Legislative Research Department September 9, 1975

M I N U T E S

SPECIAL COMMITTEE ON SOCIAL AND REHABILITATION INSTITUTIONS

August 18-19, 1975

Committee Members

Representative Roy M. Ehrlich, Chairman
Senator John W. Crofoot, Vice-Chairman
Senator Cale Hudson
Senator Robert B. Madden
Representative James Cubit
Representative Kenneth Francisco
Representative Rex B. Hoy
Representative Billie Joe Wisdom
Representative R. C. Zajic

Staff Members

Norman Furse, Revisor of Statutes Office
John Schott, Legislative Research Department
Ramon Powers, Legislative Research Department
Emalene Correll, Legislative Research Department

Others

Dr. Robert Haines, Department of Social and Rehabilitation Services, Division of Mental Health and Mental Retardation
J. Russell Mills, Sr., Superintendent, Osawatomie State Hospital
Dr. Jose Cruz, Psychiatrist, Osawatomie State Hospital
Mel Manning, Business Manager, Osawatomie State Hospital
Norma Stephens, Registrar, Osawatomie State Hospital
Jean Brown, Chief Nurse, Osawatomie State Hospital
Larry D. McCourt, PI/PR Director, Osawatomie State Hospital
Barbara Gray, YRC Director, Osawatomie State Hospital
Jack Z. Southwick, Program Director, Rainbow Unit, Kansas City
James Hays, Division of Budget
Floyd E. Sappington, Superintendent, Atchison Youth Center

The meeting was called to order by Chairman Ehrlich, at Osawatomie State Hospital, Osawatomie, Kansas. The chairman stated that Representatives Buzzi and Lawing had called stating they would be unable to attend and both were excused.

A motion was made and seconded to approve the minutes of the last meeting. The motion passed.

A question was raised regarding the decision not to utilize space at the Southeast Kansas Tuberculosis Hospital for outpatient services for tuberculosis patients. Staff distributed a letter from Dwight F. Metzler, Secretary, Department of Health and Environment, stating the reasons for this decision. (Attachment A).

The meeting was turned over to J. Russell Mills, Sr., Superintendent of Osawatomie State Hospital, who introduced staff members present. Mr. Mills stated that Osawatomie State Hospital serves the eastern tier of counties. Because of a decreased population, the hospital was reorganized in 1974 on the unit plan and includes the following units: adolescents and young adults - 108 beds; adult psychiatry - 217 beds; senior citizens - 36 beds; alcoholism - 62 beds; medical-surgical - 53 beds; youth rehabilitation unit - 45 beds.

Boys 16 to 18 years of age are committed to the Youth Rehabilitation Center Unit by a judge because they are delinquent although they may also have mental problems. All boys are admitted to an open cottage and are then assigned to a specific type cottage according to their adjustment. In 1974 approximately 53% of the boys were committed because of assault, burglarly, theft and robbery and approximately 2% for running away.

As of July 21, the capacity of this unit was increased from 20 to 45 by moving some adult patients. The staffing pattern for this section has remained the same but as more boys are admitted, staff will have to be increased. There are 23 boys on the unit now - five are in the closed security unit which has a maximum capacity of eight.

There are about 60 boys and girls 21 years of age or under on the adolescent and young adult unit but this number generally increases after school starts in the fall. This situation exists due in part to the inability of youth to cope with the closed situation and the pressures of school.

Students on this unit attend school on the hospital grounds approximately three hours per day. Under contract, the hospital determines the necessary qualifications for teachers who are hired through the local school district.

There is a 41% recidivism rate overall for all adolescent and young adult programs. A breakdown for the various units was not available.

There were 462 court and voluntary admissions to the alcoholism unit last year. In this six week program there are no age limits for admission, and in the last few months admissions have included 17 to 19 year olds.

Approximately 75% of the patients on the adult psychiatry unit stay 90 days or less; 3% to 5% stay two years or longer. All long term patients, which are all ages, are in one section. These patients will always need to be in a controlled living situation although some of them might be able to work in a sheltered workshop situation. The state picks up most of the cost for these patients unless they are on Medicaid.

There are 17 physician positions for the hospital with two positions not filled. There are four psychiatrists, all of whom are foreign doctors. Four physicians have a license; three have a Florida license which may be reciprocal; other physicians have a fellowship license. The fact the hospital does not furnish malpractice insurance for physicians is considered a serious problem. A licensed physician must purchase malpractice insurance at his own expense, and although a physician with a fellowship license can practice under the license of a licensed physician, he is not covered by that physician's malpractice insurance.

