available within the community mental health centers throughout the State of Alaska. Resources are felt to be inadequate for outpatient services, high level professional services which would allow centers to treat a larger proportion of the severely acutely mentally ill and the chronically mentally ill."

Specific responses reveal the desperation resulting from inadequate funding:

"The commitment to providing even bare minimum services is appalling....There is no continuity in over all planning, prevention, and evaluation of services."

"The biggest need for the Bush areas seem to be improved continuum of mental health services to persons with acute and chronic-serious mental health problems requiring hospitalization. Post hospitalization care is lacking..."

"Expanded programs in the rural areas have been more a result of politics than program planning in a coordinated effort."

SUMMARY:

The members of the mental health trust commission have agreed that a thorough public debate should be encouraged on the mental health program, the mental health plan, and other concerns as expressed in this paper. It is hoped by bringing forth the debate on definitions concerned publics will examine the alternatives and assist in the process of forming legislation to improve existing statutes and to formulate laws to clarify what the mental health program should be for the State of Alaska. The commission will be making recommendations on these issues before its charge is complete this June.

Section VI

RECOMMENDATIONS:

Clarification in Statute the definitions of: acute, mental illness, childrens mental illness, seriously mentally ill, mental health program, and other terms which are based on current medical thinking.

Clarification by statute that priority populations be served first from funds of the mental health trust. That priorities be based on the seriousness of the illness with consideration for appropriate services to persons withoutt private care or ability to pay.

Pass H.B. 92 which establishes a program for the seriously mentally ill with 100% State funding for such services as: case management, medication monitoring, crisis care, vocational and residential services and other psychosocial programs.

Base Alaska's mental health program on an objective collection of data and establish a specific process of public involvement.

Determine the necessary needs of the mentally ill annually based in the mental health plan following the process of data gathering and public involvement by the Mental Health Board.

The Board should be authorized to: make specific funding level recommendations to the legislature, have authority to evaluate whether or not the necessary needs are met through trust assets, and responsibility to enforce what ever mechanisms exist for assuring that adequate funding be provided.

The Board should be composed of persons who represent the interests of the mentally ill.

Establish a mechanism for assuring that the dollars follow the client into the community and procedures for monitoring and evaluating programs to more accurately assess numbers of persons in need.

Restore cuts in funding for the mental health program and provide for program growth in services for the seriously mentally ill.

REFERENCES

Alaska Department of Health and Social Services, Fiscal year 1986, position paper on SB388.

Alaska Division of Mental Health and Developmental Disabilities:

Draft Alaska Comprehensive State Plan Aug 22, 1986

Standards for Community Support Systems, for State Grants to Community Mental Health Centers 1986

Annual Mental Health Statistical Report Fiscal Year 1984 Undated, Department of Health and Social Services.

Alaska Resources Allocation Modeling Project Human Research Institute of Cambridge, Mass. 1986

Dann Associates, Alaska Psychiatric Institute Needs Assessment and Planning, 1986

A Comparison Between the Boston Study and Dann Associates Position Paper, presented to Governors Advisory Board 1986

Alaska State Legislative Affiars Agency:

Legislative Audit report on the Division of Mental Health 1985.

Legislative Budget and Audit, A Special Report on the State of Alaska's Mental Health Program Expenditures for the Interim Mental Health Trust Commission, July 1, 1978-Sept.85

Anders, Gary, "A Preliminary Needs Assessment, Mental Illness in Juneau," Juneau Alliance for the Mentally Ill, 1985

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders. Third Edition, Washington d.C. APA 1980

Knitzer, J. Unclaimed Children. Washington, D_C_: Children's Defense Fund, 1982

Gilmore, Michael, Chang,C., Coron, D. Rochester N.Y., "Defining and Counting Mentally Ill Children and Adolescents," Issue Paper 1984

Gould, M.S., Wunsch-Hitzig, R., and Dohenwend, B., "Estimating the Prevelance of Childhood Psychopathology", Journal of the American Association of Child Psychology, 20, 1981, 462-476

________ Hospital and Community Psychiatry: December 1984

League of Women Voters of Oregon, "Adult Mental Health in Oregon" Issue Paper 1986.LWV Oregon, 317 N_EN Court St. Suite 202 Salem, Oregon 97301

Maxman, Jerrold M.D. The New Psychiatry,

Orvik, J., "A Study of Mental Illness in the Northern Region of Alaska," University of Alaska, 1984

Stroud, Beth, M.ed., Toward a Community Support Systems for the Mentally Disabled., The NIMH Community Support System. The Center for Research and Training in Mental Health, Boston University 1985

Torrey, E. Fuller M.D. The Seriously Mentally Ill, A Comparison of State Programs, Public Citizen Health Research Group, ;986

Torrey, E. Fuller, M.D. Surviving Schizophrenia, a Family Manual, Harper and Rowe, 1983

APPENDIX B

Public Law 830 CHAPTER 772

AN ACT

To confer upon Alaska autonomy in the field of mental health, transfer from the Federal Government to the Territory the fiscal and functional responsibility for the hospitalization of committed mental patients, and for other purposes.

July 28, 1956 [H. R. 6376]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Alaska Mental Health Enabling Act".

Alaska Mental Health Enabling Act.

TITLE I—AUTHORITY OF THE TERRITORY OF ALASKA IN THE FIELD OF MENTAL HEALTH

POWERS OF THE TERRITORIAL GOVERNMENT

SEC. 101. For the purpose of vesting in the Territory of Alaska authority comparable in scope to that of the States and other Territories of the United States in the field of mental health, the Territorial legislature is hereby authorized to enact such laws on the subject of mental health as it may deem appropriate, and such legislation may supersede any of the Acts cited in section 301.

FUNCTIONS OF COURTS

SEC. 102. In carrying out section 101, the Territorial legislature is authorized to confer upon United States commissioners, as ex officio probate judges, and upon the United States District Court for the Territory of Alaska, such jurisdiction, functions, and duties as it may deem appropriate for such purpose.

EFFECTIVE DATE

SEC. 103. This title shall become effective on the date of enactment of this Act.

TITLE II—GRANTS

SPECIAL GRANTS TO ALASKA FOR MENTAL HEALTH

SEC. 201. Title III of the Public Health Service Act, as amended, is hereby amended by adding thereto a new part as follows:

58 Stat. 691. 42 USC 201 note.

"PART H—GRANTS TO ALASKA FOR MENTAL HEALTH

"GRANTS FOR ALASKA MENTAL HEALTH PROGRAM

"SEC. 371. (a) There are hereby authorized to be appropriated the following sums to be available to the Surgeon General of the Public Health Service for the purpose of making grants to the Territory of Alaska to assist it to carry out plans, submitted by the Governor of the Territory or his designee and approved by the Surgeon General, for an integrated mental health program for the Territory, including outpatient and inpatient care and treatment: For each of the fiscal years ending June 30, 1958, and June 30, 1959, the sum of $1,000,000; for each of the fiscal years ending June 30, 1960, and June 30, 1961, the sum of $800,000; for each of the fiscal years ending June 30, 1962, and June 30, 1963, the sum of $600,000; for each of the fiscal years ending June 30, 1964, and June 30, 1965, the sum of $400,000; and for each of the years ending June 30, 1966, and June 30, 1967, the sum of $200,000.

Appropriations.

Estimates; payments.

"(b) The Surgeon General shall, prior to the beginning of each calendar quarter or such shorter period as the Surgeon General may find necessary, estimate the cost of carrying out the approved plan, on the basis of estimates furnished by the Territory, including estimates of the amount of contractual obligations for hospitalization, and on the basis of such further investigations as he may find necessary. From the amounts appropriated for any fiscal year, the Surgeon General shall pay to the Territory the amount requested by it but not to exceed the amount so estimated by the Surgeon General for each such period, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that the amount paid for any prior period was greater or less than the amount which should have been paid. The amount of any balance of payments made to the Territory under this section and remaining unobligated on July 1, 1967, shall be repaid to the Treasury of the United States.

"(c) Whenever the Surgeon General finds, after affording opportunity for hearing, that the Territory has failed to comply substantially with any provisions of the approved plan, he shall notify the Governor that no further payments will be made under this section (or that further payments will not be made for parts of the plan affected by such failure) until he is satisfied that there will no longer be any such failure.

"(d) For the purpose of facilitating the administration of the Territory's mental health program, the Surgeon General is authorized to enter into arrangements with the Territorial government to provide for the care and treatment, in hospitals operated by the Service, of patients requiring hospitalization. Such arrangements shall be subject to the availability of suitable facilities therefor and shall provide for charges to the Territorial government in amounts determined by the Surgeon General which shall be sufficient to cover the full cost of such care and treatment. Upon payment by the Territory the amount of such charges shall be credited to the appropriation from which such costs were incurred: *Provided*, That, during the period of grants under this section, payment may be effected by deductions from the amount of such grants otherwise payable to the Territory, with such deductions to be credited to the appropriation from which such costs were incurred.

"PAYMENTS FOR CONSTRUCTION OF HOSPITAL FACILITIES

"SEC. 372. (a) There is hereby authorized to be appropriated an amount not exceeding the total sum of $6,500,000, to remain available until expended, to enable the Surgeon General to make payments to the Territory of Alaska as the total contribution of the Federal Government to be used in defraying the cost of construction of hospital and other facilities in Alaska needed for the carrying out of a comprehensive mental health program.

"(b) Such facilities shall be scheduled for construction in accordance with a comprehensive construction program, developed by the Territory in consultation with the Public Health Service and approved by the Surgeon General. Projects shall be constructed in accordance with such approved program and in accordance with plans and specifications for the project approved by the Surgeon General.

"(c) Upon certification by the Territory, based upon inspection by it, that work has been performed upon a project, or purchases have been made in accordance with approved plans and specifications, and that payment of an installment is due, the Surgeon General shall certify such installment for payment: *Provided, however*,

That the Surgeon General may cause the project to be inspected at any time, and if such inspection indicates that the project is not being constructed in accordance with approved plans and specifications, he may, after notice and affording opportunity for hearing, withhold further payment until he finds that adequate corrective measures have been taken.

"(d) The term 'cost of construction' means the amount found necessary by the Surgeon General for the construction of a project and includes the construction and initial equipment of buildings (including medical transportation facilities), architects' and engineering fees, the cost of land acquired specifically for the purpose of the project, and on-site improvements.

Recovery of value of facility.

"(e) If, within twenty years from the date of completion of construction, any hospital or other medical facility constructed with the aid of grants under this section shall cease to be a publicly owned facility operated for the care or treatment of patients under the Territory's mental health program, the United States shall be entitled to recover from the Territory the then value of the hospital or other medical facility, reduced, however, proportionately to the extent to which the Territory may have contributed to the cost of construction thereof."

LAND GRANT

Sec. 202. (a) The Territory of Alaska is hereby granted and shall be entitled to select, within ten years from the effective date of this Act, not to exceed one million acres from the public lands of the United States in Alaska which are vacant, unappropriated, and unreserved at the time of their selection: *Provided*, That nothing herein contained shall affect any valid existing rights. All lands duly selected by the Territory of Alaska pursuant to this section shall be patented to the Territory by the Secretary of the Interior.

(b) The lands authorized to be selected by the Territory of Alaska by subsection (a) of this section shall be selected in such manner as the laws of the Territory may provide, and in conformity with such regulations as the Secretary of the Interior may prescribe. The authority to make selections shall never be alienated or bargained away, in whole or in part, by the Territory. All selections shall be made in reasonably compact tracts, taking into account the situation and potential uses of the lands involved. Upon the revocation of any order of withdrawal in Alaska, the order of revocation shall provide for a period of not less than ninety days before the date on which it otherwise becomes effective during which period the Territory of Alaska shall have a preferred right of selection, subject to the requirements of this Act, except as against prior existing valid rights or as against equitable claims subject to allowance and confirmation. Such preferred right of selection shall have precedence over the preferred right of application created by section 4 of the Act of September 27, 1944 (58 Stat. 748; 43 U. S. C., sec. 282), as now or hereafter amended, but not over other preference rights now conferred by law. As used in this subsection, the words "equitable claims subject to allowance and confirmation" include, without limitation, claims of holders of permits issued by the Department of Agriculture on lands eliminated from national forests, whose permits have been terminated only because of such elimination and who own valuable improvements on such lands.

Mineral deposits.

(c) All grants made or confirmed under this section shall include mineral deposits: *Provided, however*, That mineral deposits in lands which on January 1, 1956, were subject to public land order numbered 82 of January 22, 1943, shall not be included in said grants, but shall continue to be reserved to the United States.

Leases; sales.

(d) Following the selection of lands by the Territory pursuant to subsection (b), but prior to the issuance of final patent, the Territory shall be authorized to lease and to make conditional sales of such selected lands.

(e) All lands granted to the Territory of Alaska under this section, together with the income therefrom and the proceeds from any dispositions thereof, shall be administered by the Territory of Alaska as a public trust and such proceeds and income shall first be applied to meet the necessary expenses of the mental health program of Alaska. Such lands, income, and proceeds shall be managed and utilized in such manner as the Legislature of Alaska may provide. Such lands, together with any property acquired in exchange therefor or acquired out of the income or proceeds therefrom, may be sold, leased, mortgaged, exchanged, or otherwise disposed of in such manner as the Legislature of Alaska may provide, in order to obtain funds or other property to be invested, expended, or used by the Territory of Alaska. The authority of the Legislature of Alaska under this subsection shall be exercised in a manner compatible with the conditions and requirements imposed by other provisions of this Act.

EFFECTIVE DATE

SEC. 203. This title shall become effective on the date of enactment of this Act.

TITLE III—TRANSITIONAL AND GENERAL PROVISIONS

AMENDMENTS AND REPEALS

SEC. 301. (a) Such of the following Acts or parts thereof as the Governor by proclamation shall declare to be superseded by a law or laws hereafter enacted by the Territorial legislature are repealed as of the effective date (specified in such proclamation) of such superseding law or laws, or as of the two hundred and tenth day after the date of enactment of this Act, whichever is later:

(1) Section 8 of the Act of January 27, 1905 (33 Stat. 616, 619; 48 U. S. C. 47);

(2) The first sentence of section 7 of the Act of February 6, 1909 (35 Stat. 600, 601), as amended by section 2 of the Act of October 14, 1942 (56 Stat. 782; 48 U. S. C. 46);

(3) The Act of June 25, 1910 (36 Stat 852: see 48 U. S. C. 46b);

(4) The Act of April 24, 1926 (44 Stat. 322), as amended by sections 4 and 5 of the Act of October 14, 1942 (56 Stat. 782, 783; 48 U. S. C. 50, 50a); and

48 USC 46c, 47a, 47b, 47c, 48, 48a.

(5) Sections 1, 3, 6, 7, 8, and 9 of the Act of October 14, 1942 (56 Stat. 782, 783-785; 46 U. S. C. 46c, 47a, 47b, 47c, 48, 48a).

(b) (1) The Acts and parts of Acts listed in subsection (a), except the Act of June 25, 1910, are, pending their repeal as provided in subsection (a), amended (A) by striking out the words "Secretary", "United States", "Congress", and "Department of the Interior" wherever these words appear, and inserting in lieu thereof the words "Governor of Alaska or his designee", "Territory of Alaska", "the Legislature of Alaska", and "Territory of Alaska", respectively; (B) by inserting immediately before the word "Treasury", wherever it appears, the word "Territorial"; (C) by striking out the word "Federal"; and (D) by amending section 1 (a) of the Act of October 14, 1942, to read as follows: " 'Governor' means the Governor of Alaska or his designee;": *Provided*, That the words "United States" where

they appear as a part of the term "United States Veterans' Bureau facility" in section 6 of the Act of October 14, 1942, shall not be struck.

Effective date.

(2) The amendment, by this subsection, of any Act or part of Act specified in subsection (a) shall take effect on the two hundred and tenth day after the date of enactment of this Act and shall cease to be effective upon the repeal of the Act or part of Act which it amends, as provided in subsection (a).

(c) Effective upon the date of enactment of this Act, section 3 of the Act approved August 24, 1912 (37 Stat. 512; see 48 U. S. C. 24), entitled "An Act to create a legislative assembly in the Territory of Alaska, to confer legislative power thereon, and for other purposes", is amended by inserting the following at the end of the first sentence of such section, immediately before the period: "or to prevent the legislature from altering, amending, modifying, or repealing section 8 (relating to commitment of insane persons) of the aforesaid Act approved January twenty-seventh, nineteen hundred and five".

Prior rights, etc.

(d) (1) Any vested rights or liabilities existing, and any commitment proceeding commenced, under any Act or part thereof prior to the effective date of the amendment or repeal of such Act or part thereof by this section shall not be affected by such amendment or repeal.

