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 are Caucasion patients whose residence in Alaska was very brief, less than 1 year, and who certainly, therefore, are 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 E. CORCORAN,
*Senior Nurse Officer, Psychiatric Nursing Consultant, National Institute of Mental Health.*

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EXHIBIT 6

[Excerpt from Parran 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 onslaught 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 institutions and care given to their citizens suffering from mental disorders to keep pace with the great advances in psychiatric medicine during the 54 years.

As a result, the commitment procedure of Alaska today is comparable to the 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 persons found guilty of the crime of insanity and transporting them to the "asylum" which has contracted for their keep.

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 1909 he has been limited by the requirement that contracts be awarded only to "a responsible asylum or sanitorium 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 * * * until transported to the asylum by law for their permanent care and cure." Unfortunately, funds were not appropriated for the proposed hospital at Nome. The frame structure erected in Fairbanks was never operated as a hospital, in any sense of the word. A United States marshal later branded it as less adequate and less safe than the jail and it was never replaced after it was destroyed by fire.

The Morningside Hospital of Portland, Oreg., was awarded the contract for the care of insane Alaskans in 1904 and has retained it to date. After 1915 no other institution has 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 5 years. The first committee made a careful study of the whole situation relevant to mental health and illness in Alaska, and reported in detail 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.



THE OVERHOLSER COMMITTEE REPORT

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

Appointed in 1949, the committee was requested by the Department of the Interior to make a survey of mental-health conditions in Alaska; study present methods and their legal basis of committing, detaining, and transporting insane patients, with particular reference to the problems in isolated villages; investigate the feasibility of establishing one or more mental-health clinics; "evaluate the need for constructing a complete psychiatric hospital in Alaska;" make recommendations both for immediate changes in present operations and for "a sound long-range program to provide the best possible treatment for mental patients in Alaska in line with modern psychiatric and medical practice."

After inspecting Morningside, the committee spent approximately 3 weeks in Alaska and covered a large cross section of the Territory, including both larger centers and remote native villages. They held public hearings in six places.

In regard to Morningside, the committee observed "that only custodial care is provided at the present time, and as such it is reasonably good as compared with the poorer mental State hospitals. The facilities as a whole are overcrowded, but not so seriously as in some State institutions. The patients appear to be well fed and sympathetically treated * * *. Practically no psychiatric treatment is afforded the many patients who urgently need such treatment. The professional staff is inadequate numerically and professionally to provide the required treatment. The current rate of payment, $3.538 per day (in 1949–50) is too low to provide an adequate professional and nursing staff. Although the physical layout of the plant is not good, it is evident that there have been substantial improvements made in recent years, and your committee was informed of additional betterments planned, such as an improved dining room for the patients."

The committee felt that the "fundamental principle of contract care in proprietary institutions is wrong. It has long been outmoded in the United States * * * It is subject to criticism on sound humanitarian grounds." The committee recommended (*a*) the construction of a modern mental hospital in Alaska of not less than 350 beds, so located (probably in central Alaska) that it will be close to other medical institutions and convenient to transportation; (*b*) the provision of a 50-bed treatment center at Mount Edgecumbe for short-term, acute cases; (*c*) Territorial operation of the facilities when completed; (*d*) the development of a comprehensive mental-health program by the Alaska Department of Health; (*e*) the provision of centers for emergency treatment and observation at "most of the general hospitals, to be operated by the ADH in conjunction with the mental-health program"; (*f*) all public mental-health services in Alaska to be under the direction of the ADH; and (*g*) the modernization of the commitment procedures. In making this last recommendation, the committee referred (in 1949) to model legislation "now being drafted."

PRESENT COMMITMENT PROCEDURES

During the past two seasons that we have been making studies and gathering data in Alaska, we found much concern about mental health and much discussion of needs among citizens of all categories. We often heard the cliché: "There are three sides to this problem: our side, stateside, and Morningside."

As among ourselves, we found many differences of opinions in regard to one or another of their multiple health problems. The one unanimous opinion is to the effect that the present commitment procedures for the insane in Alaska should have been changed long ago. They are archaic, cruel, inhumane, and essentially barbaric. In fact, one does not need to go farther than Capitol Hill to hear criticism in the same spirit. The Senate Committee on Interior and Insular Affairs in its report on H. R. 8009, in August 1954, spoke of the procedure as "painfully out of step with good modern practice."