In responseto a question concerning employees, Mr. Mills indicated that there are 680 employees at Osawatomie State Hospital and 112 employees at the Rainbow unit in Kansas City, and that the average daily patient census is 369. Mr. Mills emphasized that this figure is not a true indicator of the workload. He pointed out that on the weekends, the census may drop to 330 but will peak at approximately 410 during the week. Therefore, the hospital needs to be staffed for 410 patients. He stated that 44% of the admissions are admitted after hours by an O.D. who may or may not be a psychiatrist.

In response to a question concerning mental health centers, it was pointed out that while the relationships with mental health centers are good they could be improved, especially in the area of admissions. In June only 9 or 104 admissions came from mental health centers. The hospital would like for the mental health centers to be the point of entry to the hospital, noting that the centers are in a position to evaluate patients and to explore alternatives to hospitalization and then, if necessary, refer them to the hospital. Hospital staff also feel the courts should make more use of the mental health centers instead of referring directly to the hospital.

Concerning patient payments for treatment, a year ago the patient cost was $43.00 per day. A system of billing patients for services used is being developed, with the computer costs paid from Division of Mental Health and Mental Retardation funds. In order to qualify for insurance payments, all patients are billed at the same rate for the total amount of services used. If a patient cannot pay, he must contact the fiscal officer at the hospital; a determination of his financial situation is made; the amount he cannot pay is shown as deferred on the bill. If the financial situation improves the person is expected to increase the amount paid. Bills remain open until the expiration of the statute of limitations, which is three years. Some cases go to litigation through the legal section of the Division and a portion is collected. Last year a total of $2,900,000 was billed; $1,500,000 was collected ($250,000 from families and the rest from third party payments). This system, which is used only at Osawatomie, does increase the amount of money collected.

There is some problem with contraband. As long as patients go home on leave and the public comes in, there is a source for contraband. However, the philosophy of the staff is that it is better to try to control the problem than the mobility of the patient or the public. If contraband does appear, the staff is usually pretty sure who has it.

Mr. Mills stated their inability to hire psychiatrists is one of their biggest problems. The clinical director's position has been vacant for almost a year. The salary range of $40,000, which he is not asking be raised, is competitive with VA hospitals but not with mental health centers. Dr. Haines stated they have eight resident training positions at KU and are asking it be increased to 12. The state pays these residents a stipend and upon completing their residency, they can either spend two years in service to the state or buy out for about $14,000.

Mr. Mills stated they are leaving two psychiatrist positions open and in the supplemental budget requests are asking to use these funds to hire consultants from Kansas City to supervise a ward one day per week.

There is a shortage of trained psychiatric aides, especially males, on duty. Aides must compelte six months training and psychiatric aid II an additional six months training. The hospital will be receiving CETA funds to hire 20 additional trainees but this will not solve the problem. Classes are not started until there are twenty vacancies and trainees do not work on the wards. The vacancies increase during the six months students are in training compounding the problem. Mr. Mills estimates there will be a shortage of 65 to 70 aides at all times.

Dr. Haines explained the Associate Arts degree mental health technician is being written off. Psychiatric aides will be called psychiatric technicians and must pass an exam administered by the State Board of Nursing at the completion of their training. Those who do not pass can be employed as mental health workers. Salary money is used to pay stipends during training.

Dr. Haines and Mr. Mills pointed out that S.B. 26 needs additional study. This bill states the patient has a right to treatment but treatment has not been defined by the courts and that the patient can refuse treatment even if he was admitted by the court. Staff pointed out that this latter is true under the present statute. Mr. Mills stated the patient can have these rights but the hospital should be able to discharge a patient without any liability. Hospital staff feel they can be sued if they do not treat a patient even though they do not have a program which meets his needs or if he refuses treatment.

Staff reviewed court cases pertaining to this and noted the Donaldson case which established right to treatment was decided on grounds other than those contained in S.B. 26.

