Approved 2/20/85
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by REPRESENTATIVE JOE KNOPP at
Chairperson

3:30 ~~xxx~~a.m./p.m. on January 31, 1985 in room 526-S of the Capitol.

All members were present except:

Representative Adam was excused.

Committee staff present:

Jerry Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department
Mary Ann Torrence, Revisor of Statutes' Office
Becca Conrad, Secretary

Conferees appearing before the committee:

Penny Johnson
Louis Frydman, PH.D.
Charley Andrews, Topeka Attorney
Ken Carpenter, Topeka Attorney
Michael Byington, Outreach Advocate/Case Manager
Raymond Spring, Governor's Advisory Commission on Mental Health
Arlene Metzger, Legislative Chairperson of the Kansas Families for Mental Health
Paul Klotz, Executive Director of Assocation of Community Mental Health Centers of Kansas
Dr. John Randolf, Agency Head of Mental Health Center of East Central Kansas

HB 2050 - An act concerning care and treatment of mentally ill persons.

The Chairman stated that staff prepared a summary analysis of HB 2050 with the current law, the proposed changes, and a summary of those changes, Attachment No. 1. He also stated that Representative Duncan and several members of the committee will serve as a subcommittee of five to take these proposed changes and suggestions and conduct further hearings if necessary and attempt to work out some of the problems to be presented to the whole committee for them to take up.

Penny Johnson, Overland Park, spoke against HB 2050 as written in Attachment No. 2.

Louis L. Frydman, PH.D., Lawrence, spoke against HB 2050 as stated in Attachment No. 3.

Charley Andrews, Attorney in Topeka, spoke in behalf of Judge Mary Schowengerdt. He opposed the bill pointing out some of the problem areas as follows: a.) a mentally ill person does not have the right to remain silent (how do you force a mentally ill person to cooperate?); b.) investigation orders (there is a lot of privacy involved in mental illness, and where will the line be drawn in investigation - to place of employment, schools, or any place?); and c.) definitions (language needs to be brought in line).

Ken Carpenter, Attorney in Topeka, also spoke strongly against HB 2050. He stated his work and education background in the mental health field, some historical background in this area, and his opinion that it was constitutionally wrong. He said that the role of the State in a commitment proceeding should be only under the circumstances in which there are no other alternatives. He said this bill took the right to decide about treatment away from the patient, and put it in the hands of the State. He said the areas he felt were unconstitutional are as follows: a.) exparte order; b.) involvement on continuing outpatient basis; c.) protection taken away by this bill from hearsay; d.) order for investigation; e.) ignoring the guardian right to hospitalize a ward; and f.) the right to remain silent.

Michael Byington, Outreach Advocate/Case Manager, spoke on behalf of Topeka Resource Center for the Handicapped for some areas and against others as written in Attachment No. 4.

Raymond Spring, Governor's Advisory Commission on Mental Health, stated that they do endorse this bill, and also that they realize it needs work. He addressed the following areas: a.) conditional release which has been in place and working for sometime; b.) outpatient commitment section; c.) changes in time-frames; and d.) the provision of limitation of liability.

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY,

room 526S, Statehouse, at 3:30 ~~a.m./~~p.m. on January 31, 19 85.

Arlene Metzger, Legislative Chairperson of the Kansas Families for Mental Health, spoke as stated in Attachment No. 5.

Paul Klotz, Executive Director of Association of Community Mental Health Centers of Kansas, introduced Dr. John Randolf who is an agency head of Mental Health Center of East Central Kansas. He spoke in support of HB 2050 as stated in Attachment No. 6.

The Chairman announced that further testimony would continue before the subcommittee which is made up of Representatives Duncan (Chairman), Fuller, Solbach, Whiteman and O'Neal. Further testimony and handouts concerning this bill are Attachments Nos. 7, 8, 9, 10, 11 and 12.

The meeting was adjourned at 5:00 p.m., and the subcommittee continued, after a short break, with the remaining testimony.

MAJOR CHANGES IN K.S.A. CHAPTER 59, ARTICLE 29
Care and Treatment for Mentally Ill Persons

Current Law	Proposed Law	Changes
K.S.A. 59-2902 — Definition section. Mentally ill person. . . who is dangerous to self and others.	K.S.A. 59-2902 — Mentally ill person. . . likely to cause harm to self or others or suffer substantial mental or physical deterioration.	K.S.A. 59-2902 — This section: 1. Allows commitment of those whose severe and abnormal condition cause the inability to function independently. 2. Includes definition of a patient who "lacks capacity to make an informed consent concerning treatment" which assures that patients can be treated with standard psychiatric interventions notwithstanding the patients treatment refusals. 3. Added definitions include "restraints," "seclusion," and "severe mental disorder." 4. Informal patient classification deleted.
K.S.A. 59-2907 — Discharge of voluntary patients. Procedure application for determination of a mentally ill person cannot be filed concerning a voluntary patient unless the patient or someone on behalf of a minor patient, requests discharge.	K.S.A. 59-2907 — An involuntary action application can be filed against a voluntary patient who refuses treatment or requests discharge.	K.S.A. 59-2907 — The change provides that an involuntary application can be filed against a voluntary patient who has a) refused reasonable treatment efforts and who is likely to cause harm to self or others, suffer substantial mental or physical deterioration, or b) has requested discharge.
K.S.A. 59-2912 — Order of protective custody; probable cause hearing; procedure. The statute provides for an order of protective custody upon verified application by a peace officer. The order is valid "until 5:00 p.m. of the second day of business of the district court, after issuance of the order, not to exceed 72 hours." A hearing must be held within 48 hours after filing of application.	K.S.A. 59-2912 — The proposed bill allows a law enforcement officer or other individual to apply for an order of protective custody. The order is valid until 5:00 p.m. of the fifth day of business of the district court. A hearing must be held not later than 5:00 p.m. of the 5th full day after the filing of application. At the hearing, evidentiary rules and procedural matters shall be informal and allow efficient presentation of all relevant probative evidence. Hearsay evidence may be received.	K.S.A. 59-2912 — Changes in this section allow not only law enforcement officers but also "other individuals" to apply for an order of protective custody. The time frame is extended from two to five days for an order of protective custody. The time frame for a protective custody order following a probable cause hearing is extended from 48 hours to the fifth full day that the court is open for business. Evidentiary rules are expanded to include hearsay.
K.S.A. 59-2914 — Mandatory preliminary orders; procedure. The minimum time for a mental illness hearing is 7 days and the maximum is 14 days after the filing of application.	K.S.A. 59-2914 — The minimum and maximum time period for a commitment hearing is changed to a minimum of 14 and a maximum of 21 days. Mandatory investigation orders prior to the hearing are provided. Consolidation of a guardianship hearing may be allowed in conjunction with the commitment hearing. The court may allow a continuance, or advance the hearing, upon request of either party.	K.S.A. 59-2914 — The amendment changes the minimum and maximum time period for commitment hearings from a 7 day to a 14 day minimum and from a 14 day to a 21 day maximum. Mandatory investigations, prior to hearing, are required. Consolidation of commitment and guardianship hearings are allowed. Continuances or advancement of a hearing date are provided.

