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 31, 1986 in room 313-S of the Capitol.

All members ~~were~~ present ~~except~~: Senators Frey, Hoferer, 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:

Cathie Pawlicki, Kansas State Nurses Association
Louise Hayes, Topeka
Bill Rein, Social and Rehabilitation Services
Dr. William Albott, Kansas Psychological Association
Larry Rute, Kansas Legal Services
John Randolph, Association of Community Mental Health Centers of Kansas
Ken Carpenter, Topeka attorney
Louis L. Frydman, Lawrence
Dr. Erv Janssen, Kansas Psychiatric Society
Keith Landis, Christian Science Committee on Publication for Kansas
Susan Estelle Budd, Kansas City
Madeline Hynes, Wichita
Laura Cummings, Wichita
Joan Navrat, Wichita
Camille McGuire, Wichita

The chairman presented two requests for bills concerning child support enforcement to provide factors in determining child custody in domestic actions and to establish supreme court guidelines for child support. Senator Gaines moved to introduce the two bills. Senator Langworthy seconded the motion, and the motion carried.

House Bill 2050 - Treatment act for mentally ill persons.

Cathie Pawlicki, Kansas State Nurses Association, testified KSNA supports the concept of care of the mentally ill as spoken to in Substitute for House Bill 2050. Copies of her testimony with proposed amendments are attached (See Attachments I).

Louise Hayes testified she and her husband own and operate a nonprofit psychiatric care home for ten adults, and they are in support of the bill. A copy of her testimony is attached (See Attachment II).

Mr. Bill Rein appeared to distribute copies of testimony of Professor Ray Spring, Washburn University School of Law. Due to illness, Professor Spring was unable to attend the hearing (See Attachment III).

Dr. William Albott, Kansas Psychological Association, testified the position of the association is favorable toward House Bill 2050 although there are some changes which we believe are appropriate to better reflect the balance between the patients right to freedom and his equally important right to receive treatment. Copies of his testimony and proposed amendments are attached (See Attachment IV).

House Bill 2050 continued

Larry Rute, Kansas Legal Services, appeared to testify on the bill. A copy of his testimony and a copy of proposed amendments are attached (See Attachments V).

John Randolph, Association of Community Mental Health Centers of Kansas, testified the association philosophically agrees with the major thrust of the bill. A copy of his testimony is attached (See Attachment VI).

Ken Carpenter, Topeka attorney, testified he is an overall opponent to this bill. He said he feels this is taking steps backward rather than steps forward. He does support the recommended changes in Sections 36 and 37. A copy of his testimony is attached (See Attachment VII). Committee discussion with him followed.

Louis L. Frydman testified in opposition to the bill. He stated the bill is a needless adventure with awesome potential for harming mental patients and impairing our democratic way of life. Copies of his testimony plus several articles are attached (See Attachments VIII). Committee discussion with him followed.

Dr. Erv Janssen, Kansas Psychiatric Society, testified in support of the bill because the society feels that the intent and substance of the bill provides the opportunity for the humane and conscientious approach to the quality of psychiatric care we feel our fellow citizens should have made available to them. A copy of his testimony is attached (See Attachment IX).

Keith Landis, Christian Science Committee on Publication for Kansas, testified they often request amendments to bills during the legislative process which will allow those relying on spiritual means for healing to practice their religion freely. We try to limit our proposals so there will be no interference with the rights of others. He explained the proposed amendments and stated he would be available and glad to work with the committee in resolving the issues. A copy of his testimony is attached (See Attachment X).

Susan Estelle Budd stated she is representing herself and other consumers of mental health who might agree with her. She testified in opposition to the bill. A copy of her testimony is attached (See Attachment XI).

Madeline Hynes testified in support of the bill. A copy of her testimony is attached (See Attachment XII).

Laura Cummings testified in support of the bill. She stated this bill provides treatment for people who do not realize the severity of their illness, particularily those afflicted with a severe mental illness. A copy of her testimony is attached (See Attachment XIII).

Joan Navrat testified in support of the bill. A copy of her testimony is attached (See Attachment XIV).

Camille McGuire testified in support of the bill. A copy of her testimony is attached (See Attachment XV).

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 313-S, Statehouse, at 10:00 a.m./~~p.m.~~ on January 31, 1986.

The chairman announced a subcommittee consisting of Senator Frey, chairman, Senator Langworthy and Senator Parrish, will meet on Tuesday, February 4 at 4:00 P.M., to go over the proposed amendments. All interested persons are welcome.

The meeting adjourned.

A copy of a summary of the estimated fiscal impact is attached (See Attachments XVI).

A copy of testimony of Michael Byington, Topeka Resource Center For the Handicapped, is attached (See Attachment XVII).

A copy of a letter from Jim Lawing, Wichita Attorney, is attached (See Attachment XVIII).

A copy of testimony of Joan Strickler, Kansas Advocacy and Protective Services for the Developmentally Disabled, Inc., is attached (See Attachment XIX).

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

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: Jan. 31, 1986

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
MADELINE HYNES	410 N ROOSEVELT WICHITA, 67208	
Camille LeClaire	1140 N. Hayes Wichita	F.C.M.H.C.
Joan Narcat	204 N. Belmont Wichita	Families for Mental Health
Laura Cummings	1258 Burning Tree Wichita	Recovery Inc.
Nickie Stein, RN, M.Ed.	1607 College, Topeka	no authority
Cathie Pawlicki	W. Univ. 1700 College	KSNA
Audrey H. Kennedy	W.U. 1700 college	KSNA
Michele Hinds	Topeka	KSNA
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMM. ON PUBLICATION FOR KANSAS
John G. Randolph	Emporia	Association of Community mental Health Centers of Ks.
Paul M. Klotz	Topeka	Assoc. of Comm. MH Ctrs. Ks
Bill Bein	Topeka	SRS
Dr Gerald T Harrod	Topeka	KSRS
Dr Robert C. Harder	Topeka	SRS
Ethel May Miller	Topeka	—
Joan Stuhlsatz	Manhattan	KAPS
Esther L. IdeKer	Whiting Ks	Washburn University School of Nursing
Linda Becker	Hiawatha Ks.	Washburn University School of Nursing
Susan Powell	Mayetta, Ks	" " "
Laura Randolph	Topeka	Washburn School of Nsg Topeka State Hosp.
D. Trader	Topeka	Washburn School of Nsg
Lana Feldman	Lawrence	
Dan Neal	Topeka, KS	
Lu Bredt (Susan Estelle Bredt)	P.O. Box 12821 Kansas City, Kansas 66112	

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GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE:

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Joan B. Upshaw [illegible]	305 E Forbes Blvd, Topeka	Advocates for Freedom
Marjorie J. Van Buren	Topeka	OJA
Kim Clark	Topeka	KCDAA
Al Olson	Topeka	Families for Mental Health Sr. Co.
Christine Pardieu	318 No 17th Manhattan	Washburn School of Nursing
Sarah Swaggerty	Junction City Ks	"
Christine Berry	Topeka	Washburn School of Nursing
Sally Jordan	Topeka	Washburn School of Nursing
Patricia Kramer	Topeka	Washburn School of Nursing
Elizabeth Page	Topeka	Washburn School of Nursing
Michele Schuster	Topeka	Washburn School of Nursing
Brenda Davis	Topeka	Washburn Univ. School of Nursing
[illegible]	Berryton, KS	Washburn Univ. Sch of Nursing
[illegible]	Topeka, Kansas	Washburn University
Ray E Dudell	1625 Webster Topeka Ks 66604	Washburn University School of Nursing
John Kelly	State Office Bldg	Dev. Disabilities Council
Erv JANSSEN, M.D.	Box P29, Topeka, KS 66601	KS Psychiatric Society
Evelyn Grant	Washburn Univ.	Menningers/Washburn
Doris Krasin	Topeka	Washburn
Jean Marr	Lawrence	WU nursing student
Amy Adams	Topeka	Washburn nursing student
Karen Rohloder	Topeka	WUNS
Tonyia L Knapp	Topeka	Washburn University KS
Tammy Schinke	Topeka	Washburn Univ. Nsg. Student
Rhonda Stevens	Topeka	Washburn Univ Nsg Student

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: 1-31

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Margaret Becker	Topeka	Washburn Nursing Student
Kathy Irwin	Topeka	Washburn Nursing Student
Elizabeth Castaneda	Kansas City	Washburn Nursing Student
Melinda A. Hicks	"	"
Betty D Lowers	Topeka	MHAK
Judy L Deming	Topeka	611 W. 49th St.

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For Further Information:
Contact Terri Rosselot, R.N.
Executive Director
233-8638
January 31, 1986

KSNA
the voice of Nursing in Kansas

SUBSTITUTE H.B. 2050

Mr. Chairman, members of the Judicial Committee, my name is Cathie Pawlicki and I am a Registered Nurse and Clincial Specialist in Psychiatric Mental Health Nursing. I am representing the Kansas State Nurses' Association in my role as Chairperson of the KSNA Conference Group on Psychiatric Mental Health Nursing Practice.

KSNA supports the concept of care of the mentally ill as spoken to in Substitute for H.B. 2050. The expansion of the definition of a mentally ill person removes the stigma of criminalization from the civil commitment process and alleviates the ongoing victimization of the de-institutionalized mentally ill. Substitute for H.B. 2050, in concept, provides for human care of the mentally ill, their families and the community. We commend the efforts this Bill represents to facilitate continuity of care according to the least restrictive alternative concept. There are several features of this proposed legislation that concern KSNA.

ROLE OF NURSING/NURSING INPUT

In careful review of this proposed legislation, it does not appear that nursing input was sought, nor was the role of nursing spoken to - and we are one of the primary care givers in the Mental Health System in Kansas. Of particular concern is the lack of attention to the Advanced Registered Nurse Practitioners in Psychiatric Nursing who are educated and licensed to function in the manner set forth by the Kansas State Board of Nursing. Some of the functions of the ARNP as delineated by the Kansas State Board of Nursing are:

1) Evaluate the physical and psychosocial health status of a client through a comprehensive health history and physical examination.

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(2) to manage the medical regimen prescribed for the client based on written protocols developed by the nurse practitioner and the attending physician.

(3) to counsel individuals, families and groups about health, illness and promote health maintenance.

(4) to evaluate, plan, implement and re-evaluate care of clients.

From this perspective of the function of nursing we wish to discuss the following concerns:

Page 4
Line 0138

Supervision of treatment is defined as being provided by a psychiatrist or certified psychologist. KSNA considers this narrow definition of treatment supervision to be restrictive to the scope of the legitimate, independent practice by the Master's prepared ARNP. In addition, KSNA expresses reservation and questions whether the educational preparation of a certified psychologist prepares them to supervise the practice of Mental Health Nursing, the major concerns of which are medication management, physical assessment, milieu management and the use of restraints.

KSNA Proposes: (page 4 with ballon language)

That "Treatment" means service intended to promote the mental health of the patient and rendered by a qualified professional <u>authorized by law to provide either inpatient or outpatient treatment to any patient.</u>

According to the definition of "treatment facility" the ARNP is a treatment facility. The definition of "Treatment" should parallel this definition. KSNA recommends that the definitions of these two terms be evaluated from the perspective of congruency and the major role that Nursing occupies in the care of the mentally ill.

KSNA supports the intent of the proposed legislation to differentiate between criminal proceedings and commitment hearings, in Section 9, page 11-14.

KSNA acknowledges the validity of the concept of sharing relevant patient information for the purpose of continuity of care and invaluable scientific research. Care of the mentally ill involves privileged interpersonal intimacy and in our role as patient advocates we cannot support a process of exchanges of confidential information without the patients knowledge and left to the discretion of a particular treatment facility.

KSNA Supports: (page 23 line 0188) the inclusion of the following statement as ordered by the court "the transfer of copies of the patients records to the outpatient facility". Ballon

Page 35
Line 0623

KSNA acknowledges much advantage in providing a mentally ill patient not only with structured living but also with a therapeutic regimen of medication that will restore them to their optimal health. Without questioning the integrity of the mental health professional; the provision for medication without patient consent as stated in this proposed legislation does have potential for the abuse of medication being used as a chemical restraint. KSNA recommends that this section be reviewed and protocols established to provide the medication, especially psychotropics, being administered in the context of that which is most therapeutic and the least restrictive alternative..

New Section 26 has the certified psychologist identified as consulting with the patient or guardian about medication concerns. KSNA questions the educational preparedness of the certified psychologist to speak to medication issues. Speaking to medication issues is

clearly a physician and/or nursing function.

KSNA Proposes: (Page 35 line 630 Ballon language)

... during the course of treatment the responsible physician or their designee shall consult with the patient, or the patient's guardian, and give consideration to the views the patient or guardian expresses concerning treatment and any alternatives.

SUMMARY

In conclusion, KSNA supports the progressive and human concepts addressed in Substitute for H.B. 2050. As it is currently written, KSNA cannot support H.B. 2050, and asks the committee to consider the changes we have addressed.

Thank you for consideration of this matter.

(l) "Psychologist" means a certified psychologist, as defined by K.S.A. 74-5302 and amendments thereto.

(m) "Restraints" means the application of any devices, other than human force alone, to any parts of the body of the patient for the purpose of preventing the patient from causing injury to self or others.

(n) "Seclusion" means the placement of a patient, alone, in a locked room, where the patient's freedom to leave is restricted and where the patient is not under continuous observation.

(o) "Severe mental disorder" means a clinically significant behavioral or psychological syndrome or pattern associated with either a painful symptom or serious impairment in one or more important areas of functioning and involving substantial behavioral, psychologic or biologic dysfunction. "Severe mental disorder" does not include a condition which is caused by the use of chemical substances or for which the primary diagnosis is antisocial personality.

~~(j)~~ *(p)* "Treatment" means any ~~necessary services that are in the best interests of the physical and~~ *service intended to promote the* mental health of the patient and rendered by ~~or~~ *a qualified professional* under the supervision of a physician *or psychologist.*

authorized by law to provide either inpatient or outpatient treatment to any patient.

~~(k) "Discharge" means the final and complete release from treatment, by either an order of a court pursuant to K.S.A. 59-2923 or a treatment facility.~~

~~(l) "Conditional release" means release of a patient who has not been discharged but who is permitted by the head of the treatment facility to live apart from the treatment facility pursuant to K.S.A. 59-2924 and amendments thereto.~~

(q) "Treatment facility" means any mental health center or clinic, psychiatric unit of a medical care facility, psychologist, physician or other institution or individual authorized or licensed by law to provide either inpatient or outpatient treatment to any patient.

(r) "Voluntary patient" means a person who is receiving treatment at a treatment facility other than by order of any court.

New Sec. 17. (a) Following the hearing on the petition as provided for in K.S.A. 59-2917 and amendments thereto, or prior to the entry of an order provided for in K.S.A. 59-2918 and amendments thereto, if the court finds that the proposed patient is a mentally ill person, the court, as an alternative to inpatient treatment, may enter an order for outpatient treatment at a community mental health center or other private treatment facility capable of providing outpatient care. Such an order for outpatient treatment may be entered by the court only if the court finds that outpatient treatment will not constitute a danger to the community and that the patient is not likely to cause harm to self or others while under outpatient treatment. In considering this issue the court shall take into consideration all relevant factors, including but not limited to the degree of supervision and type of outpatient treatment proposed and available and the degree of security to the community provided for under outpatient treatment.

(b) No order for outpatient treatment shall be entered unless the outpatient treatment facility has previously evaluated the proposed patient, submitted a report recommending outpatient treatment and consented to treat the patient on an outpatient basis under the terms and conditions set forth by the court.

(c) If outpatient treatment is ordered, the order shall state the specific conditions to be followed by the patient and shall include the general condition that the patient shall follow all directives and treatment methods established by the head of the treatment facility or the head's designee. The court shall also make such orders as are appropriate to provide for transportation to the outpatient treatment facility and provisions for monitoring the proposed patient's progress and compliance with outpatient treatment.

, for the transfer of copies of the patients records to the outpatient facility

(d) The court shall retain jurisdiction to modify or revoke its order for outpatient treatment at any time on its own motion, on the motion of any counsel of record or upon notice from the treatment facility of any need for new conditions in the order for outpatient treatment or of material noncompliance by the patient with the order for outpatient treatment. Revocation or modifica-

department of corrections whenever patients have been administratively transferred to the state security hospital or other state psychiatric institutions pursuant to the provisions of K.S.A. 75-5209 and amendments thereto. The patient's or former patient's consent shall not be necessary to release information to the department of corrections.

(b) ~~Any person willfully violating this section shall be guilty of~~ *Willful violation of this section is* a class C misdemeanor.

New Sec. 26. (a) Medications and other treatments shall be prescribed, ordered and administered only in conformity with accepted clinical practice. Medication shall be administered only in accordance with the written order of a physician or upon a verbal order noted in the patient's medical records and subsequently signed by the physician. The attending physician shall review regularly the drug regimen of each patient or proposed patient under the physician's care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding 30 days thereafter but may be renewed.

(b) Any patient who is receiving treatment pursuant to the provisions of K.S.A. 59-2909, 59-2912, 59-2917 or 59-2918, and amendments thereto, shall not have the right to refuse any medication, including psychotropic medication, other than experimental medication, which is prescribed by a physician in conformance with the provisions of this section. Although consent to treatment is not required, during the course of treatment the responsible physician or psychologist shall consult with the their designee patient, or the patient's guardian, and give consideration to the views the patient or guardian expresses concerning treatment and any alternatives.

(c) Consent for medical or surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

Sec. 27. K.S.A. 59-2940 is hereby amended to read as follows: 59-2940. Whenever any person is taken into custody by an arresting officer and such officer has reasonable grounds to believe that such person has violated K.S.A. 21-3420, 21-3421,

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SENATE HEARING ON SUBSTITUTE FOR H B 2050
JAN 30,1986

My name is Louise Hayes. I live at 3604 Avalon Lane, Topeka, Ks. My husband and I own and operate a non profit psychiatric care home for 10 adults. Most of our residents are sent to us from the State Hospital, all are diagnosed as chronic schizophrenics. I am the mother of a thirty three year old son mentally ill with schizophrenia. I speak for the families of the mentally ill.

Please listen to the suffering and hardships the present commitment law as it now stands causes the mentally ill person and their family.

After spending a year in Memorial Hospital, my son was sent back to the community to live. His doctor told him not to live at home and to stay away from his family. After a short time he stopped taking his medicine and seeing his doctor. He became sicker and sicker. He would watch our house and wait until I left, then he would break the kitchen door down or break windows and climb in.

I searched the town over for help. My husband had died suddenly and I was all alone. The city attorney said I would have to call the police and sign a complaint against my sick son to get any help for him at all.

One night I came home to find the back door broken, glass broken everywhere, my son eating a pizza at the kitchen table, and the pizza box on fire on the stove. I told him if he wouldn't go to the hospital with me I would call the police. He said "go ahead and call the police, you are the crazy one".

I called the police, showed them the damage, and told them he was mentally ill and needed medication. They told me I would have to sign a complaint, so I did, and as soon as I had signed my son was hand cuffed and searched. I asked them to take him to the state hospital and I would follow them, but the police said "you stay at home". "He is under arrest and we are taking him to jail to await trail". The next day I wasn't allowed to see my son.

I went to the court house, I don't remember why, maybe to see the city attorney, and I met judge Hope in the hall. Maybe he could see the despair I was going through, but he took me to his office and listened to my story. He put my son on the docket for the next morning.

My son was brought into the courtroom handcuffed. He had been beaten and his face, nose, eyes and mouth were swollen and covered with black bruises. He looked at me with such hatred and said "you did this to me". Judge Hope told him it was too bad the law made me do it in order to get help for him. I quickly withdrew my complaint and Judge Hope ordered him to State Hospital for help.

Please put yourself in my shoes. Could you put your sick son or daughter or loved one through the suffering I put my son through to get help for them? I couldn't do it again.

Please pass the Substitute for House Bill No. 2050 into law so that everyone can secure early treatment for their mentally ill loved one. Early treatment will save a lot of pain for the patient and his family and will usually mean a shorter hospital stay so it will save money as well. I speak not only for myself, but for the many families who are going through similar experiences every day.

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COMMENTARY ON H.B. 2050

Prepared for the Senate Committee on Judiciary

by Raymond L. Spring

on behalf of the

Governor's Advisory Commission of Mental Health

and Retardation Services

January 31, 1986

The enclosed commentary is an extension of remarks to be made at the committee hearing on January 31, 1986. While many areas are covered by the proposed amendments, these comments are limited to the matter of redefining "mentally ill person," evidentiary issues, and outpatient commitment.

The Governor's Advisory Commission and I appreciate the opportunity the committee has given us to contribute to the discussion of these important matters.

