Approved February 13, 1986
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Senator Robert Frey at
Chairperson

10:00 a.m./p.m. on January 30, 1986 in room 313-S of the Capitol.

All members were present except: Senators Frey, Burke, Feleciano, Gaines, Langworthy, Parrish, Steineger, Talkington, Winter and Yost.

Committee staff present:

Mary Sue Hack, Office of Revisor of Statutes
Mike Heim, Legislative Research Department

Conferees appearing before the committee:

Dr. Robert C. Harder, Social and Rehiabilitation Services
Representative Sandy Duncan
Howard Snyder, Kansas Families for Mental Health
Cecil Eystone, Manhattan
Charley A. Carver, Manhattan
Michele Davis, Southeast Kansas Mental Health Center
Penny Johnson, Kansas City

Sub. House Bill 2050 - An act concerning care and treatment of mentally ill persons.

Dr. Robert C. Harder, Social and Rehiabilitation Services, appeared in support of the bill. A copy of the department's statement regarding the bill is attached (See Attachment I).

Representative Sandy Duncan stated he was a member of a subcommittee in the House. They had seven hours of hearings in preparation of this bill, and the result was to issue a substitute bill. Representative Duncan explained the bill section by section. He stated the amendments that will be proposed by the psychologists are very good amendments, and this bill is a significant step forward for the mentally ill people of the state.

Howard Snyder, Kansas Families for Mental Health, testified in support of the bill (See Attachment II).

Cecil Eystone, Manhattan, testified he wants to go on record in support of the changes in the law for the care and treatment of mentally ill persons. A copy of his remarks is attached (See Attachment III). Mr. Eystone asked that the balance in the law be restored, so that a person's need for treatment is considered as well as their criminal behavior.

Charley A. Carver, Manhattan, testified in support of the bill. A copy of his testimony is attached (See Attachment IV). Mr. Carver urged the committee to quickly change the Kansas laws to allow persons like his daughter to get treatment when they need it even if they say they don't want it.

Michelle Davis, Southeast Kansas Mental Health Center, appeared in strong support of the bill. A copy of her testimony is attached (See Attachment V).

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 514-S, Statehouse, at 10:00 a.m./p.m. on January 30, 1986.

Sub. House Bill 2050 continued

Penny Johnson appeared in support of the bill. She stated she worked out of the system, and that there are caring people in our system. Why are we institutionizing people? We shouldn't be building administrative buildings but take the people out and teach them how to walk through life.

Since time for adjournment had arrived, the chairman asked the conferees who had not testified today to return tomorrow for the hearing.

The meeting adjourned.

Copy of the guest list is attached (See Attachment VI).

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: 1-30-86

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
JOHN KELLY	TOPEKA	MH/RS
Donald Roberts	TOPEKA	
LOIS SPRING	TOPEKA	
RAY SPRING	TOPEKA	Gov. Adv Comm/MH/MR
Margaret Bearse	Lawrence	LWVK
Louis Frydman	Lawrence	
Cheryl [illegible]	Logan	Logan High School
Robert J. Rockey	Logan	Logan High School
Jennifer Soodsma	Logan	Logan High School
Leroy J. Shea	LOGAN	Logan High School
Willie Williams	Logan	Logan High School
Nancy Book	Prairie View	Logan High School
Karen Hildebrand	Logan	Logan High School
Julie Wallgren	Logan	Logan High School
Douglas Graham	Logan	Logan High School
Ken Hansen	Logan	Logan High School
[illegible]	Topeka	Kansas Legal Services
Gerdon B West	Topeka	Shawnee Co Families for Mental Health
Marjorie West	"	"
Al Olson	"	"
Rebecca Crenshaw	"	Prof. l Psych hol
Robert L. Leffel	Topeka	First Church of the Nazarene
Neva Entrekin	Lawrence KS	K.U. Classified Senate
Claudia Smith Ditton	" "	Regents Class. Council
REV JOHN P. GILSENAN	307 E. CENTRAL, WICHITA 67202	CATHOLIC DIOCESE of WICHITA

VI

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE:

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Rev. R. LeRoy Rayson	2915 Lincoln Topeka	Grace Un. Meth Church
HARVEY L. LATSHAW, Mr & Mrs	2025 Stone	Most Pur Heart Church
John Strickler	Suite 2 513 Leavenworth	KAPS
Jim Clark	Manhattan Topeka	KCDAA
Betty Lou FERRELL	GREAT Bend, KS.	CHURCH OF CHRIST
Gene M Webb	Lyons, Ks	Baptist church
Mrs. Bill Morris	Wichita	—
Ruth Wilkin	Topeka	Girl Scouts
Betty Stowers	Topeka	MHAK
Marjorie VanBuren	Topeka	OJA
Janet Shaw	Topeka	
R. Kevin Kalee	Topeka	UMC
Sen. Leroy Hayden	Satanta	
Ron Calbert	Newton	United Transportation Union
Rep. Kenneth W Green	Eldorado Ks	State Rep.
Vanora Fry	Little River	Wife - Rep

1-30-86

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Statement Regarding Substitute for House Bill 2050

1. Title - This is a comprehensive bill concerning the Act for Obtaining Treatment of Mentally Ill Persons, K.S.A. 59-2901, et. seq.

2. Purpose - Laws pertaining to the civil commitment of mentally ill persons were last addressed on a comprehensive basis in 1976. Many issues have been addressed since that time by legislatures and courts throughout the nation. Among the most notable are the need for involuntary outpatient treatment, the need for diversion from state hospitals to community care, the right of involuntary patients to refuse treatment, the definition of persons who are subject to involuntary commitment, and the proper conduct of involuntary commitment proceedings. Passage of this bill would assure that Kansas has addressed each of these major policy issues for the guidance and protection of both patients and mental health professionals.

3. Background - The guiding philosophy of this legislation is that persons subject to commitment must suffer from a "severe mental disorder" which renders them both "unable to engage in a rational decision-making process regarding hospitalization or treatment" and "likely to cause harm to self or others." The proposed Act also makes provisions for referrals from state hospitals to community care by either hospital diversion authority or court orders for outpatient treatment. The authority of hospital physicians to treat involuntary patients with non-experimental medication is both established and regulated by the Act. The procedures for periodic judicial review hearings are clarified, and the type of evidence allowed during probable cause and commitment hearings is specified. Institutional rights of patients are unchanged, and all of the procedural rights for patients continue as under current law.

4. Effect of Passage - Passage of this legislation would provide a proper balance between "patients rights" and the ability of mental health professionals to treat involuntary patients. It would also foster greater cooperation between community mental health centers and state hospitals in treating patients in the most appropriate setting.

5. SRS Recommendation - The Department of Social and Rehabilitation Services supports this legislation because it protects patients without sacrificing the ability of professionals to provide treatment which has been ordered by the court.

Robert C. Harder, Secretary
Social & Rehabilitation Services
296-3271

S. Judiciary
1/30/86
A-I

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Statement Regarding Substitute for House Bill 2050

TESTIMONY

There are a number of specific problems which have gained the attention of courts and legislatures throughout the nation since passage of the last comprehensive commitment act in 1976. Major issues include the need for involuntary outpatient commitment orders, the right of hospital staff to divert patients to community settings whenever appropriate, the right of an involuntary patient to refuse medication, the definition of those persons who are subject to involuntary commitment, the proper conduct of involuntary commitment proceedings, and the civil liability of treatment professionals for the assaultive actions of their patients following discharge. All but the last of these issues are addressed in this legislation. Mental health law is a rapidly developing area which must be periodically reassessed in order to assure that major policy issues are resolved through appropriate legislation. Passage of this bill would assure that Kansas has addressed each of these major policy issues for the guidance and protection of both patients and mental health professionals.

It is the philosophy of this act that patients who have a "severe mental disorder," other than a primary diagnosis of antisocial personality, which renders them both "unable to engage in a rational decision-making process regarding hospitalization or treatment" and "likely to cause harm to self or others" should be subject to commitment. Current law does not require a finding that the proposed patient is unable to make treatment decisions, but only that he or she is dangerous to self or others. This creates a major area of uncertainty.

Recent federal court decisions have indicated that even involuntary patients have the right to refuse standard psychotropic medications if there has never been a determination of their inability to make treatment decisions. Rennie v. Klein, 653 F. 2d 836 (1980); Rogers v. Okin, 634 F. 2d 650 (1980); see also Mills v. Rogers, 102 S.Ct. 2442 (1982). These rulings have required some states to establish a second level of administrative and judicial proceedings in order to determine whether or not committed patients can make such decisions. Kansas law carefully protects the procedural rights of proposed patients by affording them the right to notice, a probable cause hearing, appointment of counsel, and a regular commitment hearing at which the patient's presence is guaranteed. If involuntary patients have the constitutional right to refuse treatment in those situations where their capacity has not been determined by the committing court, it should not require two hearings to reach that critical issue. Nor should treatment staff be placed in the very difficult position of not knowing whether they have the authority to treat.

This legislation protects the right of competent adults to refuse hospitalization absent criminal processes. The only persons subject to commitment are those who are both unable to make treatment decisions and are likely to cause harm to themselves or others if treatment is not provided. However, it also protects the authority of mental health professionals to provide standard psychiatric treatment to those patients who are committed. It would be a legitimate hardship, and waste of important judicial and administrative resources, to commit a person for professional care without allowing those professionals to treat. In such cases, they could only stand by watching further deterioration, hoping the patient will change his or her mind, even when the rational ability to understand the effects of illness may be gone. Mental health professionals are not agents of social control. Hospitals are not detention centers for the dangerous; they are to treat seriously ill persons who either seek treatment voluntarily or who are unable to make treatment decisions for themselves.

It is recognized that the right to refuse treatment issue gives rise to the most difficult dilemma facing the system. It is extremely important to assure the patient's maximum involvement in treatment. Without a doubt, patients cannot be taken for granted; they cannot be ignored; they cannot be treated as a non-entity; they cannot be denied access to explanations and alternatives; and in short, they cannot be left out of their own treatment. In 1983, the Department of Social and Rehabilitation Services, Mental Health & Retardation Services, published its PATIENT'S RIGHTS SOURCE BOOK which attempted to deal with many difficult issues facing mental health care in state hospitals, including the rights of patients to question their treatment. The SOURCE BOOK specifies that patients have the right to challenge any aspect of their treatment, including psychotropic medication, through direct appeal to the hospital's chief medical officer. Although the patient's physician may continue with treatment over objections, the chief medical officer or psychiatric designee must personally review a patient's objections and issue a decision within ten days. This procedure, coupled with a patient's rights to refuse experimental medication and to be fully informed of all medication prescribed, fairly protects both the patient and treatment staff. K.S.A. 59-2929.

At a later point in this TESTIMONY, there is discussion concerning the definition of "likely to cause harm to self or others." In this introduction it is only important to note that Substitute for House Bill 2050 was never intended simply to make it easier to obtain commitments. This legislation was intended to reach those persons who should be the subject of involuntary commitment and to see that they are treated in the most appropriate setting, whether institutional or community based. It seeks to provide treatment for the severely mentally ill who are unable to make treatment decisions on their own in either state hospitals or in the community. It does not seek to detain the "dangerously mentally ill" who have already committed overt acts of violence. Providing treatment to the latter usually arrives too late and tends to convert hospitals into detention centers.

Current law should also be amended to assure that treatment is provided in state hospitals only when absolutely necessary. The authority of hospital staff to divert patients to community care at ALL stages of involuntary proceedings should be clearly established. Courts should also be authorized to enter orders for outpatient treatment to consenting community facilities, with the ability to revoke those orders and rehospitalize when necessary. In some cases, patients may need only a few days in the hospital to recover sufficiently from a difficult episode, enabling a return to community living with appropriate psychiatric follow-up. In still other cases, however, patients may be reluctant to accept follow-up care or have a past record of non-compliance, so that a recommendation for outpatient commitment may be the most appropriate alternative. Finally, in other cases, it may be necessary to recommend an order for treatment at a state hospital during regular commitment proceedings. The important point is that all of these options should be available to patients, hospital staff, and district court judges so that treatment can be provided in the most economical and clinically reasonable setting. Any increase in patients served should be spread among hospital and community providers.

These are the important considerations which Substitute for House Bill 2050 asks the legislature to address. The issues are extremely difficult, but they are also very important. The mental health system must accommodate the privacy, dignity, and intellectual needs of patients. However, the ability of mental health professionals to treat patients who are not able to make decisions on their own, and who present a likelihood of harm to self or others, must also be protected if psychiatric hospitals are to remain both psychiatric and hospitals. The proper role of hospital staff, community providers, patients, families, and district courts should be aligned in such a way that the most appropriate treatment is available to those patients who might best benefit from it.