Public conscience should have prompted the enactment of a modern commitment law long ago. In addition, the Government, many feel, is vulnerable as regards its obligations under the Charter of the United Nations to provide humane treatment of native peoples in territories under its jurisdiction, whether colonized, captured, acquired by purchase, or mandated.

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 laymen is impaneled "to inquire, try and determine whether the person so complained of is really insane." If a licensed physician or surgeon is available, the Commissioner is required to appoint him to make an examination of the accused person 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 in another jurisdiction where a physician may be found.

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 choice or one appointed by the court. Miscarriages of justice are possible—in both directions. A homicidal paranoid can put on an air of sweet reasonableness at times. If he has a shrewd lawyer, it will be entirely possible for him to "prove" his sanity to a jury of six laymen, as might a suicidal maniac-depressive not at the moment in either extreme of his malady. On the other hand, a friendless native in the throes of a hangover, might prove so unresponsive to questioning or so ignorant of the import of the hearing, that the lay 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 1954, 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 mental disorder, the result of the ordeal 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 Congress over the past 5 years. None of them has been enacted in spite of "widespread demand from all segments of the Alaska population" (S. Committee Rept. No. 2486), and from dispassionate professional organizations, such as the American Psychiatric Association and the United States Public Health Service.

H. R. 8009, the latest measure to be introduced, was passed by the House of Representatives on July 6, 1954, 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. 8009. Both proposed modernization of the commitment procedures. In addition, the House set current Federal appropriations for mental health ($798,600 in 1954 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, any changes in the present contract with Morningside Hospital were prohibited: but the restrictive phrase, "west of the main range of the Rocky Mountains," which was repealed by the House for any future contracts, was reinstated by the Senate committee.

The Senate committee version (see Rept. No. 2486, August 13, 1954) introduced a new financial formula, under which (*a*) patients now 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 land 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."

### THE NEW MENTAL-HEALTH PROGRAM IN ALASKA

The Alaska Department of Health recently organized a very limited mental-health program with a staff of three: a psychiatrist, a psychologist, and a social worker. Aided by Federal grants from the National Institute of Mental Health, a research arm of the United States Public Health Service, headquarters have been set up at Anchorage.



Our statistical data show that Alaska needs more mental-health services than the average State. The higher death rates among whites from suicide, homicide, and alcoholism are significant. Many observations, moreover, by qualified reporters, suggest that although some people come to Alaska for the solace of its wide-open spaces, they may find because of the shortage of housing so much crowding together through the long winters that they may succumb to the disease known to pioneers in all northern countries as "cabin fever." With only two certified psychiatrists nonmilitary in the Territory—one of them having retired from practice—it is not possible for mentally ailing individuals to procure professional help for themselves; although many human tragedies might be averted if such help were available.

In our opinion, the new mental-health program has gotten off to a good start. This opinion was shared by every physician in Anchorage and elsewhere with whom we discussed the matter. We have, however, a single, mild criticism: We believe—and in this judgment, also, we found concurrence—that instead of spending nearly all of its time with the problems of individual patients, the new mental-health team should do more to educate the medical profession and the public generally in the fundamentals of mental hygiene.

Planned for but not yet opened for patients, the 18 psychiatric beds in the Alaska Native Service Hospital at Anchorage are acutely needed. More psychiatrists and other medical specialists are needed throughout the Territory. As health and medical facilities grow in number and improve in quality, there will be more practical inducement to settle there. In the meantime, some serious thought should be given to ways and means of recruiting these essential skills for potentially rewarding areas.

### MORNINGSIDE HOSPITAL

Having reported above the conclusions of the Overholser Committee about Morningside in 1949, a summary of a 1952 inspection will give further background for our 1954 findings and recommendations.

*The Schumacher report.*—The second survey of Morningside Hospital requested by the Department of the Interior was made in June 1952 by representatives of the United States Public Health Service. The report calls attention to very inadequate housing for female tuberculosis patients and to the "exceedingly poor" dining room. The shortage of professional personnel is emphasized. Although the Department of the Interior maintains as its representative at the hospital a psychiatrist to supervise the treatment and expedite discharges of patients cared for under the contract, only one clinical psychiatrist, with a minimum of training, was available for the psychiatric care of 344 patients. There was but one graduate nurse whose duties were limited to the care of patients receiving shock therapy. There was one registered occupational therapist, no social workers and no nutritionist. The ratio of professional personnel to patients, the report points out, falls far short of professional standards.

