assurance that there will be a satisfactory environmental setting for the patient, nor is there any possibility of engaging in any family care program.

Both from staff and patients we obtained the impression that there were Caucasian patients whose residence in Alaska was very brief, less than 1 year, and who, certainly, were not the responsibility of the Territory of Alaska but that of the States of which they are residents.

HENRY C. SCHUMACHER,
Medical Director, Consultant in Mental Health Activities,
Region X, San Francisco.

MARY F. CONGER,
Research Nurse Officer, Psychiatric Nursing Consultant,
National Institute of Mental Health.

EXHIBIT 6

[Excerpt from Parish Committee Survey, 1954]

MENTAL HEALTH

Congressional action dating back to 1900 provides the basic authority for the long-outmoded Alaskan system of dealing with the mentally ill. The original legislation was an attempt to deal with one urgent problem arising from the outlook of white men and women upon the Territory during the gold rush. The law has been amended as to detail several times without any substantial change in its general structure. Yet there are few, indeed, of our self-governing States in this country that have not altered the legal basis of the commitment to keep pace with the great advances in psychiatric medicine during the 50 years, apprehension and commitment of a criminal. For more than half a century the Department of Justice, through the courts of the United States Commissioners, has had the responsibility for detaining, hearing, and committing all persons found guilty of the crime of insanity and transporting them to the "asylum," which has confined their freedom.

The act of June 6, 1900, authorized the Governor of the Territory to make such contracts for the care and custody of the insane: the first was with the State Insane Asylum of Oregon. In 1904 this authority to contract was transferred from the Governor to the Secretary of the Interior; since 1910 he has been limited by the requirement that contracts be awarded only to a responsible asylum or sanatorium west of the main range of the Rocky Mountains. An act of 1910 authorized the establishment at Nome and at Fairbanks of a "detention hospital for the temporary care and detention of the insane, as a matter of public policy" until transported to the asylum by law for their permanent care and cure. The emergency situation created in Fairbanks was never operated as a hospital, in any sense of the word. A United States marshal later branded it as useless and less safe than the jail and it was never replaced after it was destroyed by fire.

The Morningside Hospital of Portland, Ore., was awarded the contract for the care of insane Alaskans in 1910 and has retained it to date. After 1915 no other institution had submitted a bid for the contract; its terms since then have been arrived at by negotiation.

The Department of the Interior has requested 2 reports on mental health during the past 3 years. The first committee made a careful study of the whole situation relevant to mental health and illness in Alaska, and reported to the then Secretary with recommendations for action; the second was only an inspection of the hospital in 1952.

As conditions in Alaska have altered very little since 1949, when the report was prepared for the Department by an able committee under the chairmanship of Dr. Winfred Overholser, an outstanding psychiatrist, we decided that it was unnecessary to have psychiatrists conduct another field survey in the Territory at this time. We did, however, make thorough Inspections of Morningside Hospital in August and September 1954 and present the results later in this section.

MORNINGSIDE HOSPITAL

THE GOVERNOR'S COMMITTEE REPORT

Since this report served as a baseline for our own observations, we shall summarize it briefly:

Since this report served as a baseline for our own observations, we shall summarize it briefly.

MORNINGSIDE HOSPITAL

THE GOVERNOR'S COMMITTEE REPORT

Since this report served as a baseline for our own observations, we shall summarize it briefly.

Since this report served as a baseline for our own observations, we shall summarize it briefly.

Since this report served as a baseline for our own observations, we shall summarize it briefly.

Since this report served as a baseline for our own observations, we shall summarize it briefly.
Any adult may file a complaint that some individual is "an insane person at large" with the United States Commissioner, and the United States marshal takes the accused person into custody and detains him in jail.

A jury of six men must inquest "to inquire, try and determine whether the person in custody is really insane," and if it is satisfied that the person so certified is insane, the United States Commissioner is required to appoint him to a hospital or an asylum for the incurable insane and to appear as a technical witness before the jury.

If no physician is available, the Commissioner is authorized to transfer the case for trial to another jurisdiction where a physician is available.