A summary of the major changes which passage of this bill would bring to the civil commitment process follows:

1. On page two, at line 0070 is the definition of a "mentally ill person" who is subject to commitment for psychiatric treatment. Before a district court could enter an order for treatment, four different elements would have to be proved by clear and convincing evidence. The person petitioning for an order of treatment would have to prove that the proposed patient (1) is suffering from a severe mental disorder, (2) is in need of treatment, (3) lacks capacity to make an informed decision concerning treatment, and (4) is likely to cause harm to self or others. As a result, persons could not be committed unless the court had found that they were unable, due to a severe mental disorder, to engage in a rational decision-making process regarding the need for treatment.

2. On page two, at line 0058 is the definition of "likely to cause harm to self or others." The current definition of "mentally ill person" makes almost no attempt to define the meaning of "dangerous to self or others." Therefore, courts are free to determine the meaning of "dangerous to self or others" from the facts existing in individual cases. Substitute for H.B. #2050 defines this important language. It would allow the court to commit a proposed patient for treatment who is (1) likely, in the reasonably foreseeable future, to cause physical injury or physical abuse to self or others or substantial damage to another's property, or (2) substantially unable, except for reason of indigency, to provide for any of the person's basic needs, such as food, clothing, shelter, health or safety, or (3) suffering severe or abnormal mental, emotional or physical distress causing a substantial deterioration of the person's ability to function on the person's own. It is important to understand that the definition of "likely to cause harm to self or others" is only one of the four elements which must be proved by clear and convincing evidence before an order of treatment could be entered by the court. Therefore, inability to function on a person's own would have to be the result of a "severe mental disorder" which required treatment and also rendered the person unable to make an informed decision concerning that treatment.

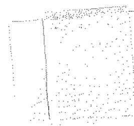
3. On page four, at line 0130 is the definition of "severe mental disorder." Current law has no definition of the term "mental impairment" which is the counterpart of this new language. The definition of "severe mental disorder" is taken from the Diagnostic and Statistical Manual III (DSM III) which is used in daily practice by mental health professionals. The definition also makes it clear that persons whose need for treatment "is caused by the use of chemical substances or for which the primary diagnosis is antisocial personality" are excluded from commitment. As a result, proposed patients who are in need of alcohol or drug treatment will be subject to specific commitment acts elsewhere in the law.

4. On page six, at line 0205 is a new provision which would allow a hospital to file an application for determination of mental illness with respect to a voluntary patient who had either (1) requested discharge or (2) is refusing reasonable treatment efforts and is likely to cause harm to self or others if discharged. If voluntary patients are refusing reasonable treatment efforts, and yet are not subject to discharge because they may harm self or others, hospital staff have no choice but to seek a court order for treatment. As under current law, patients who refuse reasonable treatment efforts, but do not fit the definition of "mentally ill person," will be discharged and allowed to seek treatment more in line with their personal desires.

5. On page 10, at line 0365 is a provision concerning orders of protective custody. The statute is merely simplified as it exists under current law. Since this section deals with orders of protective custody and not emergency admission, there is no reason to distinguish between applications which are filed by law enforcement officers and applications filed by any other person. In both cases, the regular application for determination of mental illness must be filed before an order of protective custody can be issued, so that both law enforcement officers and other persons would need a physician's statement, or a verified statement that the proposed patient had refused medical examination, before seeking protective custody. An order of protective custody may be issued ex parte under this section as is the case with current law, but such an order is only effective until 5:00 p.m. of the second court day.

On page 13, at line 0462 is a new provision which indicates the type of evidence allowed at probable cause hearings. The current wording in Substitute for H.B. #2050 is that "hearsay evidence may be received, and experts and other witnesses may testify to any relevant and probative facts at the discretion of the court." This provision recognizes the fact that there are real differences between criminal trials and civil commitment hearings. In criminal trials, the only relevant evidence is what happened on the day that the alleged criminal act occurred. However, commitment hearings must answer the question of whether or not the patient is likely to cause harm to self or others if treatment is not provided. As a result, the patient's previous behavior and history of psychiatric treatment are extremely important, and not simply what happened on any one day. Mental health professionals, especially psychiatrists and psychologists, must rely upon what is often referred to as "psychiatric history" in making reliable professional judgments. An expert may not be limited to their personal observations during the course of treatment. He or she should be allowed to testify on the basis of data that is reasonably relied upon by experts in the medial and mental health professions. Federal Rules of Evidence #703 and #705 currently recognize this fact. If preferred, the following language might be substituted for what now appears on page 13, line 0462:

> The rules governing evidentiary and procedural matters under this section shall be so as to facilitate informal, efficient presentation, of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties. The facts or data upon which a duly qualified expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in a particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence. The expert may testify in terms of opinion or inference and give the expert's reasons therefor without prior disclosure of the underlying facts or data unless the court requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross-examination.



Although the Kansas House of Representatives decided on a different rule at the regular commitment hearing, it is recommended that this language also be placed on page 21, at line 0088. The expert witness, as authorized by the federal rules of evidence, should be allowed to base an opinion upon data reasonably relied upon by experts in the mental health profession at both the probable cause and regular commitment hearings.

6. On page 14, at line 0500 is the section concerning the issuance of mandatory orders following the filing of an application for determination of mental illness. This provision would consolidate both the mandatory and permissive order provisions of current law. This would again simplify the issuance of orders, and make commitment proceedings consistent throughout the district courts. There are no new orders proposed by this section, except one which would allow civil commitment and guardianship proceedings to be consolidated for hearing.

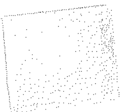
7. On page 16, at line 0576 is a section concerning orders for mental evaluation. The bill would provide that an order for mental evaluation could be entered without the necessity of a probable cause hearing. The hospital must be allowed to evaluate a patient immediately upon admission to ascertain what types of protective measures against self abuse or dangerousness need to be taken. Moreover, the bill allows hospital staff to divert patients to community treatment whenever further inpatient hospitalization is unnecessary. This right occurs in a later section on page 29, at line 0386, and is further reason why staff must be allowed to begin evaluation at the time of admission.

8. On page 19, at line 0040 is a provision which clarifies the use of medication prior to and during commitment hearings. Current law provides that patients need only be removed from medication if the physician believes that such medication "adversely effects such patient's judgment or hampers such patient in preparing for or participating in the hearing." Some attorneys have argued that this means patients must not receive any psychotropic medication, which is not appropriate for either the patient's treatment needs or ability to take a meaningful part in the hearing. In most cases, psychotropic medication greatly assists the patient in taking a meaningful part in his or her hearing. The amendment would indicate in clearer terms that patients need not be removed from medication unless it will have an adverse impact on hearing competency. In all cases, counsel for the patient may examine the treating physician on this issue during any hearings conducted pursuant to the act.

9. On page 23, at line 0160 is the new provision providing for outpatient treatment. Following a regular commitment hearing, this section would authorize the court to enter an order for outpatient treatment. Currently, some courts have fashioned outpatient treatment orders, while others have felt that present law does not authorize outpatient commitment. The provision does not effect either the burden of proof or the definition of mentally ill person, but only indicates that the court has an additional option in ordering the place of treatment. It attempts to deal with the original order for outpatient treatment, terms of the treatment, and revocation of the order in a method that will require the least possible amount of actual court involvement.

10. On page 24, at line 0232 is a revised provision concerning changes of venue from one court to another. There have been times under current law when a treatment facility is caught between two courts, neither of which is wishing to exercise jurisdiction over the patient. On occasion, venue of a case has been changed from the originating court to another court, and therefore the originating court is not willing to issue further orders. In contacting the receiving court, however, it has not felt that venue was properly changed, or it has not been willing to accept the change of venue. This has left both the treatment facility and the patient in an unclear situation concerning further authorization for treatment. As a result, change of venue should be simplified to the greatest possible extent to avoid leaving patients and treatment facilities in a position where no court is desiring to exercise jurisdiction. The proposed amendments would indicate that venue of an action could be changed to the court where the treatment facility is located at anytime, but could be changed to any other court only if the originating court finds that the patient cannot obtain a fair hearing.

11. On page 26, at line 0287 is a new provision concerning judicial review of commitment decisions. Current law indicates that patients have the right to a review proceeding every 90 days, as well as a right to petition for their discharge every six months. Courts differ in their interpretation of whether or not both of these authorize an adversary hearing. In order to avoid confusion, it seems reasonable to consolidate these procedures into one procedure which is clearly defined by statute. The proposed provisions would allow a patient to request a hearing every 90 days during the first six months of treatment, and every 180 days thereafter to determine whether or not the patient continues by clear and convincing evidence to be a mentally ill person. These hearings would be conducted in an adversary manner, and the attorney for the proposed patient would be required by law to consult with the patient concerning the patient's desire for a hearing. The requirement that the hospital initiate a report to the court every 90 or 180 days would continue, so that the patient would not have to be responsible for deciding when a request for hearing should be filed.

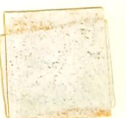


12. On page 27, at line 0334 is a revised section dealing with administrative transfers between state hospitals. Current law is very vague, and simply states that "the director of Mental Health and Retardation Services may transfer any patient from any institution under the director's control to any other such institution whenever the director considers it to be in the best interest of the patient." The revision would distinguish between transfers to state psychiatric hospitals and state institutions for the mentally retarded. It also provides for notice, except in the case of an emergency, to the patient's next of kin or guardian and to the committing court prior to transfer. In addition, the patient's next of kin or guardian may request a hearing before the Secretary prior to final decision on the proposed transfer.

13. On page 30, at line 0440 is a section concerning the return of patients who have eloped from treatment facilities. The section would authorize a treatment facility to order a law enforcement officer to take an involuntary patient into custody when the patient was absent without official leave. This authorization could be done either orally or in writing, but oral authorization would have to be confirmed in writing as soon as possible.

14. On page 31, at line 0457 is the section concerning restraints and seclusion. This section would allow the use of seclusion and restraints, not to exceed two hours, without review and approval by a physician or psychologist. Moreover, it would allow staff at State Security Hospital to confine patients in their rooms when that was deemed necessary for security or proper institutional management. Due to the fact that many of these patients have been transferred from county jails or the Secretary of Corrections, as well as the fact that they are all under orders for criminal commitment, State Security Hospital should be allowed some additional authority in maintaining appropriate security.

15. On page 31, at line 0486 is the section concerning institutional patient rights. No changes are proposed to this section. In the original draft of H.B. #2050, one change had been proposed, but it was deleted by the House Judiciary Committee. That change would have allowed the head of the treatment facility to restrict outgoing mail, for good cause only, when such restrictions were entered on the medical record and fully explained to the patient and the patient's attorney. On occasion, patients have mailed extremely disturbing documents to people in the community (mutilated pages from magazines or bizarre letters), or have repeatedly ordered a large amount of merchandise for which they could not pay resulting in return to the distributor at state expense. Hospital superintendents and agency attorneys have been contacted by adults and parents of children who believe that patients should not be allowed to mail frightening and bizarre letters



to people in the community. However, under current law, "the right to mail any correspondence which does not violate postal regulations, shall not be restricted by the head of the treatment facility under any circumstances." (page 33, at line 0530). It was originally proposed that this language be struck in favor of continuing to operate under the language stated on page 32, at line 0494. That provision would allow the patient "both to mail and receive unopened correspondence" unless restricted by the head of the treatment facility under the guidelines set forth in subsection (b) at line 0527.

16. On page 33, at line 0554 is the confidentiality section. This section would be amended to clearly state that those minors, at least 14 years of age, who have requested voluntary admission should also have the capacity to consent to the release of their treatment records. In addition, this provision would allow treatment facilities to share medical records with Kansas mental health centers and the Department of Corrections for purposes of aiding in the continuity of treatment following discharge. Since the state is attempting to move toward an integrated mental health system between state hospitals and mental health centers, these provisions would be extremely helpful.

17. On page 35, at line 0612 is a section concerning the prescribing and administration of medication. The section makes it clear that prescriptions for psychotropic medication must be written with a termination date not exceeding 30 days, but may be renewed by the treating physician. It also makes it clear that involuntary patients do not have the right "to refuse any medication, including psychotropic medication, other than experimental medication, which is prescribed by a physician" and intended to promote the mental health of the patient. This is an extremely important provision since civil commitment is an involuntary proceeding, and court ordered treatment would be of little benefit to either the patient or society if it could be refused by the committed patient. In addition to statutory regulations, relevant portions of the Patient's Rights Source Book allow patients to appeal treatment objections to the clinical director for adminsitrative review and written deicision.