Mr. Mills pointed out the real problem is in the definition of mental illness - dangerous to himself or others - which the psychiatric association beleives cannot be predicted. Making this determination is more of a problem when the OD doing the admitting is not a psychiatrist. Every patient is given a physical and psychological exam at admission. Under the present law the sheriff does not have to wait until these exams are completed but the hospital staff feels he would under the new law. Staff pointed out that S.B. 26 allows for temporary admissions with the same procedure as is now used. The registrar stated she believed admissions under S.B. 26 would be a problem because an attorney would have to be present at all times.

The paper work and time involved in duplication of accrediting agencies and in complying with requirements for grants with insufficient clerical staff is another problem. The additional clerical staff needed is not much when compared to the three million dollars received through the grants. Mr. Mills emphasized that compliance in order to become an accredited institution does mean better quality services and facilities.

Another problem is that accreditation standards now require that fire and safety standards must be met by the time the time the accreditation teams makes it visit. This may mean that, although money is allocated to bring some institutions up to specifications, they may lose accreditation because the work will not be completed in time. Also accreditation teams are using the 1967 standards although the 1970 standards are less restrictive. Dr. Haines stated the Department will have its own architect after September 8 and this may help alleviate the problem.

Mr. Mills discussed a recommendation to use the facility at Chanute for long term patients. This would make 60 additional beds available at Osawatomie for the YRC program. Dr. Haines is to provide the Committee with copies of this proposal.

Dr. Haines pointed out there are still problems with the Rainbow unit located in Kansas City which is legally a part of Osawatomie Hopsital but is operated as a part of the comprehensive mental health centers of Wyandotte and Johnson Counties. The programs are controlled by the directors and boards of these centers rather than by hospital staff and the Department. It was pointed out this was not the way it was presented to the legislature. Dr. Haines stated he knew this and had called this to the attention of the legislature but the reprimand the legislature gave the centers had not been strong enough to change the situation. Dr. Haines pointed out the state furnished all the matching money for construction, and that the centers now apply for matching staffing monies and forward $250,000 to the Department for the Rainbow unit.

Following further discussion the meeting was recessed for lunch and a tour of the hospital facilities.

The meeting was reconvened at 2:45 p.m. for comments and questions.

The hospital staff stated that in general group therapy is used although individual therapy is available depending on the patient's needs. Electroshock treatments require concurrence of two or three doctor's outside this setting. These treatments are administered at the KU Medical Center since their insurance covers this type treatment, which is rarely used.

Responding to questions concerning staff at Osawatomie, Mr. Mills stated that aide salaries range from about $488 to $608 per month, and that many male aides hold down a second job. It is difficult to recruit male aides because they can earn more in Kansas City or working elsewhere. Some borderline employees are kept on the assumption they are better than having none but most potential problem employees are screened out in the long training program. It was noted that the civil service process makes it difficult to fire an employee.

In response to medical services questions, Mr. Mills stated that Osawatomie has a fulltime pharmacist and pharmacy. A unit dosage system is used now because of some problems which showed up in a post audit. If drugs are nearing the expiration date, they are returned to the manufacturer for replacement or credit. He also noted that he feels the medical-surgical unit is sufficient since they can use the KU Medical Center facilities whenever necessary.

The chairman thanked Mr. Mills and his staff and thanked Dr. Haines for being with the committee. The meeting was adjourned until 9:00 a.m. at the Rainbow Unit in Kansas City.

August 19, 1975

The meeting was called to order by Chairman Ehrlich at 9:00 a.m. at the Rainbow Unit in Kansas City.

Dr. Haines stated that after the reorganization of the Division, he discussed the problems of the rainbow unit with Dr. Harder who felt the unit needed its own director. He then introduced Mr. Southwick, who was hired for this position.

Mr. Southwick stated that on administrative matters he works with Osawatomie State Hospital; on program and patient matters he works with the directors of the mental health centers in Johnson and Wyandotte counties.

At the time a decision was made to enlarge the Osawatomie facility, Johnson and Wyandotte counties were putting together plans for comprehensive mental health centers. Rainbow contracted to provide the 24 hour and partial hospitalization portion of this plan. Psychiatric emergency services were to be provided by the KU Medical Center. Each group (Johnson County, Wyandotte County and the State) had its own idea of what the Rainbow unit would be and at points these were in conflict.

In January, 1975, the first patients were received. Staff and program components were added to keep up with patient needs. All programs envisioned by the planners are now available. Representatives of each group meet once a week and while there is cooperation on patient care, certain problems exist in the administrative and fiscal areas. The Rainbow program is described in Attachment B. Their goals are listed in Attachment C.