In actual practice, relatively few such transfers are made. The proceedings resemble a trial on criminal charges. The "defendant" is represented by counsel of his own choosing or one appointed by the court. Misconceptions of justice are possible in both directions as to the desirability of the defendant being free during the trial. If he has a shrewd lawyer, he may be entirely possible for the defendant to "prove" his sanity to a jury of six men, as might a suicidal mania-depressive not at the time in a "partial hospitalization." On the other hand, a defendant is likely to be found incompetent to question or to neglect the import of the hearing, that the jury might in good conscience adjudge him "insane as charged."

The Commissioner is authorized to approve the findings of the jury, but is not bound by it; but rarely does a Commissioner use his discretionary authority to override a jury verdict.

In 1964, the present commitment procedures are an anachronism. They carry the stigma of criminal accusation and are humiliating whether or not the accused person is mentally ill. If he happens to be in the early stages of an depressive disorder, the result of the order would be the worsening of his condition. In addition, contrary to the American concept of justice, these court trials for insanity lay the burden of proof upon the accused person.

**Efforts to Secure a Modern Law**

Model legislation providing for the commitment of the mentally ill has been adopted in many States and has been recommended to them by the Council of State Governments. The principles of such legislation, adapted to the conditions in Alaska, have been incorporated into a number of bills introduced into the Alaska Legislature over the past 5 years. None of them has been enacted in spite of a "widespread demand from all segments of the Alaska population" (8 Committee Rept. No. 24696), and from dispassionate professional organizations, such as the American Psychiatric Association and the United States Public Health Service.

H. R. 8999, the latest measure to be introduced, was passed by the House of Representatives on June 26, 1964, and was reported favorably, with amendments, on August 13, by the Senate Committee on Interior and Insular Affairs. Unfortunately, the Senate took no action.

In spite of its failure to be enacted into law, there is food for thought in the House and Senate versions of H. R. 8999. Both proposed modernization of the current commitment procedures. In addition, the House set current Federal appropriations for mental health ($726,604 in 1964 for contract costs at Morningside) as the maximum for future years. Future financial participation in mental-health programs by the Territory was encouraged, but ultimate authority rested with the Secretary of the Interior. Interestingly enough, the intent to phase in the contract program with Morningside Hospital were prohibited; but the most interesting phase of the new plan, was, "west of the main range of the Rocky Mountains," which was repealed by the Senate for any future contracts, was reinstated by the Senate committee.

The Senate committee (see Rept. No. 2486, August 13, 1964) introduced a new financial formula, under which (a) patients no longer hospitalized would continue to be a charge upon the Federal Government; (b) the care of all new admissions would be paid by the Territory; (c) a grant would be made of 200,000 acres to be selected by the Territory, all proceeds from which shall be devoted to the mental-health program.
1. Administration.—The hospital, now licensed by the Oregon Health Department, is managed by the owner and his son, with two assistants whose duties are divided. The male assistant acts as paramedic, maintains the farm, and supervises the employees of the farm, as well as supervising the male attendants and assisting them on the wards. The female assistant as housekeeper, employs the female attendants and supervises them on the wards, plans the menus and is in charge of the food service.

2. Psychiatry.—The Psychiatrist responsible for the physical and mental health of the patients is an able and devoted physician. Unfortunately, his substantial psychiatric training does not qualify him for certification by the specialty board in this sector of the medical specialties. At the time of inspection, two young physicians were assisting him in the general medical care of the patients.

There is a resident psychiatrist representing the Department of the Interior who does not participate actively in the treatment program. He supervises the assignment of patients to work at the hospital and in the community. The occupational therapy, the dental program, and the consultant services—technically, all standards of service for Alaskan patients—do not involve the patient receiving services.

Since the Schuermann survey, a second registered nurse has been added to the staff. Both nurses are assigned exclusively to the care of patients receiving shock therapy and those with active tuberculosis. Patients in the regular wards are served only by attendants; most of whom have had some previous hospital experience. Their work schedule is unusual; a 48-hour week made up of 4 consecutive days when they are on duty from 6 a.m. to 6 p.m., then they have 3 days off duty.

Allowing for days off, vacations, and sick leave, the ratio of nursing service personnel to patients is about 1 to 10, which is similar to the ratio in many of our understaffed State mental hospitals.