18. The remainder of the bill was put together either by the Revisor of Statutes or the House Judiciary Committee. It is important to note on page 49, at line 0411 that a guardian can place a ward in a state psychiatric hospital following an order by the guardianship court pursuant to specific criteria set forth on page 50 at line 0455.

    This was not a part of the original bill drafted by S.R.S. and has implications for the case of Powell v. Harder, Case No. 78-4217, currently pending in the Federal District Court for the District of Kansas. That case was begun on August 16, 1978, with the filing of a complaint challenging the provisions of the Kansas Act for Obtaining Treatment for a Mentally Ill Person, K.S.A. 59-2901, et. seq., insofar as they authorize the placement of persons eighteen (18) years of age or older who have guardians at treatment facilities under the jurisdiction of S.R.S. on a different basis than for other adult persons who do not choose to seek admission to such facilities.

The plaintiffs claim that these statutes deny to them due process of law and the equal protection of the laws, in violation of the Fourteenth Amendment of the United States Constitution. On December 13, 1978, the Court ordered that the case should be maintained as a class action consisting of all wards in the eight state psychiatric hospitals and institutions for the mentally retarded which are operated by S.R.S.

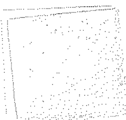
In April of 1983, the Governor of the state of Kansas signed into law Senate Bill 11 of the 1983 Session of the Kansas Legislature substantially amending the "act for obtaining a guardian or conservator or both," K.S.A. 59-3001, et. seq. The effect of these amendments was to give the plaintiffs some of the relief they are seeking. Specifically, 59-3018(g)(1) now provides:

> A guardian shall not have the power: (1) To place a ward in a facility or institution unless such placement has been approved for that person by the court, except that a ward may be placed in a treatment facility under the act for obtaining treatment for a mentally ill person only after a hearing conducted in accordance with the provisions of K.S.A. 59-2917 and amendments thereto and a finding by the court under that section that the ward is in need of treatment at a treatment facility. Except as otherwise provided by law, a ward may voluntarily consent to the admission of oneself to such a facility or institution if able and permitted to do so according to the court's findings of fact set forth in the court's order issued at the conclusion of the hearing on the petition for guardianship.

As a result, guardians may not admit wards to a state psychiatric hospital without obtaining an order for treatment "after a hearing conducted in accordance with the provisions of K.S.A. 59-2917." At the present time, yDecember 1, 1985), only 31 wards remain in this status at the state's four psychiatric hospitals, all having been admitted prior to the effective date of the guardianship amendments, July 1, 1983. Enacting Sec. 36 beginning on page 49 at line 0411 would renew the challenges of Powell plaintiffs and reverse the findings of the 1983 Legislature. S.R.S. wants to make sure that the implications of this important amendment offered by the House Judiciary Committee are fully understood.

SUMMARY

While Substitute for H.B. 2050 would broaden the scope of persons who may be committed for treatment, it affects only those who are suffering from a severe mental disorder to the extent that they are unable to engage in a rational decision-making process regarding hospitalization or treatment. The bill also provides for outpatient treatment and a continuation of all institutional rights set forth by current law under K.S.A. 59-2929. In every case, treatment orders must be issued by a judge of the district court upon being convinced by clear and convincing evidence that all of the elements set forth on page two at line 0070 have been met by the petitioning party.



STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Statement Regarding Substitute for House Bill 2050

III. BACKGROUND INFORMATION - In August of 1983, the Mental Disability Law Reporter, Vol. 7, No. 4 conducted an overview of involuntary commitment statutes in the 50 states. A copy of relevant commitment criteria and maximum length of disposition which appeared in that volume of the Reporter is attached. Most states have three general criteria for commitment which are variously defined and consist of (1) dangerousness to self, (2) dangerousness to others, and (3) gravely disabled. However, it is important to note a few things about some of the state definitions:

Colorado - Persons may be committed if "gravely disabled" which means a condition, resulting from mental illness, which renders the person unable to take care of his basic personal needs or who is making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so.

Delaware - Persons may be committed if they are either unable to make responsible decisions with respect to his hospitalization," or is "likely to commit or suffer serious harm to self or others or to property if not given immediate hospital care and treatment."

Hawaii - Persons may be committed if dangerous to self or others or to property and in need of care and treatment.

Louisiana - Persons may be committed if dangerous to self or others or gravely disabled. "Dangerous to self" exists when there is "a reasonable expectation that there is a substantial risk that [the person] will inflict physical or severe emotional harm upon his own person."

Maine - Persons may be committed if mentally ill and if presenting a likelihood of serious harm and inpatient hospitalization is the best available means of treatment. Mentally ill persons exclude "sociopathic" individuals, and those suffering from "drugs, narcotics, hallucinogins or intoxicants, including alcohol.

Maryland - Persons may be committed if they have a mental disorder and need inpatient care or treatment for the protection of self or others. The protection of self or others means that the individual must not present a danger to the life or safety of the individual or others.

Rhode Island - A person is subject to commitment if "so insane as to be dangerous to the peace or safety of the people of the state or so as to render his restraint and treatment necessary for his own welfare."

South Carolina - A person may be committed if he or she "lacks sufficient insight or capacity to make responsible decisions with respect to treatment."

South Dakota - A person may be committed if he or she "lacks sufficient understanding and capacity to meet the ordinary demands of life."

Vermont - A person may be committed as posing a "danger of harm to himself" if "he has behaved in such a manner as to indicate that he is unable, without supervision and the assistance of others, to satisfy his need for nourishment, personal or medical care, shelter or self-protection and safety, so that it is probable that death, substantial bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

The definitions of "mentally ill persons" for all 50 states are attached as they appeared in August of 1983. The purpose of this brief review is to indicate that other states are obviously concerned with the treatment of persons who lack sufficient insight or capacity to make responsible decisions and are seriously deteriorating by reason of severe mental disorder.

In an article which appeared in Hospital and Community Psychiatry, Vol. 36, No. 3 (March 1985) entitled "The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commitment," Dr. Darold A. Treffert discussed recent commitment laws in a number states since 1972. In reacting to the "patients' rights movement," these states:

> ...Created new commitment statutes embodying the three relatively standard dangerous criteria for commitment-danger to self, danger to others, or gravely disabled. In addition to more stringent criteria for commitment, the mental health acts of most of the states contained other revisions, such as prompt probable cause hearings; thorough judicial review before final commitment; enumeration of patients' rights to adequate treatment; provision of least restrictive alternative; a specified length of commitment; and clearly delineated emergency detention provisions. With these revisions in state mental health laws, in almost every jurisdiction involuntary hospitalization of the mentally ill became predicted solely on dangerousness, be it suicidal threats or behavior, homicidal threats or behavior, or inability to meet basic living needs for food, clothing, or shelter. Provisions for the state to use parens patriae powers in the absence of dangerousness narrowly defined were effectively abolished: The pendulum swung entirely to dangerousness in terms of imminent physical harm as the only authority on which the state could infringe on individual liberty.
>
> The pendulum swung too far.

Dr. Treffert concludes his article by stating that "in enthusiastic advocacy and concern for the welfare for the mentally ill, society must be certain that it does not do irreparable harm. Changes in mental health law, well intended and necessary, have produced a pendulum swing too harsh, too restrictive, and too unyielding. Obviously ill psychiatric patients are left to deteriorate in order to qualify for treatment, or, just as wrongly, to be treated in jails or prisons, or, just as cruelly, to wander the streets untreated and suffering."

Also attached is the text of a presentation by William C. Rein, SRS Attorney, which discusses the major issues addressed by Substitute for House Bill No. 2050 in greater detail.

State Involuntary Commitment Statutes

by Edward Beis

The following charts contain an overview of involuntary commitment statutes in the 50 states. The information in these charts is taken from *Mental Health and the Law* (tentative title) by Edward B. Beis, to be published by Aspen Systems Corporation in December, 1983. The book, written for mental health professionals, discusses the legal responsibilities and liabilities of psychiatrists, psychologists, psychiatric nurses and social workers, administrators, governing board members and hospitals in the delivery of outpatient and inpatient mental health care and treatment. It provides a legal perspective on mental health systems from the initiation of treatment to termination, and covers such subjects as proper medical records and the use of quality assurance and risk management programs to improve the quality of care and reduce exposure to liability. Finally, it discusses the roles of mental health professionals as expert witnesses and what is expected of them by lawyers and judges. For further information about *Mental Health and the Law*, contact Aspen Systems Corporation, 1600 Research Blvd., Rockville, Maryland 20850. ©Aspen Systems Corporation, 1983. Edward Beis, *Mental Health and the Law*. Reprinted with permission from Aspen Systems Corporation.

Alabama

Criteria

Mentally ill and as a consequence poses a real and present threat of substantial harm to himself or others as evidenced by a recent overt act. Ala. Code §22-52-10(a) (1982 Cum. Supp.).

Maximum Length of Disposition

None.

Alaska

Criteria

Mentally ill and likely to injure himself or others or in need of immediate care or treatment, and because of illness lacks sufficient insight or capacity to make responsible decisions concerning hospitalization. Alaska Stat. §47.30.070(i).

Maximum Length of Disposition

Indeterminate. §47.30.070(i).

Arizona

Criteria

Mental disorder and as a result poses a danger to himself or others or is gravely disabled. Ariz. Rev. Stat. Ann. §36-540 (1982 Supp. Pamph.)

Maximum Length of Disposition

Variable: 60 days to one year. §36-540.

Arkansas

Criteria

Person has a mental illness, disease or disorder and as a result is homicidal, suicidal or gravely disabled. Ark. Stat. Ann. §59-1410 (1981 Cum. Supp.).

Homicidal means the person poses a significant risk of physical harm to others as manifested by recent overt behavior evidencing homicidal or other assaultive tendencies toward others. §59-1401(a).

Suicidal means the person "poses a substantial risk of physical harms to himself as manifested by evidence of threats of, or attempt at suicide or serious self-inflicted bodily harm, or by evidence of other behavior or thoughts that create a grave and imminent risk to his physical condition. §59-1401(b).

Gravely disabled "refers to a person who is likely to injure himself or others if allowed to remain at liberty or is unable to provide for his own food, clothes, or other shelter by reason of mental illness or disorder. §59-1401(c).

Maximum Length of Disposition

Initial 45 days. §49-1409. With additional 120 days. §49-1410.

California

Criteria

Mental disorder and as a result attempted, inflicted or made a substantial threat of physical harm upon the person of another. (Cal. Welf. & Inst. Code §5300, 5304), or himself (§5213) or is gravely disabled (§5358) ("a condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing or shelter.") §5008(h)(i)

Maximum Length of Disposition

194 days for persons dangerous to others (§5300); 28 days for suicidal persons (§5260); and no limit for gravely disabled except dissolution of conservatorship.

Colorado

Criteria

Mentally ill and as a result person is dangerous to others, himself or is gravely disabled. Colo. Rev. Stat. Ann. §27-10-111(1).

"Mentally ill person" means a person who is of such mental condition that he is in need of medical supervision, treatment, care, or restraint. §27-10-101(7).

"Gravely disabled" means a condition in which a person, as a result of mental illness, is unable to take care of his basic personal needs or is making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so. §27-10-101(5).

Maximum Length of Disposition

12 months. §27-10-109.

Connecticut

Criteria

Mentally ill and dangerous to himself or others or gravely disabled. Conn. Gen. Stat. Ann. §17-178(c) (1982).

"Mentally ill person" means any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment excluding drug dependence and alcoholism. §17-1.

"Dangerous to self or others" means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person. §17-176.

"Gravely disabled" means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital care is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his mental illness. §17-176.

Maximum Length of Disposition

Duration of mental illness. §17-178(c).

Delaware

Criteria

Mental disease and poses a real and present threat to himself or others, or to property. Threat must be based upon manifest indication that person is likely to commit or suffer serious harm to himself or others or property if immediate care and treatment is not given.

"Mentally ill person" means a person suffering from a mental disease or condition which requires such person to be observed and treated at a mental hospital for his own welfare and which either (1) renders such person unable to make responsible decisions with respect to his hospitalization, or (2) poses a real and present threat, based upon manifest indications that such person is likely to commit or suffer serious harm to himself or others or to property if not given immediate hospital care and treatment.

Maximum Length of Disposition

6 months to indefinite. Del. Code Ann. tit. 16 §§5010, 5012 (1982 Cum. Supp.).