(2) With respect to the money or property of any patient who has died or eloped prior to the enactment of this Act, or who will have died or eloped prior to the two hundred and tenth day following such enactment, the functions of the Secretary of the Interior under the Act of April 24, 1926, as amended (48 U. S. C. 50, 50a), and the requirement of certification of the claim to Congress if established more than five years after such death or elopement, shall remain in effect notwithstanding the amendment or repeal of such Act by this section.

EXISTING CONTRACT AND APPROPRIATIONS

SEC. 302. (a) Within two hundred and ten days after the date of enactment of this Act, the Secretary of the Interior, with the concurrence of the Governor of Alaska, may either (i) assign all of his rights and duties under contract numbered 14-04-001-81, entered into on June 18, 1953, between the Secretary of the Interior on behalf of the United States, and the Sanitarium Company of Portland, Oregon, to the Territory of Alaska, such assignment to become effective on the two hundred and tenth day after the date of enactment of this Act, or (ii) terminate the said contract in accordance with the terms thereof. Upon the effective date of any such assignment, such contract shall have the same binding effect upon the Territory as it had upon the United States prior to such assignment.

(b) On the two hundred and tenth day after the date of enactment of this Act, so much of all unexpended balances of appropriations as are available to the Department of the Interior for the care of the Alaska insane shall be transferred to the Governor of Alaska to be available for expenditure by him for the administration of the Acts specified in, and in part amended by, section 301 and for the administration of the laws of the Territory of Alaska enacted pursuant to section 101 of this Act, and the Secretary of the Interior shall, upon such transfer or as soon as practicable thereafter, transfer to the Governor of Alaska all papers and documents used primarily in the administration of all laws pertaining to the Alaska insane. For the remainder of the fiscal year ending June 30, 1957, there are hereby authorized to be appropriated to the Secretary of the Interior for transfer to the Governor of Alaska such additional sums as may be necessary for the care of the Alaska insane during that fiscal year.

Appropriation.

(c) Until July 1, 1957, expenses for the transportation to a mental institution outside of Alaska of all patients to be hospitalized pursuant to a commitment under section 8 of the Act of January 27, 1905 (33 Stat. 616, 619, 48 U. S. C. 47), or to be hospitalized in such a mental institution pursuant to a commitment under a law of the Territorial legislature superseding such Act of January 27, 1905, shall be paid by the Department of Justice.

Approved July 28, 1956.

Public Law 831 CHAPTER 773

AN ACT

July 28, 1956 [H. R. 10111]

To amend sections 657 and 1006 of title 18 of the United States Code in order to include certain savings and loan associations within its provisions.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 657 of title 18 of the United States Code is amended as follows: After the words "United States" where they first appear in section 657, strike the comma immediately after the word "States" and insert in lieu thereof "or any institution the accounts of which are insured by the Federal Savings and Loan Insurance Corporation,".

Savings and loan associations. Embezzlement, etc. 62 Stat. 729.

62 Stat. 750.

SEC. 2. Section 1006 of title 18 is amended as follows: After the words "United States" where they first appear, strike the comma immediately after the word "States" and insert in lieu thereof "or any institution the accounts of which are insured by the Federal Savings and Loan Insurance Corporation,".

Approved July 28, 1956.

Public Law 832 CHAPTER 776

JOINT RESOLUTION

July 30, 1956 [S. J. Res. 183]

Authorizing an appropriation to enable the United States to extend an invitation to the World Health Organization to hold the Eleventh World Health Assembly in the United States in 1958.

Whereas the Eleventh World Health Assembly is scheduled to be held in 1958; and

Whereas the year 1958 is considered particularly appropriate for holding the assembly in the United States since that year will mark the decennial anniversary of the entry into force of the constitution of the World Health Organization, which was originally drawn up and signed in New York City; and

Whereas the assembly and related functions will provide outstanding opportunities for the Ministers and Directors of Health of the World Health Organization's eighty-eight member countries to view American health and medical methods in practice, and to make and renew friendships among American health and medical leaders; and

Whereas the assembly will focus public attention in the United States on the important work of the World Health Organization as an integral part of the economic and social program of the United Nations and as a constructive work contributing to better international appreciation and world peace; and

Whereas American health and medical groups and certain urban organizations have suggested arrangements to make the World Health Assembly in the United States a particularly useful professional occasion through related seminars, field trips, and social activities; and

DEPARTMENT OF HEALTH & HUMAN SER ICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

DEC 17 1986

The Honorable Pat Pourchot
Alaska House of Representatives
1024 W. 6th Avenue, Suite 201E
Anchorage, Alaska 99501

Dear Mr. Pourchot:

I want to follow up on the meetings we had November 21-22 in Anchorage on the Alaska Mental Health Enabling Act and the legal issues now surrounding as a result of Alaska v. Weiss.

I hope you felt the information on the State of Alaska's mental health system provided by Robert Glover, Ph.D., through the National Conference of State Legislatures, was useful. I believe the suggestions and recommendations he made were pertinent as Alaska strives to develop a more effective and efficient mental health system of care.

I also wanted to inform you that at the meeting, and subsequent to it, Mr. Jim Gottstein asked whether the National Institute of Mental Health (NIMH) could locate a specific document that was referenced in a letter from Assistant Secretary Roswell B. Perkins to Senator Barry Goldwater, dated April 16, 1956, (see enclosure, page 3657). I believe that Mr. Gottstein is seeking the document as an indication that those persons with mental retardation should be part of the final decision that is rendered or developed.

While NIMH is attempting to locate that document in the Federal Records Center, I want to make it clear that this should not be construed as the National Institute of Mental Health taking a position with the plaintiffs, just as we would not take a position with the defendants. We are simply responding to a request from the public to obtain public information.

However, let me add that I have reviewed the Senate legislative materials in the National Archives, and it appears that not including the mentally retarded in the definition of mental illness was probably deliberate on the part of the Congress.

1. As passed by the House of Representatives, H.R. 6376 contained within Title I a definition of mental illness.

"Section 101(i)--The term mentally ill individual means an individual having a psychiatric or other disease which substantially impairs his mental health or an individual who is mentally defective or mentally retarded."

2. On January 19, 1956, H.R. 6376 was introduced into the Senate with the above section and referred to the Senate Committee on Interior and Insular Affairs.

3. In a printed Senate committee markup of H.R. 6376, dated April 10, 1956, Section 101(i) was amended to read:

   "The term mentally ill individual means an individual having a psychiatric disease which might be the cause of injury to that individual or others."

4. In a subsequent printed Senate committee markup of H.R. 6376, dated April 19, 1956, and labeled Committee Print No. 3, Section 101(i) was marked up further. The committee print contains printed comments from the Department of Health, Education, and Welfare. Specifically it reads:

   "The term mentally ill individual means an individual having a psychiatric disease which might be the cause of injury to that individual or others."

   Following this there is a printed note from the American Association of Physicians and Surgeons (AAPS) which reads:

   "AAPS Proposal-HEW suggests...The change in the definition would have the effect of excluding the mentally defective or retarded from provisions for institutional care or the benefits of the programs aided by grants under Title II."

5. Senate Committee Print No. 4 of H.R. 6376 is dated April 20, 1956. The committee print is characterized as the HEW proposed amendments to the legislative proposal submitted by Senator Goldwater. (This may be the staff document or the result of the staff document referred to in the letter of April 16.)

   Committee Print No. 4 does not contain a Section 101(i) but does contain a Section 105 entitled "Right to Humane Care and Treatment" and reads as follows:

   "Every mentally ill or mentally defective or retarded person of Alaska who is hospitalized under the laws of the Territor of Alaska, shall be entitled to humane care and treatment, and to medical care and treatment in accordance with the highest standards accepted in medical practice."

With regard to the above-underscored parts, which I have done for illustration, it is noted in the committee print that HEW recommended adding the reference concerning the mentally retarded and recommended deleting the concluding phrase as being vague.

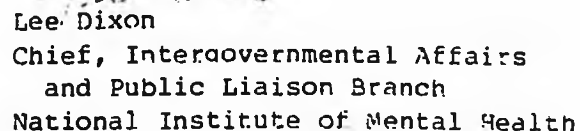
6. Committee Print No. 5 of H.R. 6376 is dated April 26, 1956. It no longer contains a Section 105, nor does it contain any definitions. These have all been deleted. It is similar to the final Act.

7. Committee Print No. 6 of H.R. 6376 dated May 4, 1956, continues to have Section 101(i), Section 105 and all other definitions are deleted.

I believe the legislative history speaks for itself on this issue.

In closing, while I do not know what progress has been made to resolve the mental health land grant issue, I do recall there being the potential for this issue to continue for a prolonged period. Certainly beyond January 10, at which time the legislative authority for the Special Joint Committee on Mental Health Trust expires and perhaps even beyond a 6-month extension of the committee authorization. I understand that Governor Steve Cowper was once associated with the plaintiffs in Alaska v. Weiss. He now could be considered the ultimate representative of the defendants. As such he has credibility and standing with both sides on the issue and therefore may be able to exercise leadership in resolving the issue. My personal suggestion would be that the legislature consider recommending to the Governor the appointment of an independent person, not currently associated with the plaintiffs, defendents, or State government to mediate a solution that could then be presented to the court as a proposal which all sides have agreed upon. It appears that a decisive, perhaps even bold, step needs to be taken to break the logjam or else it will be up to the court to decide and State government will have to live with that solution. Again, these suggestions are mine personally and are offered to assist the State legislature, State government, and those in need of mental health services in Alaska.

Sincerely yours,



Lee Dixon
Chief, Intergovernmental Affairs
and Public Liaison Branch
National Institute of Mental Health

Enclosure

cc: Ms. Rebecca Craig, NCSL

joyment of the natural, scenic, recreational, and other aspects of the national forests.

DEPARTMENTAL VIEWS

DEPARTMENT OF AGRICULTURE,
Washington, D. C., August 5, 1955.

Hon. ALLEN J. ELLENDER,
Chairman, Committee on Agriculture and Forestry,
United States Senate.

DEAR SENATOR ELLENDER: Reference is made to your request of June 15 for a report on S. 2216, a bill to amend the act of March 4, 1915 (38 Stat. 1086, 1101; 16 U.S.C. 497). The purpose of this bill is to facilitate and simplify some of this Department's problems relating to the issuance of permits for use of national-forest lands.

We recommend enactment of S. 2216.

S. 2216 is identical to H.R. 2762 as passed by the House in the 83d Congress. It would authorize the Secretary of Agriculture, under such regulations as he may make and upon such terms and conditions as he may deem proper, to permit the use and occupancy of not to exceed 80 acres of national-forest land for periods not exceeding 30 years, for the following purposes: (1) Constructing or maintaining hotels, resorts, and any other structures or facilities necessary or desirable for recreation, public convenience, or safety; (2) constructing or maintaining buildings, structures, and facilities for industrial or commercial purposes whenever such use is related to or consistent with other uses on the national forests; (3) construction or maintenance, by any State, political subdivision thereof, or any public or nonprofit agency, of buildings, structures, or facilities necessary or desirable for education or for any public use or in connection with any public activity. This bill would also authorize the Secretary to permit the use and occupancy of not to exceed 5 acres of national-forest land, for periods not exceeding 30 years, for the construction or maintenance of summer homes and stores.

Under existing laws this Department has adequate authority to issue revocable permits for uses for which long-term tenure is unnecessary or undesirable. Also, the authority to issue leases and term permits is adequate for communication and television purposes, for the use of Government-owned structures, for permits and leases to States, political subdivisions thereof and public agencies for public purposes, and for all types of uses in Alaska.

The act of March 4, 1915, however, is inadequate to meet other needs for term permits on the national forests because it limits use and occupancy to summer homes, hotels, stores, or other structures needed for recreation or public convenience, and the permit area to a maximum of 5 acres. It is frequently found that term permits would be desirable for uses not specified in the act of March 4, 1915, and permittees often need more than 5 acres for their authorized operations.

S. 2216 would meet needs to grant term permits up to 80 acres for such public and semipublic uses as landing fields, resorts, campgrounds, picnic areas, organization camps and ski lifts, and to industrial and commercial enterprises such as sawmills, mining camps, wharves, and warehouses, which would contribute to the general welfare and which could be located so as not to interfere with the proper utilization of national-forest resources. In numerous instances individuals cannot finance prospective commercial ventures on national forest lands because banks and commercial credit companies are unwilling to make loans to applicants who cannot obtain term permits or leases.

The act of September 3, 1954 (68 Stat. 1146) provides somewhat similar, but in some respects more restrictive, authority to issue term permits to States, counties, and other public agencies for public buildings and other public works. That act and S. 2216 are the same as to length of perm[illegible] differ as to acreage allowances, the kind of lessees which would be eligible, requirements for consideration and land to which the authority would apply.

The passage of this bill would not require additional appropriations. Receipts from national forests would be somewhat increased since leases could be issued for developments which are not undertaken now because of the insecurity of a revocable permit.

The Bureau of the Budget advises that, from the standpoint of the program of the President, there is no objection to the submission of this report.

Sincerely yours,

TRUE D. MORSE,
Acting Secretary.

ALASKA MENTAL HEALTH ENABLING ACT

For text of Act see p. 825

Senate Report No. 2053, May 25, 1956 [To accompany H.R. 6376]

House Report No. 1399, July 25, 1955 [To accompany H.R. 6376]

Conference Report No. 2735, July 17, 1956 [To accompany H.R. 6376]

The Senate Report and the Conference Report are set out.

Senate Report No. 2053 May 25, 1956

THE Committee on Interior and Insular Affairs, to whom was referred the bill (H.R. 6376) to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

The committee held public hearings on the measure, which are available in printed form, and carefully considered all of the views expressed at the hearings and in the many hundreds of written communications received.

Committee action was unanimous.

PURPOSE AND GENERAL STATEMENT

As passed by the House, H.R. 6376 contained in title I detailed provisions for commitment, hospitalization, and care of the mentally ill of Alaska. The committee amendment, however, strikes all of these controversial provisions from the bill, leaving it up to the people of Alaska to enact their own mental-health program.

In the form reported by the committee, H.R. 6376 would merely—

(1) Vest in the people of Alaska responsibility in the field of mental health comparable to that of the several States and the other Territories of the United States; and

(2) Authorize certain grants-in-aid to the Territory to enable it to assume full financial responsibility for such a program.

The legislation is needed for two reasons:

First, because a Federal statute, section 3 of the act of August 24, 1912 (37 Stat. 512; found in 48 U.S.C. 24), which is the Organic Act of Alaska, specifically prohibits the Territorial legislature from changing the existing law respecting commitment of the insane of Alaska. At present [illegible]mit-

ment is und[illegible] Federal law, enacted more than half a century ago, subjecting perso[illegible] accused of being insane to procedures similar to those of a criminal trial (33 Stat. 619; 48 U.S.C. 47).

Secondly, the legislation is needed to divest the Federal Government of its fiscal and functional responsibility for hospitalization and care of the mentally ill of Alaska. Responsibility for such care now is vested in the Secretary of the Interior in Washington. There are no facilities in Alaska for care of the mentally ill, and for more than 50 years the Secretary has contracted with a private institution in Portland, Oreg., for hospitalization, care, and treatment. Under this procedure, Alaskans adjudicated insane must be sent long distances from their home environment in the Territory to Oregon for hospitalization. This contract between the Secretary of the Interior and the Oregon institution is authorized by the act of February 6, 1909, as amended (48 U.S.C. 46).

All costs of such commitment and care, as well as transportation to and from Portland, are at the expense of the Federal Government. Currently appropriations for such purposes amount to nearly $1 million a year, the committee is informed.

Under H.R. 6376, the Territory would assume full responsibility for enactment of commitment, hospitalization, and care procedures, and gradually assume full responsibility for all costs, except for the limited grants-in-aid provided in the measure.

THE COMMITTEE AMENDMENT

The committee's substitute, with certain clarifying changes, is the amendment proposed originally by Senator Barry Goldwater, of Arizona. The text of the amendment is set forth in full in the appendix. As stated, H.R. 6376 as it came from the House contained detailed commitment, hospitalization, and care provisions to replace the present procedures which were described in the Senate hearings by technical experts as "barbaric." (See testimony of Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, p. 98 of hearings on H.R. 6376 and related bills, Senate Interior Committee, 84th Cong.)

The proposed new procedures were patterned after the Draft Act Governing Hospitalization of the Mentally Ill, published by the United States Public Health Service. The text of this draft act is set forth in the appendix to the hearings, beginning at page 289. The language of the House bill was carefully worked out to meet conditions in Alaska after extensive hearings by the House Territories Subcommittee in Alaska and in Portland, Oreg., where the mentally ill of Alaska presently are hospitalized, and in Washington, D. C.