In answer to a question, Mr. Southwick stated the primary catchment area of Rainbow is Johnson and Wyandotte counties, with a secondary catchment area, eligible only for children and substance abuse services, including the 22 surrounding counties. Services were not to be offered to the secondary catchment area until all components of the program are operating. Now that this has been accomplished guidelines for serving people from the secondary area are being developed.

Referrals to Rainbow are made through the mental health centers. If Osawatomie wants to transfer a patient to Rainbow, they refer them to the mental health center which then refers them to Rainbow. The courts also refer to the mental health center. Dr. Haines stated that the HEW Regional Office has said that the comprehensive mental health center directors must determine referrals, admissions and discharges. Mr. Southwick stated he did not object to this and feels it makes sense in terms of patient care and expense. Since a patient should be treated with the least expense and disruption of the family as possible, it makes sense to

screen for outpatients care and this should be done by the outpatient unit at the mental health center. If more care is needed, they can arrange for transfer to an inpatient unit. At the discharge end, a patient can be discharged sooner if the inpatient knows there is a well established outpatient program.

In answer to a question, Mr. Southwick stated they hope to work out a plan for shared staff with the community mental health centers to improve the flow of patients between the two. A pilot program is now operating with one psychiatrist who is assigned as the liaison psychiatrist with the Wyandotte center. Rainbow can refer patients directly to Osawatomie without going back through the mental health centers. However, they do notify the center of the transfer.

In answer to a question, Mr. Mills stated they prepare a budget, work on it with the people at Rainbow and then submit it directly to Dr. Haines office. Approximately one million dollars of the Rainbow budget is from state funds, and $400,000 is from the mental health centers. Technically, the federal government contracts with the two counties to provide mental health services, Rainbow works with Osawatomie to bill the mental health centers for services provided, and the centers write the checks to pay the bill. If Rainbow cancelled its contract with the mental health centers, the centers would have to contract elsewhere for in-patient services if they wanted to continue receiving federal comprehensive mental health funds.

Dr. Haines pointed out that state statutes permit counties to levy money for buildings separate from the mill levy for mental health services. Wyandotte did levy this money and used it to build their present mental health center. The statute is still on the books and money could be levied by the two counties to purchase the Rainbow unit over a period of time. In answer to a question, Dr. Haines stated that the federal grant money for construction of Rainbow had to come through the two counties and then to the state, which furnished all of the local matching money.

In answer to a question, Dr. Haines stated that the Division budgeted for full operation of Rainbow beginning July 1973 and Dr. Zubowitz, superintendent of Osawatomie, started hiring and training staff for it. Federal staffing funds were held up, necessitating total state funding of this staff for the first year. Rainbow did not get into operation until this year when federal funding became available.

Following further discussion, Mr. Southwick took the committee on a tour of the facilities. At the conclusion of the tour, the Chairman thanked Mr. Southwick and the Committee recessed for lunch.

The meeting reconvened at 2:00 p.m. at the Youth Center in Atchison, Kansas.

Floyd E. Sappington, Superintendent, explained that they have two programs: (1) A rehabilitation program for boys 13 to 14½ years of age at time of admission who have been adjudicated delinquent or miscreant. Status offenders are admitted for evaluation only. At the end of the evaluation, which is no longer than 120 days, they are returned to the referring agency. House parents are psychologists and social workers. The boys in this program can progress through levels from a small cottage to a larger cottage to the half-way house on campus.

(2) A 60 to 90 day evaluation program for boys and girls ages 6 to 16. Mr. Sappington stated he would not accept anyone who had been evaluated by another agency which had made recommendations. He will accept a child evaluated by a mental health center if the center feels the child should be evaluated outside of the home.

In answer to questions, Mr. Sappington stated the cost was approximately $28.00 per day last year. No breakdown is available for each type unit or program. Approximately 25% of the children come from families which are not indigent. Parents can provide for clothing and medical care but there is no provision for them to pay for food, shelter and program services. If the child has been on ADC, the center is supposed to receive 100% of the initial clothing allotment. A small percentage of children are covered by some type of health insurance. There is no charge to the referring agency or the family for evaluations.

The youth center accepts admissions from all counties. Families can refer their children directly through the schools. Parental consent is needed for all admissions except those made by the juvenile court in cases where they have jurisdiction over the child.