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STANDARD FOR COMMITMENT

Since commitment is dependent upon a finding that the proposed patient is a "mentally ill person," the true standard for commitment lies in the definition of "mentally ill person." (59-2902(i)). It may be helpful to align the existing and proposed definitions. Thus a "mentally ill person is:

EXISTING	PROPOSED
MENTALLY IMPAIRED and in need of treatment	SUFFERING FROM A SEVERE MENTAL DISORDER and in need of treatment (59-2902(h)(1))
and	and
DANGEROUS TO SELF OR OTHERS	LIKELY TO CAUSE HARM TO SELF OR OTHERS (59-2902(h)(3))
and	and
either:	LACKS CAPACITY TO MAKE AN INFORMED DECISION CONCERNING TREATMENT (59-2902(h)(2))
1) LACKS SUFFICIENT UNDERSTANDING OR CAPACITY TO MAKE RESPONSIBLE DECISIONS WITH RESPECT TO THE PERSON'S NEED FOR TREATMENT	
or	
2) REFUSES TO SEEK TREATMENT.	

The first part of the standard, substituting "Severe Mental Disorder" for "Mentally Impaired" is further clarified by the definition of "Severe Mental Disorder" in 59-2902(o). This definition demonstrates that this act deals only with commitment of persons whose thought, preception or other mental processes are substantially impaired by illness, disease, organic brain disorder or some other existing condition. Persons whose condition is a result of alcohol or drug abuse are dealt with elsewhere (65-4001 et seq.; 65-5201 et seq.) and persons with primary diagnosis of antisocial personality are commonly regarded as inappropriate for hospitalization because they are untreatable. The antisocial personality or sociopath is better dealt with (and almost surely will be) by the penal system. I short, this change serves only to clarify and limit the act's application to appropriate persons.

Turning next to the second part of the definition, (59-2902(h)(2)) the only real change is the elimination of refusal to seek treatment as a means of committing persons who have capacity to make informed decisions with respect to treatment, and insures that only persons without such capacity will be involuntarily committed. This change recognizes the developing "right to refuse treatment," which has been held to severely limit the authority of hospital staff to impose treatment over the objection of competent involuntary committee. See Rogers v. Okin, 634 F.2d 650 (1980), vacated and remanded, Mills v. Rogers, 457 U.S. 291 (1982); Rennie v. Klein, 653 F.2d 836 (1981). That situation of course creates an intolerable situation; a commitment resting on the need for treatment is useless if treatment can be refused. This is not to say, of course, that a person who has capacity to make informed treatment decisions cannot gain admission to the hospital. They may enter as voluntary patients and, if they do not choose to accept the recommended treatment, they may leave.

Lest there be debate over what is meant by "Lacks capacity to make an informed decision concerning treatment," that phrase is further defined in 59-2902(e). Because this provision, like many others in the proposed amendments, is drawn from the APA's Model State Law in Civil Commitment of the Mentally Ill, the commentary thereto should be important in interpreting these provisions. That commentary makes clear that a proposed patient does not lack capacity merely because the physician, or the court, disagrees, nor because he is regarded as excessively risk averse, nor because he uses a rational process different than others might employ. 20 Harv. J. Legis. 301-302. This is both a clearer and tighter definition than previously existed.

The third part of the definition of "mentally ill person" (59-2902(h)(3)) would seem to be the only focus of controversy, and then only in part. Substituting "likely to cause harm to self" or "likely to cause harm to others" for the nebulous "dangerousness" changes little. Harm to self is defined in terms of substantial physical injury (59-2902(g)(1)) or inability to provide for basic needs (59-2902(g)(2)), both of which are well within established concepts of dangerousness. Harm to others is defined in (59-2902(g)(1)) in terms of physical injury or abuse (again well within established concepts of dangerousness). "Likely to cause substantial damage to another person's property" (59-2902(g)(1)) is new to this act, although that standard is already contained in the standard for retention of persons determined NGRI in criminal cases (22-3428(1)). Commitment for likelihood of harm to person or property arises under the police power, and the state has an unquestioned right to protect persons and property where the risk of harm is substantial. Some will no doubt raise the spectre of vagueness in use of the term "likely" to cause harm or damage it must be remembered, though, that the evidentiary standard of "clear and convincing evidence" still applies, as it

must since Addington v. Texas, 441 U.S. 418 (1979). Thus a court must be satisfied by clear and convincing evidence that the proposed patient is likely to cause harm. Furthermore, there is a requirement that this likelihood be evidenced by an overt act or threat. Putting the evidentiary standard and harm standard together demonstrates the substantial burden of showing both need and appropriateness of commitment the applicant must carry.

If there is to be real controversy over the definition of "mentally ill" as a standard for commitment, it must be focused on the phrase "likely . . . to suffer substantial mental or physical deterioration," which is further defined in 59-2902(g)(3). This is new, but is fully justifiable under the parens patriae approach. While the states' parens patriae authority is appropriately more limited than when acting under the police power, it is not necessary for the state to wait until tragedy occurs before acting. Help which comes too late is no help at all, and this standard authorizes intervention at an appropriate time. The commentary to the Model Law says:

> "This requirement suggests an acute episode or sudden collapse of mental state (decompensation). If a usually withdrawn and solitary person shuns society, it may be less solid evidence of a sudden change in mental condition than if a gregarious, well-adjusted person does so. The Model Law thus avoids judging individual lifestyles, but permits commitment of severely mentally ill individuals who are moving toward sudden collapse." (20 Harv. J. Legis. 305).

It is important to keep in mind that this standard does not stand alone. The evidentiary standard of clear and convincing evidence applies, and of course no one can be committed solely because of substantial mental or physical deterioration. Such a person must also meet the requirements of subsections (h)(1) and (h)(2): severe mental disorder and lack of capacity to make informed treatment decisions.

Some would argue that an absolute requirement of "dangerousness" has been required for involuntary commitment since O'Connor v. Donaldson, 422 U.S. 563 (1975). That is simply not so. Donaldson held that "a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." The statement itself recognizes at least one appropriate case for confinement of the nondangerous: when the person is not capable of surviving safely in freedom. That seems an apt description for the severely disordered persons who lack

capacity to make treatment decisions and face the prospect of further substantial deterioration.

APPLICATION OF RULES OF EVIDENCE

The proposed amendments contain provisions relaxing the rules of evidence at the probable cause hearing (59-2912c) and the full hearing (59-2917).

Use of hearsay evidence in civil commitment proceedings is both necessary (sometimes) and abused (sometimes). It is not uncommon for courts sitting in civil cases without juries to relax the rules of evidence, then assigning to evidence whatever weight it appears to warrant given any obvious weaknesses, but this practice has not been formalized into specific provisions of law. There is authority for the position that the rules of evidence, including the hearsay rules, must be applied in commitment proceedings. Lessard v. Schmidt, supra. The frequent equation of civil commitment proceedings to criminal trials because of the element of deprivation of liberty raises the spectre of a possible holding that admission of hearsay, at least on a broad scale, violates due process through the confrontation clause of the 6th Amendment.

Still, there is need for some flexibility. Much of the information upon which the experts evaluation and diagnosis is based is necessarily obtained from others, and it would be impossible for the expert to personally verify every such item of information. It would also be burdensome in the hearing to independently prove each fact relied upon by the expert in arriving at an opinion. Rather, it should be acceptable for the expert to testify to the information which has formed the basis for the opinion, whatever the source. Counsel for the proposed patient will then have ample opportunity to challenge the accuracy of such information through cross-examination or by offering evidence to the contrary. In this respect, there is an additional safeguard in the requirement in 59-2914a that a written report of the evaluation be submitted to the court and to counsel for the parties at least five days before the commitment hearing. This allows opportunity for investigation of information on which the opinion is based.

OUTPATIENT COMMITMENT

The idea of outpatient commitment is not new to Kansas law. The authority - in fact the requirement to use outpatient commitment where appropriate is contained in K.S.A. 59-2917:

> ". . . if the court or jury finds by clear and convincing evidence that the proposed patient is a mentally ill person, and after

> a careful consideration of reasonable alternatives to inpatient treatment, the court shall order treatment for such person at any treatment facility." (emphasis added).

The legislative statement would seem to make clear the obligation of the court to consider outpatient treatment. It is clear that consideration of such treatment is constitutionally required by due process under the principle of least restrictive alternative. That principle, through the phrasing is relatively new, is ancient law. In Matter of Josiah Oakes, 8 Law Rep. 123 (Mass. 1845) the Massachusetts Supreme court held that:

> "the right to restrain an insane person of his liberty is found in that great law of humanity which makes it necessary to confine those whose going at large would be dangerous to themselves or others . . . . and the necessity which creates the law, creates the limitation of the law. The questions must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restricted for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation, and the proper limitation."

Put another way, the least restrictive alternative principle simply recognizes the constitutional requirement that a "compelling state interest" must exist to warrant restriction of the individual's right to liberty. If the individual can live safely with the lesser restrictions involved in outpatient status, the state's interest in confinement is substantially reduced, and not sufficiently "compelling" to justify inpatient commitment.

In practice, however, the authority for outpatient treatment that already exists has rarely been used. This is probably so partly because courts and counsel have not in some cases been fully aware of the implication of the brief phrase in 59-2917 and partly because of lack of guidelines for outpatient commitment. In either case it is appropriate now to set out clear policy and procedural guidelines. Proposed new section 17 appears to provide this.

1-31-86

KANSAS PSYCHOLOGICAL ASSOCIATION

January 31, 1986

Senator Frey, members of the committee, my name is Dr. William Albott. I am appearing before you today on behalf of the Kansas Psychological Association, its President, Dr. John Helton, and its Board of Governors. The position of the association is favorable toward H.B. 2050 although there are some changes which we believe are appropriate to better reflect the balance between the patients right to freedom and his equally important right to receive treatment. The position of our association is that a very delicate balance must be struck between making it too easy to have anyone committed for treatment and making it so difficult that those who truely need treatment, are essentially denied this needed action.

The changes we are proposing are presented in the material distributed to the committee. Beginning on page 1, we recommend changing the definition of the "head of the treatment facility" to include the language "if the administrative director is a physician or psychologist or, if the administrative director is not a physician or psychologist, then the clinical director of the treatment facility who shall be a physician or a psychologist."

On page 2, line 0060, we propose to insert the word "substantial" and in line 0063 adding the word "or". We propose striking line 0067 and the words "physical distress" from line 0068. Subsection (2) would thus read "is substantially unable, except for reason of indigency, to provide for any of the person's basic needs, such as food, clothing, shelter, health or

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saftey causing a sustantial deterioriation of the person's ability to function on the person's own".

On page 7, line 267, we propose to delete the phrase "because of the person's illness".

On page 13, lines 467-468, we propose to delete, on line 467 the words "experts and" and on line 468 the word "either".

On page 18, line 0639, we propose to add the language "and the examiner's opinion as to the least restrictive treatment alternative which will protect the proposed patient and others and allow for the improvement of the proposed patient".

On page 23, line 0174, we propose to insert the phrase ",the preferences of the patient". On line 0178, we propose to delete the word "previously".

Also on page 23, we propose to insert on line 0188 the language ", for the transfer of copies of the patient's records to the outpatient facility". This change is related to another change found on page 34 where we propose to delete section (5). It is our position that the confidentiality, i.e. control, over the treatment record is retained by the patient in the absence of commitment to a treatment facility. If a patient is unconditionally discharged--with or without further treatment recommendations, it would seem that they are in a mental, emotional status such that they have the capacity to make an informed decision and thus regain the rights attendent with this status.

On page 29, line 0411, we propose to insert the sentence: "The treatment facility in the community shall inform the head of

the treatment facility from which the patient was discharged of any material noncompliance with the treatment plan".

On page 31, line 0468, we propose to insert the sentence: "When restraints or seclusion are applied, there shall be a monitering of the patient's condition at a frequency determined by the treating physician or psychologist, which shall be no less than once per hour."

On page 32, we propose to delete the phrase "if requested" on line 513 and insert the phrase on line 514.

The change on page 34, lines 596-602, have been noted above.

The final change proposed by our association is on page 35, subsection (b). We propose here to allow the commited patient to refuse medication and before such refusal may be overridden, a panel of three non-treating physicans review the need for such medication.

Members of the committee, thank you for considering our proposed changes. If I can answer any questions I would be happy to do so.

1-31-86
Rep. Abbott

[As Amended by House Committee of the Whole]

Session of 1985

ubstitute for HOUSE BILL No. 2050

By Committee on Judiciary

3-6

AN ACT concerning care and treatment of mentally ill persons; amending K.S.A. 59-212, 59-2212, 59-2901, 59-2902, 59-2906 through 59-2912, 59-2914, 59-2914a, 59-2916, 59-2916a, 59-2917, 59-2918, 59-2919, 59-2922, 59-2924, 59-2926, 59-2928, 59-2929, 59-2931, 59-2940, 59-3002, 59-3018, 75-5209 and 77-201 and K.S.A. 1984 Supp. 22-3428, 22-3428a, 28-170, 38-1513 and 38-1614 and repealing the existing sections; also repealing K.S.A. 59-2904, 59-2915, 59-2917a, 59-2921, 59-2923 and 59-2942.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 59-2901 is hereby amended to read as follows: 59-2901. This act shall be known and may be cited as the ~~act for obtaining treatment for a mentally ill person~~ *treatment act for mentally ill persons.*

Sec. 2. K.S.A. 59-2902 is hereby amended to read as follows: 59-2902. When used in this act:

(a) "Conditional release" means release of a patient who has not been discharged but who is permitted by the head of the treatment facility to live apart from the treatment facility pursuant to K.S.A. 59-2924 and amendments thereto.

(b) "Discharge" means the final and complete release from treatment, by either an order of a court pursuant to K.S.A. 59-2923 and amendments thereto or a treatment facility.

(c) "Head of the treatment facility" means the administrative director of a treatment facility.

(d) "Involuntary patient" means a mentally ill person who is receiving treatment under order of a court of competent juris-

Lacks capacity to make an informed decision concern-

if the administrative director is a physician or psychologist or, if the administrative director is not a physician or psychologist, then the clinical director of the treatment facility, who shall be a physician or psychologist

ing treatment" means that the person, by reason of the person's mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.

(f) "Law enforcement officer" means any sheriff, regularly employed deputy sheriff, state highway patrol officer, regularly employed city police officer or a law enforcement officer of any county law enforcement department.

(g) "Likely to cause harm to self or others" means that the person:

(1) Is likely, in the reasonably foreseeable future, to cause physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior causing, attempting or threatening such injury, abuse or damage; substantial

or

(2) is 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) is suffering severe and abnormal mental, emotional or physical distress*~~ *causing a substantial deterioration of the person's ability to function on the person's own.*

~~(a)~~ *(h)* "Mentally ill person" means any person who ~~is mentally impaired~~*:*

(1) Is suffering from a severe mental disorder to the extent that such person is in need of treatment ~~and who is dangerous to self or others and:~~

~~(1) who lacks sufficient understanding or capacity to make responsible decisions with respect to the person's need for treatment, or~~

~~(2) who refuses to seek treatment. Proof of a person's failure to meet the person's basic physical needs, to the extent that the failure threatens such person's life, shall be deemed as proof that the person is dangerous to self, except that~~*;*

(2) lacks capacity to make an informed decision concerning treatment; and

(3) is likely to cause harm to self or others.

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 self or~~ *likely to cause harm to self or* others.

~~(b)~~ *(i)* "Patient" means a person who is ~~an informal patient,~~ a voluntary patient, a proposed patient~~,~~ or an involuntary patient.

~~(c) "Informal patient" means a person either receiving out-patient treatment at a treatment facility or who is admitted to a treatment facility pursuant to K.S.A. 59-2904.~~

~~(d) "Voluntary patient" means a person, other than an informal patient, who is receiving treatment at a treatment facility other than by order of any court.~~

~~(e) "Proposed patient" means a person for whom an application pursuant to K.S.A. 59-2913 has been filed.~~

~~(f) "Involuntary patient" means a mentally ill person who is receiving treatment under an order of a court of competent jurisdiction.~~

~~(g) "Treatment facility" means any mental health clinic, psychiatric unit of a medical care facility, adult care home, physician or any other institution or individual authorized or licensed by law to give treatment to any patient.~~

~~(h)~~ *(j)* "Physician" means a person licensed to practice medicine and surgery as provided by the Kansas healing arts act or a person who is employed by a Kansas state hospital or by an agency of the United States and who is authorized by either government to practice medicine and surgery.

~~(i) "Head of the treatment facility" means the administrative director of a treatment facility if the administrative director is a physician or, if the administrative director is not a physician, the chief medical officer or a physician designated by the chief medical officer.~~

(k) "Proposed patient" means a person for whom an application pursuant to K.S.A. 59-2913 and amendments thereto has been filed.

(l) "Psychologist" means a certified psychologist, as defined by K.S.A. 74-5302 and amendments thereto.

(m) "Restraints" means the application of any devices, other than human force alone, to any parts of the body of the patient for the purpose of preventing the patient from causing injury to self or others.

(n) "Seclusion" means the placement of a patient, alone, in a locked room, where the patient's freedom to leave is restricted and where the patient is not under continuous observation.

(o) "Severe mental disorder" means a clinically significant behavioral or psychological syndrome or pattern associated with either a painful symptom or serious impairment in one or more important areas of functioning and involving substantial behavioral, psychologic or biologic dysfunction. "Severe mental disorder" does not include a condition which is caused by the use of chemical substances or for which the primary diagnosis is antisocial personality.

~~(j)~~ *(p)* "Treatment" means any ~~necessary services that are in the best interests of the physical and~~ *service intended to promote the* mental health of the patient and rendered by ~~or~~ *a qualified professional* under the supervision of a physician *or psychologist.*

~~(k) "Discharge" means the final and complete release from treatment, by either an order of a court pursuant to K.S.A. 59-2923 or a treatment facility.~~

~~(l) "Conditional release" means release of a patient who has not been discharged but who is permitted by the head of the treatment facility to live apart from the treatment facility pursuant to K.S.A. 59-2924 and amendments thereto.~~

(q) "Treatment facility" means any mental health center or clinic, psychiatric unit of a medical care facility, psychologist, physician or other institution or individual authorized or licensed by law to provide either inpatient or outpatient treatment to any patient.

(r) "Voluntary patient" means a person who is receiving treatment at a treatment facility other than by order of any court.

~~(m)~~ *(s)* The terms defined in K.S.A. 59-3002 *and amendments thereto* shall have the meanings provided by that section.

~~(n) "Peace officer" means any sheriff, regularly employed deputy sheriff, state highway patrolman, regularly employed city police officer or a law enforcement officer of any county law enforcement department.~~

Sec. 3. K.S.A. 59-2906 is hereby amended to read as follows: 59-2906. The head of ~~the~~ *a* treatment facility shall discharge any ~~informal patient or~~ voluntary patient whose treatment ~~therein such head of the treatment facility determines~~ *in the facility is determined by the head of the treatment facility* to be no longer advisable. The head of the treatment facility shall give written notice of ~~such~~ *the* discharge to the patient and, ~~where~~ *if* appropriate, to ~~such~~ *the* patient's parent, guardian or person *in loco parentis*.

Sec. 4. K.S.A. 59-2907 is hereby amended to read as follows: 59-2907. ~~Except as hereinafter provided,~~ The head of ~~the~~ *a* treatment facility shall discharge ~~any~~ *a* voluntary patient ~~who has requested discharge, in writing, or whose discharge is requested, in writing, by another person,~~ within a reasonable time but not to exceed three ~~(3)~~ days, excluding *Saturdays*, Sundays and legal holidays, after the receipt of ~~such request. If, however, such request is made by another person, such discharge shall be conditioned upon the written consent of the voluntary patient, except that if the voluntary patient be under eighteen (18) years of age, such discharge shall be conditioned upon the consent of such patient's parent, guardian or person *in loco parentis* unless such patient~~ *such patient's written request for discharge. If the voluntary patient is a minor, the written request for discharge shall be made by the minor's parent or person in loco parentis unless the minor* made written application to become a voluntary patient on ~~his or her own behalf. If, however, such voluntary patient is over eighteen (18) years of age and has a guardian, such discharge shall be conditioned only upon the consent of the guardian. Whenever a minor fourteen (14) years of age or older~~ *the minor's own behalf. If a minor 14 or more years of age* has made written application to become a voluntary patient on ~~his or~~

~~her~~ *the minor's* own behalf and has requested to be discharged, the head of the treatment facility shall promptly inform the minor's parent or other person *in loco parentis* of the request.

~~No application to determine whether a person is a mentally ill person shall be filed with respect to a voluntary patient unless such patient has requested or consented to his or her discharge or, if the voluntary patient is under eighteen (18) years of age and did not apply to become a voluntary patient on his or her own behalf, the discharge has been requested by the parent, guardian or person in loco parentis to such patient.~~

Nothing in this act shall prevent the head of the treatment facility or other person from filing an application for determination of mental illness with respect to a voluntary patient who has either: (a) Requested discharge from the treatment facility or (b) is refusing reasonable treatment efforts and is likely to cause harm to self or others if discharged.