The provisions of H.R. 6376 were approved by technical experts in the Department of Health, Education, and Welfare, and by the Alaskan public health authorities. They also were approved by the leading private organizations qualified to express technical opinions, such as the American Medical Association, the American Psychiatric Association, and the National Association for Mental Health. The House-passed bill also had the approval of the Department of the Interior, which has general administrative responsibility for Alaska, and that of the Bureau of the Budget, which speaks generally for the administration.

Highly significant to the committee was the all but unanimous endorsement of the people of Alaska, including the Alaska Territ[illegible] Medical Association, the Alaska Hospital Association, and a large nu[illegible]of other organizations and private citizens. Only one resident of Ala[illegible] is on record with the Committee as opposing the provisions.

Under the House bill, the Territorial Legislature of Alaska could have annulled or amended any of the sections relative to commitment, hospitalization, and care at any time.

However, the proposed provisions were misunderstood by many persons in parts of the country other than Alaska. Partly as a result of this misunderstanding, but more because the members of the committee are convinced that the people of Alaska are fully capable of drafting their own laws for a mental health program for Alaska, the committee concluded that authority should be vested in them in this field comparable to that of the States and other Territories.

Hence, Senator Goldwater's amendment was adopted, the substance of which is the striking of the commitment procedures in title I of the House bill. In so doing, the committee wishes to go on record as stating emphatically that its action is in no way a repudiation or disapproval of the provisions approved by the House of Representatives and endorsed by such a large number of qualified experts.

THE GRANTS-IN-AID PROVISION

Under the Senate amendment, the grants-in-aid are identical, in substance, to those approved by the House. That is, three different grants for different purposes are provided:

(1) $6½ million is authorized to be appropriated for construction of mental health facilities in Alaska. At present, there are none of any kind. Persons "convicted" by the mandatory jury trial are held in jail until arrangements can be made for transporting them away from Alaska to the private institution in Oregon.

(2) $6 million is authorized to be appropriated over a 10-year period to assist the Territory in developing a rounded mental health program for its people until it can itself assume full financial responsibility. This amount would be available, subject to approval of appropriations bills for the purpose, as follows:

Fiscal year—		Fiscal year—Continued	
1958	$1,000,000	1963	$600,000
1959	1,000,000	1964	400,000
1960	800,000	1965	400,000
1961	800,000	1966	200,000
1962	600,000	1967	200,000

(3) One million acres of the "vacant, unappropriated, and unreserved" public lands of Alaska, to be selected by the Territory within a 10-year period. The income and proceeds from disposition of these lands must be administered as a public trust, with the expenses of the mental health program having first call on such funds. Amounts not needed for the mental health program can be used for other public purposes as the legislature may determine.

THE LAND GRANT

Perhaps no provision of H.R. 6376 has been more widely misunderstood than the facts and circumstances of this land grant.

The Territory of Alaska comprises some 375 million acres. More than 99 percent of this vast area is now owned by the Federal Government. The resources of by far the greater part are wholly undeveloped, and now are of no benefit to either the people of the Territory or to the Federal Government.

Even when the Territory has exercised its right of selection to the full million acres, the Federal Government still will own approximately 99 percent of Alaska. It is hoped that the local government may be able to devise policies and take action that will lead to getting at least a part of the area granted by H.R. 6376 on the tax rolls, and to the development of its natural resources for the direct benefit of the people of Alaska and indirectly for that of all of the people of the United States.

Public land grants for public purposes in the Territory of the United States are, of course, older than the Constitution itself, dating from at least the Northwest Ordinance of the Continental Congress in 1787. (See 1 Stat. 50, 51.) In all of the public land States of the West the Federal Government has made grants of the public lands in order to provide funds for schools or other public purposes. In five States, namely, Idaho, Oklahoma, South Dakota, Utah, and Wyoming, grants of public lands have been made specifically to provide means for the care of the insane. (See p. 182 of the hearings.)

"Siberia, U. S. A."

A number of persons communicating with the committee expressed the fear that this million-acre land grant would be used for a Siberia-like concentration camp in Alaska, to which political opponents of those in power in the several States and the Federal Government would be sent. The bill affords no reasonable basis for this fear, which was based on a complete misunderstanding of a section of the House measure that has been stricken by the committee amendment.

While there is nothing in the bill to prevent the construction of a mental hospital on a fractional part of the lands granted to the Territory, the committee points out that such hospitals usually are built near centers of population where other facilities are available, and where patients are accessible to their families and friends. Therefore, it is unlikely that any part of the grant will itself be used for physical facilities for the mentally ill of Alaska.

The purpose of the grant is to afford revenues to the Territory for support of its mental-health program. If such revenues are in excess of needs for the program, they may be used, as a public trust, for other public purposes.

SECTIONAL ANALYSIS OF THE BILL AS AMENDED

Title I

Section 101 vests authority in the Territory of Alaska comparable in scope to that of [illegible] States and other Territories in the field of mental

health, and authorizes the Territory to enact legislation to supersede the existing Federal law governing commitment and care of the insane of Alaska. As above explained, the Territory is now prohibited from changing the present archaic commitment procedures. Section 101 would sweep aside this prohibition and remove any other possible uncertainties as to Alaska's right to deal with its own mental-health problem.

In view of some of the fears expressed at the hearings with respect to the provisions of the bill as passed by the House, it should be emphasized that Alaska is an incorporated Territory, and that the Constitution of the United States is in full force and effect there. The territorial legislature would have no power to enact any law that in any way violated the constitutional rights of any person, in Alaska or outside of it.

As is the case with all of the other Territories of the United States, under the Constitution inherent power remains in Congress to set aside any act of the territorial legislature, which was created by Congress.

Section 102 authorizes the legislature to confer upon the United States commissioners, as ex officio probate judges, and upon the United States district court such jurisdiction, functions, and duties as may be necessary for them to exercise in carrying out the mental-health program. Because the court was created by act of Congress, and because the commissioners are, technically, Federal officers, section 102 is designed to remove any doubt that Alaska's authority under section 101 will permit their utilization. Since there are only 4 Federal judges in the 550,000-odd square miles of the Territory, it will be necessary for the 15 commissioners to have certain judicial powers in the administration of the program. Under present law, the commissioners now serve as judges in the compulsory jury-trial commitment proceedings.

Section 103 provides that title I shall become effective on the date of enactment of the act.

Title II

Section 201 would amend the Public Health Service Act (42 U.S.C., chapter 6A) by adding to title III of such act a new part, part H, to authorize the money grants discussed above. Section 371 of the new part H of title III of the Public Health Act would authorize appropriations for grants aggregating $6 million over a 10-year period, to assist in the support of a comprehensive mental health program for the Territory. In order for the Territory to obtain any part of these funds, the Surgeon General of the United States would first have to approve plans submitted by the Territory for a mental health program, including outpatient and inpatient care.

As previously pointed out, these grants would be on a descending scale over a 10-year period. After 10 years, the Territory would have full financial as well as legal responsibility for its mental health program.

Since Alaska has been prevented from developing its own mental health program over the years, the committee is of the opinion that it would be inequitable to require the Territory to assume immediate financial responsibility for the present Federal program—a program in the making of which the people of Alaska had no voice. Furthermore, with Federal expenditures now approximating $1 million a year for the care of the Alaska insane, the proposed formula would result in a net savings to the F[illegible]

with the steady increase in population.

The Surgeon General is charged with responsibility for verifying compliance of the Territory under the approved plan. Balances unobligated at the end of the 10-year period shall be repaid to the United States.

Section 371(a) of the amendment to the Public Health Service Act would authorize the Surgeon General to arrange with the Territory, on a reimbursement basis, for treatment and care of patients under the Alaska program in Public Health Service facilities, if such facilities are available.

Section 372 of the new part H addition to title III of the Public Health Service Act would authorize the appropriation of an aggregate of $6½ million in grants to aid the Territory in construction of hospital and other facilities in Alaska for carrying out its mental-health program. All such construction projects must be approved by the Surgeon General, who is charged with inspection responsibility.

Section 202 of H.R. 6376 is the land-grant section, giving the Territory the right to select, within 10 years from the date of enactment of the act, a million acres of public lands that are "vacant, unappropriated, and unreserved." National forest lands in Alaska, not being in the vacant, unappropriated, unreserved category, would not be subject to such selection. Neither, for example, would the oil and gas lands now withdrawn by Naval Petroleum Reserve No. 4.

When Federal reservations of public lands are revoked, the Territory would have a 90-day period in which to exercise its right of selection before the order of revocation otherwise becomes effective.

Mineral deposits in the lands selected go with the surface of the lands to the Territory.

Subsection (e) of section 202 provides that the income or proceeds from the lands selected shall be administered as a public trust, to be first applied to meet the necessary expenses of the mental-health program of Alaska.

Section 203 provides that title II also shall become effective on the effective date of the act.

Title III

Section 301(a) lists the Federal laws or parts of laws relating to mental health in Alaska which may be superseded by Territorial laws to be enacted by the legislature and proclaimed by the Governor. These cited laws are to be repealed either at a time specified in the Governor's proclamation as the effective date of the superseding Territorial law, or 210 days after enactment of H.R. 6376, whichever is later.

Subsection (b) makes provision for a possible interim period, in the event the Territorial legislature does not act promptly to pass Territorial legislation, by vesting in the Governor and Territorial Government, beginning with the 210th day after enactment of H.R. 6376, the authority and responsibility now exercised by the Secretary of the Interior and other officers of the Federal Government, with respect to the care of the insane of Alaska.

Section 302(a) deals with the problem presented by the existing contract between the Secretary of the Interior and the Sanitarium Co. of Portland, Oreg., proprietor of Morningside Hospital in which the mentally ill of Alaska now are being treated at Federal expense. The section provides

assign the contract to the Governor of Alaska with his concurrence, or terminate the contract in accordance with its terms. Assignment would take effect on the 210th day after the effective date of the act. The existing contract provides for termination upon 6 months' notice.

Subsection (b) provides that the unexpended balances of appropriations available to the Secretary of the Interior for the care of the Alaska insane shall be transferred to the Governor of Alaska on the 210th day after the date of enactment of H.R. 6376 and shall thereafter be available for the administration of the Territorial mental-health laws, or for the administration of the Territory of that part of the present Federal law that will remain in effect, on an interim basis, if the legislature has not acted to supersede it.

Subsection (b) also includes authorization for appropriation of funds to the Secretary of the Interior for the remainder of the fiscal year 1957 for transfer to the Territory if the balance of existing appropriations proves to be less than the amount necessary to care for Alaska's insane for fiscal 1957.

Transportation costs for the Alaska insane to and from Portland, now borne wholly by the Federal Government, have not been segregated from other portions of the applicable appropriation to the United States Department of Justice. As a result, transfer of funds for transportation for the remainder of fiscal 1957 is not feasible. Subsection (c) therefore provides that costs of transporting patients to a hospital outside of Alaska shall continue to be paid by the Department of Justice, which already has the appropriation, until July 1, 1957. There are no mental hospitals or related facilities in Alaska at present.

HISTORY OF LEGISLATION

Bills to amend the archaic laws for the commitment of the mentally ill of Alaska have been before successive Congresses for some years. In the 83d Congress, H.R. 8009, a measure similar in purpose to H.R. 6376, passed the House and was favorably reported by the Senate Interior Committee after hearings (S.Rept.No. 2486, 83d Cong.). No action was taken on H. R. 8009 by the Senate prior to the adjournment of the 83d Congress.

In the 84th Congress, a number of bills designed to accomplish the purposes of the previous measures were introduced in both the Senate and the House, including one by Delegate E. L. Bartlett, of Alaska. H.R. 6376 was sponsored by Congresswoman Edith Green, of Portland, Oreg., in whose district Morningside Hospital is located.

The provisions of Congresswoman Green's bill are based on draft legislation submitted by the administration in an executive communication.

CONCLUSION

At the hearings this year, virtually all witnesses who acquainted themselves with the facts concerning conditions in Alaska and the wishes of the people of Alaska agreed that reform was long overdue. In all of the States and all of the other Territories of America, responsibility for commitment and care of the mentally ill is a local matter, carried out under local law.

The committee is unanimously convinced that the people of Alaska, who have been American citizens for nearly half a century, should be permitted to stand on an equal footing with all other American citizens. Since Alaska would be starting from scratch, so to speak, with a caseload of mental illness equal, proportionately, to the national average, the committee is convinced that the grants-in-aid provided by H.R. 6376 are necessary and are equitable.

REPORTS OF EXECUTIVE AGENCIES

The attention of the Members of the Senate is directed to the testimony of the Assistant Secretary of the Department of Health, Education, and Welfare, and the Assistant Secretary of the Interior set forth in the hearings. In addition, the following written reports were received on H.R. 6376 and companion measures in the Senate. Also set forth is a report on the Goldwater amendment which was the substitute adopted, in substance, by the committee.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington 25, D. C., January 3, 1956.

Hon. JAMES E. MURRAY,
Chairman, Committee on Interior and Insular Affairs,
United States Senate, Washington 25, D. C.

MY DEAR MR. CHAIRMAN: This will acknowledge your request of August 11, 1955, for the views of the Bureau of the Budget on S. 2518, a bill to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes.

This bill would provide for a comprehensive mental health program in Alaska. Responsibility for the administration of the Territory's mental health program would be transferred from the Federal Government to the government of the Territory of Alaska. The new commitment procedures, as set forth in S. 2518, for mentally ill patients in Alaska would represent a major step forward in the care of such patients in that Territory. Special construction grants are provided for various facilities to care for the mentally ill. And lastly, the bill provides financial assistance and land grants by the Federal Government, not only to enable the Territory to establish a comprehensive mental health program, but also to assist it in assuming full financial responsibility for the care and treatment of all the Territory's mentally ill.

The Bureau of the Budget strongly endorses S. 2518, but urges your committee to favorably consider the amendments suggested by the Departments of Interior and Health, Education, and Welfare in their reports to you on this bill. We would like also to suggest for your committee's consideration two additional amendments.

Because the objectives of this bill are to transfer responsibility for care of the mentally ill from the Federal Government to the Territorial government and to enable it to care for its mentally ill patients in Alaska, it appears undesirable to authorize the care of the Territory's mentally ill in continental United States hospitals of the Public Health Service, as provided in section 201 of the bill. Pending the construction of mental health facilities in Alaska, it may be desirable to care for a small number of the Territory's mental patients in the Public Health Service hospitals in Alaska. However, authorizing the government of Alaska to contract with the Public Health Service hospitals in the continental United States would be contrary to the intent of the bill to place the responsibility for care of the mentally ill in Alaska on the Territory and would place the Territory on a different basis from other governmental units since the various States and other Territories cannot contract for the use of Public Health Service hospitals. It is therefore suggested that the bill be amended to restrict

mentally ill to those located in Alaska.

In order to insure that the Territory takes action at an early date to construct facilities in Alaska for the care of its mentally ill, the bill should contain time limits within which the Territory must obligate and expend the Federal construction grants authorized for this purpose in the bill. We, therefore, suggest amending section 201 of the bill to provide that the Federal construction payments be appropriated within a 10-year period, and remain available an additional 5 years for expenditure.

I am authorized to advise you that subject to consideration of the suggested amendments, S. 2518 would be in accord with the program of the President.

Sincerely yours,

(Signed) PERCY RAPPAPORT,
Assistant Director.

UNITED STATES DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington 25, D. C., January 9, 1956.

Hon. JAMES E. MURRAY,
Chairman, Committee on Interior and Insular Affairs,
United States Senate, Washington 25, D. C.

MY DEAR SENATOR MURRAY: This will refer further to your request for the views of the Department on S. 2518, a bill to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes.

I strongly recommend that S. 2518 be enacted.

S. 2518 would achieve three results which the Department strongly supports. It would, first, modernize procedures for the commitment and hospitalization of the mentally ill of Alaska. It would, secondly, transfer administrative and basic fiscal responsibility for the program to the Territorial government of Alaska. Finally, it would provide Federal financial aid to the Territory to assist Alaska in supporting an adequate program for the mentally ill.