District of Columbia

Criteria

Mental illness and likely to injure himself or others. D.C. Code Ann. §21-545 (b). "Mental illness" means a psychosis or other disease which substantially impairs the mental health of a person. §21-501.

Maximum Length of Disposition

Indeterminate. §21-545(b).

Florida

Criteria

Suffers from an apparent or manifest mental illness; has refused voluntary placement, is unable to determine for himself whether placement is necessary; is "manifestly incapable of surviving alone or with the help of willing and responsible family or friends, or alternative services, and without treatment is likely to suffer from neglect or refuse to care for himself and such neglect or refusal poses a real and present threat of substantial harm to his well being or it is more likely than not that in the near future he will inflict serious harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within 20 days prior to initiation of proceedings." Fla. Sta. Ann. §394.467 (1982).

"Mental illness" means an impairment of the emotional process, of the ability to exercise conscious con-

trol of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology, excluding developmental disabilities, simple alcoholism or conditions manifested only by antisocial behavior or drug addiction. §394.455(3).

Maximum Length of Disposition

Initial 6 month period with additional six month periods. §394.467(2)(d).

Georgia

Criteria

Mental illness and a substantial risk of imminent harm to self or others (as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself or others) or is unable to care for his own physical health and safety as to create an imminently life threatening crisis. Ga. Code Ann. §88-501(v) (1981).

Mental illness means having a disorder or thought mold which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life. §88-501(a).

Maximum Length of Disposition

Up to 20 months. §37-38-3(d).

Hawaii

Criteria

Mental illness or substance abuse and dangerous to himself or others or to property and in need of care and treatment. Hawaii Rev. Stat. §334-60(b)(1) (1982 Supp.) Must also be least restrictive alternative.

"Mentally ill person" means a person having psychiatric disorder or other disease which substantially impairs his mental health and necessitates treatment or supervision. §334-1.

"Dangerous to other" means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat. §334-1.

"Dangerous to self" means likely to do substantial physical injury to one's self, as evidenced by a recent act, attempt or threat to injure one's self physically or by neglect or refusal to take necessary care for one's own physical health and safety together with incompetence to determine whether treatment for mental illness or substance abuse is appropriate. §334-1.

"Dangerous to property" means inflicting, attempting or threatening imminently to inflict damage to any property in a manner which constitutes a crime, as evidenced by a recent act, attempt or threat. §334-1.

Maximum Length of Disposition

90 days. §334-60(b)(5).

Idaho

Criteria

Mentally ill and either likely to injure himself or others or is gravely disabled. Idaho Code §66-329(k) (1982).

"Likely to injure self or others" means:

(1) A substantial risk that physical harm will be inflicted by the proposed patient upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm upon himself; or

(2) A substantial risk that physical harm will be inflicted by the proposed patient upon another as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm.

"Mentally ill" shall mean a person who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility.

Gravely disabled shall mean a person who, as a result of mental illness, is in danger of serious physical harm due to the person's inability to provide for his essential needs. §66-317(1), (m), and (n).

Maximum Length of Disposition

3 years. §66-329(k).

Illinois

Criteria

Mental illness and as a result the person is reasonably expected to inflict serious physical harm on himself or another in the near future, or is unable to provide for his basic physical needs. Ill. Ann. Stat. ch. 91½. §1-119 (1983-1984).

Maximum Length of Disposition

180 days. §3-813.

Indiana

Criteria

Mentally ill and gravely disabled or dangerous and in need of custody, care or treatment. Ind. Code Ann. §16-14-9.1-10(d).

"Mental illness" means a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behavior and impairs the person's ability to function. It includes mental retardation, epilepsy, alcoholism or addiction to narcotics or dangerous drugs. Iowa Code Ann. §16-14-9.1-1(a) (1983-1984).

"Gravely disabled" means a condition in which a person as a result of a mental illness is in danger of coming to harm because of his inability to provide for his food, clothing, shelter or other essential needs. §16-14-9.1-1(b).

"Dangerousness" means a condition in which a person as a result of mental illness presents a substantial risk that he will harm himself or others. §16-14-9.1-1(c).

Maximum Length of Disposition

Indeterminate. §16-14-9.1-10(d).

Iowa

Criteria

Seriously mentally impaired and is likely to injure himself or herself or other persons if allowed to remain at liberty.

"Seriously mentally impaired" means a mental illness (every type of mental disease or disorder except mental retardation) and because of illness lacks sufficient judgment to make responsible decisions with respect to his or her hospitalization or treatment, and who:

(a) is likely to physically injure himself or herself or others if allowed to remain at liberty without treatment; or

(b) is likely to inflict serious emotional injury on members of his or her family or others who lack reasonable opportunity to avoid contact with the afflicted person if the afflicted person is allowed to remain at liberty.

Serious emotional injury is an injury which does not necessarily exhibit any physical characteristics but which can be recognized and diagnosed by a licensed physician or other qualified mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill. Iowa Code Ann. §299.1.1, .2. (1983-1984).

Maximum Length of Disposition

Indeterminate. §229.14.3.

Kansas

Criteria

Mentally ill person who is dangerous to himself or others or who is unable to meet his or her own basic physical needs.

(1) "Mentally ill person" means any person who is mentally impaired to the extent that such person is in need of treatment and who is dangerous to himself or herself and others, and

(a) who lacks sufficient understanding or capacity to make responsible decisions with respect to his or her need for treatment, or

(b) who refuses to seek treatment. Proof of a person's failure to meet his or her basic physical needs, to the extent that such failure threatens such person's life, shall be deemed as proof that such person is dangerous to himself or herself, except that no person who is being treated by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone through prayer for healing shall be determined to be a mentally ill person unless substantial evidence is produced upon which the district court finds that the proposed patient is dangerous to himself or herself or others. Kan. Stat. Ann. §59-2902(a) (1982).

Maximum Length of Disposition

90 days. §59-2917(a).

Kentucky

Criteria

Mentally ill person who presents a danger or threat of danger to self, family, or others and can reasonably benefit from treatment. Ky. Rev. Stat. Ann. §202A.026.

"Mentally ill person" means a person with substantially impaired capacity to use self control, judgment or discretion in the conduct of his affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior or emotional symptoms can be related to physiological, psychological or social factors. §202A.011(8).

"Danger" or "threat of danger to family or others" means substantial physical harm or threat of substantial physical harm upon self, family or other, including actions which deprive self, family or others of the basic means of survival including provision for reasonable shelter, food or clothing. §202A.011(2).

Maximum Length of Disposition

360 days. §202A.051.

Louisiana

Criteria

Mental illness or substance abuse which causes a person to be dangerous to self or others or gravely disabled. La. Rev. Stat. Ann. §28.55(E).

"Mentally ill" person "means any person with a psychiatric disorder which has substantial adverse effects on his ability to function and who requires care and treatment. It does not include persons suffering from mental retardation, epilepsy, alcoholism or drug abuse. §28:2(14).

"Dangerous to others" means the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future. §28:2(3).

"Dangerous to self" means the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person. §28:2(4).

Maximum Length of Disposition

Indeterminate. §28.56. Alcoholism 45 days (initial) and up to two 60-day periods thereafter.

Maine

Criteria

Mental illness and poses a likelihood of serious harm and inpatient hospitalization is best available means of treatment. Me. Rev. Stat. Ann. tit. 34 §2234(5).

"Mentally ill individual" means an individual having a psychiatric or other disease which substantially impairs his mental health. Does not include mentally retarded or sociopathic individuals. Does include persons suffering from drugs, narcotics, hallucinogens or intoxicants, including alcohol. 34 §2251(5).

"Likelihood of serious harm" means:

A substantial risk of physical harm to the person himself as manifested by evidence of recent threats of, or attempts at, suicide or serious bodily harm to himself, and, after consideration of less restrictive treatment settings and modalities, a determination that community resources for his care and treatment are unavailable; or

A substantial risk of physical harm to other persons as manifested by recent evidence of homicidal or other violent behavior or recent evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them and, after consideration of less restrictive treatment settings and modalities, a determination that community resources for his care and treatment are unavailable; or

A reasonable certainty that severe physical or mental impairment or injury will result to the person alleged to be mentally ill as manifested by recent evidence of his actions or behavior which demonstrate his inability to avoid or protect himself from such impairment or injury, and, after consideration of less restrictive treatment settings and modalities, a determination that suitable community resources for his care are available. 34 §2251(7).

Maximum Length of Disposition

1 year. Tit. 34 §2334(6)(A).

Maryland

Criteria

A person who has a mental disorder and needs inpatient care or treatment for the protection of self or others. Individual presents a danger to the life or safety of the individual or others. Md. Ann. Code §10-617.

Maximum Length of Disposition

Not available.

Massachusetts

Criteria

Person is mentally ill and discharge would create a likelihood of serious harm. Mass. Ann. Laws ch. 123, §8.

"Likelihood of serious harm" means:

(1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons, as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

Maximum Length of Disposition

1 year. Ch. 123 §8.

Michigan

Criteria

Mentally ill person who can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation or is unable to attend to basic physical needs, such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs. Mich. Stat. Ann. §14.800 (401(a), (b)).

"Mental illness" means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. §14.800(400(a)).

A mentally ill person is one whose judgment is so impaired that he is unable to understand his need for treatment and whose continued behavior is the result of mental illness that can reasonably be expected on the basis of competent medical opinion to result in significant physical harm to himself or others. §14.800 (401(c)).

Maximum Length of Disposition

Indeterminate, following commitment periods of 60, then 90, days. §14.800 (472).

Minnesota

Criteria

Mentally ill, mentally retarded or chemically dependent person. Minn. Stat. Ann. §253B.09.

Mentally ill person means a substantial psychiatric disorder of mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which:

(a) is manifested by instances of grossly disturbed behavior or faulty perceptions;

(b) poses a substantial likelihood of physical harm to

self or others as demonstrated by:

i. a recent attempt or threat to physically harm himself or others; or

ii. a failure to provide necessary food, clothing, shelter or medical care for himself, as a result of the impairment. §253B.02(13).

This impairment excludes (a) epilepsy, (b) mental retardation, (c) brief periods of intoxication caused by alcohol or drugs, or (d) dependence upon or addiction to any alcohol or drugs. §253B.02(13).

"Chemically dependent person" means any person (a) determined as being incapable of managing himself or his affairs by reason of the habitual and excessive use of alcohol or drugs; and (b) whose recent conduct as a result of habitual and excessive use of alcohol or drugs poses a substantial likelihood of physical harm to himself or others as demonstrated by (i) a recent attempt or threat to physically harm himself or others, (ii) evidence of recent serious physical problems, or (iii) a failure to provide necessary food, clothing, shelter, or medical care for himself. §253B.02(2).

Maximum Length of Disposition

6 months. §253B.09(5).

Mississippi

Criteria

Person afflicted with mental illness if reasonably expected at the time determination is made or within reasonable time thereafter to intentionally or unintentionally physically injure himself or others or is unable to care for himself so as to guard himself from physical injury or to provide for his own physical needs. It does not include mental retardation. Miss. Code Ann. §41-21-61.

Maximum Length of Disposition

Indeterminate. §41-21-83.

Missouri

Criteria

Mental disorder which causes the likelihood of serious physical harm to himself or others. Mo. Ann. Stat. §632.300 (Vernon 1982).

Maximum Length of Disposition

1 year, 3 months. §§632.340, .355.

Montana

Criteria

Seriously mentally ill which means suffering from a mental disorder which has resulted in self-inflicted injury to self or others or the imminent threat thereof or which has deprived the person afflicted of the ability to protect his life or health. For this purpose, injury means physical injury. No person may be involuntarily committed because he is epileptic, mentally deficient, mentally retarded, senile or suffering from a mental disorder unless the condition causes him to be seriously mentally ill. Mont. Code Ann. §53-21-102(14).

Maximum Length of Disposition

One year. §§53-21-127, 128. Thereafter, commitment proceedings must be initiated again.

Nebraska

Criteria

Mentally ill dangerous person who poses a substantial risk of serious harm to himself or others.

Mentally ill dangerous person shall mean any mentally ill person or alcoholic person who presents:

(1) a substantial risk of serious harm to another person or persons in the near future, as manifested by evidence of recent violent acts or threats of violence by placing others in reasonable fear of harm, or

(2) a substantial risk of serious harm to himself within the near future, as manifested by evidence of recent attempts at or threats of, suicide or serious bodily harm, or evidence of inability to provide for his basic human needs, including food, clothing, shelter, essential medical care or personal safety. Neb. Rev. Stat. §83-1009.

Maximum Length of Disposition

Indeterminate. §§83-1046, 83-1079.