The average population, including both programs but exclusive of the half-way house, is approximately 87. There are 78½ staff positions including dietary and maintenance.

In answer to a question, Mr. Sappington stated they have very few readmissions but he is now seeing some from the second generation of the same families.

A social worker reports at least once a month on parolees. After four or five good reports from the local agency, the boy is discharged. The superintendent makes the final decision on all discharges.

The only waiting list (about 5 or 6) is for the evaluation unit for boys 12 and older. These should be accepted sometime in September. There is always an increase in admissions when school starts in the fall and another increase in January.

Immediate medical services are provided by a local doctor. The KU Medical Center provides a senior resident in pediatrics to do a physical exam on new admissions and to see any person complaining. The KU Medical Center is used for hospitalization in cases not requiring immediate attention. Otherwise, the local hospital is used.

Dr. Haines pointed out that the Youth Center no longer gets a consulting psychiatrist from Topeka State Hospital because four psychiatrists just resigned from the children's and adolescent section there. Mr. Sappington stated they are also without the services of a psychologist. Recruitment is a problem partly because of the location. It was suggested that since there are so few beds, the facility might be moved. Dr. Haines stated that an attempt was made to move it to Topeka in 1964 which was unsuccessful.

In answer to a question, Mr. Sappington stated they do not have a work program in which residents are paid for work done because they do not have sufficient staff to supervise it. However, residents are expected to keep their rooms clean and to work around their cottage doing such things as mowing the grass.

Personnel for their school is provided through a contract with the local school district. Educational programs are individualized, and children from both programs attend the same school but are in different classes.

Mr. Sappington took the Committee on a tour of the facilities.

When the Committee reconvened it was decided that the next meeting of the Committee will be September 15 and 16. September 15 will be spent at Norton (Norton State Hospital) and September 16 at Beloit (Youth Center at Beloit). If time permits, the Committee will also visit Valley Hope in Norton on September 15.

The meeting was adjourned.

Prepared by John Schott

Approved by Committee on:

10-15-75
Date

Attachment A

State of Kansas . . . ROBERT F. BENNETT, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, *Secretary* Topeka, Kansas 66620

August 14, 1975

Norman J. Furse
Office of Revisor of Statutes
State House
Topeka, Kansas 66612

Dear Mr. Furse: Norm

Three basic criteria have been used over the years to choose locations for outpatient tuberculosis services:

1. The availability in the community of a physician licensed in Kansas who is qualified in chest diseases, especially the diagnosis and treatment of tuberculosis, and who is willing to contract with the State to serve as the clinic physician for as many sessions as are dictated by the patient load. This is usually the most difficult criteria to fulfill.

2. The location of individuals needing clinic services so that the least amount of travel possible is required of the patient.

3. A hospital or full time local health department with outpatient clinic facilities which is willing to donate space for holding the clinic and to contract with the State for taking x-rays and performing various laboratory tests at prevailing rates for these services.

As you know, the Department of Health and Environment has provided, since 1960, outpatient tuberculosis services for all areas of the State except Southeast Kansas where we have, of course, not duplicated the services available at the Tuberculosis Hospital. As the hospital closes it becomes necessary for this Department to make services available for this area of the State on the same basis as clinics are operated in the balance of the State.

The three basic criteria were taken into account in deciding not to utilize space at the Southeast Kansas Tuberculosis Hospital.

1. There are no licensed physicians in Chanute who are qualified in chest diseases. Recently we queried all Kansas hospitals relative to their interest in hospitalizing tuberculosis patients and whether or not they had physicians on their staff qualified in chest diseases. To both of these questions, we received a negative reply from Neosho Memorial Hospital.

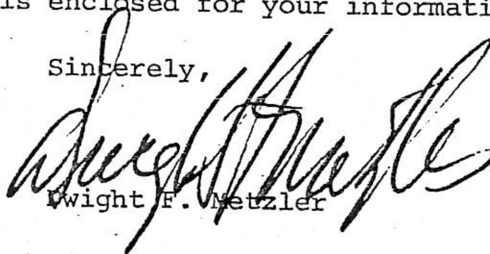
2. There are patients at both the northern and southern extremes of this area needing services.