As you know, the Department of the Interior has for over 50 years been engaged in the administration of certain laws pertaining to the mentally ill of Alaska. Although the commitment, care, and treatment of the mentally ill of the Territories is generally regarded as an inherent responsibility of the respective territorial governments, and although this responsibility has in fact been assumed by most such governments, it has not been assumed by the Territory of Alaska. Responsibility was initially assumed by the Federal Government because of the Territory's special circumstances at the turn of the century, and this function has continued as a Federal responsibility largely because of Alaska's limited financial resources. The Congress has specifically denied to the Territorial legislature authority to amend or repeal the existing Federal law pertaining to the commitment of the mentally ill (48 U.S.C., sec. 24). Alaskans have consequently been committed to a mental institution pursuant to a Federal statute (48 U.S.C., sec. 47), and they have been cared for and treated in a private hospital under contract with this Department (48 U.S.C., sec. 46). The Federal Government has borne the total cost of their commitment, transportation, care, and treatment.

This Department has long been concerned with the shortcomings of this program, particularly with regard to the commitment procedure which was established in 1905 and which has not since been modified. We have vigorously supported legislation to modernize this procedure, but such legislation has thus far failed of enactment. We are glad to have the opportunity again to endorse modern hospitalization procedures, such as those contained in title I of S. 2518. Title I of the bill appears in large part to parallel closely the provisions of the draft act governing the hospitalization of the mentally ill, which was prepared by the Public Health Service.

[illegible] ...ing to the Territory responsibility for the administration of the Territory's mental health program, including the hospitalizati[illegible] the mentally ill. Such a transfer is consistent with the current [illegible], under which the States and Territories, rather than the Federal [illegible]ment are responsible for the mentally ill.

S. 2518 also recognizes, however, that a transfer of such responsibility would place upon the Territorial government of Alaska a very sizable financial burden. In order, therefore, to assist the Territory in assuming responsibility for the hospitalization and care of the mentally ill, S. 2518 provides three kinds of Federal assistance. Under section 201 of the bill, the Surgeon General of the Public Health Service would be authorized to make special grants over a period of 10 years to the Territory for the development of a mental health program. For the first 2 fiscal years, the grants would total $1 million annually, and they would decrease at the rate of $200,000 every second year until terminated at the end of 10 years. Section 201 would also authorize the appropriation of a total of $6,500,000, to remain available until expended, to enable the Surgeon General to make payments to the Territory to be used in the construction of facilities for the care and treatment of the mentally ill.

Section 202 of title II would authorize the Territory to select 1 million acres of vacant, unappropriated, and unreserved public lands of the United States in Alaska, such selections to include mineral deposits. The Territory would be required to make selections within a period of 10 years from the effective date of the bill. The revenues obtained from this land grant shall materially assist the Territory in assuming full financial responsibility for the care and treatment of the mentally ill.

Title III of S. 2518 contains certain provisions relating to the repeal of existing laws, the disposition to be made of the current contract for the care of the mentally ill of Alaska, the transfer of appropriations, and the effective date of the legislation.

I should like, however, to suggest certain amendments for your committee's consideration. As you perhaps know, S. 2518 closely parallels H.R. 6376, which was in turn, when introduced, the bill proposed by this Department, in cooperation with the Department of Health, Education, and Welfare. H.R. 6376 was, however, amended by the House Committee on Interior and Insular Affairs, and S. 2518 carries the amendments recommended by that committee. Three of those amendments we regard as particularly undesirable, and I should like to suggest that your committee give consideration to the modification of S. 2518 in regard to them.

First, section 108 of the bill has been amended to provide for the use of juries in the judicial procedure for hospitalization. The use of a jury would not be mandatory, and to that extent the procedure would constitute a considerable improvement over that now required in Alaska by the act of January 27, 1905 (48 U.S.C., sec. 47). But we believe that the jury system is an undesirable method for determining mental illness, and we consequently believe that S. 2518 would be improved if the jury provisions were deleted. The adoption of our first proposed amendment, which is attached, would achieve that result.

Secondly, the section of this Department's proposed bill providing criminal penalties for unwarranted hospitalization or for the denial of rights has been deleted. We regard this provision as one of considerable importance, for it implements one of the primary purposes of the legislation, namely, the protection of individuals from wrongful confinement and from the deprivation of rights granted them by the bill. We therefore suggest that the criminal penalty provision be restored to the bill, a result which would be accomplished by the adoption of our second proposed amendment. Should your committee not adopt this amendment, you will wish to amend the table of contents on page 2 by deleting the reference to section 128 and the title thereof and by changing the section numbers 129 and 130 on that page to 128 and 129, respectively. The numbering of the sections within S. 2518 would, if our second amendment is not

adopted, then correspond to the suggested renumbering in the table of contents.

Finally, section 202 (e) was amended by the House com[illegible] to provide for the earmarking of funds derived from the land gra[illegible] the sole purpose of the hospitalization and care of the mentally ill. While it is, of course, anticipated that the land revenues will be used for this purpose, we are inclined to believe that it would be wiser not to restrict them in this manner. It is impossible at this time to predict accurately the cost to the Territory of the program envisaged by S. 2518. It is equally difficult to predict the amount of revenue that will accrue to the Territory under the land grant. It is possible that revenue resulting from the land grant will substantially exceed the costs of the program, in which case the Territory ought to be free to use such revenues for other purposes. It is also possible, however, that the land grant may be insufficient to sustain the Territory's financial responsibility under the program, and if that is so, the Territory should not be deterred from using funds from other sources to sustain it. We believe that it might be deterred if the earmarking requirement remains in the bill. I therefore suggest the adoption of the third proposed amendment.

The bill contains a typographical error on page 33, line 8. The title of the Public Health Service Act to be amended is title III, rather than title II.

The Bureau of the Budget has advised that there is no objection to the submission of this report.

Sincerely yours,

WESLEY A. D'EWART,
Assistant Secretary of the Interior.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
January 12, 1956.

Hon. JAMES E. MURRAY,
Chairman, Committee on Interior and Insular Affairs,
United States Senate, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of August 11, 1955, for a report on S. 2518, a bill to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes.

This bill—to be known as the Alaska Mental Health Act—is identical with H.R. 6376, in the form in which that bill was reported to the House (H.Rept. 1399). Subject to certain committee amendments shown in the House report, it incorporates proposals made jointly by the Department of the Interior and this Department to accomplish and facilitate the transfer from the Federal Government to the Territory of Alaska of basic responsibility for the hospitalization and care of the mentally ill of Alaska.

We believe that the objectives and, in the main, the specific features of the bill are sound and desirable, and recommend its enactment. For the committee's consideration, however, we propose the amendments discussed below.

As you know, this legislation has had a long history, beginning with the introduction of a number of bills and legislative action short of enactment during the 81st, 82d, and 84th Congresses, and culminating in the present bill. The history and principal features of the present bill, except as modified by the House committee amendments in certain particulars, are summarized in the Interior Department's reports of April 1, and May 17, 1955 (in connection with H.R. 610 and H.R. 3991), with which this Department fully concurred, and which are reprinted in House Report 1399 (pp. 8–14).

This bill would (a) transfer to the Territory the responsibility for the administration of the Alaska mental health program including the hospitalization of the mentally ill; (b) modernize procedures for the hospitalization of the mentally ill in Alaska; (c) provide a special grant-in-aid to

Alaska to aid in the establishment and maintenance of a comprehensive mental health program including hospitalization; (d) authorize appropriations totaling $6,500,000 to enable the Public Health Service to make special construction grants to the Territory for the construction of facilities for the care and treatment of the mentally ill; and (e) make a grant of land to the Territory of not to exceed 1 million acres to enable the Territory to gradually assume full financial responsibility for the care and treatment of the mentally ill of Alaska.

Upon the effective date of the bill, the basic responsibility and authority for the hospitalization, care, and treatment of the mentally ill of Alaska would be transferred to the Territory. Whatever may have been the justification for placement of this responsibility in the Federal Government, it's continuation is inconsistent with home rule for the Territory and has long been an anachronism. Although this Department provides some financial aid through grant programs in support of the outpatient and community mental health programs of the various States and Territories, the administration and supervision of these programs remain with the States and Territories. Therefore, we endorse the provision of the bill which transfers to the Territory the same responsibility with regard to the mentally ill of Alaska as is now possessed by the other States and Territories.

Like earlier legislation, the present bill would establish a modernized procedure for the hospitalization of the mentally ill of Alaska, which is patterned in general after the provisions of the draft act for the hospitalization of the mentally ill prepared by the Public Health Service, but with certain modifications to take account of Alaskan conditions. We are thoroughly in accord with the objectives of this feature of the bill, and with the provision which would authorize the Territory to modify or supersede these provisions in the future, in consonance with the transfer of basic program responsibility to the Territory. There are however, some aspects of the hospitalization provisions of the bill which, we believe, should be changed in the interest of the mentally ill.

(a) Section 108, relating to judicial commitment of the mentally ill, departs from modern mental health commitment practices by providing for a jury trial (before a six-member jury) upon request of the proposed patient, his counsel, or any member of his immediate family. While this is an improvement over the provisions of existing Territorial law (48 U.S.C. 47) which would make a jury trial mandatory, we believe that a jury trial in judicial commitment proceedings is not consonant with the best modern practice and is likely to be harmful to the patient rather than protective of his interests. In the first place, though a commitment proceeding is civil in nature, such a proceeding, when cast in the atmosphere of a jury trial, is somehow associated in the minds of many with criminal proceedings. This may be due in major part to the history of commitment of the mentally ill. It would be especially true in Alaska, where the present commitment procedure is discredited. In the second place, the formalism necessarily attendant upon a jury trial is likely to be far more disturbing to the patient than a nonjury proceeding, and thus more harmful to his mental health. Finally, as said in the commentary accompanying the Public Health Service's draft act, "Equally important is the consideration that the jury is a questionable instrument for evaluating the preeminently medical ingredients of a determination in this field." These considerations are not overcome by the fact that a jury trial would be ordered only if requested. Under the bill, neither the patient's nor his counsel's consent would be necessary if a member of his family requests a jury trial. We, therefore, suggest deletion of the provisions relating to a jury trial. (Enclosed is a list of the relevant provisions.)

(b) We also believe that there should be inserted in the bill a provision, originally in the House version, but deleted in committee, which would penal[illegible] a person who willfully causes, or conspires with or assists anoth[illegible]on to cause, either the unwarranted hospitalization of an individu[illegible]er the act or the denial to an individual of any rights accorded to [illegible] under the act. (Appropriate language to accomplish this

is enclosed.) We believe that such a provision is desirable in order to fortify with appropriate sanctions two principal objectives of the hospitalization procedure; namely, the protection of persons from wrongful confinement and the protection of the mentally ill against improper treatment while in the hospital.

In order to assist the Territory, on a transitional basis, in establishing and maintaining the services which are essential to an integrated and comprehensive mental health program (including preventive services and outpatient care, as well as hospitalization), the bill would provide for special annual grants to the Territory on a descending scale over a 10-year period, beginning with $1 million for each of the first 2 fiscal years and decreasing at the rate of $200,000 every second year. These grants would be made by the Surgeon General of the Public Health Service, on the basis of a plan submitted by the Governor or his designee and approved by the Surgeon General.

It is estimated that at the outset these grants would exceed by about $100,000 the annual current appropriation for the hospitalization and transportation of committed patients from Alaska. However, such a grant would enable the Territory to establish a comprehensive mental health program, including and stressing preventive and outpatient services, and would in the long run reduce the number of hospitalized patients—both because the fiscal incentive for hospitalization (caused by earmarking of Federal funds therefor) would be removed and because outpatient methods of treatment as well as additional methods of prevention would be made available and encouraged. These grants, of course, should not diminish the other grants-in-aid under the Public Health Service Act (including a very small amount for mental health) otherwise available to the Territory.

Section 201 of the bill would add to the Public Health Service Act, section 372. This would authorize appropriations not exceeding a total of $6½ million to enable the Public Health Service to make special construction grants to the Territory for the construction of facilities for the treatment of the mentally ill and is of particular significance to the development of a realistic mental health program for Alaska and assumption by the Territory of responsibility for the care of its mentally ill.

At present, there are no mental-health facilities to speak of in the Territory. Patients must be transported by air thousands of miles to a hospital in Oregon causing them to be separated for long periods of time from their family and friends. Even under the best of circumstances, the Territory will have to depend upon contract care for hospitalized patients for some time, and the bill so authorizes. However, the making of construction grants to the Territory would help solve this problem by enabling the Territory to construct a number of facilities especially designed to provide the type of inpatient and outpatient care needed by the mentally ill of Alaska.

The House bill (H.R. 6376) as originally introduced provided for a land grant of 500,000 acres to the Territory in order further to assist the Territory in assuming full financial responsibility for the care and treatment of the mentally ill on a permanent basis. S. 2518, as well as H.R. 6376 as amended in committee, would double the quantity of land to be used for this purpose and would earmark the grant for the hospitalization and care of the mentally ill in Alaska. We are in accord with the concept of a land grant to provide long-range means of defraying a substantial portion of the cost of a permanent program. We defer, however, to the Secretary of the Interior on the question whether, under the conditions prevailing in Alaska, earmarking of the grant would be desirable, and on the question of the amount of land that would provide an adequate grant in the circumstances.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

[Signed] M. B. Folsom, [illegible].

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D. C., February 17, 1956.

Hon. JAMES E. MURRAY,
Chairman, Committee on Interior and Insular Affairs,
United States Senate, Washington, D. C.

MY DEAR MR. CHAIRMAN: This will acknowledge your request of February 6, 1956, for the views of the Bureau of the Budget on S. 2973, a bill to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes.

S. 2973 is substantially the same as S. 2518 on which the Bureau of the Budget reported to your committee on January 3, 1956. The views expressed in our report on S. 2518 are also applicable to S. 2973.

The major difference between the two bills is found in section 202 (e). S. 2518 provides for the complete earmarking of funds that are derived from the Federal land grants for the hospitalization and care of the mentally ill of Alaska. S. 2973 would permit these funds to be used in a less restrictive manner than that required by S. 2518. The Bureau of the Budget recommends the deletion of the provision relating to earmarking of funds for the reasons stated in the report of the Department of the Interior on S. 2518.

I am authorized to advise you that subject to consideration of the above comments and the amendments suggested in our report of January 3, 1956, the enactment of S. 2518 or S. 2973 would be in accord with the program of the President.

Sincerely yours,

(Signed) PERCY RAPPAPORT,
Assistant Director.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
February 20, 1956.

Hon. JAMES E. MURRAY,
Chairman, Committee on Interior and Insular Affairs,
United States Senate, Washington, D. C.

DEAR MR. CHAIRMAN: This is in response to your request of February 6, 1956, for a report on S. 2973, a bill to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes.

This bill—except for the earmarking provision in subsection 202 (e), relating to a land grant (and except for the correction of some typographical errors)—is identical with H.R. 6376 which, having passed the House, is now pending before your committee, and with S. 2518, also pending before your committee, on which we reported to you in our letter of January 12, 1956.

The provisions of these bills embody, with certain modifications, proposals made jointly by this Department and the Department of the Interior, on the subject of the hospitalization and care of the mentally ill of Alaska and of a comprehensive Alaska mental-health program. We urge its enactment, but in that connection suggest consideration of the amendments proposed in our report on S. 2518, and also invite attention to the amendments proposed by the Department of the Interior and by the Bureau of the Budget in their reports on that bill, which would be agreeable to us.

There are, however, two additional matters to which we should like to invite attention.

1. We recommend that, in view of the lapse of time since the drafting and initial introduction of this legislation, the bills be amended to postpone for 1 year each of the authorizations for transitional support grants provided for in subsection 201, and, similarly, to defer for 1 year the termination date for the payment of patients' transportation expenses to a stateside hospital by the Justice Department. (This would be accomplished, (*a*) by striking out—in the sentence beginning on page 33, line

22, and ending on page 34, line 4—the figures "1957", "1958", "1959", "1960", "1961", "1962", "1963", "1964", "1965", and "1966", and by inserting in lieu thereof, respectively, the figures "1958", "1959", "1960", "1961", "1962", "1963", "1964", "1965", "1966", and "1967"; and (*b*) by striking out "1956" in subsection 302 (c) and inserting in lieu thereof "1957".)

In the absence of these postponements, the 210-day deferred effective date of the legislation (subsec. 304) would come substantially later than the dates now fixed in the bills for the commencement of support grants and for the shift, to the Territory, of financial support for the transportation of patients to a hospital outside Alaska. The above-suggested postponements on the other hand should allow adequate time to the Territory to plan and prepare for ushering in the comprehensive mental-health program for the Territory envisioned by the bills. These postponements would not interfere with the operation of the 210-day effective-date provision with respect to other parts of the bill, such as the modernized hospitalization procedures and the assumption of basic and administrative responsibility by the Territory in this connection. The Department of the Interior will continue to carry responsibility for the hospitalization program until the legislation becomes effective, at which time the bill would transfer to the Governor any unexpended balances of appropriations available to the Interior Department for the care of the Alaska insane. The Justice Department, if our suggested postponement is adopted, would until July 1, 1957, continue to pay the expenses for the transportation of any patients that are sent from Alaska to a hospital outside the Territory.