Nevada

Criteria

A person who is mentally ill and who exhibits observable behavior that he is likely to harm himself or others if allowed to remain at liberty, or that he is gravely disabled. Nev. Rev. Stat. §433A.310(1).

Maximum Length of Disposition

6 months. §433A.310(2).

New Hampshire

Criteria

Person in such mental condition as a result of illness as to create a potentially serious likelihood of danger to himself or others. N.H. Rev. Stat. Ann. §135-B:38.

"Mental illness" means a substantial impairment of emotional processes or of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to reason, which impairment is manifested by instances of extremely abnormal behavior extremely faulty perceptions. It does not include impairment primarily caused by: (a) epilepsy; (b) mental retardation; (c) continuous or noncontinuous periods of intoxication caused by substances such as

alcohol or drugs; dependence upon or addiction to any substance such as alcohol or drugs. §135-B:2X1 (1981 Cum. Supp.).

Maximum Length of Disposition

2 years. §135-13-B:38.

New Jersey

Criteria

Person so afflicted with mental disease that he requires care and treatment for his own welfare or the welfare of others or of the community. N.J. Stat. Ann. §30:4-44, 30:4-23.

Maximum Length of Disposition

Indeterminate. N.J. Court Rule 4:74-7(f).

New Mexico

Criteria

Client with mental disorder that presents a likelihood of serious harm to himself or others, the client needs and is likely to benefit from proposed treatment consistent with least restrictive alternative.

"Mental disorder" means a substantial disorder of the person's emotional processes, thought or cognition which grossly impairs judgment, behavior or capacity to recognize reality.

Likelihood of serious harm to oneself means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to himself by violent or other self-destructive means including but not limited to grave passive neglect as evidenced by behavior causing, attempting or threatening the infliction of serious bodily harm to himself.

Likelihood of serious harm to others means the person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from said person. N.M. Stat. Ann. §§43-1-13(E), 43-1-3(L), (M), (N).

Maximum Length of Disposition

One year. §43-1-12(C).

New York

Criteria

Person who has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment. N.Y. Ment. Hyg. Law §§9.39, 9.37.

Mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others; "likelihood of serious harm" shall mean:

(1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself; or

(2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

Maximum Length of Disposition

2 years. §9.33(D).

North Carolina

Criteria

Mentally ill, mentally retarded or inebriate person who because of an accompanying behavior disorder is dangerous to himself or others, or is mentally retarded and because of accompanying behavioral disorder, is dangerous to others.

a. "Dangerous to himself" shall mean that within the recent past:

1. The person has acted in such manner as to evidence:

I. That he would be unable without care, supervision, and the continued assistance of others not otherwise available to exercise self control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and

II. That there is a reasonable probability of serious physical debilitation to him within the near future unless adequate treatment is afforded. A showing of behavior that is grossly irrational or of actions which the person is unable to control or of behavior that is grossly inappropriate to the situation or other evidence of severely impaired insight and judgment shall create a *prima facie* inference that the person is unable to care for himself; or

2. The person has attempted suicide and that there is reasonable probability of suicide unless adequate treatment is afforded under this Article; or

3. The person has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is afforded under this Article.

b. "Dangerous to others" shall mean that within the recent past, the person has inflicted or threatened to inflict serious bodily harm on another or has acted in such a manner as to create a substantial risk of serious bodily harm to another and that there is a reasonable probability that such conduct will be repeated. N.C. Gen. Stat. §122.58.2.

Maximum Length of Disposition

90 days. §122-58.8.

(b) unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety. Or. Rev. Stat. §426.005.

Maximum Length of Disposition

180 days. §426.130.

Pennsylvania

Criteria

A severely mentally disabled person who poses a clear and present danger to others or himself.

(a) Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated. For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) The person has attempted suicide and that there is a reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

(iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation. Pa. Stat. Ann. tit. 50 §7301.

Maximum Length of Disposition

90 days. Up to one year if criminal charges involving dangerous acts. Tit. 50 §7304(g).

Rhode Island

Criteria

A person who is so insane as to be dangerous to the peace or safety of the people of the state or so as to render his restraint and treatment necessary for his own welfare. R.I. Gen. Laws §40.1-5.1-1.

Maximum Length of Disposition

Indeterminate. §40.1-5.1-3.

South Carolina

Criteria

A person who is mentally ill, needs treatment and because of his condition:

(1) lacks sufficient insight or capacity to make responsible decisions with respect to his treatment; or

(2) there is a likelihood of serious harm to himself or others. S.C. Code Ann. §44-17-580 (1982 Cum. Supp.).

Maximum Length of Disposition

Indeterminate. §44-17-820.

South Dakota

Criteria

Mentally ill person who lacks sufficient understanding and capacity to meet the ordinary demands of life or is dangerous to himself or others. S.D. Codified Laws Ann. §27A-1-1. The term "mentally ill" as used in this title includes any person whose mental condition is such that his behavior establishes one or more of the following:

(1) He lacks sufficient understanding or capacity to make responsible decisions concerning his person so as to interfere grossly with his capacity to meet the ordinary demands of life; or

(2) He is a danger to himself or others.

Maximum Length of Disposition

Indeterminate. §27A-9-18.

Tennessee

Criteria

A person is mentally ill and poses a likelihood of serious harm and is in need of care and treatment. Tenn. Code Ann. §33-604(a), (d).

Likelihood of serious harm" means:

(1) A substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; or

(2) A substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in a reasonable fear of violent behavior and serious physical harm to them; or

(3) A reasonable certainty that severe impairment or injury will result to the person alleged to be mentally ill as manifested by his inability to avoid or protect himself from such impairment or injury and suitable community resources for his care are unavailable. §33-604.

Maximum Length of Disposition

Indefinite. §§5547-52(b).

Texas

Criteria

A person who is mentally ill and requires hospitalization for his own welfare and protection or the welfare and protection of others. Tex. Rev. Civ. Stat. Ann. §§5547-52(b).

Mentally ill person means a person whose mental health is substantially impaired. §5547-4(k).

Maximum Length of Disposition

Indefinite. §5547-52(b).

Utah

Criteria

(a) The proposed patient has a mental illness; and

(b) Because of the patient's illness the proposed patient poses an immediate danger of physical injury to others or self, which may include the inability to provide the basic necessities of life, such as food, clothing, and shelter, if allowed to remain at liberty; and

(c) The patient lacks the ability to engage in a rational-decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of treatment; and

(d) There is no appropriate less restrictive alternative to a court order of hospitalization. Utah Code Ann. §64-7-36(10).

"Mental illness" means a psychiatric disorder as defined by the current *Diagnostic and Statistical Manual of Mental Disorder* which substantially impairs a person's mental, emotional, behavioral or related functioning. §64-7-28(1).

Maximum Length of Disposition

Indeterminate. §64-7-36(11)(a).

Vermont

Criteria

(17) "A person in need of treatment" means a person who is suffering from mental illness and, as a result of that mental illness, his capacity to exercise self-control, judgment, or discretion in the conduct of his affairs and social relations is so lessened that he poses a danger of harm to himself or others;

(A) A danger of harm to others may be shown by establishing that:

(i) he has inflicted or attempted to inflict bodily harm on another; or

(ii) by his threats or actions he has placed others in reasonable fear of physical harm to themselves; or

(iii) by his actions or inactions he has presented a danger to persons in his care.

(B) A danger of harm to himself may be shown by establishing that:

(i) he has threatened or attempted suicide or serious bodily harm; or

(ii) he has behaved in such a manner as to indicate that he is unable, without supervision and the assistance of others, to satisfy his need for nourishment, personal or medical care, shelter or self-protection and safety, so that it is probable that death, substantial bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

(14) "Mental illness" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but shall not include mental retardation. Vt. Stat. Ann. tit. 18 §7101 (17).

Maximum Length of Disposition

Indeterminate. §7621.

Virginia

Criteria

A person who (a) presents an imminent danger to himself or others as a result of mental illness, or (b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed not suitable. Va. Code §37.1-67.3 (1982 Cum. Supp.)

Maximum Length of Disposition

180 days. §37.1-67.3.

Washington

Criteria

A person who has threatened, attempted, or inflicted: (a) physical harm upon the person of another or himself, or substantial damage upon the property of another, and (b) as a result of mental disorder presents a likelihood of serious harm to others or himself; or

(2) Such person was taken into custody as a result of conduct in which he attempted or inflicted harm upon the persons of another or himself, and continues to present, as a result of mental disorder, a likelihood of serious harm to others or himself.

(3) Such person has been determined to be incompetent and criminal charges have been dismissed and has committed acts constituting a felony, and as a result of a mental disorder, presents a substantial likelihood of repeating similar acts. In any proceeding pursuant to this subsection it shall not be necessary to show intent, willfulness or state of mind as an element of the felony; or

(4) Such person is gravely disabled. Wash. Rev. Code Ann. §71.05.280 (1982).

"Gravely disabled" means a condition in which a person, as a result of mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety. §71.05.020(1).

"Mental disorder" means any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions. §71.05.020(2).

"Likelihood of serious harm" means either: (a) A substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others. §71.05.020(3).

Maximum Length of Disposition

180 days. §71.05.320.

West Virginia

Criteria

Mental illness, retarded or addicted and is likely to cause serious harm to himself or to others. Mental illness means a manifestation in a person of significantly impaired capacity to maintain acceptable rules of functioning in the areas of intellect, emotion and physical well being. W.Va. Code Ann. §27-1-2.

"Likely to cause serious harm" refers to a person who has:

(1) A substantial tendency to physically harm himself which is manifested by threats of or attempts at suicide or serious bodily harm or other conduct, either active or passive, which demonstrates that he is dangerous to himself; or

(2) A substantial tendency to physically harm other persons which is manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm; or

(3) A complete inability to care for himself by reason of mental retardation; or

(4) Become incapacitated. §27-1-12.

Maximum Length of Disposition

2 years. §27-5-4(k)-4.

Wisconsin

Criteria

(1) A person who is mentally ill, drug dependent, or developmentally disabled and is a proper subject for treatment: and

(2) Is dangerous because the individual:

(a) Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm;

(b) Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do . . . serious physical harm;

(c) Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a . . . substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury . . . *is not* substantial under this subparagraph if reasonable provision for the subject individual's protection is available in the community, . . . if the individual is appropriate for placement under s. 55.06 or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13(4) or (11). The subject individual's status as a minor does not automatically establish a . . . substantial probability of physical impairment or injury under this subparagraph; or

(d) Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treat-

ment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. Wisc. Stat. Ann. §51.20(1) (West).

Maximum Length of Disposition

One year. §51.20(13)(g).

Wyoming

Criteria

A person is mentally ill based on evidence of recent overt acts, or threats. Wyo. Stat. §25-10-110. A mentally ill person means a person who presents an imminent threat of physical harm to himself or others as a result of a physical emotional, mental or behavioral disorder which grossly impairs his ability to function socially, vocationally or interpersonally and who needs treatment and who cannot comprehend the need for or purposes of treatment and with respect to whom the potential risk and benefits are such that a reasonable person would consent to treatment. §25-10-101.

Maximum Length of Disposition

Indeterminate. §25-10-116.

Conspiracy suit

(continued from p. 334)

an influence on the termination decision."

The court stated that it would be difficult to prove a conspiracy between the association and state officials, but that there was "sufficient evidence to raise a factual issue on this claim." The court also stated that if the former superintendent had succeeded in establishing a conspiracy, the first amendment would not shield the association from liability, but that the state would be immune from retrospective monetary responsibility under the eleventh amendment. State officials, acting within the scope of their discretionary authority, would forfeit their immunity by acting with malicious intention to cause deprivation of constitutional rights, or, even if acting in sincere subjective belief that they were doing right, if their actions contravened "'settled indisputable law.'" ■

Table of Cases

(continued from p. 292)

Town of Pleasant Valley v. Wassaic Developmental Disabilities Services Office (907(a)) 342
In re T.T. (902(e)) 339
Turner v. Stumbo (303(c), 1218, 1002) 314
Twentieth Century Fox Film Corp. v. Workers' Compensation Appeals Board (904(e), 909) 342
United States v. Fogarty (303(c), 304(c), 302) 314
United States v. Lyons (304(c), (a)) 319
United States v. Rogers (303(c)) 316
Upton v. Hall (902(d), 903(d)) 339
Van Winkle v. Electric Hose & Rubber Co. (904(e), 909) 342
Vasquez v. Schweiker (1211) 342
Washington v. Davis (301, 902(c)) 313
West Virginia v. Audia (303(c)) 338
West Virginia v. Bias (304(c), 1401) 337
West Virginia v. Flint (304(c)) 337
West Virginia v. Williams (303(a), 304(c)) 335
White v. Texas (303(c)) 335
William S. et al. v. Gill et al. (1309, 955) 301
Williams v. Lallie Kemp Charity Hospital (1106, 1003) 333
Willie M. v. Hunt (1406, 402) 308
In re William Wilson (103(a)) 303
Wisconsin ex rel. Pflaum v. State of Wisconsin Psychology Examining Board (919(d)) 324
Woe v. Cuomo (401, 1309, 1101) 311
Yaris v. Special School District of St. Louis County (952, 1206, 1210) 325
Young v. Alabama (304(c)) 337
Young v. Smith (902(c), 903(d)) 340
Zimmerman v. New York City Health and Hospitals Corporation (902, 1003) 343

Are You Missing Essential Information?