Sec. 5. K.S.A. 59-2908 is hereby amended to read as follows: 59-2908. (a) Any ~~peace~~ *law enforcement* officer who has reasonable belief upon observation~~,~~ that any person is a mentally ill person and because of such person's illness is likely to ~~do physical injury to himself or herself~~ *cause harm to self* or others if allowed to remain at liberty may take ~~such~~ *the* person into custody without a warrant. ~~Said~~ *The* officer shall transport ~~such~~ *the* person to any treatment facility where ~~such~~ *the* person shall be examined by a physician *or psychologist* on duty at such facility. If no physician *or psychologist* is on duty at the time ~~such~~ *the* person is transported to the facility, ~~such examination shall be made~~ *the person shall be so examined* within a reasonable time not to exceed ~~seventeen (17)~~ *17* hours. If a written statement is made by ~~such~~ *the* physician *or psychologist* at the treatment facility that after preliminary examination ~~such~~ *the* physician *or psychologist* believes ~~such~~ *the* person to be a mentally ill person and because of ~~such~~ *the* person's illness is likely to ~~do physical injury to himself or herself~~ *cause harm to self* or others if allowed to remain at liberty, and if ~~such~~ *the* treatment facility is willing to admit ~~such person the peace~~ *the person, the law enforcement* officer shall present to ~~such~~ *the*

treatment facility the application provided for in subsection (b) of K.S.A. 59-2909 *and amendments thereto*. If the physician *or psychologist* on duty at the treatment facility does not believe ~~such~~ *the* person to be a mentally ill person, the ~~peace~~ *law enforcement* officer shall release ~~such~~ *the* person.

(b) If the physician *or psychologist* on duty at the treatment facility states that ~~said~~ *the* physician *or psychologist* believes ~~such~~ *the* person to be a mentally ill person but the treatment facility is unwilling to admit ~~such~~ *the* person, or if there is no treatment facility available to receive ~~such~~ *the* person within the territorial limits of the ~~peace~~ *law enforcement* officer's jurisdiction, the ~~peace~~ *law enforcement* officer may detain ~~such~~ *the* person in any other suitable place until the close of the first day ~~such court~~ *the district court of the county* is open for the transaction of business, unless the court orders that ~~such~~ *the* person remain in custody pursuant to the provisions of K.S.A. 59-2912 *and amendments thereto*. If a ~~peace~~ *law enforcement* officer detains a person pursuant to this subsection, the ~~peace~~ *law enforcement* officer shall file the application provided for in subsection (a) of K.S.A. 59-2912 *and amendments thereto*, as soon as the court is open for the transaction of business.

Sec. 6. K.S.A. 59-2909 is hereby amended to read as follows: 59-2909. (a) A treatment facility may admit and detain any person for emergency observation and treatment upon an order of protective custody issued by a district court pursuant to K.S.A. 59-2912 *and amendments thereto*.

(b) A treatment facility may admit and detain any person for emergency observation and treatment upon written application of any ~~peace~~ *law enforcement* officer having custody of any person pursuant to K.S.A. 59-2908 *and amendments thereto*. The application shall state:

(1) The name and address of ~~such~~ *the* person, if known;

(2) the name and address of ~~such~~ *the* person's spouse or nearest relative, if known;

(3) the officer's belief that ~~such~~ *the* person is a mentally ill person and [~~because of such the person's illness~~] is likely to ~~do physical injury to himself or herself~~ *cause harm to self* or others

if not immediately detained;

(4) the factual circumstances under which ~~such~~ *the* person was taken into custody; and

(5) the fact that the ~~peace~~ *law enforcement* officer will submit the application provided for in subsection (a) of K.S.A. 59-2912 *and amendments thereto*, by ~~five o'clock~~ *5:00* p.m. of the next full day that the district court is open for the transaction of business or that the officer has been informed by a parent, guardian or other person *in loco parentis* to the person taken into custody that such ~~person~~ *parent, guardian or other person*, whose name shall be stated in the application, will file the application provided for in subsection (b) of K.S.A. 59-2912 *and amendments thereto* within ~~such~~ *that* time.

(c) A treatment facility may admit and detain any person for emergency observation and treatment upon the written application of any individual. The application shall state:

(1) The name and address of ~~such~~ *the* person, if known;

(2) the name and address of ~~such~~ *the* person's spouse or nearest relative, if known;

(3) the applicant's belief that ~~such~~ *the* person is a mentally ill person and because of ~~such~~ *the* person's illness is likely to ~~do physical injury to himself or herself~~ *cause harm to self* or others if not immediately detained;

(4) the circumstances in support of ~~such~~ *that* belief; and

(5) the fact that the ~~person~~ *applicant* will submit the application provided for in subsection (b) of K.S.A. 59-2912 *and amendments thereto* by ~~five o'clock~~ *5:00* p.m. of the next full day that the district court is open for transaction of business.

(d) Application of an individual under subsection (c) shall be accompanied by a statement in writing of a physician *or psychologist* confirming the existence of the described condition of ~~such~~ *the* person and, upon the filing of ~~such~~ *the* application, the head of the treatment facility or ~~his or her~~ *the* designee *of the head of the treatment facility* may authorize and order in writing any ~~peace~~ *law enforcement* officer or other person to take into custody and transport ~~such~~ *the* person to the treatment facility.

(e) Any treatment facility or personnel thereof~~,~~ who in good

faith ~~renders~~ *render* treatment in accordance with law to any person admitted pursuant to subsection (b) or (c), shall not be liable in a civil or criminal action based upon a claim that ~~such~~ *the* treatment was rendered without legal consent.

Sec. 7. K.S.A. 59-2910 is hereby amended to read as follows: 59-2910. (a) Whenever any person has been taken into custody pursuant to K.S.A. 59-2908, ~~or~~ *pursuant* to subsection (d) of K.S.A. 59-2909~~,~~ or *pursuant* to K.S.A. 59-2912, ~~such~~ *and amendments thereto, the* person shall be informed immediately by the ~~person~~ *individual* taking ~~such~~ *the* person into custody that ~~he or she~~ *the person* is entitled to contact immediately ~~such~~ *the* person's legal counsel or next of kin, or both. ~~Such person~~ *the person taken into custody* shall be allowed to communicate by reasonable means with a reasonable number of persons and may consult privately with an attorney, *a* personal physician *or psychologist* and at least one ~~(1)~~ member of ~~such~~ *the* person's family, and shall be immediately notified of ~~such~~ *these* rights upon being taken into custody.

(b) Whenever any person has been admitted to a treatment facility pursuant to K.S.A. 59-2909 *and amendments thereto*, the head of the treatment facility or ~~his or her~~ *the* designee *of the head of the treatment facility* shall immediately notify ~~such~~ *the* person's legal counsel or legal guardian, spouse~~,~~ or any next of kin, if known, unless ~~such application was made by such~~ *the applicant was the* person's legal counsel or legal guardian, spouse~~,~~ or next of kin. ~~Such~~ *The* person shall be given a copy of the application of the ~~peace~~ *law enforcement* officer or individual, or a copy of the order of protective custody~~, and~~. *The person* shall be allowed to communicate by all reasonable means with a reasonable number of persons at reasonable hours of the day and night and may consult privately with an attorney, *a* personal physician *or psychologist* and at least one ~~(1)~~ member of ~~such~~ *the* person's family, and shall be immediately notified of ~~such~~ *these* rights upon admission.

(c) Whenever any person has been taken into custody pursuant to K.S.A. 59-2908, ~~or~~ pursuant to subsection (d) of K.S.A. 59-2909~~,~~ or pursuant to K.S.A. 59-2912, *and amendments thereto,*

a ~~physician~~ *treatment facility* may not administer to ~~such~~ *the* person any medication or therapy which will alter ~~such~~ *the* person's mental state in such a way *as* to adversely affect ~~such~~ *the* person's judgment, unless such medication or therapy is necessary to sustain life or protect the ~~patient~~ *person* or others. A report of all treatment provided along with any written consent shall be filed with the court.

Sec. 8. K.S.A. 59-2911 is hereby amended to read as follows: 59-2911. The head of the treatment facility ~~or his or her designee~~ shall discharge any person admitted pursuant to subsection (a) of K.S.A. 59-2909 *and amendments thereto* when the order of protective custody expires and shall discharge any person admitted pursuant to subsection (b) or (c) of K.S.A. 59-2909 *and amendments thereto* not later than ~~five o'clock~~ *5:00* p.m. of the next full day that the district court of the county ~~of the presence of such person~~ *where the person is present* is open for the transaction of business after the admission date of ~~such~~ *the* person~~, but in no case later than forty-eight (48) hours following such admission date, excluding Sundays and legal holidays,~~ unless the district court orders that such person remain in custody pursuant to the provisions of K.S.A. 59-2912 *and amendments thereto.*

Sec. 9. K.S.A. 59-2912 is hereby amended to read as follows: 59-2912. (a) A district court may issue an order of protective custody upon the verified application of any ~~peace officer~~ *law enforcement officer or other individual.* The application shall state:

(1) The name and address of the person *with respect to whom the order is sought,* if known;

(2) the name and address of ~~such~~ *the* person's spouse, legal counsel or nearest relative, if known;

(3) the affiant's belief that the person is a mentally ill person and because of ~~such~~ *the* person's illness is likely to ~~do physical injury to himself or herself~~ *cause harm to self* or others if not immediately detained;

(4) the ~~circumstances under which the person was taken into custody~~ *factual allegations upon which subsection (a)(3) is*

based; and

(5) *that* the application provided for in K.S.A. 59-2913 *and amendments thereto* has been filed.

~~This order~~ *An order issued under this subsection* shall only be valid until ~~five o'clock p.m. of the second~~ *5:00 p.m. of the second full* day the district court is open for the transaction of business after the date of issuance~~, but in no case more than seventy-two (72) hours following the issuance of such order, excluding Sundays and legal holidays~~. The district court shall not issue successive orders of protective custody pursuant to this subsection.

~~(b) A district court may issue an order of protective custody upon the verified application of any person, if the application provided for in K.S.A. 59-2913 has been filed in the court. The application shall state:~~

~~(1) The application provided for in K.S.A. 59-2913 has been filed;~~

~~(2) the affiant's belief that the proposed patient is a mentally ill person;~~

~~(3) because of the proposed patient's illness, said patient is likely to do physical injury to himself or herself or others if not immediately detained.~~

~~This order shall only be valid until the conclusion of the hearing held pursuant to K.S.A. 59-2917.~~

~~(c)~~ *(b)* A district court may issue an order of protective custody ~~at any time after the hearing provided for in K.S.A. 59-2917 when the court has found at such hearing that the proposed patient is a mentally ill person. This order shall be valid until the order for treatment is executed.~~

~~(d)~~ *upon the verified application of any person, if the application provided for in K.S.A. 59-2913 and amendments thereto has been filed in the court, and the court has found following a hearing that there is probable cause to believe that the person with respect to whom the application has been filed is a mentally ill person.* No order of protective custody shall be issued pursuant to *this* subsection ~~(a) or (b) of this section~~ until the court has held a hearing to determine ~~whether there is probable cause to believe the allegations made pursuant to subsection (a) or (b)~~

~~of this section. Such hearing shall be held within forty-eight (48) hours of the filing of such application, excluding Saturdays, Sundays and legal holidays~~ *probable cause, which hearing shall be held not later than 5:00 p.m. of the second full day the district court is open for the transaction of business after the filing of the application provided for by K.S.A. 59-2913 and amendments thereto.* The person ~~against~~ *with respect to* whom the application has been filed shall be present at ~~such~~ *the* hearing, unless the attorney for ~~such person shall request that such~~ *the person requests that the* person's presence be waived and the court finds that the person's presence at the hearing would be injurious to ~~his or her~~ *the person's* welfare. The court shall enter in the record of the proceedings the facts upon which the court has found that the presence of the person at the hearing would be injurious to such person's welfare. Notwithstanding the foregoing provisions of this subsection, if the person ~~against~~ *with respect to* whom the application has been filed requests in writing to the court or to such person's attorney that ~~he or she~~ *the person* be present at the hearing, ~~then such~~ *the* person's presence cannot be waived.

~~(e) If the person against whom the application has been filed is in custody pursuant to the provisions of K.S.A. 59-2008 or 59-2009 at the time such application is filed, the court may order that such person remain in custody at a treatment facility or other suitable place until the conclusion of the hearing held pursuant to the provisions of this section. If the person against whom the application has been filed is not in custody at the time such application is filed, the court may order that such person be taken into custody and placed in a treatment facility or other suitable place willing to receive such person until the conclusion of the hearing held pursuant to the provisions of this section.~~

~~(f)~~ *(c)* The applicant and the person ~~against~~ *with respect to* whom the application has been filed shall be notified of the time and place of the hearing and afforded an opportunity to appear at the hearing, to testify and to present and cross-examine witnesses. If the person ~~against~~ *with respect to* whom the application has been filed has not retained an attorney, the court shall

appoint an attorney for ~~such~~ *the* person in the same manner as an attorney is appointed under the provisions of ~~subsection (c) of~~ K.S.A. 59-2914 *and amendments thereto*. All persons not necessary for the conduct of the proceedings may be excluded. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the person ~~against~~ *with respect to* whom the application has been filed. The court shall receive all relevant and material evidence which may be offered. *The rules governing evidentiary and procedural matters at hearings under this section shall be applied 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. Hearsay evidence may be received, and* [~~experts and others~~] *witnesses may testify to any relevant and probative facts at the discretion of the court.* If the applicant is not represented by counsel, the county or district attorney shall represent the applicant, prepare all necessary papers, appear at the hearing and present such evidence as ~~he or she shall determine~~ *the county or district attorney determines* to be of aid to the court in determining whether or not there is probable cause to believe that the person ~~against~~ *with respect to* whom the application has been filed is a mentally ill person ~~and is likely to do physical injury to himself or herself or others if not immediately detained~~.

If the court determines from the evidence that there is probable cause to believe that the person ~~against~~ *with respect to* whom the application has been filed is a mentally ill person ~~and is likely to do physical injury to himself or herself or others~~ if not immediately detained, the court shall issue an order of protective custody; otherwise, the court shall terminate the proceedings.

~~(g)~~ *(d)* The order of protective custody issued pursuant to provisions of this section may authorize a health officer, physician, ~~peace~~ *law enforcement* officer or other person to take the person ~~against~~ *with respect to* whom the application has been filed into custody and to transport and place ~~such~~ *the* person in a designated treatment facility or other suitable place willing to receive ~~such~~ *the* person and may designate the place of deten-

tion, but no person shall be detained in protective custody in a nonmedical facility used for the detention of persons charged with or convicted of a crime unless other facilities are not available. In lieu of such detention, the order of protective custody may allow the person ~~against~~ *with respect to* whom the application has been filed to be at liberty, subject to such conditions as the court may impose, pending the hearing provided for in K.S.A. 59-2917 ~~or pending the execution of the order for treatment~~ *and amendments thereto.*

Sec. 10. K.S.A. 59-2914 is hereby amended to read as follows: 59-2914. *(a)* Upon the filing of the application provided for in K.S.A. 59-2913 *and amendments thereto*, the district court shall issue the following:

~~(a)~~ *(1)* An order fixing the time and place of the hearing on the application. Such hearing, in the court's discretion, may be conducted in the courtroom, a treatment facility or other suitable place. The time designated in the order shall in no event be earlier than seven ~~(7)~~ days or later than ~~fourteen (14)~~ *14* days after the date of the filing of the application, ~~unless advanced pursuant to subsection (d) of K.S.A. 59-2915, except that in any case where the proposed patient absents himself or herself~~ *except that if the proposed patient absents the patient's self* and the service of the notice on ~~said~~ *the* proposed patient cannot be served because of ~~said~~ *the* absence ~~then~~, the time of absence shall not be included in computing the time of the expiration of the ~~fourteen (14) day~~ *fourteen-day* limitation above set out.

~~(b)~~ *(2)* An order that the proposed patient appear at the time and place of the hearing. The proposed patient shall be present at the hearing, unless the attorney for ~~such person shall request that such person's~~ *the proposed patient requests that the proposed patient's* presence be waived and the court finds that the ~~person's~~ *proposed patient's* presence at the hearing would be injurious to ~~his or her~~ *the proposed patient's* welfare. The court shall enter in the record of the proceedings the facts upon which the court has found that the presence of the ~~person~~ *proposed patient* at the hearing would be injurious to ~~such person's~~ *the proposed patient's* welfare. Notwithstanding the foregoing pro-

visions of this subsection, if the ~~person against whom the application has been filed~~ *proposed patient* requests in writing to the court or to such person's attorney that ~~he or she~~ *the proposed patient* be present at the hearing, ~~then such person's~~ *the proposed patient's* presence cannot be waived.

~~(c)~~ *(3)* An order appointing an attorney to represent the proposed patient at all stages of the proceedings and until all orders resulting from such proceedings are terminated. The court shall give preference, in the appointment of the attorney, to any attorney who has represented the proposed patient in other matters if the court has knowledge of the prior relationship. The proposed patient shall have the right to engage an attorney of ~~said~~ *the proposed* patient's own choice and, in such event, the attorney appointed herein shall be relieved of all duties by the court.

~~(d)~~ *(4)* An order that the proposed patient shall appear at a time and place that is in the best ~~interest~~ *interests* of the patient to consult with ~~said~~ *the proposed* patient's court-appointed attorney, which time shall be *at least five days* prior to the ~~execution of the order for mental evaluation~~ *the date set for the hearing under K.S.A. 59-2917 and amendments thereto.*

~~(e)~~ *(5)* A notice in the manner provided for in K.S.A. 59-2916 *and amendments thereto.*

(6) An order of investigation, which investigation may inquire into the proposed patient's character, family relationships and past conduct; whether or not the proposed patient is likely to cause harm to self or others if allowed to remain at liberty; and other pertinent factors. The court may designate a treatment facility, licensed social worker, court services officer or social service agency to make such investigation and to promptly make a written report to the court, which report shall be made available only to counsel for the parties at least five days prior to the date set for the hearing under K.S.A. 59-2917 and amendments thereto.

(7) Upon the motion of any party, containing those statements required by K.S.A. 59-3009 and amendments thereto, orders necessary to make a determination of the need for a

guardian or conservator, or both, to act on behalf of the proposed patient. For the purposes of determining whether a guardian or conservator is needed, the hearings required by K.S.A. 59-2917 and 59-3013, and amendments thereto, may be consolidated.

(b) Nothing in this section shall prevent the court from granting an order of continuance, for good cause shown, to either party for no longer than seven days, except that such limitation does not apply to a request for an order of continuance made by the proposed patient. The court also, upon request by either party, may advance the date of the hearing if necessary in the interests of all concerned.

Sec. 11. K.S.A. 59-2914a is hereby amended to read as follows: 59-2914a. ~~(a)~~ After the filing of the application provided for in K.S.A. 59-2913 *and amendments thereto* and prior to the hearing provided for in K.S.A. 59-2917 *and amendments thereto*, the court shall issue an order for mental evaluation. The order of mental evaluation shall be served in the manner provided for in K.S.A. 59-2916 *and amendments thereto*. It shall order the proposed patient to submit ~~himself or herself for~~ *to* a mental evaluation ~~and to undergo such evaluation as may be designated by the court in the order, except that any proposed patient who is not under an order of protective custody issued pursuant to K.S.A. 59-2912 and who requests a hearing pursuant to subsection (b), need not submit to such evaluation until said hearing has been held and the court finds that there is probable cause to believe that the proposed patient is a mentally ill person~~ *by a physician or psychologist at a public or private treatment facility*. The evaluation may be held at a treatment facility, the home of the proposed patient or such other suitable place ~~as~~ *that* the court ~~shall determine~~ *determines* is not likely to have a harmful effect on the health of the proposed patient. A state psychiatric hospital shall receive and evaluate any proposed patient ordered evaluated therein.