2. As stated in our report on S. 2518, we defer to the views of the Secretary of the Interior on the question whether, under the conditions prevailing in Alaska, earmarking of the land grant would be desirable. If the Congress, in enacting the proposed legislation, deletes the earmarking provisions of the measure, no further question in this connection need be raised. If, however, your committee should decide to provide for some earmarking, and if our understanding of the differences in the provisions of the three bills is correct, we would prefer the version of S. 2973 which not only makes provision for the contingency that the land grant might turn out to be more than necessary to meet the expenses of the mental-health program in Alaska but also seems to permit the proceeds of the lands themselves to be currently expended for the program (or, in the event of a surplus, for other public purposes).

In addition, we would suggest that in the event of adoption of an earmarking provision, it be made explicit (in the legislation or at least committee report) that the income and proceeds of the land grant may be used for the purposes of the entire mental-health program for the Territory (not merely the hospitalization and care of the mentally ill), as envisioned by the provisions on page 33, lines 18–21, of the bills.

Subject to your committee's consideration of the suggestions and recommendations made and referred to above, we urge enactment of one of the bills as essential to the establishment of a modern mental health program in Alaska and of more enlightened procedures for the hospitalization and care of the mentally ill than those now provided for in the law, and further in order to transfer the basic program responsibility and the responsibility of the administration of the program to the Territory where it belongs, with such Federal assistance as is necessary to enable the Territory to assume this responsibility.

For the convenience of the committee, we enclose a copy of our report on S. 2518. (In the enclosed copy a typographical error in technical amendment 3.d. has been corrected. Also, technical amendments 3.b, c., and d. are not required for S. 2973 or for H.R. 6376.)

We are advised by the Bureau of the Budget that, subject to your committee's consideration of the above suggested amendments and of the amendments submitted by the Department of the Interior and the Bureau

of the Budget, enactment of the measure would be in accord with the program of the President.

Sincerely yours,

(Signed) M. B. FOLSOM, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
March 1, 1956.

Hon. HENRY M. JACKSON,
Chairman, Subcommittee on Territories and Insular Affairs,
Committee on Interior and Insular Affairs,
United States Senate, Washington, D. C.

DEAR MR. CHAIRMAN: At the hearings before your subcommittee on H.R. 6376 and other measures relating to a mental health program for Alaska, a number of questions were raised concerning the procedures provided by title I for the hospitalization of the mentally ill.

These procedures were not outlined in detail either in Secretary Folsom's letters of January 12 and February 20 to Senator Murray or in the testimony presented by representatives of this Department in the hearings before the subcommittee. The enclosed statement has therefore been prepared to correct this omission and particularly to cover those aspects of title I concerning which questions were raised during the course of the hearing. I hope that it may prove helpful to the committee and that both the statement and this letter may be made a part of the record.

Statutes which, like title I, set out complete procedures with respect to hospitalization of the mentally ill are necessarily fairly complex. They must provide for all individuals, including those who may not be in a condition to make responsible decisions for themselves, protection against unwarranted limitations upon their personal liberty. They must also provide for the mentally ill ready access to medical care needed to restore them, wherever possible and as speedily as possible, to normal health and activity. H.R. 6376 has been carefully drawn with a view to both these objectives. While all its provisions should be considered closely, I wish to correct certain assertions made by witnesses with reference to specific provisions of the bill which reflected a careless reading of the text or unfamiliarity with provisions commonly found in statutes of this type.

Commitment under this bill, for an indefinite period or for a temporary observational period, may be made only by order of the United States commissioner following judicial procedure provided in section 108. (In Alaska the United States commissioners now conduct commitment proceedings and order commitments (48 U.S.C. 47).) Notice and opportunity to appear at the hearing must be given to the proposed patient in all cases (subsec. (f)). The provision for omission of notice to the patient, if the commissioner has reason to believe that notice would be injurious to the patient, applies only at the time the application is first filed (subsec. (b)) and before the medical examiners make their report, a report which may cause the application to be dismissed (subsec. (e)). The object is, of course, to spare the individual the needless (and possibly very damaging) shock of a notice of judicial proceeding which may never reach the hearing phase because the medical examiners' report finds the individual is not mentally ill.

Aside from judicial proceedings under section 108, provision for compulsory hospitalization is limited to emergency situations provided for in section 104 (a) and (b), when in the opinion of the certifying physician the individual is likely to injure himself or others if allowed to remain at liberty, or when a health, welfare, or police officer has reason to believe that the individual is likely to injure himself or others if not immediately restrained pending the medical certification and official endorsem[illegible]nerally required for taking an individual into custody and for ap[illegible] for emergency admission. The individual so hospitalized must be [illegible]thwith discharged from the hospital on his request unless

the head of the hospital, within 48 hours of the request, files a certification that in his opinion discharge of the patient would be unsafe to the patient or others. In such case the commissioner may allow postponement of the patient's discharge pending commencement of commitment proceedings but not for more than 5 days or, under special circumstances, 15 days.

Section 103 (b) gives the head of the hospital authority to admit an individual for care and treatment on application by others, accompanied by a certificate of a licensed physician. The physician must certify on the basis of examination not only that the individual is mentally ill but that he is either likely to injure himself or others if allowed to remain at liberty or, being in need of care or treatment in a hospital, lacks sufficient insight or capacity to make responsible application in his own behalf. This is not a commitment provision and authorizes no compulsory taking of the individual unless, in addition, there obtain the circumstances warranting emergency hospitalization under section 104.

Provisions which involve the transfer of patients to or from Alaska were cited at the hearing as threatening the unwarranted removal of residents from the States for compulsory confinement in Alaska. Section 118 (b) of the bill relates to the transfer of patients, for example veterans, who like those originally committed to an agency of the United States pursuant to section 109 (a) are eligible for hospital care or treatment at the expense of an agency of the United States. These provisions parallel closely the language [illegible] section 18 of the Uniform Veterans' Guardianship Act which was developed by the National Conference of Commissioners on Uniform Laws and which has been in satisfactory operation for years in most of the States.

Section 119 (a) provides for the transfer of any patient who has been hospitalized by the judicial procedure in Alaska but who is not a resident of Alaska to his State of residence. Subsection (b) provides for the return to Alaska of mentally ill residents of Alaska. Such transfers are made pursuant to reciprocal arrangements. The present law applicable to Alaska (48 U.S.C. 48) likewise provides for such transfers, and similar provisions are found in the laws of most States.

Subsection (c) of section 119, as to which certain speakers at the hearing expressed alarm, is not a transfer provision at all. It authorizes arrangements by which Alaska could reimburse a State for the care and treatment of mentally ill residents of Alaska by the State, or a State could reimburse Alaska for the care and treatment by Alaska of a mentally ill resident of the State. Such arrangements would obviate the need for transfer of the patient in those cases where return to the State of residence (or to Alaska in the case of a resident of Alaska) might be detrimental to the patient. The provision is by no means a vital part of the bill, and we would suggest that in any event its intent be made unmistakably clear by changing the period at the end of the subsection to a comma and adding the following: "when it appears that transfer of the patient as provided in subsections (a) and (b) would not be in the best interest of the patient."

I hope that these examples may serve to dispel some misapprehensions voiced by speakers who appeared in opposition to H.R. 6376. Fuller comment will be found in the detailed statement transmitted herewith. We shall be glad to be of further assistance to the committee in furnishing data or in the drafting of clarifying language where need for such may appear.

Sincerely yours,

ROSWELL B. PERKINS,
Assistant Secretary.

STATEMENT RE TITLE I, "HOSPITALIZATION OF THE MENTALLY ILL," H.R. 6376

This statement covers particularly those provisions of t[illegible] concerning which questions were raised in the hearings held befor[illegible] subcom-

mittee of the Senate Committee on Interior and Insular Affairs February 20 and 21, may be grouped under the following headings:

I. The definition of mental illness—inclusion of the mentally retarded and deficient
II. Procedures for hospitalization
 Voluntary
 Compulsory
III. The rights of patients while hospitalized
 Right to discharge
 Other rights
IV. Provisions relating to the transfer of patients from or to Alaska

I. THE DEFINITION OF MENTAL ILLNESS—INCLUSION OF THE MENTALLY RETARDED AND DEFICIENT

Section 101(1)

The term "mentally ill individual" is defined as meaning: "An individual having a psychiatric or other disease which substantially impairs his mental health or an individual who is mentally defective or mentally retarded."

As will appear from the discussion of the substantive sections of this title, the fact that an individual is determined to be "mentally ill" as defined is not in itself sufficient to authorize his admission to a hospital except upon application made by the individual himself under section 103 (a). The additional factors necessary for hospitalization upon an application made by others are set forth in sections 103 (b), 104, and 108 as will be hereinafter noted.

At the present the mentally defective or mentally retarded in Alaska are hospitalized under the commitment procedure which relates to the "insane." Under this procedure, for example, there are reported to be a number of mentally retarded children who are hospitalized at Morningside. Since there is no provision in the statutes of Alaska for the hospitalization of the mentally retarded and deficient, where need for institutional treatment is indicated, this group has been included in the statutory definition. Again, however, the fact that an individual is mentally retarded is not ground in itself for hospitalization.

II. PROCEDURES FOR HOSPITALIZATION

Sections 103, 104, and 108 provide in effect four procedures by which an individual in Alaska may be hospitalized on account of "mental illness" as defined.

Section 103(a)

(1) Upon voluntary application by the patient (in the case of a minor under 16, by his guardian). An individual who is mentally ill or has symptoms of mental illness may apply for admission to a hospital and be admitted for observation, diagnosis, care, and treatment. Such application can be made, however, only by an individual "who has sufficient insight or capacity to make responsible application" in his own behalf. In the case of an individual under 16 years of age, the application must be made by the parent or legal guardian.

Such an admission is not in any sense a commitment, and unless the individual becomes dangerous while in the hospital, he must be discharged forthwith upon his request or, in the case of a person under 16, upon the request of his parent or guardian. The only exception to this is a case in which the head of the hospital considers that discharge would be unsafe to the patient or others, which must be certified to the United States commissioner within 48 hours from the request for discharge. In that event, the commissioner may postpone discharge for such period up to 5 days or, in exceptional cases, 15 days, as he may determine to be necessary for commencement of commitment proceedings (sec. 106).

Provisions for voluntary hospitalization are now found in laws of most of the States. The compilation made by the Council of State Governments in 1949 showed 40 States having such provisions at that time.

Section 103(b)

(2) Admission for care and treatment on application by others. Section 103 (b) provides that an individual may be "admitted for care and treatment" in a hospital upon written application accompanied by a certificate of a licensed physician that the individual in his opinion is mentally ill and because of his illness "either (1) is likely to injure himself or others if allowed to remain at liberty or (2), being in need of care or treatment in a hospital, lacks sufficient insight or capacity to make responsible application" for himself.

This provision is an authorization for admission only and carries with it no authority to apprehend the individual and forcibly remove him to the hospital or to have the hospital detain him against his will after admission, except in the emergency cases, as described under point (3) below.

The provision is designed to facilitate access to medical care when needed for a mentally ill individual without submitting the individual to the shock of judicial procedures. The patient admitted on such an application must be forthwith discharged from the hospital upon his own request or upon the request of an interested party which is defined to include "the legal guardian, spouse, parent or parents, adult children, other close adult relatives, or an interested, responsible adult friend" of the patient (sec. 101 (g)). The only exception provided is the same as for the voluntary patient (sec. 106 (3)).

(3) Emergency hospitalization. Section 104 covers those situations in which it may be necessary to take an individual into custody and transport him to the hospital.

If the certificate issued by a licensed physician under section 103 (b) states a belief that the individual is likely to injure himself or others if allowed to remain at liberty, the certificate may be presented for endorsement by the governor or a United States commissioner and when endorsed it will authorize taking the individual into custody and transporting him to a designated hospital. Upon such endorsement any health, welfare, or police officer or any other person deputized for the purpose by a United States commissioner may exercise this authority. The category of persons who exercise such authority is not listed to police officers. This is in line with the purpose of the bill to take the handling of the sick out of the content of a strictly police action and to avoid unnecessary shock to an already disturbed person.

Section 104 (b) is designed for those more critical situations in which it appears that the individual is mentally ill and because of his illness is likely to injure himself or others if not immediately restrained pending the medical examination or certification or the endorsement provided by subsection (a). Any health, welfare, or police officer may act in such emergency situations but must state in the application for the individual's admission to the hospital the circumstances under which the individual was taken into custody and the reasons for the officer's belief.

However, a patient admitted to a hospital under the above-described emergency procedures cannot, if he or an interested person requests his release, be detained in the hospital unless commitment proceedings are instituted within the time limits prescribed in section 106.

According to the compilation made by the Council of State Governments in 1949, some 30 States had statutory provisions for "emergency commitment without court order." The person authorized to take into custody a mentally ill individual who is dangerous varies from "any person" (State of Washington) to designated officers as, in California, a peace or health officer. The common law, of course, recognizes that any person may take a dangerous insane person into custody and hold him temporarily until he can be safely released, arrested upon legal process, or committed under legal authority.

Section 108

(4) Commitment to a hospital. This means compulsory hospitalization upon an order which carries with it the power to hold for an indeterminate or a fixed observational period. Commitment is authorized by this bill only by judicial proceedings before a United States commissioner as provided by section 108.

Orders of commitment made be made only after a hearing of which the proposed patient, as well as other interested parties as determined by the commissioner, must be given notice with opportunity to hear, to testify, to present and cross-examine witnesses. Opportunity to be represented by counsel must be afforded to every proposed patient and if neither he nor other provide counsel, the commissioner must appoint one. These provisions are found in subsection (f) of section 108.

Proceedings for commitment are instituted by the filing of a petition, accompanied by a certificate of a licensed physician stating that he has examined the individual and is of the opinion that he is mentally ill and should be hospitalized. The medical certificate is required unless the applicant files a written statement that the individual has refused to submit to an examination by a licensed physician (subsec. (a)).

Upon the filing of the application, notice is given to the patient, to his legal guardian, if any, and to other interested parties (subsec. (b)). At this stage, however, the commissioner, if he has reason to believe that notice would be likely to be injurious to the proposed patient, may omit the notice to him and proceed to the appointment of 2 designated examiners (or 1 if he finds that 2 are not available) (subsec. (c)). If the examiners report that the proposed patient is not mentally ill, the commissioner is authorized to dismiss the application (subsec. (e)). Otherwise, the date for the hearing is fixed and notice is given to the patient, as indicated above, and to the interested parties, as provided in subsection (f).

The medical examination is held at a medical facility, at the home of the patient, or at any other suitable place not likely to have a harmful effect on his health. A patient cannot be required to submit to examination against his will unless the United States commissioner has given prior notice to the patient and has ordered him to submit to an examination (subsec. (d)).

The United States commissioner may order the individual's hospitalization based upon findings made upon completion of the hearing and consideration of the record. The finding must be not only that the individual is mentally ill but in addition that the individual is either because of his illness likely to injure himself or others if allowed to remain at liberty or is in need of custody, care, or treatment in a hospital, and, because of his illness, lacks sufficient insight or capacity to make responsible decisions concerning hospitalization.

Jury trial is provided for on an optional basis. Any party may appeal from the decision of the commissioner to the district court (sec. 112).

III. RIGHTS OF PATIENTS WHILE HOSPITALIZED

H.R. 6376 contains a number of provisions to assure the prompt discharge of patients whenever the circumstances warranting either voluntary or emergency hospitalization or judicial commitment have ceased to exist.

Section 106

Any individual admitted upon his own application, or that of others, including an individual admitted because likely to injure himself or others, "shall be forthwith discharged therefrom upon his request or upon the request in writing by an interested party" (sec. 106(a)). This is conditioned on his own agreement in the case of the patient admitted on his own appli[illegible]n or the consent of the parent or guardian if the individual is under [illegible]rs of age. Exception is likewise made if the head of the hospital [illegible]ith the United States commissioner, within 48 hours after receipt of the request, a certificate that in his opinion discharge of the patient would be unsafe to the patient or others; in such case discharge may be postponed for not over 5 days for the commencement of judicial proceedings (which the commissioner may extend for 15 days if proceedings cannot reasonably be instituted within the shorter period).

Section 105

The head of the hospital must in any event arrange for examination within 5 days after admission, by a designated examiner of every patient hospitalized upon application by others. The patient must be discharged if the conditions warranting admission are not found.