The following materials are also available from the *Mental Disability Law Reporter:*

***Reporter* Back Issues**

Now is the time to purchase back issues of the *Reporter* that you do not have in your library. The complete set of volumes 1 through 6 costs only $190, which is less than $32 per volume. (Separate volumes are $50, and separate issues are $10 each.) A complete set of back issues, together with the *Reporter Four-Year Research Index* and *Two-Year Index* will give you a comprehensive, easy-to-use research library for your office.

***Reporter* Volume Binders**

Save and protect your copies of the *Reporter* with the custom volume binder. The *Reporter* magazine binders use rods to clamp issues into place. All of the issues in the binder lie flat, so turning the pages is much easier. Binders are $5.95 each.

CIVIL COMMITMENT AND
KANSAS HOUSE BILL 2050

Second Annual Conference
of Kansas Families for Mental Health

October 26, 1985

It is important that you know something about me before I share my views on involuntary commitment in general, and House Bill 2050 specifically. In my opinion, public policy is often based upon individual experiences which have shaped personal ideas. For instance, my ideas, my goals, and my objectives are a product of many things. First of all, they are a product of my legal training. Secondly, they are shaped by my early experiences as a mental health and criminal defense attorney in Pawnee County from 1977 to 1984. In addition, my objectives are based upon the needs of my clients who are presently the Secretary of Social and Rehabilitation Services and the Commissioner of Mental Health and Retardation Services. Finally, my goals and objectives flow from my own personal convictions about what is right, what is fair, what is realistic, and what is best for both consumers and providers of mental health services in Kansas.

I acknowledge at the outset my growing indebtedness to the members of Kansas Families for Mental Health for a better and more complete understanding of the many difficult issues which face all of us who are interested in mental health care today. Without the vision and determination of dedicated family members like Howard and Lou Snyder, the changes proposed during the last legislative session in House Bill 2050 would not have been made so soon. Furthermore, without the formation of Families for Mental Health, the concerns of family members might not have been recognized as of equal importance to those of patients, professional staff, direct care staff, and society in general. The

enactment of effective and fair legislation must consider the goals of all persons affected by mental illness, at least to the extent that those persons are willing to raise issues and seek solutions. Families are a key to providing more effective services. They are now being seen as a part of the solution to many of the problems facing the mental health system and the chronic mentally ill.

Since I have acknowledged the important role that Families for Mental Health have played in my own understanding of the issues, I must also acknowledge the role that patients and former patients continue to play in shaping law and public policy. It may have been the failure of the system to accommodate the privacy, dignity, and intellectual needs of patients that brought about the patients' rights revolution in the late 60's and throughout the last decade. What has been gained in resources, understanding, commitment, policy, and law cannot be lost by those of us who want to make certain changes in 1985. However, I continue to believe that the law must not place total emphasis on "dangerousness," and the commission of "violent acts," when a patient's competency to understand the effects of illness and the possibility of effective treatment are of at least equal importance. As a result, House Bill 2050 attempts to reinsert competency to understand the effects of mental illness to the commitment decision.

PERSONAL BACKGROUND

As some of you are aware, I graduated from law school in 1977 following three years of study that were never known to include a single reference to any of the terms so often discussed in the field of mental health law today. Those terms include such issues as the right to treatment, right to refuse treatment, least restrictive alternative, guilty but mentally ill, wrongful discharge, duty

to warn, and many others. Without any formal introduction to the field of mental health law, I began representing both psychiatric patients at Larned State Hospital and criminal defendants at state security hospital on a regular basis. At that time, I could find very little material to assist me in approaching these issues on behalf of my clients. There simply was no such thing as "mental health law." Therefore, I was forced to turn to a field that I had studied in law school - the criminal law. The criminal law placed great emphasis upon due process, a meaningful hearing, prior notice, presence at all judicial proceedings, confrontation of those persuading conviction, and strict proof. In the context of civil commitment, all of these rights were provided to proposed patients, including the right to strict proof of dangerousness as the only standard allowing commitment in Kansas.

Armed with principles learned from criminal cases, I began representing psychiatric patients in a new field, previously unknown to me, as best I could. During those early years, I played virtually every role possible in commitment cases. I served as the patient's attorney in hundreds of cases. On occassion, I also served as the appointed county attorney and represented petitioners in bringing commitment actions. In other cases, I served as the appointed judge and had to make the difficult decision regarding commitment. And finally, in 1978, I accepted a part-time position as the first attorney for Larned State Hospital. Obviously, from that point forward, I also served as hospital counsel. In no other area of my practice did I sense so much pain on behalf of those involved than in commitment cases. There was extreme stress for the patient, the patient's family, mental health professionals, attorneys, and judges. For I am convinced that no one was emotionally unaffected by the

hearing, regardless of the ultimate outcome of the case. For that reason alone, these cases took on an added importance in my practice.

In May of 1984, I accepted the position of Senior Counsel for Mental Health and Retardation Services. This was another new position that had not existed before. I am now in the position of working directly with the Commissioner of Mental Health and Retardation Services and all eight state psychiatric hospitals and institutions for the mentally retarded. I also have the opportunity to work indirectly with the state's system of mental health centers and many interest groups, including Families for Mental Health and the Advocates for Freedom in Mental Health. I continue to benefit from this unique opportunity to work with so many different individuals and groups, but unfortunately the issues have not become any easier to resolve. Among the difficult issues which prompted the drafting of House Bill 2050 are: (1) Who should be subject to involuntary commitment? (2) Should commitment always be to inpatient settings, or might it be to outpatient as well? (3) Should committed patients have the right to refuse medication prescribed by a doctor?

MENTALLY ILL PERSONS

Who should be subject to involuntary commitment? Should it be only the imminently dangerous? This is an issue currently being addressed by mental health professionals, former patients, and state legislators throughout the nation. Let me at least share with you my viewpoint concerning this issue.

Civil commitment to a psychiatric hospital should result in treatment. Hospitalization, whether for physical or mental illness, is not to punish but rather to treat. People who need treatment belong in hospitals. Dangerousness, then, is not the key concept in deciding who should be committed to psychiatric hospitals if hospitals are to serve their normal purpose.

How much emphasis does current law place upon treatment as opposed to dangerousness? Current law does require a "mental impairment," but makes no attempt to define that term. Therefore, judges must decide in individual cases whether proposed patients have a mental impairment before ordering treatment. How is mental impairment evidenced? Is it evidenced by unusual behavior? Is it evidenced by dangerous behavior? Or, is mental impairment anything listed in DSM III, the manual used by mental health professionals to diagnose psychiatric illness? In addition to questions concerning proof of mental impairment, how serious must the impairment be before commitment can be ordered? Must the impairment be serious, or not so serious and is there any sense of the degree of mental impairment which judges must decide in making the commitment decision?

Because of the lack of a definition for "mental impairment," and little emphasis on "need for treatment" under current law, there has been a much greater emphasis on dangerousness. The general shift in this country from proof of "need for treatment" to "dangerousness" must be understood before discussing the issue further. Certainly, there were very good reasons for the abrupt shift from need for treatment to dangerousness that occurred in almost every state during the last decade. Mental health attorneys who argued on behalf of patients brought forth at least three issues in support of the dangerousness criteria: (1) Too many people perfectly capable of getting along well in society were being committed to psychiatric hospitals (2) Too many people not getting any treatment were being committed to psychiatric hospitals, and (3) Too many patients were not being discharged because their labor was needed to continue running the hospital. These were, and are, valid issues which merit the serious concern of all individuals interested in providing mental health services. Nonetheless, it is my opinion that staff now try to turn patients

around almost as soon as they are admitted to the hospital. In fact, at least tentative discharge plans are usually formulated in the early days of treatment. Moreover, forced labor is prohibited by statues in Kansas and most other states.

I have argued thus far that for hospitals to remain hospitals, there must be a greater emphasis upon the likelihood of a favorable response to treatment and less emphasis on dangerousness in the commitment decision. In making this claim, I fully understand that some attorneys have argued dangerousness is a necessary constitutional prerequisite to commitment. However, it is my opinion that a dangerousness requirement has not been established by the U.S. Supreme Court.

In 1975, the Supreme Court decided the case of O'Connor v. Donaldson. The court prefaced its decision upon a finding of several specific facts which it felt required Donaldson's discharge from the Florida State Hospital at Chattahoochee. Specifically, the court found that Mr. Donaldson had never posed a danger to himself or others, had been capable of earning a living both before and after his commitment, had access to responsible persons able and willing to assist him with community living, had never received any meaningful psychiatric treatment during his hospitalization, had never been afforded the right to discuss his case with hospital staff, and was consistently denied ground privileges and occupational training. Faced with these facts, the court said that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." To the extent that any of the underlying facts set forth by the court had not been present, it is

difficult to determine what decision the court would have reached. Nonetheless, the court clearly refused to enunciate a general principle that only dangerous persons could be committed "for the purpose of treatment." (Some federal courts have decided that not only must a proposed patient be dangerous, but that dangerousness must be imminent and based upon recent overt acts of physical harm.)

A number of courts, including the U.S. Supreme Court at least by implication, have steered toward dangerousness out of an apparent fear that there is simply no alternative capable of protecting both society and the patient. But there may be such an alternative. In fact, it is a very old alternative - the state's authority to appoint a substitute decision-maker for those persons who, because of physical or mental disability, are unable to rationally comprehend their situation, understand the available alternatives, and act in their own best interest. This equation is based not upon dangerousness, but upon COMPETENCY, NEED FOR TREATMENT, and a reasonable probability that effective treatment can be provided. Some would argue that if a person is not imminently dangerous, there is no right, or even need, to intervene in their life. I would argue that if a person is not competent to understand the effects of illness and the possibility that effective treatment may restore that competency, then there is both a need and a right to intervene. Guardianship still exists in this state, and although the authority of guardians has been greatly limited in recent years, the need for that authority is based more on competency than dangerousness.

The key issues, in my formula at least, are competency and the availability of effective treatment. Most other issues remain the same; such as the right of the patient to be treated in the least restrictive environment, the right to procedural due process of law, and institutional rights as they currently exist.

House Bill 2050 would still require proof by clear and convincing evidence of four elements: (1) a SEVERE mental disorder, (2) the NEED for psychiatric treatment, (3) the patient's LACK OF CAPACITY to make an informed decision concerning treatment, and (4) the likelihood of HARM to self or others if treatment is not provided. However, "harm" and "dangerousness" are probably not the same. Even so, it is important to remember that just as current law makes no attempt to define "mental impairment," neither does it attempt to define "dangerousness," with one exception. Dangerousness to self must be seen as a life-threatening condition. In all other aspects, the definition of dangerousness is left to judges in individual cases. Harm as defined in House Bill 2050 would include persons who are "suffering severe or abnormal mental, emotional or physical distress causing a substantial deterioration of the person's ability to function independently." This definition would include more than physical violence, but it does not stand on its own. It would at least deal with cases such as Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), which required a recent overt act of violence. It is my understanding that at least a few Kansas judges define dangerous to self or others under a standard similar to that set forth in Lessard.

House Bill 2050 is not designed to "bring in" all of those who chose to live on the streets or who want a different life style than what might be considered the norm. In fact, it does not speak to choices at all, but rather the inability to make choices because of the effects of a severe mental disability.

It is important to remember that dangerousness is difficult to predict. Serious mental disorder and the availability of treatment are less difficult and more in line with the training and experience of mental health professionals. Simply stated, dangerousness should not be the key concept in civil commitment if psychiatric hospitals are to remain both psychiatric and hospitals. It should not be left out of the definition, but competency and need for treatment must again be emphasized.