Attachment No. 1
House Judiciary
January 31, 1985

Current Law	Proposed Law	Changes
K.S.A. 59-2914a — Mental evaluation; procedure. Currently, a proposed patient, not in protective custody, who requests a mental illness hearing need not submit to a mental evaluation.	K.S.A. 59-2914a — Mental evaluations shall be ordered for all proposed patients without waiting for a probable cause hearing.	K.S.A. 59-2914 — The change would allow for a mental evaluation of a proposed patient immediately upon admission.

New Section 12

A patient would not have a right to remain silent at the mental evaluation or any hearing conducted under this act. Any information gathered during an evaluation or hearing is admissable in any hearing without regard to privilege. In general, disclosures by a proposed patient may not be used against the proposed patient on the issue of guilt in a criminal proceeding.

K.S.A. 59-2916 — Notice; contents. This section allows any of several persons to serve notice of application, alleging mental illness, on the proposed patient. Included are a physician, head of a mental health clinic, secretary of Social and Rehabilitation Services, any peace officer, or the proposed patient's attorney. Notice must be served not less than five days prior to the hearing.	K.S.A. 59-2916 — Notice is to be served by a law enforcement officer. Treatment personnel, if called upon, shall cooperate in obtaining service. Notice must be served not less than ten days prior to the hearing.	K.S.A. 59-2916 — This section restricts those persons who can serve notice on a proposed patient to law enforcement officers. The time prior to hearing, that notice must be served is increased from five to ten days.
K.S.A. 59-2916a — Medication and therapy prior to hearing. Within 48 hours prior to and during a mental illness hearing, a patient may be administered medication that will adversely affect the patient's judgment or hamper the patient's participation in the hearing. If medication has been administered, a record of all such medication shall be presented to the court.	K.S.A. 59-2916a — Medication may not be administered to a proposed patient, within 48 hours prior to and during any hearing, which the physician believes will adversely affect the patient's judgement or hamper the patient's participation in the hearing. If medication has been administered, counsel may examine any physician who administered medication. The court, upon finding the proposed patient's judgement is adversely affected, shall order no further medication be administered until the hearing is concluded. A reasonable continuance shall be granted.	K.S.A. 59-2916a — Patients need not be removed from medication unless the medication will have an adverse impact on hearing competency.

New Section 18

This section allows the court, following a regular commitment hearing, to enter an order for outpatient treatment. Under this section it is clear that the court has an additional option in ordering the place of treatment. Terms and conditions for the initiation of and continuation of outpatient treatment are detailed. Provisions for a change from outpatient treatment to inpatient treatment are included.

K.S.A. 59-2922 — Change of venue. Venue may be changed to a county where the patient is detained in a treatment facility or upon a finding that a patient cannot receive a fair hearing in the county of the patient's residence or presence.	K.S.A. 59-2922 — Venue may be changed to the county where the patient is detained or any other county, upon patient request, and a finding that a patient cannot receive a fair hearing in the county where the patient is present.	The matter of venue is simplified to avoid confusion in the exercise of jurisdiction.

New Section 20

Under this section, procedures are established for a hearing once each 90 days during the first six months of treatment and every 180 days thereafter to determine whether or not a patient continues to be mentally ill. The question of mental illness shall be determined by clear and convincing evidence. Current law allows a review proceeding every 90 days and a petition for discharge every six months. This section consolidates the matter of judicial review.

Current Law	Proposed Law	Changes
K.S.A. 59-2924 — Transfer; discharge; conditional release. Transfer is determined by the director of mental health and retardation services when transfer is in the best interest of the patient. Discharge shall be ordered when the head of the treatment facility determines the patient no longer needs treatment. Release may be conditioned upon a plan of treatment subject to review at the end of the first year and annually thereafter.	K.S.A. 59-2924 — The Secretary of SRS or the Secretary's designee may transfer any patient between state psychiatric hospitals or to any state institution for the mentally retarded when transfer is considered in the best interest of the patient. Notice of transfer shall be given to the committing court and the patient's next of kin or guardian. The head of the treatment facility shall review all applications for involuntary treatment to recommend diversion if patients to a less restrictive treatment alternative whenever appropriate.	K.S.A. 59-2924 — This section simplifies administrative transfer. Review of conditional release in the community is held more frequently, i.e., every 120 days instead of annually.
K.S.A. 59-2926 — Unauthorized absence; procedure. Written authorization is necessary to take a patient on unauthorized absence into custody.	K.S.A. 59-2926 — The head of a treatment facility may order a law enforcement officer to take the involuntary patient on unauthorized absence into custody upon oral or written authorization.	K.S.A. 59-2926 — Oral or written authorization to take an involuntary patient, with unauthorized absence, into custody is allowed. Oral authorization must be confirmed in writing as soon as possible.
K.S.A. 59-2928 — Restraint and seclusion. Restraints and seclusion, as determined by the head of a treatment facility or member of the medical staff, shall be the least restrictive measure. The use of restraints or seclusion shall be medically reevaluated every three hours. Signed statements explaining the use of restraints or seclusion shall be made a part of the patient's medical record.	K.S.A. 59-2928 — The amendment adds the provision of patient confinement in their room when necessary for security or proper institutional management. Also added are the use of restraints, when necessary, to maintain a safe patient posture or when needed for examination, treatment, or to insure the healing process.	K.S.A. 59-2928 — Expanded use of seclusion, primarily for security reasons, without the need for seclusion orders is allowed.
K.S.A. 59-2929 — Rights of patients. Various rights of patients are detailed including the "right to mail any correspondence which does not violate postal regulations."	K.S.A. 59-2929 — This section deletes the "right to mail any correspondence which does not violate postal regulations."	K.S.A. 59-2929 — The change allows the head of a treatment facility to restrict the right of a patient to mail "any correspondence which does not violate postal regulations."