The Oregon State Department of Health had not licensed the hospital in 1952 because of unsanitary plumbing cross-connections and conditions in the tuberculosis wards.

*1954 inspection of Morningside Hospital.*—This is a private institution caring for the mentally ill located on a tract of about 100 acres—all but 10 acres are in pasture or under cultivation—in the suburbs of Portland. The bulk of the patients are those received on contract from the Territory of Alaska (see table 6). A few beneficiaries of the United States Public Health Service also receive treatment there. The very few remaining patients are committed locally for temporary custodial care, pending transfer to public institutions or Veterans' Administration facilities.

TABLE 6.—*Alaska insane—Morningside Hospital*

| | 1950 | 1951 | 1952 | 1953 | 1954 |
|---|---|---|---|---|---|
| Patients, beginning of fiscal year | 328 | 348 | 338 | 344 | 348 |
| Admissions | 82 | 52 | 55 | 77 | ---------- |
| Discharges | 29 | 24 | 20 | 39 | ---------- |
| Paroled | 14 | 11 | 8 | 13 | ---------- |
| Escaped | 1 | 1 | 1 | 0 | ---------- |
| Died | 18 | 26 | 20 | 20 | ---------- |
| On home visit | 0 | 0 | 0 | 1 | ---------- |
| Remaining, end of fiscal year | 348 | 338 | 344 | 348 | ---------- |

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 highly diversified. The male assistant acts as paymaster, maintenance man, farm manager, and supervisor of the patients who work on the farm, as well as employing the male attendants and supervising them on the wards. The female assistant serves 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 both the physical and mental care of patients is an able and devoted physician. Unfortunately, his substantial training in psychiatry does not meet the requirements for certification by the specialty board in this sector of the medical specialists' guild. At the time of inspection, two young physicians were assisting him in the general medical care of 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 about the institution and on the farm, the occupational therapy, the dental program, and the consultant service—theoretically, all standards of service for Alaskan patients—and is responsible for all paroles and discharges.

Since the Schumacher 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 and grounds.*—The institution presently consists of 10 gray wooden ward buildings with a capacity of 407, now housing 357 patients. All buildings are protected against fire by a sprinkler system. A new ward for women patients suffering from tuberculosis is under construction to replace the very unsatisfactory building now used. The interiors of several buildings have been improved and an attempt is being made to make the living quarters for the patients more attractive and comfortable. The refurnishing and redecorating of the continued treatment service for women 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 now in use; it is bright, airy, and attractive. The plans for the new building to house tuberculous 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.

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 replanned to provide more pleasant areas for patients than are available now.

4. *Patient care.*—The patients were clean and even the most helpless were decently clothed. Their food was mediocre. What was served resembled items on the written menus in name only.

Each patient admitted is given a careful physical examination with a full laboratory workup. For complications, there is consultation with a specialist, either at the hospital or in his office. A local dentist is reported to make regular visits to examine the teeth of each new patient and do what corrective work is necessary. The dental equipment in the hospital, however, seemed insufficient for first-class dentistry.

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. Necessarily it is limited, with only one partly trained psychiatrist available for the care of 348 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 physician's complete ignorance of Alaskan dialects.

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 6 students. This department seems to have improved greatly since 1952 and has active and enthusiastic workers. Even patients who mentally are very "regressed" 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 psychiatrist's recommendation. Those whom we observed at farmwork seemed to proceed at their own tempo; some working energetically and others doing very little. We saw no evidence that they were under pressure to work.

A special problem—both psychiatric and physical—is posed by the high incidence of tuberculosis among Alaskan 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 tuberculous women. The treatment of these patients is supervised by a Portland specialist.

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 remedy the situation through the use of better techniques for patient care and cerain architectural changes which will reduce contact with the infection.

Not only persons with psychiatric disorders but also mental defectives are sent to Morningside from Alaska. The former have been ill, on the average, for about 2 years before admission to the hospital—a much longer period than is found among patients admitted to State mental hospitals here. In addition, about half the admissions are of native stock who come without case records. Without information as to the development of the psychosis and separated by so long a distance—often by language—from the relatives who might supply such information, one must say in all fairness that the psychiatrist at Morningside has an unusually difficult task. As health facilities are developed in Alaska, it will be possible to admit patients more promptly for treatment when the possibility of cure 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 patient records, selected at random, and found each one carefully detailed and up to date. Exceptionally praiseworthy was the care with which the intellectual level and behavior problems of mentally defective patients has been recorded. In spite of his heavy caseload, the psychiatrist was studying this group with genuine interest. In some institutions this is neglected because the condition of many of them does not respond to therapy.