~~(b) Whenever a proposed patient requests a hearing pursuant to subsection (a), the hearing shall be held within a reasonable time thereafter. The applicant and the proposed patient shall be notified of the time and place of the hearing, afforded an oppor-~~

~~tunity to testify, and to present and cross-examine witnesses. The proposed patient shall be present at the hearing, and said patient's presence cannot be waived. All persons not necessary for the conduct of the proceedings may be excluded. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the proposed patient. The court shall receive all relevant and material evidence which may be offered. If the applicant is not represented by counsel, the county or district attorney shall represent the applicant, prepare all necessary papers, appear at the hearing and present such evidence as he or she shall determine to be of aid to the court in determining whether or not there is probable cause to believe that the proposed patient is a mentally ill person. If the court determines from the evidence that there is probable cause to believe that the proposed patient is a mentally ill person, the court shall issue the order of mental evaluation; otherwise, the court shall terminate all proceedings. At the time designated by the court in the order, but in no event later than three (3) days prior to the date of the hearing provided for in K.S.A. 59-2917, the examiner shall submit to the court a report, in writing, of the evaluation which report also shall be made available to counsel for the parties at least three (3) days prior to such hearing. The report also shall be made available to the proposed patient and to whomever said patient directs, unless for good cause recited in the order, the court orders otherwise. Such report shall state that the examiner has made an examination of the proposed patient and shall state the results of the examination on the issue of whether the proposed patient is a mentally ill person.~~ *At the time designated by the court in the order, but in no event later than five days prior to the date of the hearing provided for in K.S.A. 59-2917 and amendments thereto, the examiner shall submit to the court a written report of the evaluation, which report shall also be made available to counsel for the parties at least three days prior to such hearing. Such report shall state that the examiner has made an examination of the proposed patient and shall state the results of the examination on the issue of whether the*

proposed patient is a mentally ill person;

Sec. 12. K.S.A. 59-2916 is hereby amended to read as follows: 59-2916. *(a)* The notice required by ~~subsection (c) of~~ K.S.A. 59-2914 *and amendments thereto* shall be given to the proposed patient named in the application, the attorney appointed pursuant to ~~subsection (c) of~~ K.S.A. 59-2914~~,~~ *and amendments thereto* and ~~to~~ such other persons as the court ~~shall direct.~~ ~~(a)~~ *directs.*

(b) The notice shall state:

(1) That an application has been filed, alleging that the proposed patient is a mentally ill person and requesting that the court order treatment;

(2) the time and place of the hearing;

(3) the name of the attorney appointed to represent the proposed patient and the time and place where the proposed patient shall consult with such attorney; *and*

(4) that the proposed patient has a right to demand a hearing before a jury.

~~(b)~~ *(c)* The court ~~may order any of the following to serve the notice:~~

~~(1) The physician currently administering to the proposed patient, if the physician consents;~~

~~(2) the head of the local mental health clinic or his or her designee;~~

~~(3) the local health officer or such officer's designee;~~

~~(4) the secretary of social and rehabilitation services or said secretary's designee;~~

~~(5) any peace officer;~~

~~(6) the attorney of the proposed patient~~ *may order any of the following to serve the notice:*

(1) The physician or psychologist currently administering to the proposed patient, if the physician or psychologist consents;

(2) the head of the local mental health clinic or the designee thereof;

(3) the local health officer or such officer's designee;

(4) the secretary of social and rehabilitation services or the secretary's designee;

(5) any law enforcement officer; or

and the examiners opinion as to the least restrictive treatment alternative which will protect the proposed patient and others and allow for the improvement of the proposed patient

(6) the attorney of the proposed patient.

The notice shall be served personally on the proposed patient and the attorney appointed pursuant to ~~subsection (c) of~~ K.S.A. 59-2914 *and amendments thereto as soon as possible, but* not less than ~~five (5)~~ *10* days prior to the date of the hearing, and immediate return thereof shall be made. ~~Unless otherwise ordered by the court, notice shall be served on the proposed patient by a nonuniformed person.~~ *Unless otherwise ordered by the court, notice shall be served on the proposed patient by a nonuniformed person.* Notice to all other persons shall ~~be in such manner and within such time as the court shall direct~~ *be made in the manner directed by the court*, but such notice shall not be given less than ~~five (5)~~ *10* days prior to the date of the hearing.

Sec. 13. K.S.A. 59-2916a is hereby amended to read as follows: 59-2916a. Within ~~forty-eight (48)~~ *48* hours immediately prior to and during ~~the~~ *any* hearing provided for ~~in K.S.A. 59-2917~~ *by this act*, a ~~physician~~ *treatment facility* may not administer to a proposed patient any medication or therapy which will alter ~~such~~ *the* proposed patient's mental state in such a way as to adversely affect ~~such~~ *the proposed* patient's judgment or hamper ~~such~~ *the proposed* patient in preparing for or participating in the hearing, unless such medication or therapy is necessary to sustain life or protect the *proposed* patient or others. ~~When any medication or therapy has been administered to a proposed patient during the forty-eight (48) hours immediately prior to or during the hearing, the physician attending the proposed patient shall cause a record of all such medication or therapy to be presented to the court~~ *Counsel for the proposed patient may examine any physician who has administered medication to the proposed patient within 48 hours prior to any hearing provided for by this act. If in any case the court determines that medication has been administered which adversely affects the proposed patient's judgment or hampers the proposed patient in preparing for or participating in the hearing, the court shall order that no further medication which alters the proposed patient's mental state be administered until*

conclusion of any hearing provided for by this act, and the court shall grant to the proposed patient a reasonable continuance.

Sec. 14. K.S.A. 59-2917 is hereby amended to read as follows: 59-2917. The hearing shall be held at the time and place specified in the court's order unless a continuance as provided in K.S.A. ~~59-2915~~ *59-2914, 59-2916a* or 59-2918, *and amendments thereto,* has been granted. The hearing shall be held to the court only, unless the proposed patient shall, at least ~~48 hours~~ *four days* prior to the time of the hearing, demand in writing a hearing before a jury.

The jury, if one is demanded, shall consist of six persons. The jury panel shall be selected as provided by law and from such panel 12 qualified jurors, who have been passed for cause, shall be empaneled. Prior service as a juror in any court shall not, for that reason, exempt any person from jury service hereunder. From the panel so obtained, the proposed patient or ~~such~~ *the proposed* patient's attorney shall strike one name; the applicant, or ~~such~~ *the* applicant's attorney, one; and so on alternately until each shall have stricken three names. If either party neglects or refuses to aid in striking the names, the court shall strike ~~the~~ *a* name on behalf of such party. ~~In the event that~~ *If* 12 qualified jurors cannot be so empaneled, the court shall draw from such panel or list, by lot, sufficient additional names to empanel 12 qualified jurors.

The applicant and the proposed patient shall be afforded an opportunity to appear at the hearing, to testify, and to present and cross-examine witnesses. All persons not necessary for the conduct of the proceedings may be excluded. The hearings shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the proposed patient. The court shall receive all relevant and material evidence which may be offered, including the testimony or written findings and recommendations of the treatment facility or examiner who has examined or evaluated the proposed patient and the testimony ~~and~~ *or* written findings and recommendations of the ~~investigators~~ *investigator* appointed pursuant to ~~subsection (b) of K.S.A. 59-2915~~ *K.S.A.*

unless the Court finds that the medication is necessary to sustain the patients life

59-2914 and amendments thereto. Such evidence shall not be privileged for the purpose of this hearing.

The rules governing evidentiary and procedural matters at hearings under this section shall be applied 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.

If the applicant is not represented by counsel, the county or district attorney shall represent the applicant, prepare all necessary papers, appear at the hearing and present such evidence as the county or district attorney shall determine to be of aid to the court in determining whether the proposed patient is a mentally ill person.

Upon the completion of the hearing, if the court or jury finds by clear and convincing evidence that the proposed patient is a mentally ill person, ~~and after a careful consideration of reasonable alternatives to inpatient treatment,~~ the court shall order treatment for such person at ~~any~~ *a* treatment facility. An order for treatment in ~~any~~ *a* treatment facility, except a state psychiatric hospital, shall be conditioned upon the consent of such facility.

When the court orders treatment, it shall retain jurisdiction to modify, change or terminate such order.

If, upon the completion of the hearing the court or jury finds ~~that~~ *by* clear and convincing evidence that the proposed patient is a mentally ill person has not been shown, the court shall enter the finding in the record and by an appropriate order shall terminate the proceedings.

Sec. 15. K.S.A. 59-2918 is hereby amended to read as follows: 59-2918. The proposed patient ~~may~~, at any time prior to the hearing provided for in K.S.A. 59-2917, *and amendments thereto, may* request, in writing, that ~~said~~ *the* hearing be continued for ~~ninety~~ ~~(90)~~ *90* days so that the court may make an order of referral for short-term treatment. Upon receipt of such *a* request, the court may refer the proposed patient for a period of time not to exceed ~~ninety~~ ~~(90)~~ *90* days, for short-term treatment, to any treatment facility. An order of referral for treatment in any treatment facility, except a state psychiatric hospital, shall be

conditioned upon the consent of such facility. The court may not issue an order of referral unless the attorney representing the proposed patient has filed a statement, in writing, stating that ~~said~~ *the* attorney has explained to the proposed patient the nature of the order of referral and the right to a hearing before a court or jury to determine whether the proposed patient is a mentally ill person.

Any proposed patient who has been referred for short-term treatment under this section may be accepted for voluntary admission in a treatment facility pursuant to K.S.A. 59-2905 *and amendments thereto*. When the proposed patient has been admitted as a voluntary patient, the treatment facility shall file written notice of the patient's acceptance as a voluntary patient in the court which had ordered the referral. The filing of such notice shall constitute a dismissal of the pending application to determine whether the proposed patient is a mentally ill person.

Unless the proposed patient has been accepted as a voluntary patient by a treatment facility, the facility treating the proposed patient ~~shall~~, not later than ~~ten (10)~~ *14* days prior to the expiration date of the referral period, *shall* file a written report of its findings and recommendations with the court. The court shall then set the date for the hearing provided for in K.S.A. 59-2917 *and amendments thereto*. Such hearing date shall not be later than the expiration date of the referral ~~period~~, unless continued at the *proposed* patient's request.

Sec. 16. K.S.A. 59-2919 is hereby amended to read as follows: 59-2919. All orders of referral to or treatment in a state psychiatric hospital shall be made on the form prescribed by the secretary of social and rehabilitation services. Admission shall be to the state psychiatric hospital previously designated by the secretary of social and rehabilitation services to accept persons from the area of the court's jurisdiction; and, *if requested by the head of the treatment facility,* at a time specified by the head of the ~~hospital~~ *treatment facility,* which *time* shall be not more than ~~fifteen (15)~~ *15* days after the date of the order. Notice of the order shall be given immediately to the designated psychiatric hospital.

New Sec. 17. (a) Following the hearing on the petition as provided for in K.S.A. 59-2917 and amendments thereto, or prior to the entry of an order provided for in K.S.A. 59-2918 and amendments thereto, if the court finds that the proposed patient is a mentally ill person, the court, as an alternative to inpatient treatment, may enter an order for outpatient treatment at a community mental health center or other private treatment facility capable of providing outpatient care. Such an order for outpatient treatment may be entered by the court only if the court finds that outpatient treatment will not constitute a danger to the community and that the patient is not likely to cause harm to self or others while under outpatient treatment. In considering this issue the court shall take into consideration all relevant factors, including but not limited to the degree of supervision and type of outpatient treatment proposed and available and the degree of security to the community provided for under outpatient treatment.

, the preferences of the patient

(b) No order for outpatient treatment shall be entered unless the outpatient treatment facility has [previously] evaluated the proposed patient, submitted a report recommending outpatient treatment and consented to treat the patient on an outpatient basis under the terms and conditions set forth by the court.

(c) If outpatient treatment is ordered, the order shall state the specific conditions to be followed by the patient and shall include the general condition that the patient shall follow all directives and treatment methods established by the head of the treatment facility or the head's designee. The court shall also make such orders as are appropriate to provide for transportation to the outpatient treatment facility and provisions for monitoring the proposed patient's progress and compliance with outpatient treatment.

, for the transfer of copies of the patients records to the outpatient facility

(d) The court shall retain jurisdiction to modify or revoke its order for outpatient treatment at any time on its own motion, on the motion of any counsel of record or upon notice from the treatment facility of any need for new conditions in the order for outpatient treatment or of material noncompliance by the patient with the order for outpatient treatment. Revocation or modifica-

tion may be ordered by *ex parte* order or by order of the court after notice and hearing.

The treatment facility shall immediately report to the court any material noncompliance by the patient with the outpatient treatment order. Such notice may be verbal or by telephone but shall be followed by a verified written notice to the court and to counsel for all parties. Upon receipt of telephone, verbal or written verified notice of noncompliance, the court may enter an *ex parte* order of protective custody revoking the outpatient treatment order and providing for immediate commitment to an inpatient treatment facility.

After the entry of an *ex parte* order revoking or modifying the order for outpatient treatment, a copy of the order shall be served upon the patient and the patient's attorney. Any party to the matter, including the petitioner, the state or the patient may request a hearing on the matter if the request is filed within five days from the date of service of the *ex parte* order upon the patient. The court may also order such a hearing on its own motion within five days from the date of service of the notice. If no request or order for hearing is filed within the five-day period, the *ex parte* order shall become the final order of the court. If a hearing is requested, a written motion for revocation or modification of the outpatient treatment order shall be filed by the state or the petitioner and a hearing shall be held thereon within five days after the filing of the motion. If upon hearing the court finds that the conditions of the outpatient treatment order have not been met, the court may enter an order for inpatient treatment or may continue the order for outpatient treatment with different terms and conditions.

(e) The outpatient treatment facility shall comply with the provisions of section 19 concerning filing of medical records summaries each 90 or 180 days during the time the outpatient treatment order is in effect and the court shall receive and process such reports in the same manner as reports received from an inpatient treatment facility.

Sec. 18. K.S.A. 59-2922 is hereby amended to read as follows: 59-2922. After the application provided for in K.S.A. 59-

2913 ~~or 59-2923~~ *and amendments thereto* is filed, the district court at any time, on its own motion or upon the written request of any person, may transfer the venue of any case to ~~any of the following district courts under the following conditions:~~

~~(a) When the application is filed in the county of the residence of the patient to:~~

~~(1) The county where the patient is being detained in a treatment facility under the authority of an order issued pursuant to K.S.A. 59-2912, 59-2917 or 59-2918; or~~

~~(2) any other county designated by the court, if the patient has made a request for a change of venue and the court finds that the patient cannot obtain a fair hearing in the county of such patient's residence.~~

~~(b) When the application is filed in the county in the presence of the patient to:~~

~~(1) The county of the residence of the patient;~~

~~(2) the county where the patient is being detained in a treatment facility under the authority of an order issued pursuant to K.S.A. 1982 Supp. 59-2912 or 59-2917 or K.S.A. 59-2918; or~~

~~(3) any other county designated by the court, if the patient has made a request for a change of venue and the court finds that the patient cannot obtain a fair hearing in the county of such patient's presence.~~

~~If any patient is in a treatment facility, the district court of the county in which the treatment facility is located may not transfer venue under any circumstances unless the patient has requested such transfer~~ *the county where the patient is being detained in a treatment facility under the authority issued pursuant to K.S.A. 59-2912, 59-2917 or 59-2918, and amendments thereto. The district court also may transfer the venue of any case to any other county designated by the court if the patient has made a request for the change of venue and the court finds that the patient cannot obtain a fair hearing in the county where the patient is present.*

When any order changing venue is issued, the district court issuing such order shall transmit to the district court to which venue was changed a certified copy of all pleadings and orders in

the case. The district court issuing such order shall transmit to the district court of the residence of the proposed patient a statement of all court costs incurred by the county of the district court issuing such order and a certified copy of all pleadings and orders in the case.

Any district court to which venue is transferred shall proceed in the case as if the application had been originally filed therein and shall cause notice of the change of venue to be given to the persons and in the manner provided for in K.S.A. 59-2916 *and amendments thereto*, except that the court need not issue the order for mental evaluation pursuant to K.S.A. 59-2914a *and amendments thereto* if such order has previously been issued.

Any district court to which venue is transferred shall transmit a statement of any court costs incurred and a certified copy of all pleadings and orders in the case to the district court of the county of the residence of the patient.

New Sec. 19. (a) When treatment has been ordered for a person pursuant to K.S.A. 59-2917 and amendments thereto, the patient shall be entitled to request a hearing each 90 days during the first six months of treatment and every 180 days thereafter to determine whether or not such patient continues by clear and convincing evidence to be a mentally ill person. The district court having jurisdiction to modify, change or terminate the order of treatment shall conduct the hearings. At least two weeks prior to the end of each period of treatment, the head of the treatment facility furnishing treatment to the patient shall provide to the court a summary of the medical records of the patient. Upon the receipt of the summary, the court shall notify the patient's attorney of record that the summary has been received. If there is no attorney of record for the patient, the court shall appoint an attorney and notify such attorney that the summary has been received.

(b) When the attorney for the patient has received notice that the treatment facility has provided the district court with a summary of the medical records of a patient, the attorney shall consult with the patient to determine whether the patient desires a hearing. If the patient desires a hearing, the attorney shall file a

written request for a hearing with the district court, which request shall be filed not later than the end of the ninety-day or one-hundred-eighty-day period of treatment. Upon receiving a written request for a hearing, the district court shall set the matter for hearing and give notice of such hearing in the manner provided for notice under K.S.A. 59-2916 and amendments thereto. The hearing shall be held as soon as reasonably practical, but in no event more than 10 days following the filing of the written request for a hearing. The district court shall give notice of the time and place of the hearing to the treatment facility to which the patient was ordered for treatment. The district court shall proceed with the hearing in the same manner and with the same powers as if an application pursuant to K.S.A. 59-2913 and amendments thereto had been filed in the court.

(c) The hearing shall be conducted in the same manner as hearings provided for in K.S.A. 59-2917 and amendments thereto, except that the hearing shall be to the court and the patient shall not have the right to demand a jury.

(d) Upon completion of the hearing, if the court finds by clear and convincing evidence that the patient continues to be a mentally ill person, the court shall order continued treatment. If the court finds that it has not been shown by clear and convincing evidence that the patient continues to be a mentally ill person, it shall discharge the patient. A copy of the court's order shall be sent by mail to the patient, the patient's attorney and the treatment facility to which the patient had been ordered.

Sec. 20: K.S.A. 59-2924 is hereby amended to read as follows: 59-2924. (a) The ~~director of mental health and retardation services~~ *secretary of social and rehabilitation services or the secretary's designee* may transfer any patient from any ~~institution under the director's control to any other such institution whenever the director~~ *state psychiatric hospital under the secretary's control to any other state psychiatric hospital whenever the secretary or the secretary's designee* considers it to be in the best ~~interest~~ *interests* of the patient. *Except in the case of an emergency, the patient's next of kin or guardian, if one has been appointed, shall be notified of the transfer, and notice shall be*

sent to the committing court not less than 14 days before the proposed transfer. The notice shall state the location to which the transfer is proposed and state that, upon request of the next of kin or guardian, an opportunity for a hearing on the proposed transfer will be provided by the secretary of social and rehabilitation services prior to such transfer.

(b) *The secretary of social and rehabilitation services or the designee of the secretary may transfer any involuntary patient from any state psychiatric hospital to any state institution for the mentally retarded whenever the secretary of social and rehabilitation services or the designee of the secretary considers it to be in the best interests of the patient. Any patient transferred as provided in this subsection shall remain subject to the same statutory provisions as were applicable at the hospital from which* ~~*that*~~ *the patient was transferred and in addition thereto shall abide by and be subject to all the rules and regulations of the institution to which the patient has been transferred. Except in the case of an emergency, the patient's next of kin or guardian, if one has been appointed, shall be notified of the transfer, and notice shall be sent to the committing court not less than 14 days before the proposed transfer. The notice shall state the location to which the transfer is proposed and state that, upon request of the next of kin or guardian, an opportunity for a hearing on the proposed transfer will be provided by the secretary of social and rehabilitation services prior to such transfer. No involuntary patient shall be transferred from a state psychiatric hospital to a state institution for the mentally retarded unless the superintendent of the receiving institution has found that the patient is mentally retarded and in need of care and training and that placement in the institution is the least restrictive alternative available. Nothing in this subsection shall prevent the secretary of social and rehabilitation services or the designee of the secretary from allowing a person to be admitted as a voluntary resident to a state institution for the mentally retarded, or from discharging such person from a state psychiatric hospital.*

(c) When any proposed patient or involuntary patient has

0382 been ordered to any treatment facility ~~on referral or for treatment~~
0383 *pursuant to K.S.A. 59-2909, 59-2912, 59-2917 or 59-2918, and*
0384 *amendments thereto*, the head of the treatment facility shall
0385 discharge the patient when the patient is no longer in need of
0386 treatment *in the facility. The head of the treatment facility shall*
0387 *review and investigate all applications for involuntary admis-*
0388 *sion and, if appropriate, shall divert patients to less restrictive*
0389 *treatment alternatives before further judicial proceedings occur*
0390 *whenever it is deemed appropriate by the head of the treatment*
0391 *facility. If diversion from involuntary treatment is not appro-*
0392 *priate, the head of the treatment facility should be prepared to*
0393 *present evidence at the next hearing scheduled for the patient*
0394 *concerning further need for involuntary treatment.*

0395 ~~(c)~~ *(d)* The head of the treatment facility may release any
0396 involuntary patient *who has been committed for treatment pur-*
0397 *suant to K.S.A. 59-2917 or 59-2918, and amendments thereto*, on
0398 conditional release when the head of the treatment facility be-
0399 lieves that (1) the release is in the best ~~interest~~ *interests* of the
0400 patient and (2) the patient ~~will not be dangerous to self or~~ *is not*
0401 *likely to cause harm to self or* others as long as the patient
0402 continues a plan of treatment *in the community.* The treatment
0403 facility shall formulate a plan of treatment for each patient
0404 released on conditional release. The plan of treatment may
0405 include any conditions which the head of the treatment facility
0406 considers to be in the best ~~interest~~ *interests* of the patient or
0407 necessary to ensure that the patient ~~will not be dangerous to self~~
0408 ~~or~~ *is not likely to cause harm to self or* others. The conditions
0409 may include a requirement that the patient be supervised by and
0410 report to a treatment facility~~,~~ which shall be responsible for
0411 ensuring that the patient complies with the conditions. The head
0412 of the treatment facility from which the patient is released may
0413 change the plan of treatment or the conditions specified in the
0414 plan whenever the head ~~of the treatment facility~~ considers it to
0415 be in the best ~~interest~~ *interests* of the patient or necessary to
0416 ensure that the patient ~~will not be dangerous to self or~~ *is not*
0417 *likely to cause harm to self or* others. If the patient fails to
comply with any conditions of the treatment plan ~~and the head of~~

The treatment facility in the community shall inform the head of the treatment facility from which the patient was discharged of any material noncompliance with the treatment plan.