New Section 25

Under this section, patients can perform labor as a part of a therapeutic program.

K.S.A. 59-2931 — Disclosure of records. This section prohibits disclosure of records except under selected consent conditions including consent of a parent or guardian if the patient is under 18. Provisions allow the head of a treatment facility, under certain circumstances, to allow or refuse disclosure of a patient's records.	K.S.A. 59-2931 — Minors, 14 and older, who requested voluntary admissions shall be able to consent to release of records without parental consent. Release of records to other mental health centers or the Department of Corrections, when appropriate, will not require consent.	K.S.A. 59-2931 — The provisions makes clear that minors, over 14, who request voluntary admission do not need parental consent for release of records. Treatment facilities and the Department of Corrections would be allowed to share medical records.
K.S.A. 59-2932 — Civil and criminal liability. Liability will not accrue to any person, under this act, who acts in good faith and without negligence.	K.S.A. 59-2932 — State psychiatric hospitals and their employees, shall be immune from civil liability, absent gross or wanton negligence, arising out of a decision refusing admission or discharging a person from a treatment facility. There is no duty to notify, advise, or warn anyone concerning nonadmission, transfer, or discharge of a patient.	K.S.A. 59-2932 — Immunity from civil liability would be granted to state psychiatric hospitals and their employees concerning decisions refusing admission, discharging, or releasing a patient from a treatment facility, absent gross or wanton negligence. Kansas has recognized wrongful discharge in Durflinger v. Artiles, 234 Kan. 484 (1983).

New Section 28

This section covers the procedures to be followed concerning the administration of medication for a patient. Psychotropic medications prescriptions shall have a termination date not exceeding 30 days. Patients receiving treatment will not have the right to refuse medication, including psychotropic medication.

I would like to express my appreciation to this legislative body for the opportunity to submit testimony on behalf of fellow primary consumers, The In Place membership(a psycho-social community based alternative of Johnson County, Ks.), Advocates for Mental Health, and as a member of Families For Mental Health in the matter of House Bill No. 2050.

Today given increasing demand and limited resources primary concern in providing comprohensive mental health services the focus and legislative support must continue to seek a balance for all consumers regarding civil liberties, future opportunity, and effective treatment; in addition, should seek to expand alternative forms of public and private services for progressive mental health to include community based programs.

Historically, Kansas mental health safeguards have developed slowly especially in regard to constitutional rights; however, in 1975 Kansas citizens enbarked on a road to set a firm course towards correcting its mental health systems flaws to ensure both consumers and non-consumers at least minimal protection from abridgement of civil liberties whether primary consumers were within the deplorable confines of institutions or in the community.

House Bill 2050 in its present form reverses this positive course, specifically lacking accountability for conduct of mental health professionals, allows for disregard for confidenality, abridges basic safeguards in respect to judicial review and confinement; in additon, promotes non-development of community based support systems ultimately leaving the primary consumer vunerable to the"revolving door" of institutions, labeling, and continual hopelessness.

Specific terms of this bill regarding conditional release; commitment based on "likely to cause harm", prior history, and heresay; in addition, treatment only to be rendered primarily by licensed facilities and professionals excludes the primary consumer from the right to choose alternative services and deprives vast opportunities to self-help approaches which in mental health and para-related fields have historically reduced the states burden to provide services; in addition, the enactment of H.B. 2050 would eventually eliminate alternatives such as The In Place given the professional requirements specified throughout these amendments in H.B. 2050.

In reviewing H.B 2050 extensively It is my recommendation that this bill be killed and/or set aside for further study and development to address the areas briefly mentioned here today.

Thank You,

Penny Sue Johnson

Penny Sue Johnson
5405 Antioch #4
Overland Park, Kansas 66202
913-722-6733

January 31, 1985

Attachment No. 2
House Judiciary
January 31, 1985

Presentation re: HB 2050

before the

House Judiciary Committee

Joe Knopp, Chairman

by

Louis L. Frydman, Ph.D.

January 31, 1985

Attachment No. 3
House Judiciary
January 31, 1985

My name is Louis L. Frydman. I have a Master's degree in social work and a doctorate in psychology. During the past 20 years I have been a social work educator, the last 16 of those years at the University of Kansas. I have done research in the areas of psychiatric legislation as well as psychiatric hospitalization, and have published in professional journals on both of these subjects. I am also a clinical social worker, licensed by the State of Kansas. I am appearing here today only in my personal capacity and as a member of the Advocates for Freedom in Mental Health, a broadly-based patients' rights advocacy group which was instrumental in the drafting and passage of the 1976 legislative revision that Dr. Harder is now asking you to repeal.