3. Buildings.—The institution presently consists of 10 gray wooden ward buildings with a capacity of 407, now housing 377 patients. All buildings are protected against fire by a sprinkler system. A new ward for patients suffering from tuberculosis is under construction to replace the previous building now used. The interiors of several buildings have been improved and an attempt is being made to make the living quarters more attractive and comfortable. The refurbishing and redecorating of the continued treatment service for patients is now completed. It has comfortable furniture, pleasant wall coverings, and makes good use of bright colors.

The children's building is the newest in use; it is bright, airy, and attractive. The plans for the new building to house tuberculosis patients are quite satisfactory.

The general maintenance of the institution is excellent. Facilities are clean and free from undesirable odors. The plumbing seemed to be in good condition.

The renovation of the patients' dining room, which all earlier reports had criticized, still is incomplete.

4. Other buildings on the property are those required by the active operation of a dairy, hog raising, farming, and canning. The hospital grounds could be improved by a more judicious location of the buildings and their location.

5. Food.—The food served is on the written menus in name only. Each patient is given a menu and a quantity of food is specified by the hospital. A local dentist is reported to make regular visits to examine the teeth of each patient and to determine the best course of treatment.

6. Dentistry.—Dentistry is not considered to be of sufficient quality for the treatment of patients. The dental equipment in the hospital, however, seems insufficient for first-class dentistry.

7. After the new patient is given a regular psychiatric interview, treatment is prescribed. This may consist of electric shock or insulin shock or a combination of both. When indicated, some psychotherapy is used. In any case, it is limited, with only one party trained psychiatric assistant available for the care of 354 Alaskan patients in 1953. No matter how great his efforts, it is impossible for him to do an effective job. At the very least, he should have a qualified assistant. Another limitation is the cultural barrier between the native patient and the white psychiatrist. Not infrequently this is accentuated by the patient's limited understanding of the English language and the psychiatrist's complete ignorance of Alaskan diasters.

As soon as his condition warrants, the patient is assigned to the occupational therapy department, which now is staffed by 3 therapists, 3 aides, and 4 students. This department is thought to have improved the patients' actual performance as an industrious worker. Even patients who mentally are very "repressed" are brought in every day. Some of them gradually become interested in learning to work with their hands and show more alertness and improved behavior.

Patients who prefer it are assigned to work in the laundry, on the grounds, or about the farm. Such assignments are termed "industrial therapy." We were told that no such assignments are made except on the psychiatric recommendation of the committee that met at the hospital each week.

A special problem—both psychiatric and physical—is posed by the high incidence of tuberculosis among patients. At the time of our inspection, 24 men were in the tuberculosis ward; two-thirds of them ambulatory. Sixteen patients, of whom 12 were bedridden, were crowded into the old and completely inadequate building for tuberculosis patients. The treatment of these patients is not easily handled.

According to all earlier reports, the hospital has been negligent in the past in controlling the spread of tuberculosis among employees and patients. We were told that, under the direction of the tuberculosis consultant, plans are being made to modify the situation through the use of better techniques for patient care and certain architectural changes which will reduce contact with the infection.

Not only patients with psychiatric disorders but also mental defectives are sent to Morningside Hospital from Alaska. The former has been ill in the average, for 2 years before admission to the hospital—a much longer period than is usually the case. In addition, about half the admissions are of native stock who come without case records. Without information about the treatment they have received by so long a distance—often by language—from the relatives who might supply such information, one must rely on all sources that the psychiatrist at Morningside has in an unusually difficult task. As health services are developed in Alaska, it will be possible to admit patients more promptly, when the possibility of care is greater, and to supply the medical information on each case which is so valuable to the clinician.

The hospital maintains a satisfactory record system. We examined a number of period records, selected at random, and found each carefully detailed and up to date. Exceptionally praiseworthy was the care with which the intellectual level and behavior problems of mentally defective patients were recorded. In spite of his heavy caseload, the psychiatrist was studying this group with significant interest. In some institutions this is neglected because the condition of many of them does not respond to therapy.