OUTPATIENT COMMITMENT

The second issue presented by House Bill 2050 is whether involuntary outpatient commitment can work in Kansas. This, I must confess, was my biggest disappointment during the 1985 legislative session. From my experience in representing patients at Larned State Hospital in the late 70's, I always preferred treatment in the community over treatment in the hospital. In those cases where there were strong elements of mental impairment and dangerousness, I argued to the court that patients should be afforded treatment in the least restrictive environment, such as mental health centers. However, during hearings on House Bill 2050, some former patients and patient advocates testified against outpatient commitment as being little more than the state's desire to follow patients into the community. They did not see it as an honest attempt to further the least restrictive alternative principle by giving the judge a choice to require only outpatient therapy.

I acknowledge that there are many practical issues which are currently unknown about outpatient treatment. For instance, do we in Kansas have the resources to make outpatient commitment work? I am not certain of the answer, but at least the Association of Community Mental Health Centers is willing to

try. The Association's members have several concerns about outpatient commitment. Do they have sufficient staff to provide the monitoring and follow-up that outpatient commitment will require? Will staff have sufficient time to devote to increased judicial involvement? Finally, will mental health centers be increasing their potential for legal liability without significant improvement in the quality of mental health services? Again, none of us really know the answers to these questions.

Some have argued that outpatient commitment is inconsistent with involuntary commitment in the first place. In other words, they ask how dangerous people can be left in the community. In my opinion, it must be remembered that dangerousness is a relative concept. It must be asked: Dangerousness under what conditions? There are certainly patients who would be dangerous without immediate inpatient hospitalization and the structure, supervision, and treatment that setting provides. However, it is also possible that other patients are dangerous only if they do not receive medication, or at least minimal therapeutic monitoring and support from a community mental health center. For those patients who need only outpatient services, it seems an undo infringement to require hospitalization.

Finally, some have asked whether the state can expect to save money by specifically authorizing outpatient commitment. Whether fewer beds will be needed in hospitals as a result of successful outpatient commitment is still an open question. The design of House Bill 2050 is to reserve hospital beds for those people who clearly cannot function in the community under any conditions. However, some are skeptical of any real savings in financial terms since the additional costs of community monitoring and treatment may more than offset

hospital savings. In any event, costs to patients in terms of personal autonomy and restrictiveness seem much more severe in hospitals than in the community.

With respect to the outpatient portion of House Bill 2050, it should also be mentioned that the same due process requirements are provided for both outpatient and inpatient commitment. Some states, notably North Carolina, make fewer due process requirements for outpatient commitment under the theory that it is less restrictive of liberty than inpatient commitment. House Bill 2050 rejects that idea, and would require the same procedures for either form of commitment. In addition, the court will continue to review the need for outpatient commitment under the same timetable as that set forth for inpatient.

RIGHT TO REFUSE TREATMENT

The third important issue which House Bill 2050 addresses is whether committed patients should have the right to refuse treatment, especially psychotropic medication. In my opinion, the answer to this question may depend on what the judge decided when treatment was ordered in the first place. Did the judge only decide that the patient was dangerous and needed confinement to prevent bodily injury to self or others? Or, did the judge find that the patient was in need of psychiatric treatment? Or again, did the judge decide that the proposed patient was unable to enter a rational decision-making process with respect to need for treatment? Perhaps the judge decided all three, or some combination of any two. It is because of this uncertainty that some courts have recognized the right of involuntary patients to refuse psychotropic medication. Unless the patients' ability to make treatment decisions is presented to the court, the right may pass unaffected through the commitment decision. This is another reason why I am so insistent that competency be a

part of the commitment decision. Involuntary commitment to a hospital should be for treatment and not incarceration, punishment, housing, food, or any other overriding purpose. Hospitals must remain hospitals, whether patients are admitted voluntarily or involuntarily. If the court only decides that a person is dangerous, the right to refuse treatment makes some sense, but then commitment itself makes little sense. If commitment is based upon competency, anyone competent would have the right to refuse not only medication, but hospitalization itself, whether dangerous or not. I do not believe that competent adults should be forced to receive treatment absent criminal processes. Mental health professionals are not agents of social control. Hospitals are not detention centers for the dangerous. They are to treat, not detain.

Unfortunately, the right to refuse issue gives rise to the most difficult dilemma facing the system. It is extremely important to assure the patient's maximum involvement in treatment. Without a doubt, patients cannot be taken for granted; they cannot be ignored; they cannot be treated as a non-entity; they cannot be denied access to explanations and alternatives; and in short, they cannot be left out. I understand this issue, and I agree with great feeling. However, I must also recognize the difficulty and unfairness of committing a person to professional care, and then telling that professional he or she can neither treat nor discharge - only stand by watching further deterioration, hoping the person will change their mind, even when the rational ability to understand the effects of illness may be gone.

CONCLUSION

During the last legislative session, my vote was cast in favor of changing the almost total emphasis on dangerousness that current law sets forth. It was seen as anti-civil rights, anti-patients, and anti-reform. Having started on behalf of patients, these were very difficult labels for me to accept.

I know that I have limited knowledge. I have never been a mental health professional, never provided direct care services, nor have I ever seen the treatment setting from the perspective of a committed patient. I have seen only pieces of the puzzle, but some of those pieces do not seem to fit, at least from my vantage point. I would remove a few and add a few others. However, basic due process and institutional rights would not be affected by those changes.

Through meetings, discussion, research, and speeches such as this, I hope to learn what others have seen that I have not seen. I offer a commitment based upon seven years of personal experience as a mental health attorney. More than anything else, I want the best possible balance for the state of Kansas - its professionals, its consumers, and its families. Mine is not the only voice to be heard and for that I am very thankful. I want to be understood, but I also want to be understanding. Thank you for inviting me to share my reality with each of you.

WILLIAM C. REIN
Senior Counsel
Kansas Mental Health & Retardation Services

1-30-86

K.F.F.M.H.

Kansas Families For Mental Health

4811 W. 77th Place
Prairie Village, Kansas 66208
913-642-4389

HB 2050 January 30, 1986

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 360 families in Kansas. There are local chapters in Lawrence, Topeka, Johnson County, Kansas City, Wichita, Hiawatha, Concordia, Manhattan, Hutchinson, Baxter Springs, Newton, Winfied, Emporia, Phillipsburg, Leavenworth, Humbolt and Kingman.

Ten years ago, in response to some abuses of the commitment process for the mentally ill, legislation was passed to address patients' rights and correct abuses. The criteria for commitment was based on "dangerousness" to self or others. As often happens with social legialation, the pendulum has swung too far the other way and people who really need treatment for help in becoming productive citizens are not receiving it.

What is "dangerous"? Is it just before the knife goes in or just after? Present law has no definition, so the defining is left up to the various jurisdictions. Since "dangerousness" is virtually impossible to predict-with accuracy-many jurisdictions are using the definition-a "recent violent act." Commitment is a procedure that involves a person's medical welfare as well as their legal rights, therefore, we now have members of the legal profession who have had no medical training making decisions concerning a persons medical welfare. These decisions based only on "dangerousness," which is not a predictable behavior.

If the present law were working well, then a large percentage of our mentally ill would be in treatment programs, and living relatively productive and useful lives. The opposite is true. A study in Ohio in 1984 showed that only 20% of mentally ill people were in treatment. In my own county, less than 20% of the estimated mentally ill population are in treatment programs today. Where are the other 80-90%. They are in family homes, jails or on the streets. An American Psychiatric Association study of the homeless across the country showed that from 30-60% of various samples studied in various cities were mentally ill. They are in family homes, hiding away from society and being burdens on their families. It is estimated that 1/3 of people in criminal custody are mentally ill, and receiving little or no treatment. How can anyone say the present law is woring well, when faced with these figures?

In the 10 years since this law was adopted, there have been great changes. 10 years ago the family was blamed for causing mental illness, and consequently accused of dumping their loved ones in psychiatric hospitals to be warehoused. Today, we now know, from recent research, mental illness is a malfunction in the chemistry of the brain, which may be genetic in nature, and is triggered by unknown events or combinations of events.

In the past 10 years our state hospital system has improved dramatically under the leadership and guidance of SRS and this Legislature. More effective medications are available, and their use is better understood. More effective psychosocial treatments has been developed. The policy now is the shortest possible hospital stay and the lowest possible

S. Judiciary
1/30/86
II

medication doseage. The technology is available to help many of the mentally ill become useful productive citizens, leading reasonably fulfulling lives. The problem is getting them started into the benefits of these treatments.

10 years ago the mentally ill population in general had a history of frequent hospitalizations, and were generally more agreeable to treatment. Since then a new generation has come along. They are younger, have greater expectations than my generation, and are more resistant to treatment. For example, the average age of the homeless has lowered to approximately 34 years, per the A.P.A. Study. From their peers and from the media, they have learned to be more resistant to authority than my generation.

My son certainly fits into this description. From the age of 5 he knew he wanted to be a geologist. In high school, he became fluent in French, and was an exchange student in France. In the Geology School at Arizona University he was named top Freshman. He became mentally ill in his sophomore year, yet still finished that year with a 3.7 grade point. That was in 1979. Since then he has been unable to function normally for more than a few weeks at a time. For the past year and one half he has been existing on the streets in Tucson, refusing to face his problem, sleeping in bushes and eating from garbage cans. He came home Christmas having lost 40-50 pounds, with yellow jaundice and close to having hepatitus. All of his possessions were gone, and all he had were some old Salvation Army clothes. But the courts in both Kansas and Arizona said that since he was not visibly dying, he is not a danger to himself.

His paranoid delusions are so strong that he is unable to make a rational decision about accepting treatment. We believe that with proper help, and carefully controlled medication that would help him control his delusions, he could become a useful member of society. Without treatment his future is bleak.

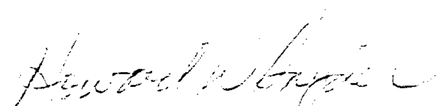
Our options as a family are few. If we let him stay home as a recluse, he will deteriorate, and become dependent on us. We will not always be available. If we put pressure on him by trying to talk him into treatment, he will run back to the streets, and we would lose track of thim.

In later testimony, we will hear of his rights, and I respect those. But, what rights does he really have? He has no freedom. He is trapped in the prison of his malfunctioning brain. He is low functioning, so will not be accepted by Society. He has no right to live where he wants to, because, a mentally ill person is automatically poor, and also rejected in many neighborhoods. He can be discriminated against-legally. If he is on the streets, his only right is to die slowly.

He is not unique. As we have travelled Kansas helping to set up FFMH Family Support Groups, we have met hundreds of families of the mentally ill. Our story, or a variation of it is common.

If we were to come on a diabetic in a coma, would we refuse to help because he could not ask for it? Of course not. Why then, do we continue to require that a mentally ill person with a malfunctioning brain ask for treatment or commit a violent act to obtain it?

I'm asking that you restore some balance in the law, so that a person's need for treatment is considered as well as their criminal behavior.



THE CITY OF PRAIRIE VILLAGE *Star of Kansas*

February 8, 1985

Mrs. Lou Snyder
4811 West 77 Place
Prairie Village, Kansas 66208

Re: House Bill #2050

Dear Mrs. Snyder:

Thank you for your visit to discuss our common concern about present laws and procedures for the care and treatment of the mentally ill person. In my 27 years as a police officer, I have worked with the mentally ill in crisis situations under the old laws and those presently in force. Neither approach has been successful in meeting the needs of the mentally ill while at the same time protecting their constitutional rights.

As a police officer who is concerned mostly with the emergency mental crisis, I find that there are two areas that do not provide the necessary tools to protect both the ill and the safety of the public.

1. The probable cause requirement stating that in order to provide involuntary treatment, it must be established that the person is a danger to themselves or others. Too often this requirement results in a violent action being taken by the mentally ill before treatment can be obtained. A lesser standard for emergency treatment and observation must be established in order to ensure that the mentally ill can receive treatment before injury takes place. I just as strongly believe that being a danger to oneself must include the long-term inability to provide the daily necessities of life, food, shelter and medical treatment. The results are the same whether a person ends their life in one violent act, or slowly starves or dies because they do not have the mental ability to obtain proper medical treatment.

The language of House Bill #2050, lines 0060 through 0074, seems to be the logical approach to provide the necessary involuntary treatment of the mentally ill and I strongly support this approach.

2. The need for upgrading the taking of the mentally ill into custody for emergency evaluation and treatment is necessary. If House Bill 2050 becomes law, the importance of this procedure will be increased. To ensure the constitutional rights of the mentally ill are protected, the need for a local crisis evaluation, holding and treatment program is desired. These decisions should be made by professional medical people, not police officers. I had written a letter to the Johnson County Mental Health

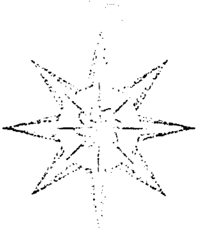
Program about this very matter. Rather than restating my position, I have attached a copy of that letter. I hope that it will be of assistance to you.