I wish to state that I am not ready to fully respond to HB 2050 and to the "supporting materials" provided by Dr. Harder and Mr. Rein. The materials submitted by these two gentlemen are so frighteningly far-reaching and so laden with distortions of facts, self-serving rationalizations, and contradictions, that I would need at least a month to separate the wheat from the chaff, if there is indeed any wheat to be found, and to submit a comprehensive, meaningful response to the issues involved. I am enclosing a statement by Sharon Jacobs, the Chairperson of the Advocates, who unfortunately is not able to appear before you today. Ms. Jacobs is calling upon you to kill this proposal. I do believe that such a move would save much time and effort on the Legislature's part. However, if you deem euthanasia not to be the answer, I am calling upon you to assign this bill to an interim committee for full and thorough review. Our group introduced our patients' rights bill in February 1973; our proposals were carefully scrutinized by a succession of interim committees over a 3-year period before being enacted by the Legislature. If our proposals warranted three years of study, HB 2050 warrants at least ten years.

The fact is that our group learned about HB 2050 only a little over one week ago. I wish to point out that prior to drafting our legislative proposals we spent a full year analyzing the issues and fully discussing them with all the parties involved: care providers, consumers, and experts in law as well as mental health. We spent many hours speaking with SRS staff and administrators, the state hospital superintendents in particular. We did our utmost to achieve the much-needed changes through negotiations and compromises. Only after all such efforts came to naught did we seek legislative changes. In contrast, Dr. Harder has apparently discussed his proposal only with himself, with his subordinates, and with those he could count on to support him, namely the various "families of the mentally ill" pressure groups who seek the power to coerce their loved ones into psychiatric treatment, institutionalization in particular.

Needless to say, Dr. Harder and his legal staff have failed to involve the Advocates, apparently hoping to steamroll the bill through the Committee before we could find out about it. As in all of our group's prior contacts with the Secretary he has similarly acted in a self-serving, high-handed, if not outright devious manner, we were hardly surprised. The Secretary can well be trusted to do everything in his power to protect the interests of his office, his organization, and his subordinates, at all costs, under all circumstances.

A case in point is the Secretary's answer to one of the members of this Committee during last week's hearing. Concern was expressed by one of the members of the Committee that under New Section 28, a prescription for psychotropic "medication" (powerful mind-altering drugs with potentially devastating side-effects) could be written with a termination date of up to 30 days and subject to renewal, apparently without any review or monitoring. (This issue is especially serious as, pursuant to New Section 28(b) involuntary patients would have absolutely no right to object to such drugging and would not even have recourse to an impartial review of such orders.) The Secretary assured the Committee that there was no need for any internal checks or controls as the Joint Commission on Accreditation of Hospitals (JCAH) monitors such prescriptions and sees to it that all treatment conforms to proper medicall standards. Nothing could be further from the truth, and Dr. Harder and his legal and medical staffs are well aware of this. Not only does JCAH not oversee or monitor each patient's treatment but, as the Secretary and his staff are well aware, Kansas hospitals do not comply with JCAH standards any more than they comply with the 1976 legislative revisions--the Kansas mental hospitals, apparently with the approval of the Secretary and his legal staff, essentially consider themselves to be above both the law and JCAH. The following grounds were listed for the "Accreditation Decision" reached by the JCAH examiners after their latest (1983) on-site team survey of Topeka State Hospital, the most fully staffed and the most highly funded of the three Kansas state hospitals:

" 1. Comprehensive assessments are not conducted in all need areas on a consistent basis.

2. Treatment plans are not reflective of the patients (sic) assessed needs and objectives are not specified in terms of measurable criteria, as previously recommended.

3. Progress notes do not document implementation of the treatment plan.

4. Treatment plan reviews are not reflective of changes in the patients (sic) actual condition.

5. Discharge summaries are frequently delinquent.-

6. Relative to therapeutic environment, the environment does not enhance the positive self-image of patients and preserve there (sic) human dignity.

7. The written plan for professional services is incomplete, fragmented, and lacks continuity.

8. The written plan for patient care monitoring is not discriptive (sic) of activities being conducted, and documentation is minimal.

9. Vocational rehabilitation assessments and service are not documented.

These nine findings, presented in their entirety, differ very little,if at all, from all the preceding JCAH accreditation findings since 1971, the year I first began to study the incredible chasm between the high reputation enjoyed by Topeka State Hospital and the actual low quality of its services. The Secretary receives a copy of all JCAH accreditation reports but he seems little concerned with the repeatedly documented failure of compliance with JCAH standards. The least he could do is to stop using JCAH as a cover for SRS's failure to provide any internal monitoring, review, or appeal channels, especially when it comes to forced drugging with powerful and risky psychotropic substances.

You should, by the way, be aware that over-"medicating" of psychiatric patients has for many years been epidemic in Kansas' psychiatric facilities. It is noteworthy that on many occasions our group has requested access to information about the nature and quantity of psychiatric drugs purchased by SRS and distributed to its various treatment facilities. Our request has invariably been turned down on the grounds of alleged confidentiality. Why is SRS so reluctant to share this information? Dr. Harder is well aware of this stonewalling.

Before concluding, I would like to return to the provisions of HB 2050. If this proposal becomes law, each and every citizen and resident of Kansas will be a candidate for involuntary treatment, on an inpatient or outpatient basis, for an indefinite period of time. Virtually all due-process safeguards would be eliminated. Not only could innocent, law-abiding citizens be involuntarily incarcerated and drugged, but after being discharged from inpatient treatment they could continue to be under the total control of the friendly local mental health center. All staff members would be granted close to total immunity for any wrongful acts. In the criminal justice area, prosecutors could readily hand over defendants to the psychiatric inquisitors, thus sparing themselves the effort of securing

convictions beyond a reasonable doubt in a court of law. Nobody could state this more clearly than William C. Rein, the apparent mastermind of HB 2050: "Some of the cases (of insanity determinations) are little more than stipulated pleas upon negotiated dispositions between the defense and prosecuting attorney. This may result from the fact that prosecutors realize that defendants may be more fully locked out of society by committing them to psychiatric treatment facilities than would be the case if sentenced to prison " (Having It Both Ways; Surveying the Area Between Least Restrictive Alternative and Wrongful Discharge,apparently unpublished, page 9, underlining added).