~~the treatment facility from which the patient is released determines that the failure to comply is likely to make the patient dangerous to self or others~~, the head of the facility may revoke the release and order the patient readmitted to the ~~treatment~~ facility. The head of the treatment facility may authorize and order ~~any peace~~ *a law enforcement* officer or other person to take into custody and transport the patient to a treatment facility.

Prior to the end of the ~~first year~~ *120 days* on conditional release, and not less often than ~~annually~~ *each 120 days* thereafter while ~~an involuntary~~ *a* patient is on conditional release, the head of the treatment facility from which the patient is released shall reexamine the facts relating to the treatment of the ~~involuntary~~ patient on conditional release.

(e) The head of the treatment facility shall not discharge an involuntary patient from conditional release unless at least seven days' notice of the intention to discharge the patient is given to any other treatment facility which is involved in the treatment plan for the patient.

~~(d)~~ *(f)* Nothing in this section shall be construed to amend or modify or repeal any law relating to the confinement of persons charged with or convicted of a criminal offense.

Sec. 21. K.S.A. 59-2926 is hereby amended to read as follows: 59-2926. *(a)* If any involuntary patient leaves the place of ~~such~~ *the* patient's treatment without the authority of the head of the treatment facility, the head of the treatment facility may authorize and order, *either orally or* in writing, ~~any peace~~ *a law enforcement* officer or other person to take ~~such~~ *the* involuntary patient into custody and transport such patient to ~~such place as may be~~ *a place* directed by the head of the treatment facility. *If oral authorization is given, it shall be confirmed in writing as soon as reasonably possible.*

(b) In addition to the authority set forth in subsection (a), the head of a treatment facility operated by the department of social and rehabilitation services may take such reasonable action as necessary to assure that a patient who is not discharged from the treatment facility or otherwise authorized to leave the treatment facility remains at or is returned to the

treatment facility.

Sec. 22. K.S.A. 59-2928 is hereby amended to read as follows: 59-2928. *(a)* Restraints or seclusion shall not be applied to a patient unless it is determined by the head of the treatment facility or a ~~member of the medical staff~~ *physician or psychologist* to be required to prevent substantial bodily injury to such patient or others. The extent of the restraint or seclusion applied to the patient shall be the least restrictive measure necessary to prevent injury to the patient or others, and the use of restraint or seclusion shall not exceed three ~~(3)~~ hours without medical reevaluation, except that such medical reevaluation shall not be required, unless necessary, between the hours of ~~12 o'clock~~ *12:00* midnight and 8:00 ~~o'clock~~ a.m. The head of the treatment facility or a ~~member of the medical staff~~ *physician or psychologist* shall sign a statement explaining the ~~medical~~ *treatment* necessity for the use of any restraint and seclusion and shall make such statement a part of the ~~medical~~ *permanent treatment* record of such patient.

When restraints or seclusion are applied, their shall be monitering of the patients condition at a frequency determined by the treating psysician or psychologist, which shall be no less than once per hour.

(b) The provisions of subsection (a) shall not prevent, for a period not exceeding two hours without review and approval thereof by the head of the treatment facility or a physician or psychologist:

(1) Staff at the state security hospital from confining patients in their rooms when it is considered necessary for security or proper institutional management;

(2) the use of such restraints as necessary for a patient who is likely to cause physical injury to self or others without the use of such restraints; or

(3) the use of restraints when needed primarily for examination or treatment or to insure the healing process.

Sec. 23. K.S.A. 59-2929 is hereby amended to read as follows: 59-2929. *(a)* Every patient being treated in any treatment facility, in addition to all other rights preserved by the provisions of this act, shall have the following rights:

(1) To wear ~~his or her~~ *the patient's* own clothes, keep and use ~~his or her~~ *the patient's* own personal possessions including toilet articles and keep and be allowed to spend ~~his or her~~ *the patient's*

own money;

(2) to communicate by telephone, both to make and receive confidential calls, and by letter, both to mail and receive unopened correspondence, except that if the head of the treatment facility should deny a patient's right to mail or to receive unopened correspondence under the provisions of subsection (b) ~~of this section~~, such correspondence shall be opened and examined in the presence of the patient;

(3) to conjugal visits if facilities are available for such visits;

(4) to receive visitors each day;

(5) to refuse involuntary labor and to be paid for any work performed other than the housekeeping of ~~his or her~~ *the patient's* own bedroom and bathroom *subject to the provisions of section 24*;

(6) not to be subject to such procedures as psychosurgery, electroshock therapy, experimental medication, aversion therapy or hazardous treatment procedures without the written consent of the patient and the written consent of a parent, guardian or other person *in loco parentis*, if such patient has a living parent or a guardian or other person *in loco parentis;*

(7) to have explained ~~if requested,~~ the nature of all medications and treatments prescribed, the reason for the prescription and the most common side effects; , if requested,

(8) to communicate by letter with the secretary of social and rehabilitation services, the head of the treatment facility and any court, physician, *psychologist* or attorney~~, and~~. All such communications shall be forwarded at once to the addressee without examination and communications from such persons shall be delivered to the patient without examination;

(9) to be visited by ~~his or her~~ *the patient's* physician, *psychologist* or attorney at ~~all times~~ *any time*; and

(10) to be informed orally and in writing of ~~his or her~~ *the patient's* rights under this section upon admission to a treatment facility.

(b) The head of the treatment facility may, for good cause only, restrict a patient's rights under this section, except that the rights enumerated in ~~subsection~~ *subsections* (a)(5) through

(a)(10) ~~of this section~~, and the right to mail any correspondence which does not violate postal regulations, hall not be restricted by the head of the treatment facility under any circumstances. Each treatment facility shall adopt regulations governing the conduct of all patients being treated in such treatment facility, which regulations shall be consistent with the provisions of this section. A statement explaining the reasons for any restriction of a patient's rights shall be immediately entered on such patient's medical record and copies of such statement shall be available to the patient and the parent, guardian or person~~,~~ *in loco parentis*, if such patient is less than ~~eighteen (18)~~ *18* years of age, and the patient's attorney.

(c) Any person willfully depriving any patient of the rights protected by this section, except for the restriction of such rights in accordance with the provisions of subsection (b) ~~of this section~~, shall be guilty of a class C misdemeanor.

New Sec. 24. (a) Patients shall have the right to perform labor as part of a therapeutic program.

(b) Patients may not be required to perform labor except as specified in subsection (a)(5) of K.S.A. 59-2929 and amendments thereto, and any patient labor that confers an economic benefit on the institution beyond merely supplementing employee performance of housekeeping tasks and routine institutional maintenance shall be compensated on a reasonable basis.

Sec. 25. K.S.A. 59-2931 is hereby amended to read as follows: 59-2931. (a) The district court records, treatment records or medical records of any patient or former patient that are in the possession of any district court or treatment facility shall be privileged and shall not be disclosed except ~~(1)~~ as otherwise provided in this act~~;~~ or ~~(2)~~ under any of the following conditions:

~~(A)~~ *(1)* Upon the *written* consent~~;~~ ~~in writing, of the patient or former patient, or if the patient be under eighteen (18) years of age, by the patient's parent, or if the patient has a guardian, by such guardian. However,~~ *of (A) the patient or former patient, if an adult who has no guardian; (B) the patient's or former patient's guardian, if any; or (C) a parent, if the patient or former patient is under 18 years of age, except that a patient or*

former patient who is 14 or more years of age and who requested voluntary admission shall have capacity to consent to release of the records without parental consent. The head of any treatment facility, other than an adult care home, who has the records may refuse to disclose portions of such records if ~~he or she shall have stated,~~ *the head of the treatment facility states* in writing, that such disclosure will be injurious to the welfare of the patient or former patient.

~~(B)~~ *(2)* Upon the sole consent of the head of the treatment facility who has the records after a *written* statement, ~~in writing, by such~~ *by the* head *of the treatment facility* that such disclosure is necessary for the treatment of the patient or former patient. ~~However, such~~ *The* head may make such disclosure to the patient or *any* former patient, the patient's next of kin, any state or national accreditation agency, or scholarly investigator without making such determination ~~except that~~ *but* the head of the treatment facility shall require, before such disclosure is made, a pledge from any state or national accreditation agency or scholarly investigator that such agency or ~~investigation~~ *investigator* will not disclose the name of any patient or former patient to any person not otherwise authorized by law to receive such information.

~~(C)~~ *(3)* Upon the order of any court of record after a determination by the court issuing the order that such records are necessary for the conduct of proceedings before it and are otherwise admissible ~~in~~ *as* evidence.

~~(D)~~ *(4)* In proceedings under this act, upon the oral or written request of any attorney representing the patient, former patient, or applicant.

~~[(5) To appropriate administrative or professional staff of any community mental health center, as defined by K.S.A. 75-3307c and amendments thereto for purposes of promoting continuity of care in the community following discharge or conditional release. The patient or former patient's consent shall not be necessary to release records to such a mental health center].~~

(6) To appropriate administrative or professional staff of the

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department of corrections whenever patients have been administratively transferred to the state security hospital or other state psychiatric institutions pursuant to the provisions of K.S.A. 75-5209 and amendments thereto. The patient's or former patient's consent shall not be necessary to release information to the department of corrections.

(b) ~~Any person willfully violating this section shall be guilty of~~ *Willful violation of this section is* a class C misdemeanor.

New Sec. 26. (a) Medications and other treatments shall be prescribed, ordered and administered only in conformity with accepted clinical practice. Medication shall be administered only in accordance with the written order of a physician or upon a verbal order noted in the patient's medical records and subsequently signed by the physician. The attending physician shall review regularly the drug regimen of each patient or proposed patient under the physician's care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding 30 days thereafter but may be renewed.

(b) Any patient who is receiving treatment pursuant to the provisions of K.S.A. 59-2909, 59-2912, 59-2917 or 59-2918, and amendments thereto, shall not have ~~the right to refuse any medication, including psychotropic medication, other than experimental medication, which is prescribed by a physician in conformance with the provisions of this section. Although consent to treatment is not required, during~~ the course of treatment the responsible physician or psychologist shall consult with the patient, or the patient's guardian, and give consideration to the views the patient or guardian expresses concerning treatment and any alternatives.

(c) Consent for medical or surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

Sec. 27. K.S.A. 59-2940 is hereby amended to read as follows: 59-2940. Whenever any person is taken into custody by an ...sting officer and such officer has reasonable grounds to ...eve that such person has violated K.S.A. 21-3420, 21-3421,

medication administered without their consent until and unless the medication order and the patients refusal has been reviewed and the necessity for such medication approved by the head of the treatment facility, and two non treating physicians. In no case shall experimental medication be administered without the patients consent. During

21-3422, 21-3502, 21-3503, 21-3504, 21-3505, 21-3506, 21-3507, 21-3508, 21-3509, 21-3510, 21-3511, 21-3512, 21-3513, 21-3602 or 21-3603, ~~or any~~ *and* amendments thereto, the officer shall forthwith report such facts to the county *or district* attorney by a written report under oath, and the county *or district* attorney may submit such report to the judge of the district court. If the court finds from an examination of ~~said~~ *the* report that there is evidence raising the issue of the sanity of such person who was arrested, the court shall direct the county *or district* attorney to sign and file a petition to institute proceedings in accordance with ~~K.S.A. 59-2901 to 59-2930, inclusive, and any amendments thereto, the same being the act for obtaining care and treatment for a mentally ill person~~ *the treatment act for mentally ill persons*.

Sec. 28. K.S.A. 1984 Supp. 22-3428 is hereby amended to read as follows: 22-3428. (1) When a person is acquitted on the ground that the person was insane at the time of the commission of the alleged crime, the verdict shall be not guilty because of insanity and the person shall be committed to the state security hospital for safekeeping and treatment. A finding of not guilty by reason of insanity shall constitute a finding that the acquitted person committed an act constituting the offense charged or an act constituting a lesser included crime, except that the person did not possess the requisite criminal intent. A finding of not guilty because of insanity shall be prima facie evidence that the acquitted person is presently ~~dangerous to the person's self or others or a substantial danger to the property of~~ *likely to cause harm to self or* others.

(2) Whenever it appears to the chief medical officer of the state security hospital that a person committed under this section is not dangerous to other patients, the officer may transfer the person to any state hospital. Any person committed under this section may be granted convalescent leave or discharge as an involuntary patient after 30 days' notice has been given to the district or county attorney, sheriff and district court of the county from which the person was committed.

(3) Within 15 days after the receipt of the notice provided for

in subsection (2), the district or county attorney may request that a hearing on the proposed leave or discharge be held. Upon receiving the request, the district court shall order that a hearing be held on the proposed leave or discharge. The court shall give notice of the hearing to the state hospital where the patient was transferred and shall order the involuntary patient to undergo a mental evaluation by a person designated by the court. A copy of all orders of the court shall be sent to the involuntary patient and the patient's attorney. The report of the court ordered mental evaluation shall be given to the district or county attorney, the involuntary patient and the patient's attorney at least five days prior to the hearing. The hearing shall be held within 30 days after the receipt by the court of the district or county attorney's request. The involuntary patient shall remain in the state hospital until the hearing on the proposed leave or discharge is to be held. At the hearing, the court shall receive all relevant evidence, including the written findings and recommendations of the chief medical officer of the state security hospital or the state hospital where the patient is under commitment, and shall determine whether the patient continues to be ~~a danger to the patient's self or others or a substantial danger to the property of~~ *likely to cause harm to self or* others. The patient shall have the right to present evidence at such hearing and to cross-examine any witnesses called by the district or county attorney. At the conclusion of the hearing, if the court finds that the patient continues to be ~~a danger to the patient's self or others or a substantial danger to the property of~~ *likely to cause harm to self or* others, the court shall order the patient to remain in the state hospital, otherwise the court shall order the patient discharged or conditionally released. If the court finds from evidence presented at the hearing that the discharge of the patient ~~will not pose a danger to the patient's self or others or a substantial danger to the property of~~ *is not likely to cause harm to self or* others if the patient continues to take prescribed medication or to receive periodic psychiatric *or psychological* treatment ~~or guidance counseling~~, the court may order the patient conditionally released in accordance with subsection (4). If the court orders

the conditional release of the patient, the court may order as an additional condition to the release that the patient continue to take prescribed medication and report as directed to a person licensed to practice medicine and surgery to determine whether or not the patient is taking the medication or that the patient continue to receive periodic psychiatric *or psychological* treatment ~~or guidance counseling~~.

(4) In order to insure the safety and welfare of a patient who is to be conditionally released and the citizenry of the state the court may allow the patient to remain in custody at a facility under the supervision of the secretary of social and rehabilitation services for a period of time not to exceed 30 days in order to permit sufficient time for the secretary to prepare recommendations to the court for a suitable reentry program for the patient. The reentry program shall be specifically designed to facilitate the return of the patient to the community as a functioning, selfsupporting citizen, and may include appropriate supportive provisions for assistance in establishing residency, securing gainful employment, undergoing needed vocational rehabilitation, receiving marital and family counseling, and such other outpatient services that appear beneficial. If a patient who is to be conditionally released will be residing in a county other than the county where the district court that ordered the conditional release is located, the court shall transfer venue of the case to the district court of the other county and send a copy of all of the court's records of the proceedings to the other court. In all cases of conditional release the court shall: (a) Order that the patient be placed under the temporary supervision of state parole and probation services, district court probation and parole services or any appropriate private agency; and (b) require as a condition precedent to the release that the patient agree in writing to waive extradition in the event a warrant is issued pursuant to K.S.A. 22-3428b *and amendments thereto.*

(5) At any time during the conditional release period, a conditionally released patient, through the patient's attorney, or the county or district attorney of the county in which the district court having venue is located may file a motion for modification

of the conditions of release, and the court shall hold an evidentiary hearing on the motion within 15 days of its filing. The court shall give notice of the time for the hearing to the patient and the county or district attorney. If the court finds from the evidence at the hearing that the conditional provisions of release should be modified or vacated, it shall so order. If at any time during the transitional period the designated medical officer or supervisory personnel *or the treatment facility* informs the court that the patient is not satisfactorily complying with the provisions of the conditional release, the court, after a hearing for which notice has been given to the county or district attorney and the patient, may make orders: (a) For additional conditions of release designed to effect the ends of the reentry program, (b) requiring the county or district attorney to file an application to determine whether the patient is a mentally ill person as provided in K.S.A. ~~1982 Supp.~~ 59-2913 *and amendments thereto*, or (c) requiring that the patient be committed to the state security hospital or any state hospital. In cases where an application is ordered to be filed, the court shall proceed to hear and determine the application pursuant to the ~~act for obtaining treatment for a mentally ill person~~ *treatment act for mentally ill persons* and that act shall apply to all subsequent proceedings. The costs of all proceedings, the mental evaluation and the reentry program authorized by this section shall be paid by the county from which the person was committed.

(6) In any case in which the defense of insanity is relied on, the court shall instruct the jury on the substance of this section.

(7) As used in this section and K.S.A. 22-3428a and amendments thereto, "likely to cause harm to self or others" has the meaning provided by K.S.A. 59-2902 and amendments thereto.

Sec. 29. K.S.A. 1984 Supp. 22-3428a is hereby amended to read as follows: 22-3428a. (1) Any person found not guilty because of insanity who remains in the state security hospital or a state hospital for over one year pursuant to a commitment under K.S.A. ~~1982 Supp.~~ 22-3428 *and amendments thereto* shall be entitled annually to request a hearing to determine whether or not the person continues to be ~~dangerous to the person's self or~~

~~others or a substantial danger to the property of~~ *likely to cause harm to self or* others. The request shall be made in writing to the district court of the county where the person is hospitalized and shall be signed by the committed person or the person's counsel. When the request is filed, the court shall give notice of the request to: (a) The county or district attorney of the county in which the person was originally ordered committed, and (b) the chief medical officer of the state security hospital or state hospital where the person is committed. The chief medical officer receiving the notice or the officer's designee, shall conduct a mental examination of the person and shall send to the district court of the county where the person is hospitalized and to the county or district attorney of the county in which the person was originally ordered committed a report of the examination within 20 days from the date when notice from the court was received. Within five days after receiving the report of the examination, the county or district attorney receiving it may file a motion with the district court that gave the notice, requesting the court to change the venue of the hearing to the district court of the county in which the person was originally committed, or the court that gave the notice on its own motion may change the venue of the hearing to the district court of the county in which the person was originally committed. Upon receipt of that motion and the report of the mental examination or upon the court's own motion, the court shall transfer the hearing to the district court specified in the motion and send a copy of the court's records of the proceedings to that court.

(2) After the time in which a change of venue may be requested has elapsed, the court having venue shall set a date for the hearing, giving notice thereof to the county or district attorney of the county, the committed person and the person's counsel. If there is no counsel of record, the court shall appoint a counsel for the committed person. The committed person shall have the right to procure, at the person's own expense, a mental examination by a physician or certified psychologist of the person's own choosing. If a committed person is financially unable to procure such an examination, the aid to indigent defendants

provisions of article 45 of chapter 22 of the Kansas Statutes Annotated shall be applicable to that person. A committed person requesting a mental examination pursuant to K.S.A. ~~1982 Supp.~~ 22-4508 *and amendments thereto* may request a physician or certified psychologist of the person's own choosing and the court shall request the physician or certified psychologist to provide an estimate of the cost of the examination. If the physician or certified psychologist agrees to accept compensation in an amount in accordance with the compensation standards set by the board of supervisors of panels to aid indigent defendants, the judge shall appoint the requested physician or certified psychologist; otherwise, the court shall designate a physician or certified psychologist to conduct the examination. Copies of each mental examination of the committed person shall be filed with the court at least five days prior to the hearing and shall be supplied to the county or district attorney receiving notice pursuant to this section and the committed person's counsel.