Section 107

Every patient, however hospitalized, is entitled to have the need for his hospitalization determined by judicial proceedings on his own petition or that of an interested party.

Section 111

Habeas corpus is provided.

Section 123

The head of the hospital must cause the condition of every patient to be reviewed as frequently as practicable, and at least every 6 months, and must discharge the patient whenever the conditions justifying hospitalization no longer obtain. Provision is also made for conditionally releasing improved patients in convalescent status and for the discharge of such patients.

Section 121

Other provisions provide for the protection of patients while in the hospital, and impose obligations upon the head of the hospital.

Section 115

Right to humane care and treatment.

Section 116

Application of mechanical restraints (limitation on).

Section 117

Right to communicate and visitation; exercise of civil rights.

Section 120

Contract care outside Alaska. This applies to those situations in which contract care outside of Alaska, as under the present Morningside contract, may still be provided for Alaska patients. Together with section 102 (b), it is designed to assure to individuals hospitalized outside the Territory protective safeguards under the law of the State where the individual is so hospitalized to the extent that such law applies, in addition to the safeguards embodied in the bill.

Section 127

Disclosure of information. Confidentiality of clinical records, etc.

IV. PROVISIONS RELATING TO THE TRANSFER OF PATIENTS FROM OR TO ALASKA

Outside of the provision for contract care of Alaska patients outside Alaska (sec. 102 (b)) these provisions relate to two groups.

1. Individuals, such as veterans, who may be entitled to hospitalization at the expense of the United States.
2. Residents of States who become mentally ill in Alaska and residents of Alaska who become mentally ill while in a State.

Sections 109 (a) and (b) and section 118 (b) relate to the first group of persons entitled to care by the United States. They are derived from section 18 of the Uniform Veterans Guardianship Act whic[illegible]develop-ed by the National Conference of Commissioners on Unif[illegible]ws and which has been in satisfactory operation for years in most [illegible]e States.

The comm[illegible]ers have commented thus on section 18 of the Uniform Veterans [illegible]nship Act.

"Those provisions will facilitate the placing of patients in appropriate Federal institutions especially equipped to treat a particular type of mental trouble and save the patient distress and sometimes definite harm incident to a second adjudication experience in the State to which transferred. It will also save substantial expense to the various States, to the Federal Government, and to the patients."

Subsections (a) and (b) of section 119 resemble 48 U.S.C. 48 of the present law applicable to Alaska in that they authorize arrangements by which a patient hospitalized under the judicial procedure in Alaska but who is not a resident of Alaska may be returned to his State of legal residence. A nonresident patient not hospitalized under the judicial procedures may also be returned if the patient or his guardian consents. Also under reciprocal arrangement, residents of Alaska who have been hospitalized in a State may be transferred back to Alaska. Such provisions are commonly found in State laws relating to the mentally ill.

An added provision—subsection (c)—is designed to obviate the need for transfer in situations where the interest of the patient would be better served by allowing his care to be continued in the State where he is, the expense to be reimbursed by the State of legal residence. (Personal liability for the expense of hospitalization is provided for by section 128 (a) which is derived from the present law. 48 U.S.C. 48a.) It is suggested that this provision be amended to make clear that it is to apply only "when it appears that transfer of the patient as provided in subsections (a) and (b) of section 119 would not be in the best interest of the patient."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
April 16, 1956.

Hon. BARRY GOLDWATER,
United States Senate,
Washington 25, D. C.

DEAR SENATOR GOLDWATER: This letter is in response to your request of March 23, 1956, for the Department's comments on a committee print of amendments (in the nature of a substitute) intended to be proposed to H. R. 6376, relating to the hospitalization and care of the mentally ill of Alaska.

The principal change which your proposed amendments would make in the bill would be to delete the hospitalization procedures included in title I, thus leaving in effect the present procedural law relating to the commitment, hospitalization, care, and treatment of the mentally ill of Alaska until the Territorial legislature has availed itself of the opportunity, afforded by the bill, to enact such legislation on the subject as it deems best.

The paramount purpose of the bill, as also of the committee print, is, of course, to effect the transfer of basic responsibility and authority in this field from the Federal Government to the Territory, where responsibility in the mental health field belongs. This—as provided in H.R. 6376—logically includes a grant of unfettered authority to the Territory to legislate in this field. It was considered, however, that if this responsibility was to be suddenly cast on the Territory, fairness demanded that the transfer be accompanied at the outset by a modernized legal base for hospitalization. This consideration is especially pertinent because a restriction in the organic act for the Territory has so far precluded the Territory from improving the present archaic commitment procedures.

The procedures contained in H.R. 6376, with the amendments suggested by us in our report on S. 2518, are consistent with modern concepts for the hospitalization and treatment of the mentally ill. At the same time, we believe, they combine an enlightened concern for the patient's health with full safeguards of his rights. For these reasons, and in view of the

widespread desire and support in Alaska for these provisi[illegible] the bill, we urge favorable consideration of the hospitalization p[illegible]res now included in title I, with the amendments we have recommended.

Your letter indicates that, basically, you share our view of the matter but that, because of opposition to, and misunderstanding of, these provisions evidenced before the committee, you consider it preferable to leave the entire matter of hospitalization procedure to the Territory from the very outset, rather than merely as a matter of future improvement. As we have indicated, we believe that complete transfer of basic responsibility and authority in this field to the Territory (together with the necessary fiscal and other economic aid provisions of the bill) is paramount. Hence, if in the judgment of the committee retention of the hospitalization procedures in the bill would jeopardize its passage, or if, in the event of retention of title I, substantial amendments contrary to the purpose of its key provisions were considered inevitable, we agree that it would be preferable to delete the entire hospitalization procedure and to rely upon the provisions of the bill authorizing the Territorial legislature to adopt desirable laws in this field.

There will be submitted to you separately a staff memorandum and marked-up copy of the committee print suggesting some revisions in the committee print which are believed necessary to carry out your purpose and provide for a smooth and timely transition from the Federal administration of the hospitalization program to administration by the Territory. In addition, the staff memorandum and markup suggest amendments to the committee print so as to make clear beyond doubt that the benefits of the bill could be made available to the mentally retarded and mentally deficient, as well as those who are in a strict sense mentally ill. Otherwise, those unfortunates who are mentally retarded or defective, and who are now as a matter of necessity dealt with under present commitment procedures, might find themselves without access to the benefits of the mental health program envisioned by the bill. For your consideration, the markup of the committee print also embodies the suggestions for amendments to title II submitted in our testimony before the subcommittee and in our report on S. 2973.

Sincerely yours,

ROSWELL B. PERKINS,
Assistant Secretary.

CONFERENCE REPORT NO. 2735

STATEMENT OF THE MANAGERS ON THE PART OF THE HOUSE

The managers on the part of the House at the conference on the disagreeing votes of the two Houses on amendments of the Senate to the bill (H.R. 6376) to provide for the hospitalization and care of the mentally ill of Alaska, and for other purposes, submit the following statement in explanation of the effect of the action agreed upon and recommended in the accompanying conference report.

H.R. 6376, as reported by the House, contained three titles. Title I contained detailed hospitalization and commitment procedures, title II contained the land and monetary grants necessary to implement the act, and title III contained miscellaneous provisions pertaining to the existing contract and appropriation of funds.

H.R. 6376, in title I, as reported by the Senate, gives authority to the Territory of Alaska to enact such laws on the subject of mental health as it may deem appropriate. This action would vest in the people of Alaska re-

sponsibility in the field of mental health comparable to that of the several States and the other Territories of the United States. In conference, the Senate version of title I was accepted in the anticipation that the Legislature of the Territory of Alaska will act to modify existing commitment, hospitalization, and treatment procedures for Alaska's mentally ill.

Both versions of title II of H.R. 6376 are identical in substance but with a minor change in wording. The House-passed bill provided that the monetary returns realized from the land grants would be administered by the Territory of Alaska as a public trust for the hospitalization and care of the mentally ill in Alaska. The Senate-reported bill specifies that these returns shall be applied to meet the necessary expenses of the mental-health program in Alaska. The managers on the part of the House accepted this Senate amendment which broadens the use of the revenues for use of the Alaska mental-health program rather than for the hospitalization and care of the mentally ill in Alaska.

Title III of H.R. 6376, as reported by the House is considerably different in section 301(b), in wording, but not in context from the Senate-reported bill. The Senate language recognized the desirability of providing a limited transition period between the effective date of the act and the time when the Territory must assume full responsibility for the implementation of the Alaska mental-health program. In recognition of this possibility, and to allow time for the Alaska Legislature to amend existing law governing care and treatment of Alaska insane, the Senate version fixes the mandatory transfer date on the 210th day after enactment of H.R. 6376. The House managers—particularly in view of agreement to delete the commitment provisions—have agreed to this Senate amendment to the House-passed bill.

Section 302(a) of the Senate-passed bill deals with the existing contract between the Secretary of the Interior and the Sanitarium Co. of Portland, Oreg., in which the mentally ill of Alaska are now being treated at Federal expense. This section provided that the Secretary shall, within 30 days after the enactment of the bill, either assign the contract to the Governor of Alaska with his concurrence, or terminate the contract in accordance with its terms. Assignment would take effect on the 210th day after the effective date of the act. The existing contract provides for termination upon 6 months' notice. The conferees amended section 302(a) to extend the time that the Secretary shall assign the contract to the Governor of Alaska or to terminate it from 30 to 210 days. This extension of time will permit the arrangement of the necessary transfer details. Prior to the acceptance of this amendment, letters of approval were obtained from the Department of the Interior and Health, Education, and Welfare. These reports are included as appendixes to this statement of managers.

Section 302(b) of the Senate-reported bill provides that 210 days after the date of the enactment of this act the unexpended balances of appropriations available to the Department of the Interior for the care of the Alaska insane shall be transferred to the Governor of Alaska to be used primarily in the administration of all laws pertaining to the Alaska insane. It also provides [illegible] for the remainder of the fiscal year ending June 30, 1957, addition[illegible]ds are authorized to be appropriated to the Secretary of the Interior [illegible]transfer to the Governor of Alaska as are necessary for the

care of the Alaska insane. Since the House conferees saw the importance of this amendment in order to be assured that the mentally ill would be properly cared for during fiscal 1957, they agreed to this Senate amendment.

Subsection 302(c) provides that costs of transporting patients to a hospital outside of Alaska shall continue to be paid by the Department of Justice until July 1, 1957. The House conferees agreed to accept subsection 302(c) which provides this transportation.

Finally, the House managers agreed to and accepted the amendment whereby the Senate substituted new language for the title of the bill as follows:

> An Act to confer upon Alaska autonomy in the field of mental health, transfer from the Federal Government to the Territory the fiscal and functional responsibility for the hospitalization of committed mental patients, and for other purposes.

In all other respects the conference committee agreed to the minor changes adopted in the Senate-passed bill.

LEO W. O'BRIEN,
ED EDMONDSON,
EDITH GREEN,
JOHN R. PILLION,
Managers on the Part of the House.

APPENDIX

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
July 11, 1956.

Hon. HENRY M. JACKSON,
Chairman, Territories Subcommittee,
Committee on Interior and Insular Affairs,
United States Senate, Washington, D. C.

DEAR MR. CHAIRMAN: This is in response to your letter of July 2, 1956, advising us of the conference agreement on H.R. 6376, the Alaska mental health bill, subject to the concurrence of this Department and the Department of the Interior concerning two amendments to section 302 (a) of the bill agreed to by the conferees.

Section 302 (a) of the bill, which would be amended by the conference amendments, relates to the authority of the Secretary of the Interior to assign to the Territory or to terminate the existing contract with Morningside Hospital for the care and treatment of mental patients committed from Alaska. Inasmuch as this, so far as the Federal Government is concerned, is entrusted solely to the Secretary of the Interior, we would defer to the views of the Interior Department as to the acceptability and workability of the conference amendments. We understand that that Department has no objection to the amendments and we therefore likewise concur.

We are gratified to know that this will make unnecessary another meeting of the conferees and will thus expedite passage of the bill which is very much needed by the people of Alaska.

Time has not permitted us to obtain the advice of the Bureau of the Budget in connection with this report.

Sincerely yours,

M. B. Fo[illegible]ecretary.

DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington, D. C., July 12, 1956.

Hon. HENRY M. JACKSON,
Chairman, Territories Subcommittee,
Committee on Interior and Insular Affairs,
United States Senate, Washington, D. C.

MY DEAR SENATOR JACKSON: This will reply to your letter of July 2, in which you request the comments of this Department on the proposed action of the conferees with respect to H.R. 6376, the Alaska mental health bill. The conferees have agreed to the Senate amendment, except that section 302 (a), the section which as reported by the committee would have required the Secretary of this Department either to assign or terminate the current hospital contract within 30 days, would be amended to authorize such an assignment or termination within 210 days.

This Department has no objection to the proposed action of the conferees.

Sincerely yours,

WESLEY A. D'EWART,
Assistant Secretary of the Interior.

FEDERAL SAVINGS AND LOAN INSURANCE CORPORATION—EMBEZZLEMENT AND FRAUD

For text of Act see p. 831

Senate Report No. 2730, July 20, 1956 [To accompany H.R. 10111]

House Report No. 2483, June 26, 1956 [To accompany H.R. 10111]

The Senate Report is set out.

Senate Report No. 2730

THE Committee on the Judiciary, to which was referred the bill (H.R. 10111) to amend sections 657 and 1006 of title 18 of the United States Code to include within the purview of such sections certain State savings and loan associations, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

PURPOSE

The purpose of the proposed legislation is to bring State-chartered savings and loan institutions whose deposits are insured by the Federal Savings and Loan Insurance Corporation within the protection of section 657 of title 18, United States Code, which provides criminal penalties for embezzlement and other types of defalcation; and within the protection of section 1006 of title 18, United States Code, which provides criminal penalties for the making of false entries and other types of fraudulent or unauthorized conduct.

STATEMENT

Section 657 of title 18, United States Code, and section 1006 of title 18, United States Code, apply to persons connected with savings

and loan associations authorized or acting under the laws of the United States, but do not apply to persons connected with savings and loan associations chartered under State or local law and insured by the Federal Savings and Loan Insurance Corporation. The proposed legislation would amend these sections to make them apply to persons connected with such savings and loan associations.

The Federal Home Loan Bank Board favors the enactment of the proposed legislation; the Department of Justice advises that there appears to be no reason why the protection should not be extended; and the enactment of the proposed legislation is urged by the non-governmental organization, the United States Savings & Loan League.

The committee believes that the proposed legislation is meritorious and recommends its enactment.

Attached and made a part of this report are (1) a statement dated April 25, 1956, submitted by the nongovernmental organization, the United States Savings & Loan League, (2) a letter, dated April 26, 1956, from the Federal Home Loan Bank Board, and (3) a letter, dated June 13, 1956, from the Department of Justice.

STATEMENT OF THE UNITED STATES SAVINGS & LOAN LEAGUE IN FAVOR OF S. 3531, PRESENTED TO THE SENATE JUDICIARY COMMITTEE, APRIL 25, 1956

The United States Savings & Loan League, which represents 4,300 member savings and loan associations and cooperative banks, heartily endorses S. 3531, a bill by Senator Dirksen to make it a Federal offense for employees of State-chartered savings and loan associations insured by the Federal Savings & Loan Insurance Corporation to embezzle or misappropriate funds of these institutions.

The effect of this bill if enacted into legislation would be to give the Federal Bureau of Investigation jurisdiction over embezzlements in State-chartered institutions which are insured by the FSLIC. Under existing law the FBI does not have this jurisdiction. However, in the case of State-chartered banks which are insured by the FDIC, existing law does make embezzlements in these institutions a Federal offense and the FBI does have jurisdiction.

S. 3531 would make the criminal statutes governing these two types of institutions identical. It would also provide a psychological deterrent to prospective embezzlers since the strong arm of the FBI would be permitted to investigate and prosecute offenders.

Embezzlements have become a more pressing problem to all financial institutions in recent years. Any reasonable step that Congress can take to reduce them is both commendable and necessary. It has long been the feeling of public officials and law-enforcement officers, as well as of the general public, that offenses involving, or under the jurisdiction of, the Federal Bureau of Investigation are somewhat less likely to occur than similar offenses involving State authorities only. The modern up-to-date investigative methods and efficiency of the FBI are, undoubtedly, a detriment to would-be offenders. It is hoped that this bill if enacted will reduce losses to institutions insured by the FSLIC and, correspondingly, reduce the contingent liability of the Federal Savings and Loan Insurance Corporation.

STATE OF ALASKA

THE LEGISLATURE

1986

Source		Legislative Resolve No.
HCS CSSCR 36(FIN)		53

Establishing a joint special committee on mental health trust land.