Freedom and democracy are too precious to be sacrificed in the name of mental health. Nothing is more "therapeutic" than our democratic way of life. It is folly to speak of mental health in a totalitarian society. The SRS administration, after doing everything in its power to derail the passage of the 1976 legislation, and after doing everything possible to avoid implementing its provisions after its passage, should not be allowed to appear before the Kansas Legislature to ask it to grant institutional psychiatry unfettered control over the lives of our citizens. No evidence has been produced to show that the 1976 enactment did not enhance the well being, as well as the freedom, of psychiatric patients, or that treatment efforts have in any way been hindered or compromised. Virtually all the federal and state court decisions since 1976 have, if anything, strengthened the rights of psychiatric patients. I know that Messrs. Harder and Rein do not appreciate being reminded of this, but they are only the servants of this state, not its masters. If any changes in the law are warranted, they should go in the direction of further protection of patients' rights and closer scrutiny of SRS's lack of compliance with the existing law and with JCAH standards. The creation of an office of SRS Ombudsman or Ombudswoman, strongly recommended by the 1979 Governor's Task Force on SRS, should be a top priority for our state, regardless of SRS's opposition to this.

Instead of cleaning his house, the Secretary is seeking to sweep the dirt under a legislative carpet and, in doing so, to turn Kansas into a totalitarian therapeutic state that would make the Soviet Union look good in comparison. We mustn't allow this to happen! Let us recognize HB 2050 for what it is and replace it with provisions which would help to keep Kansas in its traditional place as a beacon of freedom and justice.

Thank you for allowing me to appear before you.

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

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MITCH COOPER, L.M.S.W.
Executive Director

January 31, 1985

TO: Kansas House Judiciary

FROM: Michael Byington, Outreach Advocate/Case Manager

SUBJECT: HB 2050

I certainly agree that Kansas needs new legislation dealing with civil commitments and related matters. From that standpoint, I feel Dr. Harder and his staff are to be commended in getting the document represented by HB 2050 together.

My support of HB 2050 in its present form is, however, to say the least, conditional. There are several areas about which I am concerned. In this document, I shall describe each of these and suggest amendments.

On page four, I am concerned about the definition of "treatment". A service which is simply intended to promote mental health could mean no more than maintaining an individual on repressive control drugs. I am not suggesting that such drug maintenance is necessarily always bad. To the contrary, I realize that sometimes it indeed improves a mentally ill person's quality of life. I do suggest, however, that, the general category of treatment needs to be more specifically defined particularly in reference to medication as treatment. The wording in reference to the activity being in the best interest of the patient needs to stay in the law, and I also might suggest that a statement be added to the definition to the effect that treatment may include, but is not necessarily limited to (and then list some examples of some of the more frequently and successfully used treatment activities practiced in the our state facilities.)

On page 29, I have major concerns about (b). Basically this clause states that the secretary of the department of social and rehabilitation services can move an involuntarily committed individual from one facility to another if it is thought to be in the patient's best interest, and can then tell the parent, guardian, and/or court about it later. I believe that the patient, parent, guardian, and/or court should be told about the move a sufficient number of days before it is to actually take place so that, if any of these parties disagree with the assumption concerning the move being in the best interest of the patient, this matter can be brought before an S.R.S. Hearings

Attachment No. 4
House Judiciary
January 31, 1985

Officer through the S.R.S. administrative appeals process. I believe that this right to judicial review through this hearings process should be noted specifically in the Section (b) on page 29.

The right of the patient to receive and send out confidential mail is extremely confused by this bill. This section needs to be cleaned up. Page 32, Section 24 (a) (2) basically gives the head of the treatment facility the right to deny the patient the right to confidential incoming and outgoing mail, but assures that such mail must be opened in the patient's presence at any time when confidential mail is denied. Part (b) of this same section and sub-section, located on page 33, however, assures the patient the right to communicate with his/her attorney, physician, the head of the treatment facility, and/or the secretary of social and rehabilitation services in reference to incoming and outgoing mail in a confidential and private manner. Also on page 33, however, (b) strikes the patient's right to mail any correspondence which does not violate postal regulations. My comment in reference to all of this is that the provisions in (8) do not provide sufficient safeguards for the patient's right to confidentiality in light of the provisions of (2). The part of (b) which has been stricken should be put back in. Also, the patient's parents, guardian, non-attorney advocate, spouse, and state legislators should be added to the list of those with protected confidentiality shown in (8).

I realize that this bill is potentially a great step forward in reference to the area of civil commitments, and I realize that certain changes in the current law must be made to bring it into cooperative compliance with the new Kansas guardian statutes. In its current form, however, I fear this bill might in fact weaken the effectiveness of the vary guardianship statute it is intended to observe. Please therefore incorporate my proposed amendments into the bill. Thank you.

KFFMH
Arlene Metzger
4538 N.E. Meridan Rd
Topeka, Kansas, 66617

House Bill #2050

January 31, 1985

As Legislative Chairperson of the KFFMH, living in Shawnee County, and mother of a 30 year old son with a neurological impairment and diagnosed Schzophrenic at the age of 13, he had to first be hospitalized which was the hardest thing I have had to do in my lifetime. Over 15 years, he has had to be hospitalized again & again. His father was his legal guardian which lended a little help in getting him admitted each time, but now,I understand that a guardian cannot do this.

My husband and I are convinced that our son would not be alive today if his father hadn't had guardian rights to get involuntary hospitalization for him when he needed it. Our son at times would be missing for weeks. Then word would come to us that he was still alive only by receiving a hospital emergency room request for payment of treatment from that hospital which was usually in another state. He has eaten out of trash cans, jumped freight trains, slept under bridges, mugged & left for dead. Many times, he has been picked up by the police and thrown in jail because they judged him to be under the influence of a mind altering element, only to realize after several days in jail that he was afflicted by withdrawn symptoms from the many years of heavy doses of medication he received while being hospitalized. Even worse our son,like so many is very vulnerable and is used by the criminal element by the community. The only real crime he had was brain disfunction, and at one time felony for breaking a large store window when running from officers, trying to return him to the Topeka State Hospital he had ran from. Our son is 6'8" and it was hard for police, aides or others to control him when he became upset, still his physical aggressiveness was not toward persons. Today, he will tell you that some of these officers are his good friends.