(3) At the hearing the committed person shall have the right to present evidence and cross-examine the witnesses. The court shall receive all relevant evidence, including the written findings and recommendations of the chief medical officer of the state security hospital or state hospital where the person is under commitment, and shall determine whether the committed person continues to be ~~a danger to the person's self or others or a substantial danger to the property of~~ *likely to cause harm to self or* others. At the hearing the court may make any order that a court is empowered to make pursuant to subsections (3), (4) and (5) of K.S.A. 22-3428 and amendments thereto. If the court finds the committed person is no longer ~~dangerous to the person's self or others or a substantial danger to the property of~~ *likely to cause harm to self or* others, the court shall order the person discharged; otherwise, the person shall remain committed or be conditionally released.

(4) Costs of a hearing held pursuant to this section shall be assessed against and paid by the county in which the person was originally ordered committed.

Sec. 30. K.S.A. 1984 Supp. 28-170 is hereby amended to read

as follows: 28-170. (a) The docket fee prescribed by K.S.A. 60-2001 *and amendments thereto* shall be the only costs assessed for services of the clerk of the district court and the sheriff in any case filed under chapter 60 of the Kansas Statutes Annotated. For services in other matters in which no other fee is prescribed by statute, the following fees shall be charged and collected by the clerk. Only one fee shall be charged for each bond, lien or judgment:

1. For filing, entering and releasing a bond, mechanic's lien, personal property tax judgment or any judgment on which execution process cannot be issued $5
2. For filing, entering and releasing a judgment of a court of this state on which execution or other process can be issued 15
3. For a certificate, or for copying or certifying any paper or writ, such fee as shall be prescribed by the district court.

(b) The fees for entries, certificates and other papers required in naturalization cases shall be those prescribed by the federal government and, when collected, shall be disbursed as prescribed by the federal government. The clerk of the court shall remit to the state treasurer at least monthly all moneys received from fees prescribed by subsection (a) or (b) or received for any services performed which may be required by law. The state treasurer shall deposit the remittance in the state treasury and credit the entire amount to the state general fund.

(c) In actions pursuant to the Kansas code for care of children *(K.S.A. 1984 Supp. 38-1501 et seq. and amendments thereto)*, the Kansas juvenile offenders code *(K.S.A. 1984 Supp. 38-1601 et seq. and amendments thereto*, the act for treatment of alcoholism ~~(article 40 of chapter 65)~~ *(K.S.A. 65-4001 et seq. and amendments thereto)*, the act for treatment of drug abuse (K.S.A. 1984 Supp. 65-5201 *et seq. and amendments thereto)* or the ~~act for obtaining treatment for a mentally ill person~~ *treatment act for mentally ill persons (K.S.A. 59-2901 et seq. and amendments thereto*, the clerk shall charge an additional fee of $.50 which shall be deducted from the docket fee and credited to the prosecuting attorneys' training fund as provided in K.S.A. 28-170a and amendments thereto.

Sec. 31. K.S.A. 1984 Supp. 38-1513 is hereby amended to read as follows: 38-1513. (a) *Physical care and treatment.* (1) When a child less than 18 years of age is alleged to have been

sexually abused, no consent shall be required to medically examine the child to determine whether there has been sexual abuse.

(2) When the health or condition of a child who is a ward of the court requires it, the court may consent to the performing and furnishing of hospital, medical, surgical or dental treatment or procedures, including the release and inspection of medical or dental records. A child, or parent of any child, who is an adherent of a religious denomination whose religious teachings are opposed to certain medical procedures authorized by this subsection may request an opportunity for a hearing thereon before the court. Subsequent to the hearing, the court may limit the performance of matters provided for in this subsection or may authorize the performance of those matters subject to terms and conditions the court considers proper.

(3) Prior to adjudication the person having custody of the child may give consent to the following:

(A) Dental treatment for the child by a licensed dentist;

(B) diagnostic examinations of the child, including but not limited to the withdrawal of blood or other body fluids, x-rays and other laboratory examinations;

(C) releases and inspections of the child's medical history records;

(D) immunizations for the child; and

(E) administration of lawfully prescribed drugs to the child.

(4) When the court has granted legal custody of a child in a dispositional hearing to any agency, association or individual, the custodian or an agent designated by the custodian shall have authority to consent to the performance and furnishing of hospital, medical, surgical or dental treatment or procedures including the release and inspection of medical or hospital records, subject to terms and conditions the court considers proper.

(5) Any health care provider who in good faith renders hospital, medical, surgical or dental care or treatment to any child after a consent has been obtained as authorized by this section shall not be liable in any civil or criminal action for failure to obtain consent of a parent.

(6) Nothing in this section shall be construed to mean that any person shall be relieved of legal responsibility to provide care and support for a child.

(b) *Mental care and treatment.* If it is brought to the court's attention, while the court is exercising jurisdiction over the person of a child under this code, that the child may be a mentally ill person as defined in K.S.A. 59-2902 and amendments thereto, the court may:

(1) Direct or authorize the county or district attorney or the person supplying the information to file the application provided for in K.S.A. 59-2913 and amendments thereto and proceed to hear and determine the issues raised by the application as provided in the ~~act for obtaining treatment for a mentally ill person~~ *treatment for mentally ill persons*; or

(2) authorize that the child seek voluntary admission to a treatment facility as provided in K.S.A. 59-2905 and amendments thereto.

The application to determine whether the child is a mentally ill person may be filed in the same proceedings as the petition alleging the child to be a child in need of care, or may be brought in separate proceedings. In either event the court may enter an order staying any further proceedings under this code until all proceedings have been concluded under the ~~act for obtaining treatment for a mentally ill person~~ *treatment for mentally ill persons.*

Sec. 32. K.S.A. 1984 Supp. 38-1614 is hereby amended to read as follows: 38-1614. (a) *Physical care and treatment.* (1) When the health or condition of a juvenile who is subject to the jurisdiction of the court requires it, the court may consent to the performing and furnishing of hospital, medical, surgical or dental treatment or procedures including the release and inspection of medical or dental records.

(2) When the health or condition of a juvenile requires it and the juvenile has been placed in the custody of a person other than a parent or placed in or committed to a facility, the custodian or an agent designated by the custodian shall have authority to consent to the performance and furnishing of hospital, medical, surgical or dental treatment or procedures including the release and inspection of medical or dental records, subject to terms and conditions the court considers proper.

(3) Any health care provider, who in good faith renders hospital, medical, surgical or dental care or treatment to any juvenile after a consent has been obtained as authorized by this section, shall not be liable in any civil or criminal action for failure to obtain consent of a parent.

(4) Nothing in this section shall be construed to mean that any person shall be relieved of legal responsibility to provide care and support for a juvenile.

(b) *Mental care and treatment.* If it is brought to the court's attention, while the court is exercising jurisdiction over the person of a juvenile under this code, that the juvenile may be a mentally ill person as defined in K.S.A. 59-2902 and amendments thereto, the court may:

(1) Direct or authorize the county or district attorney or the person supplying the information to file the application provided for in K.S.A. 59-2913 and amendments thereto and proceed to hear and determine the issues raised by the application as provided in the ~~act for obtaining treatment for a mentally ill person~~ *treatment act for mentally ill persons*; or

(2) authorize that the juvenile seek voluntary admission to a treatment facility as provided in K.S.A. 59-2905 and amendments thereto.

The application to determine whether the juvenile is a mentally ill person may be filed in the same proceedings as the petition alleging the juvenile to be a juvenile offender or may be brought in separate proceedings. In either event, the court may enter an order staying any further proceedings under this code until all proceedings have been concluded under the ~~act for obtaining treatment for a mentally ill person~~ *treatment act for mentally ill persons.*

Sec. 33. K.S.A. 59-212 is hereby amended to read as follows: 59-212. The following shall be kept by the court for proceedings under chapter 59 of the Kansas Statutes Annotated:

(1) An appearance docket, in which shall be listed under the

name of the decedent, ward, conservatee, mentally ill person, or other person involved, all documents pertaining thereto and in the order filed, except that separate appearance dockets, not open to public inspection shall be kept for proceedings under the ~~act for obtaining treatment for a mentally ill person~~ *treatment act for mentally ill persons* and adoptions. Such list shall show the nature of the document, the date of the filing thereof, shall give a reference to the volume and page of any other book or reference to microfilm in which any record shall have been made of such document, and shall state the charge, if any, therefor.

(2) A suitable general index, in which files pertaining to estates of decedents shall be indexed under the name of the decedent, those pertaining to guardianships under the name of the ward, those pertaining to conservatorships under the name of the conservatee, those pertaining to mentally ill persons under the name of such person, those pertaining to adoption of children under both the name and adopted name of the child. After the name of each file shall be shown the file number, the appearance docket sheet, by case number, on which the documents pertaining to such file are listed, and the date of filing of the first document.

(3) A suitable index pertaining to wills deposited pursuant to K.S.A. 59-620 *and amendments thereto*, under the name of the testator.

(4) A suitable permanent duplicate copy, shall be kept by the district court of: (1) All wills admitted to probate; (2) all elections filed; (3) all letters of appointment issued; (4) all certificates of appointment filed; (5) all bonds filed; (6) all orders, judgments, and decrees, including inheritance tax orders; *and* (7) such other documents as the court may determine.

Sec. 34. K.S.A. 59-2212 is hereby amended to read as follows: 59-2212. Trials and hearings in probate proceedings shall be by the court unless otherwise provided by law. The determination of any issue of fact or controverted matter on the hearing of any probate proceedings shall be in accordance with the rules of evidence provided for civil cases by the code of civil procedure, except as provided in the ~~act entitled "act for obtaining~~

~~care or treatment for a mentally ill person"~~ ~~and in the act entitled "act~~ *treatment act for mentally ill persons and the act* for obtaining a guardian or conservator, or both."

Sec. 35. K.S.A. 59-3002 is hereby amended to read as follows: 59-3002. When used in the act for obtaining a guardian or conservator, or both:

(a) "Disabled person" means any adult person whose ability to receive and evaluate information effectively or to communicate decisions, or both, is impaired to such an extent that the person lacks the capacity to manage such person's financial resources or, *except for reason of indigency*, to meet essential requirements for such person's physical health or safety, or both. A person shall not be considered to be disabled or to lack capacity to meet the essential requirements for physical health or safety for the sole reason such person relies upon or is being furnished treatment by spiritual means through prayer in lieu of medical treatment in accordance with the tenets and practices of a recognized church or religious denomination of which such person is a member or adherent.

(b) "Manage financial resources" means those actions necessary to obtain, administer and dispose of real and personal property, intangible property, business property, benefits and income.

(c) "Meet essential requirements for physical health or safety" means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene and other care without which serious physical injury or illness is more likely than not to occur.

(d) "Guardian" means an individual or a nonprofit corporation certified in accordance with K.S.A. 59-3037 *and amendments thereto* which has been appointed by a court to act on behalf of a ward and possessed of some or all of the powers and duties set out in K.S.A. 59-3018 and amendments thereto. "Guardian" does not mean natural guardian unless specified.

(e) "Natural guardian" means both the father and mother of a legitimate minor or the mother of an illegitimate minor, provided that both such parents or parent shall not have been found to be a

disabled person or had their parental rights severed by a court of competent jurisdiction. If either parent of a legitimate minor dies, or has been found to be a disabled person or has had parental rights severed by a court of competent jurisdiction, the other shall be the "natural guardian."

(f) "Conservator" means an individual or a corporation appointed by the court to act on behalf of a conservatee and possessed of some or all of the powers and duties set out in K.S.A. 59-3019 and amendments thereto.

(g) "Minor" means any person defined by K.S.A. 38-101 and amendments thereto as being within the period of minority.

(h) "Proposed ward" means a person for whom a petition for the appointment of a guardian pursuant to K.S.A. 59-3006 and amendments thereto has been filed.

(i) "Proposed conservatee" means a person for whom a petition for the appointment of a conservator pursuant to K.S.A. 59-3006 and amendments thereto has been filed.

(j) "Ward" means a person who has a guardian.

(k) "Conservatee" means a person who has a conservator.

(l) The ~~various~~ terms defined in K.S.A. 59-2902 and amendments thereto ~~of the act entitled "act for obtaining care or treatment for a mentally ill person" mean the same herein as they do in that act~~ *have the meanings provided by that section.*

Sec. 36. K.S.A. 59-3018 is hereby amended to read as follows: 59-3018. (a) A guardian shall be subject to the control and direction of the court at all times and in all things. It is the general duty of an individual or corporation appointed to serve as a guardian to carry out diligently and in good faith the specific duties and powers assigned by the court. In carrying out these duties and powers, the guardian shall assure that personal, civil and human rights of the ward or minor whom the guardian services are protected.

(b) The guardian of a minor shall be entitled to the custody and control of the ward and shall provide for the ward's education, support and maintenance.

(c) A limited guardian shall have only such of the general duties and powers herein set out as shall be specifically set forth

in the dispositional order pursuant to K.S.A. 59-3013 and amendments thereto and as shall also be specifically set forth in "Letters of Limited Guardianship" pursuant to K.S.A. 59-3014 and amendments thereto.

(d) A guardian shall have all of the general duties and powers as set out herein and as also set out in the dispositional order and in the letters of guardianship.

(e) The general powers and duties of a guardian shall be to take charge of the person of the ward and to provide for the ward's care, treatment, habilitation, education, support and maintenance and to file an annual accounting. The powers and duties shall include, but not be limited to, the following:

(1) Assuring that the ward resides in the least restrictive setting reasonably available;

(2) assuring that the ward receives medical care or nonmedical remedial care and other services that are needed;

(3) promoting and protecting the care, comfort, safety, health and welfare of the ward;

(4) providing required consents on behalf of the ward;

(5) exercising all powers and discharging all duties necessary or proper to implement the provisions of this section.

(f) A guardian of a ward is not obligated by virtue of the guardian's appointment to use the guardian's own financial resources for the support of the ward.

(g) A guardian shall not have the power:

(1) To place a ward in a ~~facility or institution unless such treatment facility unless the 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~~ [facility or institution, other than a treatment facility, unless the placement of the ward has been approved by the court.

(2) To place a ward in a treatment facility unless authorized by the court] *pursuant to section 37.*

~~(2)~~ [(3)] To consent, on behalf of a ward, to psychosurgery, removal of a bodily organ, or amputation of a limb unless the procedure is first approved by order of the court or is necessary, in an emergency situation, to preserve the life or prevent serious impairment of the physical health of the ward.

~~(3)~~ [(4)] To consent on behalf of the ward to the withholding of life-saving medical procedures, except in accordance with provisions of K.S.A. 65-28,101 ~~to 65-28,109, inclusive~~ *through 65-28,109*, and amendments thereto.

~~(4)~~ [(5)] To consent on behalf of a ward to the performance of any experimental biomedical or behavioral procedure or to participation in any biomedical or behavioral experiment unless:

(A) It is intended to preserve the life or prevent serious impairment of the physical health of the ward; or

(B) it is intended to assist the ward to develop or regain that person's abilities and has been approved for that person by the court.

~~(5)~~ [(6)] To prohibit the marriage or divorce of a ward.

~~(6)~~ [(7)] To consent, on behalf of a ward, to the termination of the ward's parental rights.

~~(7)~~ [(8)] To consent, on behalf of a ward, to sterilization of the ward, unless the procedure is first approved by order of the court after a full due process hearing where the ward is represented by a guardian *ad litem*.

(h) The guardian shall at least annually file a report concerning the personal status of the ward as provided by K.S.A. 59-3029 and amendments thereto.

New Sec. 37. (a) A guardian may file with the court a verified petition to place the guardian's ward in a treatment facility. Upon the filing of such petition, the court shall issue the following:

(1) An order fixing the time and place of the hearing on the petition. The time designated in the order shall in no event be earlier than seven days or later than 14 days after the date of the filing of the petition.

(2) An order that the ward appear at the time and place of the hearing unless the court enters an order that the presence of the ward would be injurious to the ward's welfare. The court shall enter in the record of the proceedings the facts upon which the court has found that the presence of the ward at the hearing would be injurious to the ward's welfare. Notwithstanding the foregoing provisions of this subsection, if the ward or the ward's attorney files with the court a written request that the ward be present at the hearing, the ward's presence cannot be waived.

(3) An order appointing an attorney to represent the ward at all stages of the proceedings. The court shall give preference, in the appointment of the attorney, to any attorney who has represented the ward in other matters if the court has knowledge of the prior relationship. The ward shall have the right to choose and to engage an attorney and, in that event, the attorney appointed by the court shall be relieved of all duties by the court.

(4) An order that the ward appear at the time and place that is in the best interest of the ward to consult with the court appointed attorney, which time shall be prior to the hearing on the petition.

(5) Notice in the manner provided by subsections (a)(1)(A) through (C), (a)(2) and (b) of K.S.A. 59-3012 and amendments thereto.

(b) At or after the filing of a petition pursuant to this section, the court may issue the following:

(1) An order for mental evaluation in the manner provided by subsection (a)(6) of K.S.A. 59-3012 and amendments thereto.

(2) An order of continuance, for good cause shown, upon request of the petitioner, the ward or the ward's attorney.

(3) An order advancing the date of the hearing to as early a date as is practicable upon request of the ward or the ward's attorney.

(c) The hearing on a petition filed pursuant to this section shall be held at the time and place specified in the court's order unless an advancement or continuance has been granted. The

hearing shall be to the court only. The petitioner and the ward shall be afforded an opportunity to appear at the hearing, to testify and to present and crossexamine witnesses. All persons not necessary for the conduct of the hearing may be excluded. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the ward. The court shall receive all relevant and material evidence which may be offered, including the testimony or written findings and recommendations of the treatment facility, hospital, clinic, physician or psychologist who has examined or evaluated the ward. Such evidence shall not be privileged for the purpose of this hearing.

If, upon the completion of the hearing, the court finds by clear and convincing evidence that the ward is in need of mental treatment and that commitment to a treatment facility would be in the best interest of the ward, the court may enter an order authorizing the guardian to commit the ward to a treatment facility. The order of the court shall be for a period of time to be determined by the court but not exceeding three years.

(d) Except as otherwise provided by law, a ward may voluntarily consent to the ward's admission to a treatment facility 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.

(e) This section shall be part of and supplemental to the act for obtaining a guardian or conservator, or both.

Sec. 38. K.S.A. 75-5209 is hereby amended to read as follows: 75-5209. The secretary of corrections may arrange for the transfer of an inmate for observation and diagnosis or treatment to other appropriate state institutions with the prior consent of the administrators of the agencies. The administrator of such institution shall accept the transfer of such inmate unless such administrator shows that no facilities are available for the accommodation of such inmate and shall have access to any Kansas reception and diagnostic center case study, diagnosis or report relating to an inmate transferred to such institution. While the inmate is in another institution ~~his or her~~ *the inmate's* sentence

shall continue to run. When, in the judgment of the administrator of the institution to which an inmate has been transferred, ~~he or she~~ *the inmate* has recovered from the condition which occasioned the transfer, the administrator shall provide for ~~his or her~~ *the inmate's* return to the secretary, unless ~~his or her~~ *the inmate's* sentence has expired.

The costs of transfer as well as the transportation of the inmate to the appropriate state institution shall be borne by the correctional institution from which such inmate is transferred. No inmate shall receive ~~care or~~ treatment at the state security hospital after expiration of ~~his or her~~ *the inmate's* sentence: ~~*Provided, however,* That~~. If the inmate shall be in need of continued ~~care and~~ treatment for mental illness at the expiration of ~~his or her~~ *the inmate's* term of confinement, ~~then~~ an application to obtain such ~~care or~~ treatment for ~~said person~~ *the inmate* shall be filed ~~in conformance with the provisions of the act for obtaining care or treatment of a mentally ill person~~ *pursuant to the treatment act for mentally ill persons*.

Any inmate transferred to the state security hospital pursuant to this section may correspond freely, without censorship, with any person, except that any such incoming correspondence or parcels may be opened and examined for the purpose of intercepting any items which the superintendent of such institution has declared to be contraband.

Sec. 39. K.S.A. 77-201 is hereby amended to read as follows: 77-201. In the construction of the statutes of this state the following rules shall be observed, unless the construction would be inconsistent with the manifest intent of the legislature or repugnant to the context of the statute:

First. The repeal of a statute does not revive a statute previously repealed, nor does the repeal affect any right which accrued, any duty imposed, any penalty incurred or any proceeding commenced, under or by virtue of the statute repealed. The provisions of any statute, so far as they are the same as those of any prior statute, shall be construed as a continuation of the prior provisions and not as a new enactment.

Second. Words and phrases shall be construed according to the

context and the approved usage of the language, but technical words and phrases, and other words and phrases that have acquired a peculiar and appropriate meaning in law, shall be construed according to their peculiar and appropriate meanings.

Third. Words importing the singular number only may be extended to several persons or things, and words importing the plural number only may be applied to one person or thing. Words importing the masculine gender only may be extended to females.

Fourth. Words giving a joint authority to three or more public officers or other persons shall be construed as given that authority to a majority of them, unless it is otherwise expressed in the act giving the authority.

Fifth. "Highway" and "road" include public bridges and may be construed to be equivalent to "county way," "county road," "common road," "state road" and "territorial road."