5. *Rates of admission, discharge, and death.*—Admission rates for the population cannot be accurately determined. The military and their dependents and the transient construction workers undoubtedly obtain admissions elsewhere when mentally ill. Of the 1953 admissions, 18.3 percent were alcoholic psychoses, which is high; 18.3 percent were senile or arteriosclerotic; 51.6 percent were functional psychoses; 6.6 percent were personality disorders; and 3.3 percent were without psychosis. The significant figure seemed to be the high rate of psychotic alcoholism.

The institutions discharge rate per 1,000 patients was 164.3, almost exactly the national rate 164.6. The death rate in Morningside was 60.2 per 1,000 under treatment, while the national rate was 65.3. This indicates good physical care, particularly because many patients have tuberculosis on admission.

6. *Parole.*—It is very difficult to operate a proper parole system for psychiatric cases at a distance such as that between Alaska and Portland, particularly with so 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 but, because of the great distances within the Territory itself and the lack of trained personnel there, it would still remain a problem.

*1954 appraisal.*—In our judgement, the so-called chronic patients at Morningside Hospital are receiving as good, if not better, custodial care than is rendered in many State mental hospitals. Every person who is up and about is actively

engaged either in occupational therapy or in work about the farm, grounds, or buildings which is known as industrial therapy.

A limited but creditable psychiatric treatment is employed for patients who are acutely ill with a mental disease. At the time of our visit—and for many months before that, we were told—no patient was under any kind of restraint. The open men's ward was not even locked at night, yet for many years there had been virtually no runaways.

There should be no objection to the practice of selected patients working at household tasks, about the grounds, or on the well-run farm, since the task do not appear arduous and their hours of work were reported to be reasonable. We were told also that such assignments were on a voluntary basis and were much sought after by the patients, who were deprived of them for uncooperative behavior.

The occupational therapy department is now very good and very active in proportion to the patient population. It is affiliated with two local colleges which teach occupational therapy.

Specialist services are provided by a group of part-time consultants, including 19 physicians, 2 dentists, and psychologist, many of whom are associated with the University of Oregon Medical School. The diagnostic facilities for tuberculosis seemed adequate, but the housing of female tuberculous patients still is extremely bad. Practical control of infectious cases to prevent spread of the infection to employees still seems to be in the planning stage. Clinical records are complete and well kept; the autopsy record is excellent.

If one judged by the written menus, the food served the patients is dietetically adequate. Food actually served, however, is below standard. The renovation of the patients' dining room, a project started several years ago, now appears to be nearing completion, and the new equipment is good. At long last, too, a start has been made on the acutely needed women's tuberculosis unit, but we were not given a firm date for its completion.

*Conclusions about Morningside.*—It is the opinion of our mental health consultant, who has had a broad experience in the operation of mental hospitals, that all recommendations made here for the improvement of plant and services at Morningside Hospital could be financed within the present contract rate of about $6 a day per person. Since we had no opportunity to examine figures on the cost of operations at the hospital the final judgment on this point should be that of a qualified accountant.

It is our general impression that the Morningside management and personnel wish to do a good job and are willing to accept supervision and guidance. They reacted to our genuine interest in their problems. It is possible that they have profited substantially from their contract over the years since 1904—particularly before recent and contemplated improvements—and now can well afford to upgrade their plant and its services without financial hardship.

The people of Alaska need not fear for their friends and relatives who are sent to Morningside at this time. They are getting satisfactory care—not by any means the best obtainable, but far from the worst in State mental hospitals. Although the plant still has many deficiencies, and the professional staff badly needs reinforcement, the level of care at Morningside is about what one finds in an average State mental institution.

## RECOMMENDATIONS

1. *Commitment procedures.*—The Congress has not been sufficiently informed as to the need for enacting a modern law for the commitment of mental patients in Alaska. Such a law, drawn by competent authorities, has been recommended for enactment by the Council of State Governments. It has been modified to fit the conditions in all areas of Alaska; as modified, it has been contained in legislation considered by the Congress. We have found no valid objections to it. Since full hearings have been held on the subject by the 83d Congress, enactment should have high priority in the next session.