Because of deinstitutionalization families have been given more responsibility than ever for the care of the loved ones with mental illness, but the right to seek treatment has been taken from us. As responsible citizens, how can our lawmakers expect a person who cannot even reason to decide for him or herself to receive treatment or hospitalization? A diabetic is not given sugar, a heart patient is told not to run five miles, nor should a brain diseased person supposed to make logical decisions at a time when it can be detrimental to their well being.

How many times this week have you picked up your newspaper or heard on T.V. or radio of a suicide, criminally insane act or accident that was caused by a person who's families to no avail, seeked help or hospitalization for that person. The National Institute of Mental Health reports that one out of every 5 adults at one time, is faced with mental illness of some sort. It is likely to happen to 20% of us here in this room. Will you or one of your loved ones be the next? What will you or can you do to help them? Even your family may need HB 2050 in order for them to receive treatment.

Our son is now doing better than the proffesional said was possible. He is living in Topeka with the help of SSI, a medical card, food stamps, Breakthrough House & has friends and family that cares. The history of mental illness is preventing him from finding employment. But he is alive and trying.

The three things the families need to know is that the state will see that treatment is accessible to our loved ones even when they are not able to choose. It is to bad when our mentally ill know that they cannot receive treatment until they try taking their own life or harming another. We feel that the availability and accessibility of hospitalization be insured, but also that these services be available in the community, auch as housing, medication management, outreach case management, and vocational training, to hopefully prevent the neccessity of rehospitalization.

Attachment No. 5
House Judiciary
January 31, 1985

Association of Community
Mental Health Centers of Kansas
820 Quincy, Suite 416/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

STATEMENT OF HOUSE JUDICIARY COMMITTEE
Joe Knopp, Chairman
January 31, 1985

Presented by John G. Randolph, Ph.D.

Mr. Chairman and Members of the Committee:

The Association of Community Mental Health Centers of Kansas supports House Bill 2050. We have a vested interest, as we stand to gain more "business" should this bill pass into law as written. Actually, this anticipated "increased business" will require a major commitment from Centers to mount and sustain a reliable and organized service program for a significant new group of outpatients. We believe that this proposed legislation is consistent with the Kansas Long-Range Mental Health Plan, with its focus on optional use of public-supported treatment facilities, including maximum coordination of effort between state hospitals and community mental health centers. We believe that new provisions for involuntary outpatient treatment, continuation of provision for conditional release, and the new provision for diversion of proposed patients and involuntary patients from inpatient hospitalization create important opportunities for treatment through the least restrictive appropriate alternative.

We believe that the modified definition of a "mentally ill person" set forth in House Bill 2050 represents a major improvement over current law. By including likelihood of suffering "substantial mental or physical deterioration" as a possible element of the definition, the bill allows for proper and humane intervention on behalf of certain proposed patients that is not sanctioned by current law.

We are concerned about the potential ramifications of a change in the definition of "treatment" set forth in the bill, which adds "under the orders"... of a physician. Could the amended definition of "treatment" be held to create a legal requirement that all voluntary treatment provided by a community mental health center be ordered by a physician?

Finally, because of the increased responsibility and liability Centers will experience should this legislation pass, we request the following amendment:

On page 36, we request the following be inserted on line 0271 after ... "(b) State psychiatric hospitals and their employees," community mental health centers as licensed by K.S.A. 75-3307b and their employees, ... Also, we request insertion on line 0276 after ..." of a state psychiatric hospital" or community mental health center ...

Thank you for the opportunity to present our views.

Attachment No. 6
House Judiciary
January 31, 1985

TESTIMONY ON INVOLUNTARY HOSPITALIZATION: H.B. 2050
January 23, 1985
Erwin T. Janssen, M.D.

Mr. Chairman, and members of the Judicial Committee, my name is Erv Janssen, M.D., and I am a physician and psychiatrist practicing here in Topeka. I am representing the Kansas Psychiatric Society and the Kansas Medical Society since I am chairman of both legislative committees.

I wish to speak in favor of House Bill 2050. The changes contained within the proposed statute are designed to be humane and conceptually sound for the medical and psychiatric treatment of patients who suffer from a severe mental disorder. Physicians have found the current statute to be inhibiting for the early treatment of severe mental disorders. The more humane approach is the early treatment which is more likely to reduce the length of treatment, the pain and suffering of the patient, as well as the impact upon those who are close to the patient, namely, family and friends. Clinically we see patients who without early and prompt hospitalization are likely to suffer substantial mental or physical deterioration. Family members and physicians stand helplessly by since our current statute does not allow adequate, early treatment of these individuals. If they are not treated, they will suffer continued mental, emotional, or physical distress, with the end result being the deterioration of their ability to function on their own, thus becoming virtual prisoners to their illness, wandering the streets or incarcerated inappropriately in jails.

Several other features of the proposed legislation have clinical relevance:

1. The sequence of legal steps has been altered to allow for added time to obtain greater diagnostic understanding and to obtain added information regarding family or community resources, thus providing more information for appropriate treatment planning. From clinical experience we recognize that a number of patients who are involuntarily committed will, when their apprehension and anxiety have decreased, recognize the potential value of the hospital and voluntarily sign for continued hospitalization, thus avoiding the legal actions which often are confusing and anti-therapeutic for the patient and time consuming for the professional.

2. The bill also contains measures to help integrate the public mental health system (the state hospitals and mental health centers).

3. Clinicians will be able to have more flexibility in working with patients for timely discharge and follow-up in the least restrictive environment possible.

In summary, the bill has clear advantages over the current statute, and the Kansas Psychiatric Society and Kansas Medical Society would recommend passage of this legislation.

