MENTAL HEALTH SERVICES IN ALASKA: PAST, PRESENT, FUTURE

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Alaska, the American North, with its great ecological diversity and reservoir of untapped resources, is undergoing an intense exploitation and development. The construction of pipelines brings a large number of individuals into an alien arctic and subarctic environment. The 1980 census reports the Alaskan population to be 408,481 including a native population (Eskimo, Indian, Aleut) of 64,047 (16 %) (6, 12). Estimates at the time of Western contact (1740-1780) place the Alaskan indigenous population at approximately 74,000 (3).

The history of psychotherapy and mental health services for these indigenous Alaskans begins with shamanism (5). However, shamanism as a therapeutic practice was discouraged by early missionaries (5). The Eskimos' remarkably effective adjustment to an unkind environment was greatly upset by men from other lands introducing new ways, new ideas, new technology, and new diseases (2).

After western contact, the development of services for the mentally ill depended exclusively on the federal government for guidance (7). The federal government was, however, reluctant to assume responsibility for the mentally ill. Alaskans were unable to secure legislation which would provide for the treatment of the noncriminal mentally ill in mental institutions and, consequently, the mentally ill were incarcerated. Before a mentally ill person could be adjudged insane, he or she was convicted of a disdemeanor and sentenced to jail. After serving the required sentence, the individual was pronounced insane. This practice obliged the Justice Department under United States law to provide care for the insane prisoner at government expense until the mentally ill person could be transported to a Washington, D.C., government hospital (11). In 1898 Alaska legislators passed a criminal code which made provisions for the criminally insane. In 1900 a civil government bill became law and a civil procedure was established to be implemented by the three judicial courts in Alaska located in St. Michael, Juneau, and Eagle City (7).

In 1901 Governor Brady met with Oregon authorities and developed a contract for the care and treatment of Alaska's mentally ill in a Salem, Oregon facility for 20 USD per month per person (7). Morningside Hospital in Portland, Oregon held this contract from 1903 to 1962.

Alaska experienced a population explosion in the early 20th century when gold was discovered in Alaska and in the Yukon Territory. In October of 1905 sixty-five Alaskans were being treated in Morningside Hospital, Portland, Oregon, 1800 kilometers from Alaska's border. Two detention hospitals had been built in Fairbanks and Nome in 1913 so that at least the mentally ill would not have to be housed in jail while waiting for transport to Portland, Oregon.

United States Congress remained convinced that it was unwise economically and medically to treat the mentally ill in an Alaskan institution, consequently, home rule over the mentally ill was refused when Alaska was granted territorial status in 1912. Total responsibility for care and treatment of Alaska's mentally ill was not transferred to the Territory until 1957.

Five years earlier, the Territorial Division of Mental Health had established a clinic in Anchorage, Alaska. A second mental health facility was organized in Juneau in 1955 which was staffed by a psychologist. In 1959 the Juneau Clinic added a psychiatrist and social worker. The Northern Regional Clinic in Fairbanks began in 1959 with a psychiatric social worker and a psychologist.

A culmination of this effort was Alaska Psychiatric Institute, a 225 bed hospital for the mentally ill, opened in 1962 in Anchorage. Thus ended the era that forced thousands of Alaskans to be hospitalized at Morningside Hospital in Portland, Oregon (1).

In the meantime, rural Alaska in the 1950's and 1960's received mental health services from an informal network of Indian Health Service personnel, Public Health nurses, social workers, and clergymen (3). Psychiatric manpower in the 1950's and 1960's emanated from the three regional mental health clinics, the private sector, the

Public Health Service (Indian Health Service), and the military (4).

A pivotal event in Alaska history was the 1971 passage of the Alaska Native Claims Settlement Act establishing twelve Native Regional Corporations, and a Regional Health Corporation.

Four years later, in 1975, the Alaska State Legislature enacted the Community Mental Health Services Act with a provision for the first state-wide mental health advisory council. As a result of this enabling legislation, Alaska today has 23 mental health clinics. These clinics receive grants from the state and all have local citizen advisory boards. Eight of these mental health clinics are administered through Regional Native Health Corporations.

A landmark year for mental health care in Alaska was 1981. The State Legislature replaced obsolete statutes with a new commitment act for the mentally ill which provides for mental health services in the least retrictive environment closest to an individual's home. This legislation will further regionalize mental health services, thus enabling Alaskans to receive hospital services in general hospitals throughout Alaska. Therefore, in three decades Alaska's inpatient services will have gone from Portland, Oregon (Morningside Hospital), Anchorage, Alaska (Alaska Psychiatric Institute), to regional general hospitals.

This increase in number of mental health clinics from three to 22 in one decade markedly increased the capability of Alaskans to receive more specialized mental health services closer to their community of origin. Manpower recruitment and retention is a problem for this system of decentralized service delivery since the mean length of stay for mental health professionals in the 19 rural clinics is only 17.4 months (9, 10).

The next era of growth will require the development of regional community support systems including acute psychiatric hospital services, day hospital services, transitional facilities, and local regional case management targeted towards the chronic mentally ill. This spectrum of services will provide the mentally ill a continuity of care at a local level, thereby greatly decreasing the need for travel to a distant mental institution. The historical reliance in Alaska on distant mental hospitals has fostered the extrusion of the mentally ill from their families and communities. Additionally, geographically remote mental hospitals prevent individuals from successfully graduating from institutional care.

An area of research which has not received proper exploration is the effect of living in high latitudes with cold temperatures and extreme diurnal variations. The need for biobehavioral research in Alaska should receive high priority funding by State government. The mental health of a population is an integral part of the quality of life of future Alaskans, the State's greatest renewable resource. Alaska's mental health system must, therefore, stimulate and promote research endeavors that impact behavioral morbidity and morality in arctic and sub-arctic areas. Special research attention should be given to the safe and efficacious delivery of mental health services to native Alaskans taking into account socio-cultural differences.

Future mental health delivery in Alaska will have to utilize telecommunication technology to provide available specialized diagnostic and therapeutic services to remote areas. One such promising tool in telemedicine is slow scan television that sends a two-way audio-visual signal over telephone lines (8). Such a communicational network would allow specialized diagnostic services such as forensic psychiatric evaluations and pharmacotherapy to be performed by centralized professionals to remote patients via the telephone system. The local mental health professional in each Alaska district could regularly consult with the urban mental health specialist.

The first 60 years of Alaskan mental health service delivery has relied heavily on distant mental health hospitals, centralized service delivery, rapid changeover in mental health manpower, and a paucity of research. The challenge of the future depends on the stimulation of applied biobehavioral research, the applications and telemedicine to remote and scattered high latitude populations and continued development of a mental health manpower retention system.

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