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

WHEREAS the United States Congress granted 1,000,000 acres of land to the Territory of Alaska to be administered as a public trust for the necessary expenses and support of mental health in the territory; and

WHEREAS in October 1985, the Alaska Supreme Court determined that the 1978 decision of the Alaska Legislature to redesignate mental health trust land as general grant land had breached the trust established by the Congress; and

WHEREAS the funding level for the mental health programs in the state is one of the lowest in the nation on a per capita basis; and

WHEREAS the legislature, the administration, and mental health advocates agree that the state must comply with the intent of the Congress that mental health programs in the state receive sufficient funding; and

WHEREAS it is not in the public interest that continued litigation over the mental health land trust divert attention from the underlying goal of increased funding for mental health programs and care in the state; and

WHEREAS present state statutes do not explicitly provide for the management of mental health trust land for maximum revenue production; and

WHEREAS the return of mental health trust land to trust status precludes management of mental health trust land for its highest and best use;

BE IT RESOLVED by the Alaska State Legislature that a Joint Special Committee on Mental Health Trust Land is established under Uniform Rule 21; and be it

FURTHER RESOLVED that the Joint Special Committee on Mental Health Trust Land is composed of three members of the Senate appointed by the president of the Senate, three members of the House of Representatives appointed by the speaker of the House of Representatives, and two public members interested in the mental health trust land issue; the public members shall be selected by the other members of the Joint Special Committee on Mental Health Trust Land; and be it

FURTHER RESOLVED that one member appointed from the House of Representatives be from the membership of the House Finance Committee and one member appointed from the Senate be from the membership of the Senate Finance Committee; and be it

FURTHER RESOLVED that the Joint Special Committee on Mental Health Trust Land develop, after public hearings, a proposal to resolve the mental health trust litigation and recommend a level of appropriations adequate to provide sufficient funding for mental health programs in the future; and be it

FURTHER RESOLVED that the committee is authorized to meet during and between sessions of the legislature and is to report its recommendations and findings on the first day of the First Session of the Fifteenth State Legislature; and be it

FURTHER RESOLVED that the committee terminates on the 10th day of the First Session of the Fifteenth State Legislature.

LAWS OF ALASKA

1986

Source

HCS CSSB 472(Fin)

Chapter No.

132

AN ACT

Relating to the interim management of the mental health trust; and providing for an effective date.

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

THE ACT FOLLOWS ON PAGE 1, LINE 10

Approved by the Governor: June 9, 1986
Actual Effective Date: June 10, 1986

AN ACT

Relating to the interim management of the mental health trust; and providing for an effective date.

---

* Section 1. INTERIM MENTAL HEALTH TRUST COMMISSION ESTABLISHED. (a) The interim mental health trust commission is established in the Department of Natural Resources.

(b) The commission established under (a) of this section consists of five members, including the commissioner of natural resources and the commissioner of health and social services, or their designees, and three members and three alternates appointed by the governor as follows:

(1) a member and an alternate representing the plaintiffs, appointed by the governor from a list of three names submitted to the governor by the plaintiffs in Weiss v. State, 4 FA 82-2208 Civil;

(2) a member and an alternate representing the intervenors, appointed by the governor from a list of three names submitted to the governor by the intervenors in Weiss v. State, 4 FA 82-2208 Civil; and

(3) a member and an alternate representing the Governor's Mental Health Advisory Council, appointed by the governor from a list of three names submitted to the governor by the Governor's Mental Health Advisory Council.

(c) The members of the commission shall elect a presiding officer. A majority of the commission constitutes a quorum. The affirmative vote of three members is required to take official action. A vacancy does not

impair the power of the remaining members to exercise the powers of the commission.

(d) In the absence of the member, an alternate appointed under (b) of this section may vote and has all the powers of a member.

(e) Members of the commission serve without compensation but are entitled to per diem and travel expenses authorized by law for other boards under AS 39.20.180.

(f) The commission shall meet at least quarterly and may meet more frequently, either in person or by teleconference.

(g) The commission shall prepare a budget allocating the funds appropriated to it for the performance of its responsibilities and may contract with parties or individuals for the performance of functions it considers necessary, including the services of an executive director and staff.

* Sec. 2. RESPONSIBILITIES OF THE COMMISSIONER OF NATURAL RESOURCES AND THE COMMISSION. (a) The commissioner of natural resources shall inventory and catalog the mental health trust land of the state, shall audit and appraise each transaction involving land that has been part of the mental health trust land of the state, and determine the status of mental health trust land on October 4, 1985, under procedures and guidelines established by the commissioner of natural resources with the approval of the commission. In the exercise of the commission's responsibilities under this section, the commission and its staff may review the records of the Department of Natural Resources that are made confidential by law or regulation.

(b) An individual who acquires information made confidential by law or regulation in the performance of functions authorized by this Act and discloses it without proper authority violates AS 11.56.860.

(c) The commissioner of natural resources shall, with the approval of the commission, retain an appraiser or appraisers to appraise all or a portion of land that, at any time, was part of the mental health trust land

of the state. The commissioner shall provide an appraiser conducting an appraisal with written procedures and instructions that have been approved by the commission.

(d) The commissioner of natural resources is responsible for the management of the mental health land of the state as a public trust under P.L. 84-830, 70 Stat. 709. Except as provided in (e) of this section, the commissioner of natural resources may not sell, lease, or exchange mental health trust land of the state or an interest in the mental health trust land of the state without the prior approval of the commission. In reviewing a proposal for the sale, lease, or exchange of mental health trust land from the commissioner of natural resources, the commission may approve the proposal of the commissioner on its determination that the proposal is consistent with the terms of the trust established by the Alaska Mental Health Enabling Act.

(e) The commissioner of natural resources may transfer trust land to the federal government under AS 38.05.035(b)(9) without approval of the commission. The commissioner of natural resources shall advise the commission of an intention to transfer trust land to the federal government and, after the transfer, shall make every effort to acquire replacement land to fulfill the state's remaining entitlement based on a prioritization, approved by the commission, of existing valid mental health selection.

(f) The proceeds from the management of the mental health trust land of the state shall be deposited in a special trust account in the general fund of the state and shall first be applied to meet the necessary expenses of the mental health program of the state.

* Sec. 3. RESPONSIBILITIES OF THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES AND THE COMMISSION. (a) The commissioner of health and social services, with the approval of the commission, shall

(1) establish the procedures and guidelines for the audit of the

1 state's mental health program; and

2 (2) propose the guidelines and procedures to be used in de-

3 termining a range of expenditures for mental health programs necessary to

4 comply with the state's comprehensive mental health plan.

5 (b) The legislative auditor shall audit the state's mental health

6 program under the procedures and guidelines established in (a) of this

7 section.

8 * Sec. 4. ADDITIONAL RESPONSIBILITIES OF THE COMMISSION. The commis-

9 sion shall submit a report to the legislature by the 10th day of the First

10 Session of the Fifteenth State Legislature on matters of concern to the

11 commission. The report shall include its recommendations for amendment of

12 the laws relating to the management of the mental health trust account, the

13 mental health trust land, and the mental health program of the state.

14 * Sec. 5. DEFINITION. In this Act "commission" means the interim

15 mental health trust commission established in sec. 1 of this Act.

16 * Sec. 6. This Act is repealed July 1, 1987.

17 * Sec. 7. This Act takes effect immediately in accordance with AS 01.-

18 10.070(c).

19

20

21

22

23

24

25

26

27

28

29

APPENDIX C

APPENDIX C: THE MENTAL HEALTH LAND TRUST

Obtaining a workable solution to the mental health trust litigation requires an understanding of why the trust was created and why it was later dissolved. The following narrative provides the necessary background.

The 1956 Mental Health Enabling Act

In 1956, Congress passed Public Law 84-830, commonly known as the Alaska Mental Health Enabling Act (AMHEA), which put Alaska's mental health program on a par with other states' and territories' by turning over responsibility for the program to the territory. AMHEA granted the state the right to select and manage 1 million acres of land as a public trust to function as a long-term revenue source for the program.

Trust Land Selections

Congress allowed the territory to select "any vacant, unappropriated, and unreserved" federal land for the mental health trust. The territory quickly began selecting lands with the greatest promise for revenue generation in the near and/or not-too-distant future. Usually, these lands were close to communities or appeared to have commercially developable resources. The Alaska Statehood Act in January 1959, granted the new state the right to select 103,500,000 acres for settlement, economic development and revenue generation. Simultaneously selecting lands for two different entitlements presented state lands officers with a dilemma, and sometimes the choicest parcels went to the state instead of to the mental health trust.
Figure 1 maps the general location of the selections and Table 2 identifies the types of revenue potential they were believed to promise.

TRUST LANDS: MENTAL HEALTH GRANT (1956)

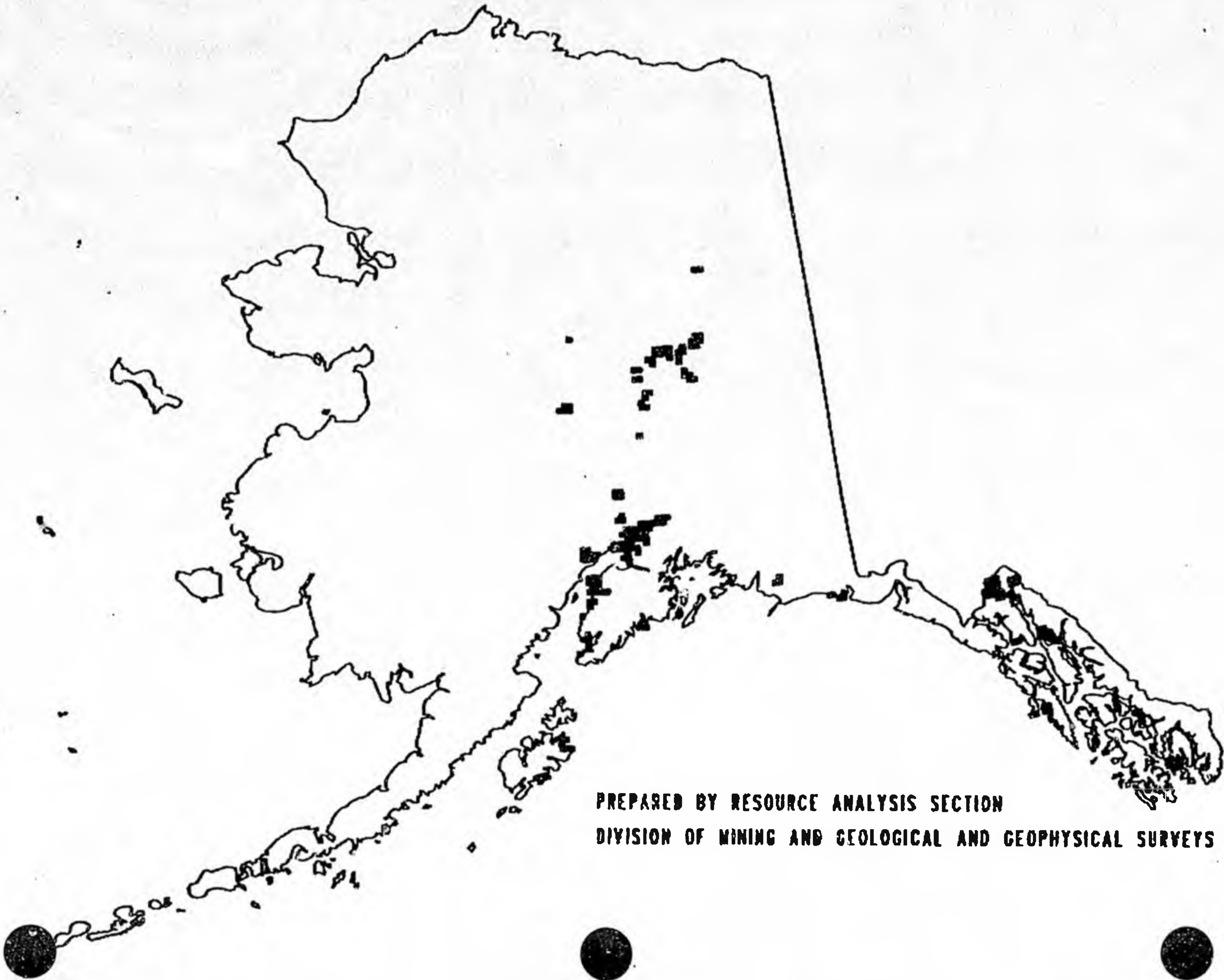


Table 1

Mental Health Land Selections
by
Location and Anticipated Type of Income Generation

Area	Projected Source of Income
Anchorage Area (Proper)	Settlement*, commercial
Beluga River	Oil, gas, coal, and timber
Fairbanks	Settlement, timber
Haines	Timber, recreation**, minerals
Healy	Coal
Juneau	Settlement, recreation
Kenai Peninsula	Oil, gas, settlement, agriculture timber
Susitna Valley	Timber, agriculture, settlement, recreation
Yaku at-Icy Straits	Oil, gas, timber, recreation

* settlement probably means residential development
** recreation probably means commercial recreation development

Source: DNR records

Managing the Land Trust: 1956-78

AMHEA provided that all lands granted be administrated "as a public trust and such proceeds and income shall first be applied to meet the necessary expenses of the mental health program." Trust principles generally require preservation of the corpus from dissipation and active management of trust assets to maximize revenue generation. AMHEA left these matters to the state legislature's discretion, but the legislature enacted no legislation regarding these matters.

Instead, DNR managed all public lands in accordance with multiple use principles for the maximum benefit of all Alaskans (i.e. the highest and best use of the land, not necessarily the highest monetary yield).

Absent statutes mandating active management and corpus preservation, the trust was prey to various forces, beginning with a prolonged economic recession immediately after statehood. To meet the new government's immediate revenue needs, all state lands, including mental health trust lands, were subject to pressures to sell for quick cash return. Population growth increased the demand for using mental health lands to accommodate municipal expansion, public facilities, parks and recreation, utilities and charitable organizations. Active management would have been incompatible with DNR's multiple-use mandate. Finally, existing statutes provided for transactions inimical to trust principles. As a result of a combination of such forces, between 1960 and 1977 approximately 104,000 acres were disposed of from the trust corpus, most at less than fair market value.

Although land sales by lottery were tied to appraised values, statutes provided for less than fair market conveyance in certain cases: negotiated sales, discounted sales (preference rights, sales to charitable organizations, odd lot sales, etc.) and the substitute of "sweat equity" for monetary compensations (e.g. homesites and agricultural homesteads). Other statues which precluded active management and were applied to trust lands were related leases, rights of way, and resource sales (e.g. long term land leases for token annual payment and "mining claims" renewable on the basis of $200 of labor per year, special treatment for charitable and public agencies, etc.)

Between 1956 and 1977, mental health trust lands produced only $23,179,503 in revenues (from DNR records). This sum fell far short of matching the "necessary expenses of the mental health program" during that same period. For example, in FY 78 alone,

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02-576(2/77)

APPENDIX C: THE MENTAL HEALTH LAND TRUST

Obtaining a workable solution to the mental health trust litigation requires an understanding of why the trust was created and why it was later dissolved. The following narrative provides the necessary background.

The 1956 Mental Health Enabling Act

In 1956, Congress passed Public Law 84-830, commonly known as the Alaska Mental Health Enabling Act (AMHEA), which put Alaska's mental health program on a par with other states' and territories' by turning over responsibility for the program to the territory. AMHEA granted the state the right to select and manage 1 million acres of land as a public trust to function as a long-term revenue source for the program.

Trust Land Selections

Congress allowed the territory to select "any vacant, unappropriated, and unreserved" federal land for the mental health trust. The territory quickly began selecting lands with the greatest promise for revenue generation in the near and/or not-too-distant future. Usually, these lands were close to communities or appeared to have commercially developable resources. The Alaska Statehood Act in January 1959, granted the new state the right to select 103,500,000 acres for settlement, economic development and revenue generation. Simultaneously selecting lands for two different entitlements presented state lands officers with a dilemma, and sometimes the choicest parcels went to the state instead of to the mental health trust.
Figure 1 maps the general location of the selections and Table 2 identifies the types of revenue potential they were believed to promise.