Attachment No. 7
House Judiciary
January 31, 1985

STATE OF KANSAS
JOHN CARLIN, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MENTAL HEALTH AND
RETARDATION SERVICES

ROBERT C. HARDER, *Secretary*

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612
(913) 296-3774
KANS-A-N 561-3774

MEMORANDUM

FROM: Gerald T. Hannah, Ph.D., Commissioner
Mental Health & Retardation Services

DATE: January 31, 1985

TO: Representative Knopp, Chairperson
and Members of the Judiciary Committee

SUBJECT: Ammendment to
HB 2050 & HB 2053

HB:2053, Line 71 "Except in cases of emergency, the notice shall be given at least two weeks prior to the date of the transfer."

HB:2050, Page 29, Line 34, "Except in cases of emergency, the notice shall be given at least two weeks prior to the date of the transfer."

cc: Secretary Harder
Mary Ann Torrence

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Attachment No. 8
House Judiciary
January 31, 1985

Advocates for Freedom in Mental Health

Sharon Jacobs
Chairperson
~~4448 Francis~~ 1026 S 56th Terrace
Kansas City, Kansas ~~66106~~ 66106
913-~~262-6812~~ 287-6498

Branch
Lawrence, Kansas
913-842-4088

January 31, 1985

TO: Committee on Judiciary
Capitol Building, Topeka, Kansas
Hearing Proceedings
House Bill #2050
Room 526S

FROM: The Advocates for Freedom in Mental Health

RE: Response to House Bill #2050

The Advocates are requesting that House Bill #2050 be killed in Committee.

The provisions are so antiquated that the passage of this bill in its present form will set back the civil rights and care and treatment of patients. It appears the State of Kansas wants to return to a police state and have total control over the lives of mental patients.

The present legislation has not prohibited the care and treatment of patients. Without repealing a law, there are avenues in present legal due process that provides emergency hospitalization and care and treatment for people.

Across the country, states have passed laws that provide a minimum floor of bill of rights. In Kansas, the law passed in 1976 originally provides such a floor of rights and there wasn't any intention of returning to the middle ages in providing care and treatment, protection of due process, safeguarding civil rights, or freedom of choice in alternatives. We would hope the State of Kansas would be progressive and expand civil rights instead of proposing House Bill 2050.

At the present time, the care and treatment of patients are controlled by the psychiatrists. They have couched their treatment based on theraputic judgement and infringed and ran rampant over peoples' rights

The passage of House Bill 2050 would hand over the rights of patients to the complete control of the mental health establishment, repeal years of civil rights protection and dismantle present legislation that provides protection of patients.

Sharon Jacobs
Chairperson

Attachment No. 9
House Judiciary
January 31, 1985

K.F.F.M.H.

Kansas Families For Mental Health

1268 Western
Topeka, Kansas 66612
913-232-6807

HB 2050 January 31, 1985

My name is Howard Snyder, and I'm from Prairie Village. I'm testifying today as President of KFFMH in support of HB2050. KFFMH is a state-wide organization of family support groups made up of families who have long term mentally ill family members. We represent approximately 300 families in Kansas. There are local chapters in Lawrence, Topeka, Johnson County, Kansas City, Wichita, Hiawatha, Concordia, Manhattan, Hutchinson, Newton, McPherson, Winfied and Emporia.

The most pressing reason for our support of this bill grows out of the deinstitutionalication movement of the 1960s. The theory of deinstitutionalization consists of 2 parts. 1. People would be moved out of the hospitals to live in their communities, because it was assumed that they would be able to function at a high level if they regularly took the new Psychotropic Medications which had been recently discovered. 2. Services which had been provided in the hospitals were to be provided in their own caring community.

Part 1 was implemented quickly. For example, Osawatomie State Hospital was reduced from a capacity of 2000 to 400, thereby saving the state millions of dollars each year. Part 2, the development of community services has just begun to be addressed in the past 3 years (20years late). The development of caring communities is still to be addressed, and the fact is that most communities are still extremely resistant to accepting people suffering from long term mental illness, because of fear and ignorance.

The net result of all of this is that the primary care providers have become: the family, a few nursing homes, our jails and finally a blot on our society-the streets. Some good community programs have been developed by SRS and the Mental Health Centers, but they are few when viewed against the need.

The family, by default, has become the most important primary care provider for the long term mentally ill. But the family has no tools to work with. The problem which I want to focus on today is the barrier that families meet when they need to get treatment for their family member and their family member refuses to seek or accept treatment. They are faced then with only two options. They can either choose to continue to live with a person who is an intolerable burden for many reasons, or they can choose to put this non-functioning person out on the streets to face all the miseries and dangers of that life. Some choice!

The hope of the 60s that mentally ill people would voluntarily seek treatment was just a myth. They most often do <u>not</u> seek treatment. The Ohio Dept. of Mental Health did a study that showed that only 20% of the long term mentally ill in Ohio voluntarily seek treatment. Closer to home, in my county less than 20% of the estimated total of long term mentally ill are in treatment. A large majority refuse treatment. It would be unthinkable to require a person with a broken leg to walk to the hospital to have it set, but we require a person with a malfunctioning brain to make rational decisions about their own welfare.

When a family seeks help through treatment for their loved one, they run head on into the barrier of "dangerousness". Present law states that a person must be "dangerous"

Attachment No. 10
House Judiciary
January 31, 1985

to self or others, but it does not define "dangerous". Is dangerous just before the knife goes in, or just after? Many jurisdictions recognize only the "just after." Dangerous is therefore defined only be a recent overt act. Mental illness is the only handicap that requires that the handicapped person commit a violent act to get help.

Another serious problem is the very narrow area between "dangerous" and "criminal" acts. It may only be the difference between the knife going in $\frac{1}{2}$" and 2" to the heart. The additonal $1\frac{1}{2}$" is the difference between getting help and being judged a murderer; the difference between getting help and ruining the lives of 2 people and their families. "Dangerousness" is a dangerous criteria when it is not coupled with the consideration of a persons need for and right to treatment, and society's right to protection from the uncontrolled acts of untreated persons.