8. Rate of admission, discharge, and death.—Admission rates for the population of patients are considered to be relatively low. The military and their dependents and the construction workers undoubtedly admitted all patients when mentally ill. Of the 1953 admissions, 18.5 percent were alcoholic psychotics; 18.5 percent were senile or arteriosclerotic; 51.8 percent were functional psychotics; 2.5 percent were senile. The discharge rate was 0 percent. The significant figure seemed to be the high rate of psychotic alcoholism.

The institution discharge rate per 1,000 patients for 1953 was 164.3, almost exactly the national rate. The death rate in Montrose was 90 per 1,000 under treatment, while the national rate was 63. This indicates good physical care, particularly because many patients have tuberculosis on admission.

9. Paradigm.—It is very difficult to operate a proper psych ward for psychiatric cases in such a small area. Between Alaska and Portland, particularly with the few trained people on the Alaska end to do any supervising. This is one of the situations which might be somewhat improved were the institution located in the Territory, the Base, because of the great distances within the Territory itself and the lack of trained personnel there, it would still remain a problem.
MORNINGSIDE HOSPITAL

should be prescribed as to standards of care to be furnished; periodic inspections of performance should be made; and the present arrangements of having a psychiatrist—governmentally employed—at the institution should be terminated.

3. Sharing of cost—There has been much difference of opinion as to whether the Federal Government should be required to pay for care of Federal and Territorial Government employees or for veterans (natives, veterans, etc.) expense. To this end, Alaska should be authorized by the Congress to enact its own laws dealing with mental health, not subject to veto by the Congress or approval of either the Secretary of Interior or of Health, Education, and Welfare.

To enable Alaska to assume the substantial costs ultimately required, the Federal Government should authorize a special appropriation on a descending scale over a period of several years.

4. Mental hospital facilities.—We do not feel that a new mental hospital is required at this time in Alaska. We are satisfied with the present number of its patients taken as a part of the small unit at the Anchorage Hospital. However, Alaska should be fully activated for diagnosis and classification of patients as well as for intensive treatment. Comparable units should be provided elsewhere, at a lower cost, for the patients who are now in the hospital.

5. Costs of contract care.—We do not feel that, under proper controls, there is anything inherently wrong in utilizing privately owned facilities

6. Eagar improvements needed at Morningside.—(a) Morningside should hire an competent psychiatric nurse to select, train, and add to the present ward service personnel. This requirement is imperative and is consistent with good hospital practice everywhere.

(b) The food service must be improved by the employment of a well-trained, efficient cook who will have the total supervision of the feeding of patients, including the cooking and serving.

(c) A psychiatric social worker should be employed. In addition to the usual duties, she might obtain from Alaskan sources more information about the patient from his relatives and make it possible to plan better for his return home. She might also develop a system of regular reports to relatives through home. Sometimes this might make possible an earlier discharge.

(d) A half-time clinical psychologist should be employed because of the increase of children and mental defective among Alaska patients. He could be helpful, also, in the psychiatric examination of patients and their selection for treatment.

(e) A qualified assistant psychiatrist should be employed. The present case load is far too great for one psychiatrist. It is not possible for one man to give really effective care to so many mental patients. All staff of the occupational therapy department should be enrolled by someone especially trained in recreational therapy.

(g) A better schoolroom should be supplied for the mental defective who are teachable and for whom a part-time teacher is employed by the Portland school system.

7. Other improvements.—(a) The hospital should give careful thought to architectural changes in order to separate the women's tuberculosis ward from the men's infirmary which now needs to be enlarged.

(b) A small addition to the men's infirmary would provide needed day-room space. A similar addition to the women's building would provide a place for the care of personnel, thus keeping the area of infirmary apart from other buildings and services.
interest in membership in local organizations for mental health and psychiatric nurses.
This was a good way to meet the people with whom we will have continuing contact as the programs in Alaska evolve. The specific impressions gained from this tour by Miss Morgan will be incorporated in the overall report on Alaska.

FRANCES A. WILLIAMS.

October 18, 1956
Respectfully forwarded to: Chief, Community Services Branch, NIMH.
CHARLES P. BLANCHESH, M. D., Regional Medical Director.