3. In order to provide outpatient services for southeast Kansas, we estimate that it will require 2 1/2 days per month of physician services. It is not financially feasible to maintain a full time physical facility including x-ray and laboratory equipment and to hire laboratory and x-ray technicians and a physician to operate a clinic on this basis, when there are private hospitals in the area willing to donate physical space and which already have full time personnel on their staff willing to perform the necessary x-ray and laboratory services 2 1/2 days per month on a minimum fee for service basis.

If we had been assured that the Southeast Kansas Hospital was going to continue as some type of State medical facility and would continue to have on its staff x-ray and laboratory technicians and especially a physician qualified in the diagnosis and treatment of tuberculosis who could have been utilized 2 1/2 days per month for tuberculosis clinics then doubtlessly a different decision could have been made. We of course, had no such assurance. In the meantime it was necessary for us to begin planning for uninterrupted outpatient services to the tuberculosis patients of southeast Kansas, with quality care at the lowest possible cost to the State.

A map of the current outpatient clinic locations (including the two proposed locations for southeast Kansas) is enclosed for your information.

Sincerely,



Dwight F. Metzler

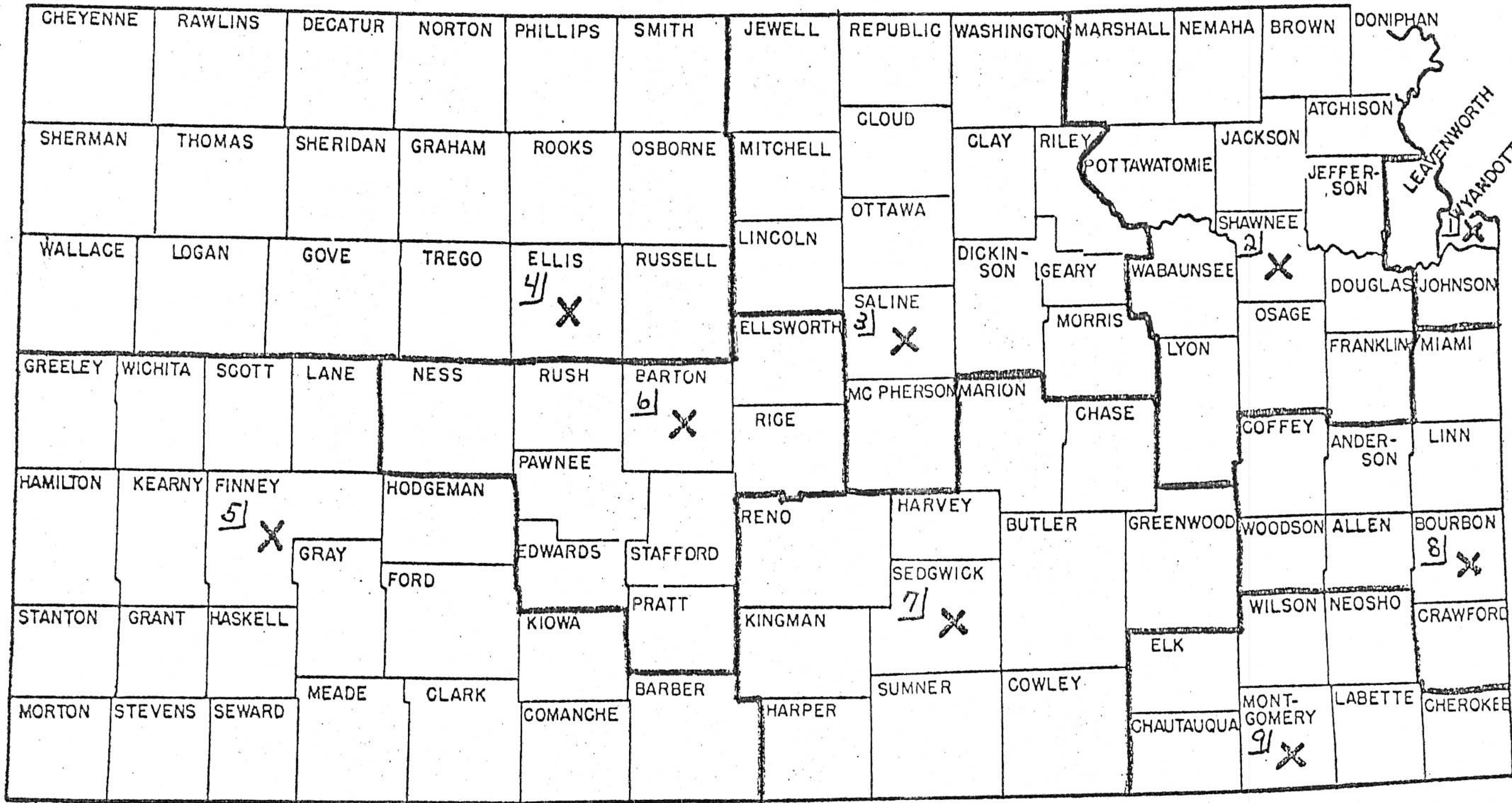
DFM:dh

Enclosure

cc: Dr. Wiese
Dr. Wilcox

REGIONAL TUBERCULOSIS OUTPATIENT CLINIC AREAS

STATE OF KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT



CENTERS

1. Kansas City
2. Topeka
3. Salina
4. Hays
5. Garden City
6. Great Bend
7. Wichita
8. Ft. Scott
9. Coffeyville

Attachment 13

RAINBOW UNIT

2205 West 36th Street

P. O. Box 3208

Kansas City, Kansas 66103

State of Kansas

Department of Social and Rehabilitation Services

PURPOSE:

Rainbow Unit works in conjunction with the Mental Health Centers of Johnson and Wyandotte Counties to provide a comprehensive range of mental health services to the residents of Johnson and Wyandotte Counties.

Rainbow Unit provides Inpatient and Partial Hospitalization services for children, adolescents and adults. The inpatient program provides a total of 30 beds for adults and 30 beds for children and adolescents arranged in 10-bed Cottage living units. Up to 60 adults and 60 children may be treated in the partial hospitalization program.

Short term mental health treatment is provided. Patients participate in a Cottage group which approximates a home environment. A patient assumes as much responsibility for his daily life as he is capable of assuming and avoids the development of dependency. This program makes it possible for him to continue to deal directly with problems of interpersonal and family relationships.