Sixth. "Incompetent person" includes disabled person as that term is defined in K.S.A. 59-3002 and amendments thereto.

Seventh. "Issue," as applied to the descent of estates, includes all the lawful lineal descendants of the ancestor.

Eighth. "Land," "real estate" and "real property" include lands, tenements and hereditaments, and all rights thereto and interest therein, equitable as well as legal.

Ninth. "Personal property" includes money, goods, chattels, evidences of debt and things in action.

Tenth. "Property" includes personal and real property.

Eleventh. "Month" means a calendar month, unless otherwise expressed. "Year" alone, and also the abbreviation "A.D.," is equivalent to the expression "year of our Lord."

Twelfth. "Oath" includes an affirmation in all cases where an affirmation may be substituted for an oath and in similar cases "swear" includes affirm.

Thirteenth. "Person" may be extended to bodies politic and corporate.

Fourteenth. If the seal of a court or public office or officer is required by law to be affixed to any paper, "seal" includes an impression of the seal upon the paper alone, as well as upon wax

or a wafer affixed to the paper. "Seal" also includes both a rubber stamp seal used with permanent ink and the word "seal" printed on court documents produced by computer systems, so that the seal may be legibly reproduced by photographic process.

Fifteenth. "State," when applied to the different parts of the United States, includes the District of Columbia and the territories. "United States" may include that district and those territories.

Sixteenth. "Town" may mean a civil township, unless a different meaning is plainly intended.

Seventeenth. "Will" includes codicils.

Eighteenth. "Written" and "in writing" may include printing, engraving, lithography and any other mode of representing words and letters, excepting those cases where the written signature or the mark of any person is required by law.

Nineteenth. "Sheriff" may be extended to any person performing the duties of the sheriff, either generally or in special cases.

Twentieth. "Deed" is applied to an instrument conveying lands but does not imply a sealed instrument. "Bond" and "indenture" do not necessarily imply a seal but in other respects mean the same kind of instruments as above. "Undertaking" means a promise or security in any form where required by law.

Twenty-first. "Executor" includes an administrator where the subject-matter applies to an administrator.

Twenty-second. Roman numerals and Arabic figures are to be taken as a part of the English language.

Twenty-third. "Residence" means the place which is adopted by a person as the person's place of habitation and to which, whenever the person is absent, the person has the intention of returning. When a person eats at one place and sleeps at another, the place where the person sleeps shall be deemed the person's residence.

Twenty-fourth. "Usual place of residence" and "usual place of abode," when applied to the service of any process or notice, means the place usually occupied by a person. If a person has no family, or does not have family with the person, the person's

office or place of business or, if the person has no place of business, the room or place where the person usually sleeps shall be construed to be the person's place of residence or abode.

Twenty-fifth. "Householder" means a person who is 18 or more years of age and who owns or occupies a house as a place of residence and not as a boarder or lodger.

Twenty-sixth. "General election" refers to the election required to be held on the Tuesday following the first Monday in November of each even-numbered year.

Twenty-seventh. "Under legal disability" includes persons who are within the period of minority, incapacitated or imprisoned.

Twenty-eighth. When a person is required to be disinterested or indifferent in acting on any question or matter affecting other parties, relationship within the degree of second cousin, inclusive, shall disqualify the person from acting, except by consent of parties.

Twenty-ninth. "Head of a family" shall include any person who has charge of children, relatives or others living with the person.

Thirtieth. "Mentally ill person" means ~~any person who is mentally impaired to the extent that the person is in need of treatment and who is dangerous to self or others and:~~

~~(a) Who lacks sufficient understanding or capacity to make responsible decisions with respect to the person's need for treatment; or~~

~~(b) who refuses to seek treatment. Proof of a person's failure to meet the person's basic physical needs, to the extent that the failure threatens the person's life, shall be considered proof that the person is dangerous to self, 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 court finds that the person is dangerous to self or others~~ *a mentally ill person as defined in K.S.A. 59-2902 and amendments thereto.*

Thirty-first. "Incapacitated person" means disabled person as

~~that term is~~ defined in K.S.A. 59-3002 and amendments thereto.

Thirty-second. "Guardian" means an individual or a nonprofit corporation certified in accordance with K.S.A. 59-3037 which has been appointed by a court to act on behalf of a ward and possessed of some or all of the powers and duties set out in K.S.A. 59-3018 and amendments thereto. "Guardian" does not mean natural guardian unless specified.

Thirty-third. "Natural guardian" means both the father and mother of a legitimate minor or the mother of an illegitimate minor, unless both such parents or parent have been found to be a disabled person or have had their parental rights severed by a court of competent jurisdiction. If either parent of a legitimate minor dies, is found to be a disabled person or has had parental rights severed by a court of competent jurisdiction, the other shall be the natural guardian.

Thirty-fourth. "Conservator" means an individual or corporation appointed by the court to act on behalf of a conservatee and possessed of some or all of the powers and duties set out in K.S.A. 59-3019 and amendments thereto.

Thirty-fifth. "Minor" means any person defined by K.S.A. 38-101 and amendments thereto as being within the period of minority.

Thirty-sixth. "Proposed ward" means a person for whom an application for the appointment of a guardian pursuant to K.S.A. 59-3006 and amendments thereto has been filed.

Thirty-seventh. "Proposed conservatee" means a person for whom a petition for the appointment of a conservator pursuant to K.S.A. 59-3006 and amendments thereto has been filed.

Thirty-eighth. "Ward" means a person who has a guardian.

Thirty-ninth. "Conservatee" means a person who has a conservator.

Sec. 40. K.S.A. 59-212, 59-2212, 59-2901, 59-2902, 59-2904, 59-2906 through 59-2912, 59-2914, 59-2914a, 59-2915, 59-2916, 59-2916a, 59-2917, 59-2917a, 59-2918, 59-2919, 59-2921, 59-2922, 59-2923, 59-2924, 59-2926, 59-2928, 59-2929, 59-2931, 59-2940, 59-2942, 59-3002, 59-3018, 75-5209 and 77-201 and K.S.A. 1984 Supp. 22-3428, 22-3428a, 28-170, 38-1513 and 38-1614 are

hereby repealed.

Sec. 41. This act shall take effect and be in force from and after its publication in the statute book.

TESTIMONY OF LARRY R. RUTE BEFORE SENATE JUDICIARY COMMITTEE
January 31, 1986

My name is Larry R. Rute. I serve as legal counsel in the matter of Powell et al. vs. Harder et al., which is a class action which my office represents of which there is approximate 538 unfortunate individuals that have been placed in state institutions for the mentally ill and mentally retarded.

This case was filed on August 16, 1978, with the filing a complaint in this Court by the plaintiffs. The complaint challenges 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 the Kansas Department of Social and Rehabilitation Services on a different basis than for other adult persons who do not choose to seek admission to such facilities. Plaintiffs allege that these statutes do not afford them a complete and meaningful opportunity to be heard with respect to either their admission to or discharge from such treatment facilities, judicial consideration of reasonable alternatives to in-patient hospitalization, or periodic judicial review of the continued need for in-patient treatment at such facilities. 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. The plaintiffs seek declaratory and injunctive relief enjoining the defendants from admitting members of the plain-

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tiff class to, and detaining them in, a treatment facility on terms and under procedures different from those applicable to all other adults who do not seek admission and are admitted and detained as emergency or involuntary patients, pursuant to K.S.A. 59-2902, 59-2917, and 59-2917a.

The Department of Social and Rehabilitation Services (SRS) has answered and denied the allegations of the plaintiffs' complaint. In addition, they have filed a motion to dismiss the complaint on numerous grounds. This motion was denied by the Court on December 15, 1978.

On December 13, 1978, the Court ordered that this action should be maintained as a class action pursuant to the provisions of Rule 23(1) and 23(b)(2) of the Federal Rules of Civil Procedure, and that notice of this action should be sent to the class. The class consists of all persons eighteen (18) years of age or older who have been found to be legally incapacitated and for whom a guardian has been appointed, and all those who will become wards in the future, who have either been admitted to a public treatment facility as "voluntary" patients pursuant to K.S.A. § 59-2905, or for whom admission will be sought in the future. The term "public treatment facility" encompasses the following institutions: Topeka State Hospital, Osawatomie State Hos-

SRS acknowledges that, pursuant to this statute, a ward with a primary diagnosis of mental illness may not be placed in a state treatment facility except through the involuntary commitment procedure of K.S.A. 59-2901 et seq., unless the ward has been found by the court in the guardianship proceeding to be able and permitted to make deci-

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sions with respect to his or her need for treatment at such a facility, in which case the ward may voluntarily consent to admission.Consequently, it is the stated policy of SRS to admit adult wards to state institutions for the mentally ill only upon an order for treatment issued by the court pursuant to the provisions of K.S.A. 59-2917, unless the ward retains the capacity to seek voluntary admission. For those patients admitted to treatment facilities pursuant to court order, it is further the stated policy of the defendants to submit periodic summaries of the ward's medical records to the court pursuant to the provisions of K.S.A. 59-2917a. SRS has assured the plaintiffs that there are no adult wards in state treatment facilities for the mentally ill who have not been admitted in accordance with the above criteria, unless they were admitted by their guardians prior to July 1, 1983, and have been continuously placed since that date. There are currently 29 such patients.

In 1984, the Kansas Legislature passed House Bill 2697, which became law on July 1, 1984, and which is codified at K.S.A. 76-12b01 et seq. This Act establishes criteria and procedures for the admission to and discharge from state institutions for the mentally retarded of mentally-retarded persons. SRS maintains that this Act makes clear that mentally-retarded wards are not placed in treatment facilities under the Act for Obtaining Treatment for a Mentally Ill Person, and that a guardian may have the power to seek placement of a mentally-retarded ward in a state institution for the mentally retarded without a hearing if the court has given its approval pursuant to K.S.A. 59-3018(g)(1). They further maintain that the provisions of

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K.S.A. 76-12b05 with respect to periodic review of persons in state institutions for the mentally retarded are applicable to wards so placed.

The plaintiffs contend that the Act for Obtaining Treatment for a Mentally Ill Person, K.S.A. 59-2901 et seq., covers both mentally retarded and mentally-ill persons, and that no adult ward, whether diagnosed as mentally ill or mentally retarded, may be placed by a guardian in a state treatment facility except through the involuntary commitment procedure of that Act, unless the ward is competent to make the decision personally. The plaintiffs further contend that, if the Kansas law does in fact establish different standards for the placement of adult wards by their guardians in state institutions for the mentally retarded than in state institutions for the mentally ill, this law violates the Equal Protection Provisions of the Kansas Constitution and the Fourteenth Amendment to the United States Constitution.

Neither party to this action concedes the validity of the claims made by the other. However, in order to resolve the controversy chief counsel for SRS, Mr. Peter Rinn, and myself submitted to the Kansas Supreme Court a proposed court rule (attached) that would have substantially settled this litigation. The Chief Justice of the Kansas Supreme Court later responded to our request by indicating that the Court felt such a rule would serve as legislative action and for reason declined to issue the rule.

I would like to propose to this Committee several changes that I would recommend be added to Substitute for HB 2050 as amended by HCW.

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Such changes would, in my view, resolve all issues in the current litigation and, at the same time, relieve SRS institutional staff of the costly discovery necessary to conclude this litigation. The proposed changes are as follows:

1. Lines 0426 - 0427 (2) To place a ward in a treatment facility, including a facility for the mentally retarded, unless authorized by the court] pursuant to section 37.

2. Lines 0509 - 0515 If, upon the completion of the hearing, the court finds by clear and convincing evidence that the criteria set out in either K.S.A. 59-2902a or K.S.A. 76-12b03 are met, and after a careful consideration of reasonable alternatives to placement treatment, the court may enter an order authorizing the guardian to admit the ward to an appropriate treatment facility. The order of the court shall be subject to periodic review in the manner set out in K.S.A. 59-2917a and K.S.A. 59-2923.

Section 36 of the bill amends the provisions of 59-3018(g)(1) governing the placement of a ward in a treatment facility by his or her guardian. Basically, the statute currently provides that a commitment hearing must be held in accordance with the provisions of K.S.A. 59-2917 before a ward can be admitted to a treatment facility, unless the ward has been found by the court to be capable of making such treatment decisions for himself or herself. Section 36 would no longer require a hearing pursuant to K.S.A. 59-2917 before a ward could be placed in a treatment facility. Instead, it would require that a hearing in accordance with Section 37 of the bill be held.

It is not clear from the language of Section 36 whether this provision for a hearing prior to admission to a treatment facility applies to the admission of mentally retarded wards to facilities for the mentally retarded. I would recommend that the language of that section be amended to make clear that it does so apply. The reasons

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granting a hearing for the mentally retarded are every bit as compelling, if not more so, as the reasons for granting a hearing for the mentally ill. Certainly the loss of liberty which is at stake for the mentally retarded is as great, if not greater, as that for the mentally ill. The mentally retarded, once institutionalized, spend a much longer time in the institution than do the mentally ill. They are at a greater risk of infection and physical injury. And as the Legislature is well aware from the events surrounding the investigations of the state institutions for the mentally retarded last year, until very recntly the mentally retarded could not even expect to receive any active treatment while institutionalized, and only a huge infusion of state funds has made minimal active treatment a possibility for the mentally retarded. Certainly judicial scrutiny of a request to place a ward in an institution for the mentally retarded is appropriate, given what is at stake.

Section 37 sets out in detail the hearing procedures which must be followed upon the filing of a petition by a guardian to place a ward in a treatment facility. I believe these procedures are adequate and have no objection to them. The problems with Section 37 begin after the hearing is over. First, it authorizes the court to enter an orderauthorizing a guardian to commit a ward to a treatment facility if the court finds the ward to be in need of mental treatment and commitment to be in the best interest of the ward. However, it provides no standards whatever for determining whether the ward is in need of mental treatment. In my opinion, this is inadequate to protect the vital interests of the ward at issue. Kansas law has clearly defined

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standards both for the commitment of mentally ill persons to a treatment facility (K.S.A. 59-2902(a)) and for the admission of mentally retarded persons to a state institution (K.S.A. 76-12b03), and I believe these standards should be incorporated by reference into Section 37. The current lack of standards undercuts to a large degree the value of the hearing procedures designed to protect the wards' interests.

The second problem with Section 37 is that it permits the court's order authorizing the guardian to commit the ward to be good for up to three (3) years, and it provides no opportunity for periodic review. Again, this is not in the best interests of the wards, and I would recommend that the periodic review provisisions of K.S.A. 59-2917a and K.S.A. 59-2923 be incorporated by reference into this section. Given the massive deprivation of liberty which is at issue in commitment to a treatment facility, a review only once every three years is clearly inadequate.

I very much appreciate Senator Frey's request that I testify today with respect to this matter. Thank you for the Committee's consideration.

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1-31-86

Statement to the Senate Judiciary Committee
Senator Robert Frey, Chairman

Presented on behalf of the Association of Community Mental Health Centers of Kansas by John G. Randolph, Ph.D.

Mr. Chairman and Members of the Committee:

The Association of Community Mental Health Centers of Kansas philosophically agrees with the major thrust of the Substitute for House Bill 2050. The bill corrects an excessive swing of the pendulum which had created undue barriers to treatment of seriously mentally ill persons who, because of their illness, are unable to make reasonable decisions about their treatment. Since we are among a range of providers of treatment services, we could understandably be viewed as pursuing vested interests (though a great many persons committed to involuntary treatment have little or no financial means). Nonetheless, we believe that the bill provides improved opportunities for access to treatment, and treatment through the least restrictive appropriate alternatives.

This proposed legislation is consistent with the Kansas Long-Range Mental Health Plan, with its focus on maximum coordination of effort between state hospitals and community mental health centers.

We do have concerns about the increased responsibilities and liabilities Centers will experience should this bill pass, and we understand that these issues are being addressed in other legislation.

Thank you for the opportunity to present our views.

S. Judiciary
1/31/86
A-VI

1-31-86

To: Chairman and Committee Members of Senate Judiciary Committee

Re: HB 2050

Dear Chairman & Members of the Senate Judiciary Committee:

CRITIQUE OF H.B. 2050

The fundamental problem with the House Bill 2050 is the dramatic and retrogressive shift from an objective standard under the current law, which requires a dual finding of fact by the trier of fact of, first, medical determination of mental illness; and second, an objective factual standard of danger to self or others, to a subjective tests that requires a trier of fact to find only that a person suffering from a mental illness, "is likely to cause harm to others." This proposed standard must be merely evidenced by "behavior causing, attempting or threatening harm to others, and that the person is likely, in the foreseeable future, to cause physical injury ..."

It is dangerous to the personal liberties of the citizens of the State of Kansas to have such a subjective standard employed in mental illness cases. This standard is so vague as to be constitutionally violative. How is a trier of fact, judge or jury, to evaluate a proposed patient;'s behavior with the proposed standard of "likely to cause harm"? Or is the implication that the legislation is surely asserting that if one is suffering from a mental illness, then ipso facto the person is "likely to cause harm". It is my genuine concern that such a

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standard would turn backward the sensitivity with which this state now tires to treat their citizens who suffer from mental illness to a circumstance in which the mere filing of a petition for involuntary treatment would result in the indefinite involvement of the state in the personal and emotional affairs fo the proposed patient. How under this act is a judge or a jury, once advised by a psychiatrist or psychologist that a person is suffering from a mental illness, to evaluate in the language of H.B. 2050 that a person is "likely to do harm, in the reasonably foreseeable future"? Does the trier of fact consider "reasonably forseeable future" to be in the next week, next month, next three months, or next six months? How far in the future does the trier of fact speculate? How far in the future should the state speculate? Of further concern is the test established for release from the seemingly never-ending jurisdiction of the committing court. That test would be that a person is no longer likely to cause harm in the reasonably forseeable future. The reality is that the treatment facility or the court is going to have to guess, speculate or just imagine what is going to happen in the future. The futility as well as the inherent danger of such subjectivity must be apparent. No judge, no jury, is capable of applying such a standard without erring as often as they are correct. The reality is that with such a standard the rule will be to error on the side of involuntarily committing persons who do not need involuntary treatment, rather than risk allowing a person the rights, the opportunity and the fundamental privilege of a citizen on this state to decide for himself

whether he or she should receive psychiatric care.

The next radical concept in this bill is found at Section 2(a) "Conditional Release" which provides for outpatient court ordered treatment. This concept is expanded in new Section 17(a) which provides for a court ordered "outpatient treatment" regimen. This notion is novel and I am certain well-meaning, but it likewise sets the stage for an incredible intrusion into the right of an individual to decide whether or not to seek treatment. Is the State of Kansas really prepared to interpose the judgment of the individual with a court ordered mandate that they submit involuntarily to treatment? This bill provides that should the individual refuse or "deteriorate" or not "follow all directives and treatment modalities", he <u>will</u> be returned to inpatient hospitalization. This notion is mind boggling in its pervasive implications. Not the least of which is the potential of a "mental health police force" required to monitor compliance with this court ordered outpatient treatment programs. The "Gestaposesque" visions are reinforced when new section 17(d) is examined. This provision allows for the issuance of an "ex parte" order from a court for an order of protective custody for immediate admission to an inpatient facility. With the legal euphemisms removed, the reality is the person will be arrested without notice, by law enforcement officers and thrown in the "mental health jail." This jeopardy to personal liberty cannot be tolerated, regardless of the purity of motive.

This bill seeks to create a new procedural process in which, contrary to the existing statutory rules of evidence, hearsay would be admissible. This is incomprehensible. There is no rational or reasonable justification for altering the rules of evidence in mental illness cases. The question that needs to be asked is "why"? What justification can be offered as to why evidence inadmissible in a civil case; on a contract, for personal injury, for damages can be offered in a mental illness case? Why can evidence inadmissible in a criminal case be offered in an involuntary committment case? Is a person involuntarily committed for psychiatric treatment any less deprived of his liberty than a person who commits and is convicted of a crime? Why then should the rules of evidence be relaxed? Does it not make greater sense to make more stringent the evidentiary standards then one's fundamental right to liberty is at stake?

This legislation is dangerously eroding the individual's right to privacy and reasonable expectation of confidentiality surrounding their treatment for mental disorders. Section 10, K.S.A. 59-2914(6) provides for "an order of investigation." The proposed amendment would require an investigation which "shall inquire into the proposed patient's character, family relationships and past conduct..." The question again occurs, "why?" Why would you give any court authority the right to investigate a person's character, family or past conduct? Once again, the implications for potential abuse of such a process must be apparent. This amendment fails to state the necessity or

purpose for such an investigation. It fails to state how such an investigation will be sued. Of profound concern is the lack of any mandate for confidentiality of such an investigation. It is obvious that such an investigation into so personal an area of human affairs, that maintaining an confidentiality would be impossible. Such a report only compounds the problems created in allowing the court to accept hearsay. These reports will without question contain a potpouri of conjecture, bias and prejudices which can not be cross-examined by the patient's counsel because they appear only in their whispers and innuendo contained in a report.