Exhibit 8

PUBLIC HEALTH SERVICE, HAWAII, REGION IX,
San Francisco, Calif., October 18, 1956.

To: Regional medical director.
From: Mental health consultant in social work.
Subject: Field trip report—Oregon.

Date of departure (from Denver): October 11, 1956.
Date of return (to San Francisco): October 13, 1956.
Field trip report.

Place: Morningside Hospital, Portland, Ore.
Purpose: Morningside Hospital was visited as a part of the Alaska survey team study.

Principal persons seen:
1. Wayne Coe and Mr. Henry Coe, administrative officers.
2. Dr. Ray Langdon, chief psychiatrist.
3. Dr. Allen Parker, chief psychiatrist.
5. Mrs. Dorothy Mickelson, registrar.
6. Dr. George Keller, psychiatrist, Department of the Interior.

SUMMARY

Information was secured to assist in a later detailed evaluation of the patient population from Alaska. A number of cases were read to observe content and material pertinent to planning for future disposition. The present status of their convalescence and discharge was observed. This report does not enter into the aspects of hospital administration, treatment facilities, or statistics.

DETAILED REPORT

Morningside Hospital (known by contract with the Department of the Interior, June 1953, as the Sanitarium) has admitted mentally ill and mentally deficient patients from Alaska since 1904. It now consists of 200 acres of land on the Horine Block Street in Portland, Ore., and has a staff of 225 employees. The plant consists of a number of rambling buildings in good repair and a farm, which includes a hostel dairy and a poultry. There is a considerable amount of truck farming done in which patients participate, and a canning operation, adequate to meet the needs of the hospital.

The permanent medical staff consists of 2 psychiatrists (1 currently on leave), 2 physicians, a clinical psychologist, 2 psychiatric nurses, 4 nurses, 2 occupational therapists, and a special education teacher. There are 6 physicians on the attending staff and 7 on the consultant staff. Dr. George Keller, representing the Department of the Interior, has an office in the administration building. The hospital has never employed a psychiatric social worker. Wayne and Henry Coe, father and son, own and manage the institution.

Admission

There are approximately 400 patients in Morningside from Alaska (refer to statistical breakdown available elsewhere). All commitments are routed through the office of the section of mental health, Alaska Department of Health. Patients arrive by airplane accompanied by a medical (a police officer) who may be assisted by a public health nurse. Dr. Keller officially approves both admissions and discharges.
and the Portland Office of Employment Security. These have been cases in which a physical handicapped was emphasized.

Concurrent leave and discharge planning

Pre-discharge planning primarily involves the nurse and psychiatrist. The nurse may assist in motivating the patient to leave, if possible, or to make him aware of the need to leave. Consecutively, the psychiatrist contacts relatives, if available, to secure information about their attitudes about taking care of the patient. Other material pertinent to leave status. Because there is a social worker charged with the responsibility of leaving and discharge planning, whether at Morningside or in Alaska, the amount of basic planning appears to be minimal and is done entirely by correspondence. There are no opportunities for aftercare or followup of patients when they return to home and community.

On October 12, 1955, there were 12 patients on leave as follows: Washington, 4; California, 2; Alaska, 2; Missouri, New York, Ohio, Oregon, Texas, 1 each.

The patient is placed on leave status for a maximum of 1 year, but may be discharged prior to that time on the basis of medical decision. At the time of discharge, the patient is given suitable clothing, a maximum of $25, and transportation to local residence or elsewhere. The patient signs a form releasing Morningside Hospital of all responsibility. The patient is then placed in his own custody or in the custody of relatives. He agrees to pay expenses for return to the hospital should such return be necessary, but in emergency situations the hospital may pay transportation costs for readmission.

When a patient is discharged, a medical summary is prepared by the hospital physician and psychiatrist and forwarded to the section of mental health. The patient's name and pertinent data are included in the discharge summary. The discharge summary is then sent to the Department of the Interior, and the patient is automatically billed for reimbursement by the Department of the Interior. The patient is discharged in accordance with the rules of the United States Bureau of Labor Statistics, Wholesale Price Index. Territorial statutes prohibit old-age assistance payments to any patient in an institution for tuberculosis or mental disorders (ch. 161, S. C. A., 1955).