Close associations are maintained with community groups and activities so that the patient's reintegration back into the community is made easier.

STAFF:

120 staff members include Psychiatrists, Social Workers, Mental Health Technicians, Psychologists, Activity Therapists, Registered Nurses, Special Education Teachers, dietary, business, and maintenance and security personnel.

COST:

The cost of the program is $43.00 per day for Inpatient, and $10.00 per day for Partial Hospitalization. Charges are based on the patient's ability to pay.

ADMISSION:

Admission procedures for Rainbow Unit are initiated by Wyandot Mental Health Center, Johnson County Mental Health Center and the University of Kansas Medical Center Emergency Room. Admission to Rainbow Unit must be arranged through one of these facilities. Patients are evaluated there and a treatment plan is proposed. Those patients needing inpatient or partial hospitalization treatment are then referred to Rainbow Unit.

PROGRAMS:

CHILDREN'S & ADOLESCENTS' INPATIENT PROGRAM -
This program provides mental health services to children and adolescents who need full time inpatient treatment and/or an extended inpatient evaluation. Children are usually treated for 3 to 6 months. Referrals are then made for partial hospitalization or outpatient treatment. The treatment plan may include group and individual therapy; play therapy; family therapy; parents' groups; medication when necessary; special education; music, recreation, arts and crafts, and other activity therapies; and the provision of an accepting climate for the child. The treatment plan is individualized for each youngster.

ADULTS' INPATIENT PROGRAM -
This program provides mental health services to adults who need full time inpatient treatment and/or an extended inpatient evaluation. Adults are usually treated for less than 30 days. Referrals are then made for partial hospitalization or outpatient treatment. The treatment plan may include group and individual therapy; family therapy; family groups; medication when necessary; music, recreation, arts and crafts, and other activity therapies; and the provision of an accepting climate for the adult. The treatment plan is individualized for each adult.

SUBSTANCE ABUSE PROGRAM -
This program provides mental health services to people who abuse alcohol or drugs. Patients may be seen for

a 10-14 day inpatient period and/or for a period of partial hospitalization. The treatment plan may include individual or group therapy; family therapy; family groups; alcohol and drug education; medication when necessary; introduction to A.A.; music, recreation, arts and crafts, and other activity therapies; and the provision of an accepting climate for the patient. The treatment plan is individualized for each patient.