The emergency and long-term treatment of the mentally ill is a topic that every police officer should be concerned about. I believe most are. Given proper time, I believe that the support of law enforcement organizations such as the Johnson County Police Chiefs, the Kansas Chiefs of Police and others, could be developed.

Very truly yours,

Louis E. LeManske
Chief of Police

LEL:mgl
Enclosure



THE CITY OF PRAIRIE VILLAGE *State of Kansas*

January 31, 1985

Johnson County Mental Health Program
15580 South 169 Highway
Olathe, Kansas 66062

Re: Program Evaluation and Needs

To Whom It May Concern:

The need for services provided to citizens during periods of mental stress is of such importance that I could not just respond to the form, but would like to offer the following comments.

In my 27 years as a police officer, I have been called upon many times to assist persons with mental stress. The responsibilities placed upon police officers and crisis intervention workers is awesome. More importantly, the trauma placed upon the patient is beyond belief. I have attempted to put myself in their place just to evaluate the added stress our procedures cause. To enter a home, remove a person under mental stress, transport them to police stations, K.U. Medical Center, then to Osawatomie in the middle of the night cannot but further harm the persons mental well-being and prolong the treatment period.

Johnson County must come out of the dark ages and develop a modern after-hours mental treatment facility. A fully staffed receiving room which can receive and evaluate a person after hours, away from police stations, etc., must be developed. Just as importantly, an in-house holding and treatment facility would provide a place for evaluation without the trauma of the long trip to the State Hospital. The local programs at K.U. and other holding areas have not worked. All too often the officers hear the story: "No beds are available"; "You will have to transport to the State Hospital". This should come to an end for emergency commitments after hours.

I hope that the mental health officials, courts and local police departments can gather the necessary citizen and financial support for this type of program. Anything less does not do proper service to the citizen in need of emergency mental health treatment.

Very truly yours,

Louis E. LeManske
Chief of Police

LEL:mgl

CITY HALL

2 North 19th Street
Marshalltown, Iowa
December 11, 1985

Kansas Families for Mental Health
1268 Western Street
Topeka, Kansas 66612

Dear Friends:

I understand that you will be lobbying for House Bill 2050 when the Kansas Legislature is again in session. I would like to add my voice in support of a change in Kansas Involuntary Commitment Laws.

I have a paranoid schizophrenic brother who resides in Pottawatomie County with my parents. Regular medication is the only hope for him to live a "normal" life. His condition continues to deteriorate because my parents can't get him hospitalized so that professionals can determine what medication will work best for him. If my brother realizes he is sick, he gives no indication, and will never seek help for himself without a court order. He has attacked my father more than once, and has abused my mother physically and emotionally when he is in one of his schizophrenic rages. The situation is filled with danger for the three of them.

I have written to Governor Carlin and State Senator Don Montgomery. Please let me know if there is something else that I can do to encourage the changing of the commitment laws to become more inclusive.

Thank you for your good work.

Sincerely yours,

Mary A. Stewart

Mary A. Stewart
(Mrs. Lawrence M. Stewart)

1-30-86

Support of House Bill 2050

Representing a family with a mentally ill son, we want to go on record in support of the changes in the law for the Care and Treatment of Mentally Ill Persons. As the present law is up-held in the Kansas courts to-day, it is next to impossible to get help for a mentally ill person, who is too sick to commit himself voluntarily for treatment. We have a mentally ill son, who has been without medical care for over three years, because he refuses to seek any help. Even though he is existing like an animal on the street, has no friends, no money, and thinks his parents are poisoning him, he cannot see himself as ill. One word from loved ones, or even those who would like to befriend him, that he should seek medical help sends him into a rage, or he'll leave the scene.

An example of our latest frustration: After being picked up by the police for several confused mistakes, he was brought before a judge for a protective custody hearing. The county jail personnel couldn't care for him, a doctor and a psychologist couldn't help as he refused to see them. He was placed in the Topeka State Hospital for care and evaluation. Nineteen days later he was dismissed from the hospital by a judge because there wasn't evidence that he was injurious to himself or others. The hospital psychologist had testified, "As a patient he had been under restraint, had demonstrated an inability to care for himself physically, and suffered a severe mental disorder." He is back in the community, existing through his animal instincts to survive.

I ask you, doesn't our society owe these mentally ill human beings a chance to live a somewhat normal life? Advances in mental illness research indicates medications and other approaches are helping those so afflicted. Our son has a college education, was gainfully employed before becoming ill and could become a useful, productive citizen IF our laws allowed him to be <u>helped</u>. Now we must wait for him to viewed as a criminal, before the court will help him receive the medical attention he will not seek because of his illness.

S. Judiciary
1/30/86
III

Cecil & Phyllis Eyestone
Manhattan, KS

1-30-86

Gentlemen. I appreciate the opportunity to testify on behalf of a revised HB2050 pertaining to the commitment process for persons who are unquestionably ill and exhibit symptoms that are so pronuunced that family, friends, social workers and medical professionals consider them a probable threat to harm themselves or others.

Presently, our commitment process basically places these people in the criminal justice system. They must overtly harm someone or themselves to get treatment. They are too ill to know that they are ill and it places the family in a living hell trying to care for them when the persons reasoning process has been altered by a chemical change in the brain called mental illness. They want to deny that they are ill.

Judges now are poorly equipped to hear these commitment cases. Our old laws protect a persons so-called personal rights to the point of ridiculousness. I know; I have a 25 year old daughter who has been mentally ill for eight years. My wife and I live in constant fear that our daughter will become a street person if something happens to us. By both working, we can keep our daughter in a private rehbilitation and care facility. She is in such a place now and is doing well ; she is protected.

Our daughter spent two years at Menningers Foundation in Topeka and was dismissed when her insurance money ran out. She went directly to Topeka State Hospital as a so-called "Volunteer Patient" and was in and out of Topeka State, Memorial and Stormont-Vail in Topeka for five years.

My daughter will never harm you or anyone else but if she gets into too many activities and tension builds up, she will try to kill herself. We have lost track of the times and ways that she has tried to end her life. She has slashed her wrists and has been sutured over 20 times; she has laid on the interstate and tried to get run over; she has overdosed on prescribed medications five or six times, she attempted to hang herself with her panty hose in her hospital room once; she climbed on the roof of a three story house and was rescued by Topeka police in an ice storm. I tried to get her comitted after the roof episode but the judge released her after hearing medical testimony about her state of mind. Why? There were two reaseons: one, she said she did not want treatment and, two, the boarding home house mother, a recovered former patient, said Rene could come back. My daughter was represented by legal counsel. A couple of weeks later, she hurt herself again and received emergency treatment a Stormon-Vail and agreed to go to Topeka State as a "Volunteer Patient".

Topeka State is understaffed and overworked but they do a great --even a fantastic job of stabilizing a patient and with counselling and medication they teach many ill persons how to cope with stress and work themselves through these situations. The big problem that we family members face is getting our ill offspring committed where they can get treatment.

My daughter received good care at Topeka State and has been out for 18 months now. But what happens if Reneee becomes unmanageable at her current care facility? She will not willingly return to Topeka State. Will our justice system allow her to kill herself in the name of personal rights? Let us quickly change the Kansas laws to allow persons like Renee get treatment when they need it even if they say they don't want it. We need HB 2050.

Charley A. Carver

Charley A. Carver
1806 Laramie St.
Manhattan, KS 66502

S. Judiciary
1/30/86
IV

1-30-86

PRESENTED TO

THE SENATE COMMITTEE

ON

REVISED HOUSE BILL #2050

State House

Topeka, Kansas

Submitted by:

Michelle Davis, Case Manager

Southeast Kansas Mental Health Center

January 30, 1986

S. Judiciary
1/30/86
V

PRO-REVISED HOUSE BILL #2050

My name is Michelle Davis. My title is Case Manager. As Case Manager I work with the long term mentally ill. My job requires me in their environment 90% of my time - in our program, they are not seen very often in a clinical setting.

I strongly support House Bill #2050. I will not go into detail orally with you why I feel this way, but please take the time to read my feelings on this bill.

The revised K.S.A. 59-2902 deals with "(e) Lacks capacity to make an informed decision concerning treatment". As a person that works with the long term mentally ill everyday, when a client is unable, despite efforts of explanation of care and treatment that might be recommended through hospitalization and an ill person has not made proper decisions towards his basic needs such as food, clothing, shelter, health or safety, our court system should have the opportunity to hear evidence towards making the best possible decision for the welfare of the ill person. The way the law stands now - "Lacking sufficient understanding or capacity to make responsible decisions" - What can we consider responsible? - Someone who has discontinued eating for a couple of days? - Or went off their prescribed medication? This is done everyday by what is considered a normal individual. You take the same circumstances on a person with a mental disorder or condition; they are unable to realize the risks. A mentally ill person, depending on what medication is prescribed and how long it will stay in the blood stream, can, without proper medication end up in a psychotic condition that is very harmful to their well being - When do we consider them a danger to themselves? How do we decide that a person with a gun and ammunition, that has a mental disorder, becomes a danger to themselves or others? - When the gun is loaded or when the gun is cocked? With the revised K.S.A. 59-2901-(g) - "Likely to cause harm to self or others" gives us the opportunity to "help" the mentally ill - as this part of the bill is broken down very specifically for the individual or group of individuals to understand and use as guidelines towards the welfare of the ill person. I feel it is imperative that you give this part of the bill your utmost consideration.

The concern that I would like to bring to your attention is, K.S.A. 59-2916a which has to do with the proposed patient's mental state when the treatment facility does not administer medication or therapy within 48 hours immediately prior to the proposed patient's hearing. A long term ill individual is taken from a structured hospital environment, off their medication, normally picked up by a law enforcement officer, driven to their county, some a 2 hour drive, put in a courtroom setting - the stress is tremendous. Our long term ill individuals cannot handle this stress and although it is being done, these ill individuals are not able to cry help. Instead we might see a bizarre reaction - this is a travesty. These ill individuals depend on their medication everyday to survive in our society as a diabetic needs their insulin to live.

I want to share with you an experience I had approximately two weeks ago in using our commitment laws as they stand now. I have a client, I will call Jane, that has a diagnosis of schizoaffective disorder. The disorder goes into remission when proper medications have been taken. At the end of last month, I saw Jane and she was walking downtown, as she does daily, happy and as normal as possible for Jane. Her home environment is very poor as she lives with an alcoholic husband and he basically "helps" her with her needs. I use the term "helps" loosely in this respect in my professional opinion after being around Jane and her home.

Six days later I went to pick Jane up for an appointment she had with our psychiatrist for medication. She has a tendency to abuse her medication or as we have learned through hearsay, that her husband takes her medication himself and also has been known to sell it for money for his alcohol. This evidence would be allowable through House Bill 2050 as hearsay evidence if needed. So we have learned that monitoring Jane's medication is very important.

S. Judiciary
1/30/86
Atch. V

Jane could not or would not talk and could barely walk, a different sight than walking approximately 2 or 4 miles a day, six days earlier. Halfway to the Center, Jane had a bowel movement in my car seat with no expression that she had done anything. Her catatnoic state saddened me.

After conversing with the psychiatrist, we called the County Attorney to take the proper procedure to have Jane committed to our State Hospital. Needless to say, at this time, the County Attorney did not feel she was "dangerous to herself or others", as our commitment law reads. To make a long story short, six days later I again approached the County Attorney. It was evident that she was off her medication, totally catatonic, and not eaten for as much as I could tell, approximately 2-3 days. At this point, the commitment papers were filed. The County Attorney turned to me and said "I feel guilty, hurrying this commitment through like this". My comment was "Come to Jane's home with me. If you still feel guilty, I promise to never bother you again". That is how strong I felt about this commitment. He did not take me up on my offer.

The Sheriff's Deputy and I went to the home and brought Jane to court - no, we carried Jane to court - she could not walk, her talking was irrational and sometimes with screaming paranoid delusions. Anyone in the building was scared of Jane. Was it necessary that we had to wait until this ill individual had to be in such a state, to be what we consider a "danger to herself or others" before we could put House Bill 2050 in effect? I think not. Jane suffered needlessly as she was too mentally sick to realize she needed help.

By the way, as the Deputy and I drug Jane out of the Court to proceed with her to the State Hospital, I turned to the County Attorney and asked him if his conscience was clear. He raised his hands and said "I'm sorry".

Please don't feel "sorry". Please approve the revised House Bill 2050.

Thank you for your consideration.