The Departments of the Interior, and Health, Education, and Welfare, should support such legislation strongly.

2. *Administration of contract care.*—The present responsibility to negotiate contracts for the care of the mentally ill Alaskans which now is lodged in the Division of the Territories of the Department of the Interior should be transferred to the United States Public Health Service, which has competent professional staff especially in its Mental Health Institute. The present location is remote from a medical setting. In any future contracts, much more detail



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 resident psychiatrist—governmentally employed—at the institution should be terminated.

3. *Sharing of costs.*—There has been much difference of opinion as to appropriate sharing of costs between the Federal and Territorial Governments for the care of Alaska's mental patients.

So long as the Federal Government has responsibility for health care of the native population, we believe this should include the costs of hospitalizing mental illness. Alaska should gradually assume the cost of providing for hospitalization of its residents unable to pay for such care and ineligible for care at Federal (natives, veterans, etc ) expense. To this end Alaska should be authorized to enact its own laws dealing with mental health, not subject to veto by the Congress nor to 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 either should provide a land grant as a source of revenue, or should authorize a special appropriation on a descending scale over a period of years.

4. *Mental hospital facilities.*—We do not feel that a new mental hospital is required at this time in Alaska to care for the present number of its patients (about 350). The present small unit at the Anchorage Hospital, however, should be fully activated for diagnosis and classification of patients as well as for intensive treatment. Comparable units should be provided elsewhere, determined by the number of trained psychiatrists who can be encouraged to settle in Alaska.

5. *Costs of contract care.*—We do not feel that, under proper controls, there is anything inherently wrong in utilizing privately owned hospital facilities for the care of Federal Government beneficiaries. Nevertheless, a thorough cost analysis should be made by the Government of the operations at Morningside Hospital during the past decade. Only through such a cost analysis based upon accurate accounting is the Government in a good position to negotiate the per diem rates at Morningside Hospital by relating the actual cost of services to the per diem payments. Such a cost analysis also would reveal the extent to which the sale of farm products, produced and processed to a large extent by patient labor, have benefited the owners rather than the patients.

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

(*b*) The food service must be improved by the employment of a well-trained nutritionist who would have the total supervision of the feeding of patients, including the ordering of the food, its 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 whom the patient would be enabled to keep in touch with friends. 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 defectives among Alaska patients. He could be helpful, also, in the psychiatric examination of patients and in their selection for treatment.

(*e*) A qualified assistant psychiatrist should be employed. The present caseload is far too great for one psychiatrist. It is not possible for one man to give really effective care to so many mental patients.

(*f*) The staff of the occupational therapy department should be enriched by someone especially trained in recreational therapy.

(*g*) A better schoolroom should be supplied for the mental defectives 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 new women's tuberculosis ward from the infirmary. A small addition to the men's infirmary would provide needed day-room space. A similar addition to the women's building would provide for the passage of personnel, thus keeping the area of infection apart from other buildings and services.

(b) The present arrangement of a psychiatrist in residence representing the Department of the Interior is unsound. It would be better if the hospital were held completely responsible for the program and were inspected by the Department at regular intervals. If the control of the program were placed in the Public Health Service, the Institute of Mental Health would be of great value for advice and supervision.

(c) In the event of future need to replace the present psychiatrist, we suggest that both the Director of Clinical Services and his chief assistant should be diplomates of the American Board of Psychiatry and Neurology.

(d) When or if future contracts are negotiated with Morningside Hospital, we suggest that the Public Health Service, through its Mental Health Institute, prescribe program and personnel in much more detail than is presently the case, and define exactly what type of care the Government expects its Alaska patients to receive in a mental hospital.

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Report No. 2486; Senate, 83d Congress, 2d session, August 13, 1954 (Mr. Kuchel).
Special report submitted by Morningside Hospital (unpublished), August 1954.
The (Portland) Oregonian, July 18, 1954.