TRUST LANDS: MENTAL HEALTH GRANT (1956)

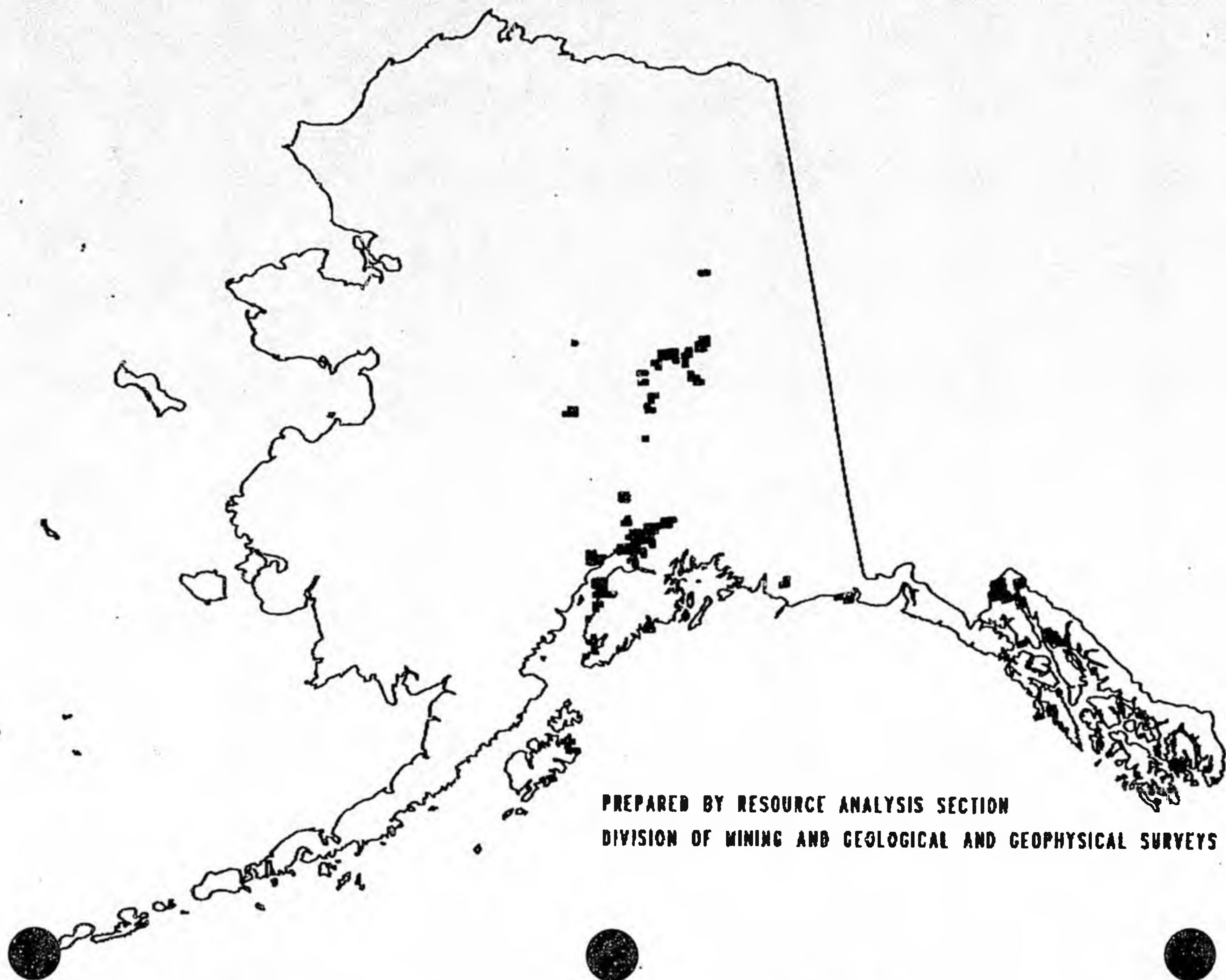


Table 1

Mental Health Land Selections
by
Location and Anticipated Type of Income Generation

Area	Projected Source of Income
Anchorage Area (Proper)	Settlement*, commercial
Beluga River	Oil, gas, coal, and timber
Fairbanks	Settlement, timber
Haines	Timber, recreation**, minerals
Healy	Coal
Juneau	Settlement, recreation
Kenai Peninsula	Oil, gas, settlement, agriculture timber
Susitna Valley	Timber, agriculture, settlement, recreation
Yakutat-Icy Straits	Oil, gas, timber, recreation

* settlement probably means residential development
** recreation probably means commercial recreation development

Source: DNR records

Managing the Land Trust: 1956-78

AMHEA provided that all lands granted be administrated "as a public trust and such proceeds and income shall first be applied to meet the necessary expenses of the mental health program." Trust principles generally require preservation of the corpus from dissipation and active management of trust assets to maximize revenue generation. AMHEA left these matters to the state legislature's discretion, but the legislature enacted no legislation regarding these matters.

Instead, DNR managed all public lands in accordance with multiple use principles for the maximum benefit of all Alaskans (i.e. the highest and best use of the land, not necessarily the highest monetary yield).

Absent statutes mandating active management and corpus preservation, the trust was prey to various forces, beginning with a prolonged economic recession immediately after statehood. To meet the new government's immediate revenue needs, all state lands, including mental health trust lands, were subject to pressures to sell for quick cash return. Population growth increased the demand for using mental health lands to accommodate municipal expansion, public facilities, parks and recreation, utilities and charitable organizations. Active management would have been incompatible with DNR's multiple-use mandate. Finally, existing statutes provided for transactions inimical to trust principles. As a result of a combination of such forces, between 1960 and 1977 approximately 104,000 acres were disposed of from the trust corpus, most at less than fair market value.

Although land sales by lottery were tied to appraised values, statutes provided for less than fair market conveyance in certain cases: negotiated sales, discounted sales (preference rights, sales to charitable organizations, odd lot sales, etc.) and the substitute of "sweat equity" for monetary compensations (e.g. homesites and agricultural homesteads). Other statues which precluded active management and were applied to trust lands were related leases, rights of way, and resource sales (e.g. long term land leases for token annual payment and "mining claims" renewable on the basis of $200 of labor per year, special treatment for charitable and public agencies, etc.)

Between 1956 and 1977, mental health trust lands produced only $23,179,503 in revenues (from DNR records). This sum fell far short of matching the "necessary expenses of the mental health program" during that same period. For example, in FY 78 alone,

the Division of Mental Health expended approximately $10 million for Alaska's mental health program.

Competing Demands for Land and Uses, 1956-77

In the years immediately after the enactment of AMHEA, the Congress continued to use land to solve problems and transfer responsibilities for programs. The Alaska Statehood Act of 1958 granted the selection of 103,350,000 acres to assist the new state in directing its settlement, develop its economy, and generate revenues. At the same time, new constituencies were clamoring for public lands.

The 1960's and 1979's saw the rise of national and Alaskan movements to protect fish, wildlife, recreational, and wilderness resources from unbridled development. Substantial acreages of mental health trust lands were drawn upon to achieve these purposes. Habitat protection utilized 47,672 acres (90% of which were designated in 1976) and state parks took another 116,713 acres (68% of which were designated in 1975). Although the state retained titles to these lands, they were in effect removed from the mental health trust.

Environmentalists succeeded in obtaining moratoria of developmental activities on huge tracts of federal land in Alaska through special provisions in ANCSA. In accordance with these provisions and in anticipation of the 1980 passage of the Alaska National Interest Lands Conservation Act (ANILCA), the Secretary of Interior in 1978 reserved 132 million acres for wildlife refuges, parks, wilderness areas, etc., and under the Antiquities Act another 56 million acres.

A similar Alaska-based constituency for preservation of such areas emerged as a powerful local political force. For example, the Kachemak Bay oil and gas leases were purchased back by the state in response to fisheries and recreational pressures. Expansion of the state park system was launched in earnest and many of the mental health trust lands were looked upon as prime candidates for this program or for exchange with Native corporations for park areas within the corporations' region. Finally, changes in state land policies from disposal to reservation resulted in only 100 acres of state land being sold to the public in 1976-77, down considerably from prior years.

Countering forces propounded the accelerated disposal of state lands. The 1978 "Beirne Initiative" would have required the state to make 50,000 acres of land available per year for 50

years or until 30 percent of all state lands had passed into private ownership. Although the Initiative was declared unconstitutional in 1979, the 1978 vote which passed it into law indicated the popular support for such land transfers and identified a further threat to the trust. The Initiative also reflected the climate in which the 1978 redesignation legislation was passed.

To accommodate land selections by other recipients of federal grants during this period, arrangements for future conveyances from the mental health trust by exchange were made. In the early 1960's when municipalities began to look for 712,360 acres under the Municipal Entitlements Act, location and resources made mental health lands ideal candidates. The Attorney General ruled in 1964, however, that mental health, university, and school lands were "not unappropriated, unrestricted federal lands within the meaning of AS 07.10.150 and are not subject to selection by a borough under that Act." A legislative remedy was sought in the 1978 amendment to the 1972 municipal entitlement act. This lifted the previous prohibition on trust land selection so that qualifying communities could receive trust lands--provided equivalent lands were identified in advance of conveyance and transferred to the trust. Subsequently, mental health lands were conveyed to several communities although equivalent lands were not identified and returned to the trust.

The 1968 discovery of oil at Prudhoe Bay set in motion a sequence of events leading to additional conveyances from the trust. In order to allow construction of the Trans Alaska Pipeline to proceed, Congress first had to resolve outstanding Native land claims. The solution, the Alaska Native Claims Settlement Act (ANCSA) of 1971, granted 44 million acres of federal land and $1 billion to provide an economic base for Alaska's Natives.

The Native Corporation in the Cook Inlet region, CIRI found little commercial land remaining in their selection area. Negotiations between federal and state governments led to Land Consolidation and Management in the Cook Inlet Area, a complex, three-way exchange agreement designed to provide prime commercial acreage for the corporation and prime park land for the state. Although not implemented until 1979, the agreement's terms and conditions in 1975 earmarked 29,394.26 acres of mental health lands for CIRI with the lands received in exchange going into new state parks.

The 1978 Trust Lands Redesignation

The legislature, the Department of Natural Resources, and the federal trusts were caught in the cross-currents of desires both to develop and protect land. The checkerboard distribution of the mental health, schools and university trusts further complicated management. In an attempt to accommodate the competing interests, legitimize past management and redesignations, and simplify future land management, the legislature in 1978 redesignated all mental health, university, and public school lands as general grant lands.

To compensate the mental health trust, the Redesignation Act (Chapters 181-182, SLA 1978) called for depositing 1.5% of all revenues produced from state lands in a special trust account. A three member Mental Health Fund Advisory Board was created to oversee the investment and management of the Fund by the Commissioner of Revenue. However, beyond initial organizational meetings, the Board never met, and no deposits were ever made into this account. By January, 1987, $164,138,000 should have been deposited and, with 10.5% interest, would have grown to $271,068,000 (DNR figures). Had this been done, the suit might never have been brought against the state for breach of its trust responsibilities.

By dissolving the Trust, redesignation completed in dramatic fashion a piecemeal process of trust dissipation that had been in progress since 1960. Of the trust's original one million acres, only 194,672 acres of unencumbered land and an additional 291,034 acres encumbered with less-than-fee disposals remained in general grant land status as of October 4, 1985. Sales and condemnation conveyed 51,143 acres out of the trust and out of state ownership between 1960 and 1985. In many cases, the 39,269 acres received by the state as replacement for trust lands used in exchanges "cannot be readily identified." A total of 486,706 acres of formal mental health lands were designated for uses (habitat areas, parks, and forests) incompatible with trust purposes (maximum revenue generation). Conveyances and selections for mental health lands to municipalities total 55,640 acres, but no replacement lands were identified or produced as provided for by the 1978 amendment to the Municipal Entitlement Act.

The forces and conditions leading to the current status are still operative and promise to continue to exert a profound effect upon any future land trust and its management.

APPENDIX D

APPENDIX D: OTHER PUBLIC LAND TRUSTS

The following tables summarize public land trusts in other states. The data shows that every state land trust is accompanied by a state cash trust or permanent fund. In some states (e.g. Washington, where much of acreage is commercial timber land) management is extremely labor-intensive, consuming as much as 25% of the land trust's annual income.

Small, high-value land trusts generally show more favorable ratios between management costs and revenue production. The programs require that the trust manager compile a trust land portfolio of developable lands situated in urban areas. This sometimes requires that rural trust lands be sold or exchanged in order to acquire or upgrade the amount of available urban land in the trust. The urban lands are then platted, planned and zoned for their highest use, usually commercial or industrial. Finally, urban trust lands are leased or sold, depending upon market conditions and long-term revenue maximization objectives. In some cases, active management also entails construction and management by the trust manager of development projects on the land.

The University Trust Land Settlement

The recent negotiated reconstitution of the University land trust provides an example of a mixed cash and land settlement and suggests how complex a complete accounting can be--and how costly the final settlement could be for the state. The 1978 Redesignation Act also reclassified University Grant Lands as general grant lands. Although less complicated and extensive than the mental health case, a study of the University settlement is informative. The text of the settlement follows the tables on public land trusts in other states.

COMPARISON: LAND TRUST MANAGEMENT IN SELECTED STATES

State	Arizona	Colorado	Mississippi	Washington
Trust Name	School + 14 miscellaneous	School	School	School and other
Acres	9,500,000	3,000,000 (4,000,000 orig.)	650,000 (817,000 orig.)	3,000,000 (1.8 mil. school)
Date Established	1912	1876	1817	1889
Permanent Fund Amount	$200,000,000	$150,000,000	$44,000,000	$650,000,000 (5 funds)
Annual Earnings From Land	$62,000,000	$21,000,000	$21,500,000	$140,000,000
Annual Earnings From Fund	$22,000,000	$16,000,000	$5,000,000	$3,500,000
Distribution of Funds (dedication)	Revenue appropriated to particular funds.	State treasury - earnings only - (education)	Income only (direct to local school districts)	(school, universitys, mental inst., capitol bld.)
Land Management Structure	State Land Department	Appointed Board (3-6 year overlapping terms)	Local School Boards	Bd. of Natural Resources + Dept. of Natural Resource
Size of Staff	130	30	3 (central office)	1,038; 640 temporary
Pay for Own Management?	No	Yes	Yes	Yes
Cost of Management	$6,500,000	$1,800,000 (or 10% income)	Unknown (varies)	$42,200,000 (25% income)*
Sales Allowed?	Yes	Yes (cautious)	Yes (indust. dev. only)	No (may be exceptions)
Major Sources of Revenue	leasing: grazing, commercial, agricultrual, mineral and land sales	Oil and gas 60%	rents & leases, oil & gas royalties, timber sales	- timber sales - land leases
Special Programs?	Urban lands	Urban lands	No	Urban lands
Comments	$37 mil. from rights-of-way '85 (Central AZ Project)	Mineral estate retained	Reform act in 1978 due to previous abuse.	Must balance revenue production w/other public uses.

*Addition 25% income may be reinvested to enhance land values and productivity ($4.3 million FY '85).

COMPARISON: LAND TRUST MANAGEMENT IN SELECTED STATES

State	Louisiana	Louisiana	Texas	Texas
Trust Name	Education Quality Trust	Education Quality Support	Permanent University	Available University
Acres	N/A	N/A	2,100,000 (2,000,000 orig.)	See permanent fund
Date Established	1985/1986	1985/1986	1876	1876
Permanent Fund Amount	To reach $2 billion	N/A	$3.1 billion (market) $2.6 billion (book)	N/A
Annual Earnings From Land	25% of outer continental shelf recurring revenues	75% of outer continental shelf recurring revenues	$117.3 mil. (from non-renewable resources)	$3.75 mil. (surface income and investment income)
Annual Earnings From Fund	25% of earnings on investments	75% of trust fund earnings on investments	N/A	$214.5 mil. (cash) $216.1 mil. (total accrued)
Distribution of Funds (dedication)	N/A	Appropriation (higher education, elementary/sec.)	N/A	2/3 University of Texas 1/3 Texas A&M
Land Management Structure	N/A	N/A	See "Available University"	Bd. of Regents, Univ. of Texas - Bd. for Lease of University Land
Size of Staff	N/A	N/A	25± (fin. sup. personnel)	75 - 100±
Pay for Own Management?	N/A	N/A	Yes	Yes
Cost of Management	N/A	N/A	1 million	$6.5 million* (land proj.)
Sales Allowed?	N/A	N/A	No	N/A
Major Sources of Revenue	See above	See above	Oil & gas (90%) mineral, water, royalties & lease bonuses	grazing and surface income
Special Programs?	N/A	N/A	N/A	Urban lands
Comments	When trust fund at 2 bil., OCS $$$ go to general fund	Will receive 100% of rev. when trust fund at 2 bil.	School Land Bd. 1st option to purchase excess pub land	Often use pro. contract personnel rather than staff

*Includes cost of university legal system which largely supports oil and gas leasing (1.3 million).