CHILDREN'S & ADOLESCENTS' PARTIAL HOSPITALIZATION PROGRAM-
This program provides mental health services while allowing the youngster to live at home. The treatment plan for a child or adolescent may include group and individual therapy; play therapy; family therapy; parents' groups; medication when necessary; special education; music, recreation, arts and crafts, and other activity therapies; and the provision of an accepting climate for the child. The treatment plan is individualized for each youngster.

ADULTS' PARTIAL HOSPITALIZATION PROGRAM -
This program provides mental health services while allowing the adult to live at home or work at his job. The program serves as an alternative to inpatient treatment. The treatment plan for an adult may include group and individual therapy; family therapy; family groups; medication when necessary; music, recreation, arts and crafts and other activity therapies; and the provision of an accepting climate for the adult. The treatment plan is individualized for each adult.

Attachment

RAINBOW UNIT
MISSION AND GOALS
July 1, 1975 - June 30, 1976

The mission of Rainbow Unit of Osawatomie State Hospital is:

1) To work in conjunction with the Community Mental Health Centers of Johnson and Wyandotte Counties and with the University of Kansas Medical Center to provide comprehensive mental health services.

2) To develop and implement new models of delivering mental health services between a State Hospital and Community Mental Health Centers.

3) To provide child, adolescent, adult and specialized inpatient and partial hospital psychiatric services to the residents of Johnson and Wyandotte Counties.

4) To provide short term psychiatric treatment of optimum length and effectiveness, with maximum family involvement and minimum family disruption.

5) To work with other community agencies to reintegrate patients into their communities (homes, families, schools, jobs) by synthesizing the emotional support programs of the hospital with community emotional support systems (health, welfare, education, recreation, religion).

Specific goals have been established for the program operation between July 1, 1975, and June 30, 1976. Objectives and work plans are being developed to assure the accomplishment of these goals. The established goals are:

I. Quantity of Service:

1) To increase the number of children and adolescents receiving partial hospitalization treatment between July 1, 1975, and June 30, 1976, to 72 children.

2) To increase the number of children and adolescents receiving inpatient hospitalization treatment between July 1, 1975, and June 30, 1976, to 80 children.

3) To increase the number of adults receiving psychiatric partial hospitalization treatment between July 1, 1975, and June 30, 1976, to 280 adults.

4) To increase the number of adults receiving psychiatric inpatient hospitalization treatment between July 1, 1975, and June 30, 1976, to 200 adults.

5) To increase the number of adults receiving substance abuse partial hospitalization treatment between July 1, 1975, and June 30, 1976, to 144 adults.

6) To increase the number of adults receiving substance abuse inpatient hospitalization treatment between July 1, 1975, and June 30, 1976, to 200 adults.

7) To implement a treatment service for young adults and older adolescents and have 80 percent utilization by June 30, 1976.

II. Quality of Service:

1) To receive full accreditation from JCAH.

2) To insure that 60% of all discharged adult patients report improvement in the behavior for which the patient was referred to Rainbow Unit, as reported by a survey of patients, their families and/or referral sources.

3) To insure that 75% of all discharged children or adolescent patients report improvement in the behavior for which the patient was referred to Rainbow Unit, as reported by a survey of patients, their families, schools, referral sources, and/or placement source.

4) To insure that 10% of all adults who were considered unemployed because of emotional problems upon entering Rainbow Unit will be employed or in job training as reported by a survey of the patient or family six months after discharge.

5) To insure that 20% of all adolescents or young adults who were considered school dropouts upon entering Rainbow Unit go on to take their GED's, are in school, or vocational training, as reported by a survey of the patient, parents, and/or schools six months after discharge.

6) To insure that 10% of all children or adolescents removed from their families by court action upon entering Rainbow Unit will be able to return to their families and function as an appropriate family unit as reported by the family and SRS worker six months after discharge.

7) To insure that 40% of persons treated for substance abuse achieve improved functioning as reported by the family and the referring source six months after discharge.

III. "Communitization" of Service:

1) To survey and list comments from referral sources and citizen's Boards to determine that the Rainbow program meets the mental health needs of the community for psychiatric inpatient and partial hospitalization services, and to assure that 60% report satisfaction with the Rainbow program.

2) To develop smooth admission and discharge planning to insure continuity of care between units of the comprehensive mental health system and other community care agencies - demonstrated by 50% of discharged patients following through on established discharge plans as reported by other agencies.