Visitors

The visitors' record book was examined. Each visitor signs this book and occasionally notes the name and relationship of the patient. Friends also sign the visitors' book at the time of visit. It was observed that (1) there are comparatively few visitors over a period of time; (2) the larger number of visitors appear to be friends from the Portland geographical area, and (3) the same visitors tend to repeat their visits to the hospital. There is no indication that any effort is made to interview visitors by the professional staff or to involve them in the total treatment of the patient. The visitors' book is handled by the registrar.

School

A school is operated on the hospital grounds for both adults and children. This is taught by a person trained in special education. In the event a student is able to earn academic credits, these are validated by the Department of Education of Oregon.

Occupational therapy

Both occupational therapists, a man and woman, are trained in their profession. The occupational therapy shops are adequately supplied with necessary materials. The vocational therapeutic program includes participation in recreational activities such as parties, and picnics. A moving picture show is given periodically such as, parties, and picnics. A moving picture show is given periodically.
Case records

A folder is maintained for each patient. It is divided into two parts: the first, for various forms; and the second, for correspondence. Attached to this report is a complete group of the types of forms used by Morningside Hospital. The progress notes in the cases observed run from sparse contents to more detailed recording. At this time, not one case remained unrecorded, therefore, it was regarded by the psychiatrist, who also wrote letters to relatives. We were informed that correspondence with the family was not encouraged prior to 1955. Pictures of patients are taken and sent to relatives, when known, on the birthday of a patient or when the patient may be participating in a holiday group.

Boarding out

The contract with Morningside notes that patients may be boarded out in Alaska or elsewhere in homes other than their own in which not more than two patients are kept in any one home. The contract reads: "The company shall be responsible for the expense and support of boarded-out patients and such patients shall continue to be regarded by the psychiatrist, who also wrote letters to relatives. We were informed that correspondence with the family was not encouraged prior to 1955. Pictures of patients are taken and sent to relatives, when known, on the birthday of a patient or when the patient may be participating in a holiday group.

Evaluation of case load for eventual disposition of patient population

There is a case record on every patient, but the contents of these records vary in completeness. The medical records appear to be adequate, but psychiatric, psychological, and social information is more often minimal or nonexistent. A social worker from the Section of Mental Health, or one specially employed, would need an estimated minimum of 6 months to review each case for basic and essential information necessary for planning for disposition and to evaluate existing information. Planning would include correspondence with relatives, social workers, and possibly friends in certain instances. Each patient, therefore, would be approached on a case-by-case basis for interviews directed to assisting him to consider a possible way for leaving the hospital. The social worker would also be concerned with the evaluation of a patient's interest, potentials, employment record, and any planning which has been developed in relation to vocational rehabilitation.

Discharge planning would include the following possibilities:

1. Patients who might return to their own home and community in Alaska.
2. Patients who might return to their State of former residence.
3. Patients who might be transferred to federal or state hospitals.
4. Patients who might be placed in foster homes.
5. Patients who might be placed in foster home care under existing authority for boarding care.

In reference to the last item, it is noted that approximately one-fourth of the patients in Morningside are over 60 years of age. It is presumed that many of these persons might be placed in foster home care under supervision of social workers of the section of mental health in Alaska.

Conclusion

The care received by patients at Morningside is adequate and possibly equal or superior to that found at the average State hospital. The basic problem, however, is of course, that these patients are far removed from their relatives. It is of course, financially difficult for relatives to visit or for the patient to return home for brief visits or on convalescent leave. No casework services are available at Morningside and, thus, there is no means of planning with relatives in Alaska. On the other hand, there is no means in Alaska of offering interpretation of the patient's illness to the relatives as well as providing them with support during the hospitalization of the patient which might lead to active participation in the return of the patient to his home and community. It is felt that in a number of individual cases, the social worker should be basically involved in the "discovery of the patient and the resurrection of the relative."

RAYMOND W. CRAIG.

October 19, 1956.

Respectfully forwarded to: Chief, Community Services Branch, NMHH.

CHARLES F. BLANKENSHIP, M.D.
Regional Medical Director.