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EXHIBIT 7

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

To: Regional medical director.
From: Psychiatric nursing consultant.
Subject: Field trip report—Oregon.
Date of departure (from Denver): October 11, 1956.
Date of return (to San Francisco): October 13, 1956.
Place: Morningside Hospital, Portland, Oreg.
Purpose: Regional nursing consultant accompanied Miss Tirzah Morgan (NIMH Mental Hospital Consultation and Survey Service) in her visit to Morningside Hospital in connection with the Alaska Survey.
Principal persons seen:
Mr. Wayne Coe, Mr. Henry Coe, owner and manager of hospital.
Dr. Allen Parker, psychologist.
Dr. J. Ray Langdon, psychiatrist.
Helen Nye, Lynnette McCoy, psychiatric nurses.
Dr. George Keller, Department of the Interior Administrator.
Matron, 2 occupational therapists, 1 teacher, several attendants.

SUMMARY

During this 2-day visit all of the hospital units were observed and the professional staff related their activities. The focus was on the patients' needs and how they were being met. However, it was impossible to discourage some comments which revealed differences in philosophies, personality conflict, and need for further interpretation of the role of the psychiatric nurse.

The two graduate nurses, with prior experience in psychiatric nursing, have been employed less than 2 years. They freely shared what information they had about the patients on treatment programs. They showed sincere interest in the patients and were appreciative of the opportunity to discuss Alaska cultural patterns with someone who had first-hand observations to relate.

The nurses apparently want to become more involved in hospital programs in such things as case conferences and attendant training. We discussed their 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 program in Alaska evolves. 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 F. BLANKENSHIP, M. D.,
*Regional Medical Director.*

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EXHIBIT 8

PUBLIC HEALTH SERVICE, HEW, 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.
Place: Morningside Hospital, Portland, Oreg.
Purpose: Morningside Hospital was visited as a part of the Alaska survey team study.
Principal persons seen:
Mr. Wayne Coe and Mr. Henry Coe, administrative officers.
Dr. Ray Langdon, staff psychiatrist.
Dr. Allen Parker, staff psychiatrist.
Mrs. V'Ona Schlappi, teacher.
Mrs. Dorothy Mickelson, registrar.
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 current status of their convalescent leave 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 Co.) has admitted mentally ill and mentally deficient patients from Alaska since 1904. It now consists of 100 acres of land at 10008 Southeast Stark Street in Portland, Oreg., and has a staff of 125 employees. The plant consists of a number of rambling buildings in good repair and a farm, which includes a Holstein dairy and a piggery. There is a considerable amount of truck farming done in which patients participate, and a cannery 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 21 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 now 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 marshal (a police officer) who may be assisted by a public health nurse. Dr. Keller officially approves both admissions and discharges and is responsible for investigations related to citi-

zenship, naturalization, and legal residence. He may request aid from the United States Department of Justice, Immigration and Naturalization Service in Portland. At the time of admission of a patient, the hospital receives a warrant for commitment to asylum for the insane to "commit and deliver * * * to Morningside Asylum at Portland * * *" and the judgment of the court. This becomes a part of the patient's record together with an informational form which is usually completed in Alaska by the referring physician, a public health nurse, a social worker, or anyone who is able to furnish the requested material. "We use every resource available in Alaska." This form includes the names and addresses of relatives and friends and information on the patient's education, guardianship, attitudes of relatives toward hospitalization, evidence of need for hospitalization, previous medical history (from physicians who may have treated the patient in recent years), records of previous hospitalization, and by material which might be available from social agencies with knowledge of the patient. This form may be followed by a more detailed account of the patient's life and behavior from relatives or other sources in Alaska.

At the time of admission, a letter is sent by the registrar to the nearest relative. This is in reality a form letter, but is typed for each case, with information changed as may be indicated by the psychiatrist. When possible, a social history is obtained from some source in Alaska, which may be a family physician or a public agency. This information is often meager and may consist of brief comments by the respondent.

At the time of admission, the admitting physician fills out a numbered receipt in triplicate: 1 copy is given to the accompanying marshal, 1 is retained in office files, and 1 is attached to the patient's commitment papers. It is from this receipt that the hospital number is assigned to each patient. A property list and receipt is made out for each patient and, when possible, the patient signs authorization for release of medical and personal records.

The initial diagnostic study and physical status of the patient are sent to the section of mental health. Process or continued recording are not forwarded, although a final summary in the event of convalescent leave or discharge is sent with recommendations. The section of mental health is informed of any change in the mental status of any patient during hospitalization.

*Treatment*

The six physicians on the attending staff visit the hospital several times monthly, or in emergent situations. Although the hospital is licensed by the State of Oregon, no sterilization is permitted at Morningside as provided for in Oregon law relating to State hospitals. Electroencephalograms are completed in Portland. There are complete medical reports in the case records, and both the psychiatrists and nurses provide progress records. (Refer to attached forms for these purposes.)