On a personal basis, my wife and I have a 25 year old son who is a Paranoid Schizophrenic. He has been seriously ill for 6 years. He is one who cannot face or accept his illness, and absolutely refuses to seek treatment or even admit he has a problem. Because of his paranoid delusions he is very fearful, believing that everyone is out to get him, because he is the "Role Model for the Universe." We have this in a note he has written. He sees no one; eats mostly pizza which he has delivered so that he does not have to go out; keeps all of his shades pulled at all times; cannot watch TV, because he can't concentrate enough to understand; can no longer read for the same reason; has to move every 3 or 4 weeks, because he believes his neighbors are going to hurt him. There is no possibility now, with all his fears, that he will or can voluntarily seek treatment. The police, understanding his problem, have agitated him for an hour, trying to get him to hit them, so he could be taken in for help. That is barbaric. Not the actions of the police-I commend them for being willing to be hit so they could get him help. What's barbaric is the law that forces the police to treat my son in this manner. This is a boy who was named top freshman in the School of Earth Sciences at the University of Arizona and carried a 3.7 grade point average until he became ill. I hope we can keep our son alive until this bill passes, and he no longer has to commit a violent act to get help he so desperately needs.

There is another myth-that families just want to dump their ill member in a hospital forever. This myth came out of the theory of the last 30 years that families were the cause of mental illness. Research of the past several years has shown conclusively that this is not true. Mental illness is bio-chemical in nature with probably some genetic pre-disposition. Families only want to help their loved one, not put them away forever. We support wholeheartly existing law which requires periodic review of each person hospitalized.

In closing I would like to point out that 2 in 100 people will suffer long term mental illness. Most will live normal happy lives until they are 17-25 years old. If it is someone in your family, you will suffer the same pain, guilt, fear, frustration and anger that we have when you cannot get them help, even when it's avalable.

Howard Snyder

Howard Snyder
President

BILL OF RIGHTS

FOR DISABLED PERSONS

DRAFT

A disabled person shall be defined as: any person with a physical, developmental, mental, or emotional impairment which would substantially limit one or more major life activities such as learning, communication, mobility, self and health care, socialization, employment, housing, and recreation. This would include any individual who is so limited as a result of having a record of such an impairment or being regarded as having such an impairment. Major areas of disability include but are not limited to : vision, hearing, sensory, mobility, respiratory, and/or mental impairments, mental illness, learning disabilities, deafness, head trauma, chronic, disabling, life threatening, and/or terminal illness, intractable pain, job related injuries, aging, epilepsy, and substance abuse.

1. Persons with disabilities have the right to appropriate treatment, education, and habilitation services for such disabilities. Functional services include: self care, receptive and expressive language, learning, mobility, self direction, capacity for independent living, and economic self sufficiency.

2. Persons with disabilities have a right to services and programs which meet standards designed and monitored to assure the most favorable outcomes.

3. Persons with disabilities have the right to normalized community housing to the maximum extent possible.

4. The disabled person has the right to equal opportunities in recreation and leisure time activities.

5. The disabled person has the right to petition for and receive all protections and remedies provided by law.

6. Persons with disabilities shall have the right to information about and access to, protection, assistance, and representation independent of any state agency which provides treatment, education, other services, or habilitation.

7. Disabled persons have the right to a qualified, involved guardian and/or conservator when this is required to protect their personal well-being and interest.

8. Disabled persons have the right to assume responsibility for their own lives, make decisions, and solve their own problems to the maximum extent possible.

9. The disabled person has the right to a decent standard of living.

Attachment No. 11
House Judiciary
January 31, 1985

10. Disabled persons have the right to hold a competitive job, perform productive work, and/or to engage in other meaningful occupations to the fullest possible extent of their capacities; they have the right to receive equitable pay and benefits for their labor.

11. Disabled persons have the right to be informed of the rights afforded them through this Act in the manner most understandable by them.

12. The rights of persons with disabilities described in this Act are in addition to any Constitutional or other rights otherwise afforded to all persons.

This act shall hence forth and upon publication in the statute book be known as The Kansas Bill of Rights for Disabled Persons.

Kansas City Star 1-31-85

The Associated Press

Street people and friends of Josie Winn attend a funeral for the 70-year-old woman, a diagnosed schizophrenic who died of exposure during a New Year's Eve snowstorm in Chicago.

Lonely woman finds friends in death

The Associated Press

CHICAGO — She had few friends and no family, but dozens of people were drawn to the funeral of 70-year-old Josie Winn, a "confused and really alone" woman who died of exposure next to a garbage container during a New Year's Eve snowstorm.

"I'm like Josie," said one of the mourners, Louis Phillips, 50, unemployed. "She drank; I drink. She's dead; I could be, too.

"But she's not forgotten. Josie was my friend, and I will always remember her."

At least two dozen street people joined Mr. Phillips and about 50 others who gathered before the gray pine coffin Tuesday.

Ms. Winn, a diagnosed schizophrenic, had lived alone for four years in a stark, $245-a-month, 11th-floor studio apartment on the North Side.

The last 14 years of her life had been spent shuttling between transient hotels and Chicago-Read Mental Health Center.

"This is kind of symbolic of a lot of people with the same problem, who are confused and really alone," said Barbara Blaine, a staff member at Residents for Emergency Shelter, which houses homeless people in the basement of the Uptown Baptist Church.

Ms. Blaine never knew Ms. Winn, but she organized the service and collected $400 to pay for a meal of beef stew and croissants afterward.

"She could not go without some respect," Ms. Blaine said. "Just because someone has mental problems, it doesn't mean she's expendable."

Ms. Winn had attended Bible study and a seniors program at the church for several years but dropped out about 1½ years ago.

"There were a lot of times when I couldn't find her and I just fretted," recalled former neighbor Rosemary Smith, 59. She remembered Ms. Winn as a "good-hearted soul who helped wash dishes after Bible meetings."

Ms. Winn was last released from Chicago-Read in 1983 with medication to keep her illness under control and a referral to a community health center.

But workers at the hotel where she lived said she had stopped taking her medicine and had begun to withdraw in the weeks before her death.

A hotel housekeeper last saw Ms. Winn late in the afternoon on New Year's Eve, dancing in the middle of the street outside.

Attachment No. 12
House Judiciary
January 31, 1985