The hospital may admit patients other than those from Alaska for observational or holding purposes for the Department of Justice, the Veterans' Administration, the United States Public Health Service, the County Health Department, or pending admittance to local private hospitals, Fairlawn Sanitarium, and Holiday Park Hospital. Such patients are usually held for a maximum of 72 hours.

*Psychologists*

Dr. Allen Parker was employed in August 1955. He is a graduate of the University of Portland and prior to his present position he was on the staff of the university and in charge of its psychological clinic. He continues to teach there. His work at Morningside is in process of definition. In addition to psychological testing, he is to give general supervision to occupational therapy, the school program, and to work with problems arising in staff relationships. He is also interested in the development of group therapy.

*Vocational rehabilitation*

Since February 1956, the Seattle representative of the Alaska Department of Vocational Rehabilitation has visited Morningside twice monthly to interview patients who might be helped to leave the hospital through this type of assistance. At present, 10 patients are in process of evaluation and 1 patient has been placed on a job in Seattle. (The counselor is Mr. Raymond Hruschka, rehabilitation office, Firland Sanatorium, Seattle. Refer to the Annual Report of the Bureau of Vocational Rehabilitation, June 30, 1956.) Morningside patients have also received assistance in job placements from the Oregon State Employment Office



and the Portland Office of Employment Security. These have been cases in which a physical handicap was emphasized.

*Convalescent leave and discharge planning*

Predischarge planning primarily involves the nurse and psychiatrist. The nurse may assist in motivating the patient to consider leave; the psychiatrist contacts relatives, if available, to secure information about their attitudes about taking the patient, or other material pertinent to leave status. Because there is no social worker charged with the responsibility of leave 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 organized provisions for aftercare or followup of patients when they return to home and community.

On October 12, 1956, there were 12 patients on leave as follows: Washington, 4; California, 2; Alaska, Missouri, New York, Ohio, Oregon, Texas, 1 each.

A 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 to leave, the patient is given suitable clothing, a maximum of $25, and transportation to legal residence or elsewhere, but not exceeding cost to legal residence. The patient signs a form relieving Morningside Hospital of all responsibility at the time of leave, when he is 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. This summary may include recommendations for continued service. A letter of discharge is sent to the relative of the patient by the Department of the Interior, and the patient is automatically billed for reimbursement by the Department of the Interior. (Cost of patient care is set forth in the contract as $184 monthly, plus adjustment in accordance with the United States Bureau of Labor Statistics, Wholesale Price Index. Territorial statutes prohibits old-age assistance payments to any patient in an institution for tuberculosis or mental disorders (ch. 101, S. C. A., 1953).

*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 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 occupational therapy personnel also participate in recreational projects, such as, parties and picnics. A moving-picture show is given each Friday afternoon. Assignment to occupational therapy is made by the psychiatrist, with the approval of Dr. Keller. (Dr. Keller also approves any special assignments of patients, referrals to vocational rehabilitation, and both home visits and convalescent leave.)

*Volunteers*

There are no volunteers at Morningside. The use of volunteers from the Portland area is of interest to Dr. Parker who intends to investigate the possibility of securing such services from the American Red Cross or the Portland Community Chest.

*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 comments to more detailed recording. At this point, case recording is kept primarily by the psychiatrist, who also writes 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 as patients of the company." At this time, no patients are boarded out under these provisions.

*Evaluation of caseload for eventual disposition of patient population*

There is a case record on every patient, but the content 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 agencies, and possibly friends in certain instances. Each patient would be approached on a casework 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, potentialities, employment record, and any planning which has been developed in relation to vocational rehabilitation.

Disposition 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 return to Alaska for hospitalization.
(5) Patients who might be placed on convalescent leave or discharged.
(6) Patients who might be placed in foster home care under existing authority for boarding home care.

In reference to the last item, it is noted that approximately one-half of the patients in Morningside are over 60 years of age. It is assumed 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 in the average State hospital. The basic problem, however, is the fact that these patients are far removed from their relatives. It is, of course, financially difficult for relatives to visit or for patients to return home for either 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 their active participation in planning for the return of the patient to his home and community. It is felt that in a number of individual cases, the social worker would be basically involved in the "discovery of the patient and the resurrection of the relative."

RAYMOND W. CRAIG