My real frustration with this proposal is the failure to recognize the effectiveness of the existing laws in this area. Not only the current statues concerning involuntary hospitalization, but the guardianship statues. The effect of adopting HB 2050 is to over react to a problem which can be remedied by a refinement of existing law without the need for such a radical departure from the status quo. The refinement process should focus on the segregation between a medical determination and a factual one. The medical professionals should be allowed to use their medical jargon and terminology and the legislature should clarify its goals in the role of the state in providing mental health treatment for the "mentally disabled".

It is not necessary to destroy the objective tests of "dangerousness to self or others". It is only necessary to clarify how the state truly desires to deal with the needs of the mentally disabled and at the same time balance the need for

protection of the citizens of this state. These are goals which can be accomplished with a minimal modification of the existing law. It is not necessary to treat all mentally disabled persons as though they represented threats to our society. It is necessary to clarify and specify what the state's expectations are and how those expectations can be accomplished with the least impairment on the liberty of its citizens. However, there clearly are times in which the state's interest is paramount to the interest of the individual. Fundamentally, if the person represents an immediate and present danger to self or others; his or her liberty should be, in the interst of the society, restrained for involuntary hospitalization, but only until that crisis passes. Next, the other consideration is if a person suffering from a mental disability commits a crime. In that circumstance, the person's liberty should be impaired, again until such a time as the community can be assured that person's disability will not result in further violation of the law. But these circumstances represent the extremes of persons who are mentally disabled. The vast majority of the mentally disabled are neither dangerous not committing crimes. These persons should not have their liberty impaired as those in extreme circumstances.

There is an additional area which should be commented upon in this critique. Section 20 KSA 59-2924(a)(b) which gives the authority to the Secretary of SRS to "transfer any involuntary patient from any state psychiatric hospital to any state institution for the mentally retarded whenever the

secretary considers it in the best interest of the patient." This provision completely lacks procedural due process of law. It does not provide for an opportunity for the patient to be heard on the question of the transfer. It does not provide for judicial review of the appropriateness, necessity of, accuracy of the secretary's evaluation of best interest. It seems fundamentally fair to give even an involuntarily committed person an opportunity for judicial review of a move from one institution to another and allow a court to determine whether such a move is in the best interests of the patient. The drafters of this statute claim that due process is provided by giving the Court 14 days notice, but two elements of due process are missing; first notice to the patient and second a opportunity to be heard on the proposed transfer. The addition of these to elements would allow for judicial review that such transfer is in fact in the best interest of the patient.

SPECIFIC RECOMMENDATIONS TO SENATE JUDICIARY COMMITTEE

As mentioned in my critique of H.B. 2050, I believe the remedy here is one of refinement, not a radical change in focus. In that regard, I would submit for your consideration the following analysis. I would recommend that this matter be referred for interim legislative study and/or referral to judicial council. However, an outline for such modifications is hereby submitted. A "Preamble" to the mental health act should be drafted, setting the tone and purpose. I have prepared the

following:

PREAMBLE

This Act is intended to acknowledge that from time to time and in certain circumstances citizens of this state shall become "mentally disabled". This Act is an attempt to afford such persons humane, appropriate and effective treatment for such conditions. This Act assumes that all treatment carried out pursuant to this Act shall be in the best interests of the patient and only when medically necessary, not for punitive motivations.

I believe that the Committee should refer this Bill to interim study. It has significant constitutional defects, in its present form specifically in the definition reduction from the standard of dangerousness and the proposal of New Section 18 which would provide for court committed out-patient treatment. I would direct the Committee's attention to Colyar v. Third Judicial Dist. Court, etc., 469 Federal Supplement 424 (1979). This case outlines the specific constitutional defects discussed which I believe would render H.B. 2050 unconstitutional if adopted in its current form.

I would also like to recommend that the Committee review a law journal from the University of North Carolina Law Review, entitled "Involuntary Civil Committment: The Dangerousness Standard and Its Problems," 63 North Carolina Law Review 243 (1984) While I do not agree with all of its conclusions, it does recommend a compromise on this issue which the Committee may

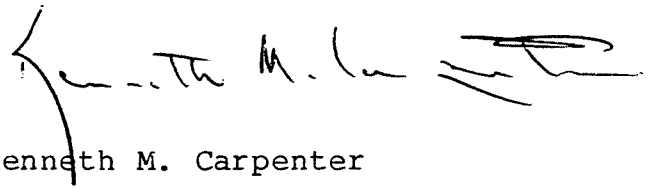
want to consider. Specifically, that if the standard is reduced from dangerousness to one requiring evidence of "substantial risk of harm" to self or others, then this broad evidentiary standard should be counterbalanced by a "beyond a reasonable doubt standard of proof" that impresses upon the trier of fact that seriousness of the decision they must make. While I am not entirely satisfied that this could stand constitution muster, it would certainly be preferable to the current status of H.B. 2050. In the final analysis a civil committment involves a significant and profound curtailment of an individual's liberty. When such an action is undertaken by the state, it should do so with caution and adequate safeguard from abuse, misuse or well-meaning interference with the right of the individual to make and carry out what is, perhaps, on of the most important decisions of his life.

I would like to recommend that the Committee include in H.B. 2050, if it is to be adopted, specific statutory guidelines to the triers of fact as to those things which they should take into consideration in finding a person in need fo involuntary treatment. Those considerations should be, but not limited to, the following: Recent over act or acts; ability without treatment to control behavior; exercise independent judgment; make decisions concerning need and type of treatment; harm done to self or others; serious physical deteriorations; serious mental deterioration; grossly irrational behavior; history of combative or self-destructive behavior; ability to understand consequences of behavior toward self or others; within recent

past significant harm inflicted or threatened actions in such a manner to create the risk of substantial or serious bodily harm to self or others; the probability that such acts or conduct will be repeated.

I hope these comments have been helpful to you in your deliberations in this matter.

Respectfully Submitted,



Kenneth M. Carpenter

Attorney at Law

VII

1-31-86

Presentation re: HB 2050

before the

Senate Judiciary Committee

Robert Frey, Chairman

by

Louis L. Frydman, Ph.D.

January 31, 1986

S. Judiciary
1/31/86
A-VIII

Mr. Chairman, Members of the Judiciary Committee,

Thank you for allowing me to appear before you.

My name is Louis Frydman. I have been on the faculty of Schools of Social Work for over twenty years and am a licensed specialist in clinical social work. I have conducted research on psychiatric hospitalization and psychiatric legislation in the United States and Europe. I was instrumental, as a member of the Advocates for Freedom in Mental Health, in the drafting of the 1976 legislative amendment, known as the Kansas Mental Patients' Rights Act. In appearing before you today I am representing no one but myself.

It would take too long and it wouldn't be very productive for me to discuss the various provisions of HB 2050. I am not here to critique this Bill. I am here to try to bury it. It's beyond salvation.

I regard HB 2050, stripped of its mystifications and illusions, as an all-out power-grab attempt by SRS institutional managers who yearn for the good old pre-1976 days when they enjoyed unbridled control, lavish funding, and virtually no need to account to anyone. After apparently failing to find any mental patients, or ex-patients, who could be persuaded to sing praises for a bill such as HB 2050, these administrators have latched on to a group of relatives of mental patients and somehow succeeded in convincing them that the only hope for their loved ones lies in stripping them of all their rights and dignity and in handing them over to the SRS institutional keepers who have a strong track record of patient abuse, overmedication (drugging?), and oppressive control, and no record, whatsoever, of helping patients.

I was saddened yesterday to hear a deeply distraught father tell this Committee about his daughter's two-year long hospitalization at the Menninger Foundation, about her subsequent transfer to Topeka State Hospital once her insurance coverage had run out, and about seeing her repeatedly discharged and re-admitted to this facility over a five year period till she was no longer willing to return and there were no sufficient grounds under the current Kansas law to commit her. I was stunned to hear him implore this Committee to pass HB 2050 so that his daughter could have a chance to be restored to normal and productive life. If seven years of voluntary treatment, including two years of continuous very expensive treatment at the Foundation, has done her no good, how could anyone expect that indeterminate forced confinement in a state mental hospital, coercive control of her mind and her body, and forced administration of dangerous drugs has any chance of restoring her to normal and productive living? If this is not a delusion, I don't know what is.

It is strange that if a mental patient resists involuntary commitment because he is certain that he will be deprived of his freedom and dignity without having any reason to expect to be helped to feel better, he is seen as irrational. But when an SRS Secretary is pushing for passage of a legislative amendment

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hat is expected by the Office of the Judicial Administrator to result in over 2,000 additional commitments which will cost the State over a half a million dollars for judicial expenses alone, with no evidence whatsoever that such forced treatment will be effective, he is seen as a capable planner.

But this is not all the Secretary is seeking for his institutional empire. He is also asking for over 250 new staff positions for our state mental retardation institutions and psychiatric hospitals, costing the state tax-payers a total of well over four million dollars. As the quid pro quo for these massive new expenditures the Secretary is offering truly devastating cutbacks in assistance programs for the very needy, such as 25% reduction of all Aid to Dependent Children grants, limiting dental care to simple extractions, eliminating virtually all prescription drugs from reimbursement, and totally terminating all psychological, optometric, audiological and chiropractic coverage for adults. Is this a rational trade-off?

To pressure the Legislature into meeting his funding demands, the Secretary is raising the specter of adverse actions by the Joint Commission on the Accreditation of Hospitals. Certainly, our state mental retardation and psychiatric institutions are in danger of losing their accreditation. But, at least as far as the state mental hospitals are concerned, the Joint Commission is much more concerned about the poor quality and effectiveness of the treatment programs than about supposed staff shortages. I am enclosing the summaries of findings for the last two accreditation surveys of Topeka State Hospital, the most highly staffed, the most costly, and, from all indications, the least effective and most repressive of our four state mental hospitals. No mention is made in these reports of any staff shortages while much mention is made of deficient staff practices. It's quality, not quantity, that counts.

It should thus come as no surprise that none of our state mental hospitals has ever even made a serious effort to study treatment effectiveness or even patient satisfaction. The Secretary has done evrything in his power to shield his staff and his programs from public and legislative scrutiny. He has successfully warded off all attempts to institute an Ombudsman or a patients' advocacy program in any of the institutions under his control. His one-year and five-year plans for program improvement are essentially public relations gimmicks, old wine in new bottles.

I am calling upon the Kansas Legislature to demand accountability from SRS institutions before even considering their requests for additional funding, certainly before considering their requests for additional power. Kansas psychiatrists, as well as the other mental health professionals, should make money the old-fashioned way - they should earn it.

HB 2050 is a needless adventure with awesome potential for harming mental patients and impairing our democratic way of life. The Bill raises the specter of totalitarianism that has no place in our society. I have looked at the current Soviet Mental Health Act. Its similarity to HB 2050 is too close for comfort. It frankly scares me.

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I am enclosing copies of several articles published in a recent issue of "Hospital and Community Psychiatry", a publication of the American Psychiatric Association. Please take a close look at them. And please don't let HB 2050 see the light of day in the Senate Chamber.

Thank you.

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TOPEKA STATE HOSPITAL
TOPEKA, KANSAS

DATES OF SURVEY
March 28 - 31, 1983

SURVEYORS
A. Brooks Cagle, ACSW
Harold Domres, M.D.
John Harden, MHA

ACCREDITATION DECISION:

Your hospital's adult and child/adolescent psychiatric programs have received a three-year accreditation contingent upon compliance with recommendations in this report preceded by the symbol (C) and summarized below:

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

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

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

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

5. Discharge summaries are frequently delinquent.

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

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

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

9. Vocational rehabilitation assessments and service are not documented.

Failure to achieve compliance with the recommendations preceded with the symbol (C) may jeopardize your accreditation status.

TOPEKA STATE HOSPITAL
TOPEKA, KANSAS

(Adult, Child/Adolescent, Alcohol, Drug, Alcohol/Drug Programs)

DATES OF SURVEY

OCTOBER 20,21,22,23,24, 1980

SURVEYORS

JANICE T. RABALAIS, R.N., M.S.N.
OTTO SCHAEFER, M.D.

ACCREDITATION PROGRAM FOR PSYCHIATRIC FACILITIES

*COMPLIANCE ASSESSMENT FACTORS

1. There is no written plan for evaluating the program's level of attainment of its goals and objectives.

2. The utilization review program does not address underutilization and overutilization of the program's resources.

3. Treatment plans do not adequately reflect the patients' fundamental needs, objectives that are specified in terms of measurable criteria, and the clinical justification for the use of seclusion and/or restraint.

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

APA's Model Law: Hurting the People It Seeks to Help

Leonard S. Rubenstein, J.D.

In the view of some patient advocates, APA's model law excessively increases psychiatrists' decision-making power in commitment proceedings and heightens the chances of unnecessary commitments by expanding grounds for commitment to include a substantial-deterioration standard, incorporating open-ended commitment criteria, and removing legal safeguards. The model law's encouragement of hospitalization is inconsistent with growing evidence that many patients do not benefit from hospitalization and obscures the need for greater resources for community care. Finally, by granting legal immunity to professionals, the law undercuts its professed desire to protect patients.

Mr. Rubenstein is an attorney with the Mental Health Law Project, 2021 L Street, N.W., Washington, D.C. 20036.

Fifteen years ago, efforts to impose safeguards on the civil commitment process were part of a campaign to end long-term hospitalization, particularly custodial care in frightful and inhumane institutions. Since then, the context in which we debate civil commitment has changed. Naive expectations about transition to community treatment have been crushed. States continue to channel their funds into large institutions, leaving chronic patients on the streets without housing, treatment, or support. Reinstitutionalization has become politically fashionable.

In the midst of this crisis, the American Psychiatric Association has published its model law on civil

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commitment (1,2). According to its exegetes, attorney Clifford Stromberg and psychiatrist Alan Stone (1), the law represents an effort to address the new generation of mental health problems, particularly the "social disaster" in which "severely mentally ill people . . . ignored by current commitment laws and abandoned by the mental health system . . . roam the streets aimlessly and without hope."

The mission is large, and APA's proposals are ambitious. Unfortunately adoption of APA's standards by the states might well exacerbate the social disaster. Although the law takes a strong stand against custodial confinement, it encourages institutional care rather than the development of the community resources that patients so badly need. It undermines the fairness of the civil commitment process by stripping away legal safeguards. And it prevents redress for wrongs done in institutions. The likely result is to hurt the very people APA hopes to help.

Grounds for commitment

The substantial-deterioration standard. The centerpiece of the model law is a proposal for more institutional treatment on *parens patriae* grounds. Over the past 20 years, there have emerged two grounds for *parens patriae* commitment of individuals with severe mental illness: dangerousness to self and inability to care for one's basic needs (gravely disabled). The APA now suggests a third grounds for *parens patriae* commitment: the likelihood that a person will suffer substantial deterioration in mental or physical functioning. To be committed on this basis, the individual, due to a severe mental illness (roughly defined as a psychotic disorder), must be likely to suffer or continue to suffer "severe and abnormal mental, emotional, or physical distress" associated with a substantial deterioration of prior ability to function independently. The definition of substantial deterioration also includes impairment of judgment, reason, or behavior, but this element is redundant because it is a part of the definition of mental disorder.

I agree with the law's drafters that the substantial-deterioration standard would increase the number of *parens patriae* commitments. Two questions, however, must be asked: is it workable as law, and is it good policy? It is neither.

An unworkable standard. The standard's difficulties begin with its extremely broad and ultimately incoherent criteria. In developing this standard, the drafters seem to have had in mind the chronic patient who experiences a psychotic episode, severely decompensates, and needs immediate intervention. But according to what the model law actually says, the section could apply equally to someone with a chronic psychotic disorder who suffers severe distress and deterioration in functioning to the point where he is unable to do high-stress work but otherwise is able to function appropriately. By applying a standard that uses only the person's prior functioning as a benchmark, the law permits commitment of anyone with a serious mental disorder that has worsened. The imprecision of the standard not only would lead to more commitments but would frustrate consistent application.

The substantial-deterioration standard, because of its relativity, is virtually impossible to apply fairly after the first few days of commitment. For example, at the hearing to determine whether the person meets the commitment standard, which occurs after the patient has been hospitalized for up to two, six, or 15 weeks, the court must determine whether the patient has "substantially deteriorated." But how is the deterioration to be measured? If the comparison is between behavior before the episode that triggered the commitment process and behavior at the time of initial hospitalization, the law becomes a sham, for it would permit open-ended commitment based on the patient's past, not present, condition. If the patient's behavior at the time of initial commitment is compared to his present behavior, which at least is not deteriorating because the patient presumably is under treatment, the standard would almost always be irrelevant. The drafters of the law, though, clearly intended the deterioration standard to apply throughout the patient's hospitalization, since it is the vehicle for extending compelled institutional treatment. What measure of deterioration, then, would a court apply when confronted with this standard?

To give any meaning to the standard, the court would be tempted to interpret the standard not as requiring evidence of deterioration, but as permitting a prediction that without continued treatment the patient might get worse. The latter standard is even more open-ended, speculative, and overinclusive than the former.

The substantial-deterioration standard emerges as a 1980s version of the rejected in-need-of-treatment standard. Although Stromberg and Stone (1) argue that the model law moves away from complete medical discretion, it is hard to see how the standard

Obtaining Copies of the Model Law

The Model State Law on Civil Commitment of the Mentally Ill, with extensive commentary, was published in the Summer 1983 issue of the *Harvard Journal on Legislation*. A limited number of reprints of the article are available free from Linda Hughes, Division of Government Relations, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005.

Copies of the Summer 1983 issue of the *Harvard Journal on Legislation* may be obtained from Fred B. Rothman & Company, 10368 West Centennial Road, Littleton, Colorado 80127. The cost is $7.50 per copy.

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imposes any real limitations on the discretion of psychiatrists. Virtually all chronic patients will periodically get worse and thus will meet this criterion with some frequency; the model law allows the psychiatrist to decide, without reference to concrete standards, which of those patients should be committed.

The additional criteria for involuntary commitment included in the model law, moreover, are not likely to be effective in preventing improper commitments. The model law presents them as a checklist that seems designed to assure that some psychiatric judgment has been exercised. The list of criteria includes evidence of refusal of voluntary admission for treatment and a reasonable prospect that the person is treatable at or through the facility. These criteria are salutary guideposts for preventing mere custodial confinement, but they are unlikely, except in a few cases, to change outcomes compared with present practices.

The only criterion that might make a real difference, inability to make an informed decision about treatment, is so loosely defined that it invites the trap Stromberg and Stone (1) identify—reasoning backward from disagreement with the patient's decision to an inference of the patient's incompetence. Thus while I agree with Stromberg and Stone that this criterion is novel, I believe it is unlikely to separate patients who are appropriate for involuntary commitment from those who are not. Moreover, the most obvious safeguard against improper commitment, a judicial order for outpatient treatment, is nowhere to be found in the model law.

Lack of justification. It is apparent that the law's open-ended criteria will lead to institutional treatment of more people, to more unnecessary or counterproductive confinements, and to more pointless infringements on individual liberty. APA can justify those costs only by demonstrating that more commitments are necessary and desirable as a matter of social policy. But the only justification Stromberg and Stone (1) offer is "hope" for those "desperately in need of treatment." Providing treatment to those who need it is a laudable goal, but Stromberg and Stone fail to show that the model law is likely to make appropriate treatment available to chronic mentally ill people who inhabit shelters, doorways, and streets.

Moreover, the most obvious safeguard against improper commitment, a judicial order for outpatient treatment, is nowhere to be found in the model law.

In the first place, there is little evidence that current commitment laws, at least those in the two-thirds of the states with some version of a gravely-disabled standard, preclude institutional treatment of individuals considered by the drafters to require it.

Indeed, Stromberg and Stone (1) themselves concede that the broad gravely-disabled standard in the model law—the individual's inability to provide for some of his basic needs—would cover a homeless mentally ill "bag lady." Evidence shows that the number of admissions of chronic schizophrenics, precisely the group for which the model law expresses most concern, is rising in state hospitals (3–5). Moreover there is little evidence that strict commitment standards have caused a substantial number of people not to be admitted for treatment. Other factors, such as lack of available beds and medical decisions not to treat, have probably played a larger role (6). Accordingly, the principal argument Stromberg and Stone offer for establishing the substantial-deterioration standard does not hold up.

Second, the model law is based on the notion that the avenue of hope is short-term hospitalization. While acute care is useful for many patients, there is increasing evidence that for other patients short-term hospital treatment is not productive or helpful (7,8). Despite somewhat sketchy data, empirical studies have shown that with some exceptions, alternative programs for chronic patients, including innovative mobile treatment centers, emergency homes, and crisis resolution units, are often more effective in treating and rehabilitating patients than are hospitals (9–13). Indeed, one study of homeless individuals living at a temporary emergency shelter found that although 84 percent of subjects were diagnosed as mentally ill, the vast majority of them were placed in settings other than hospitals (13). Based on these data, one would expect that a model law would follow efforts to develop clinical standards narrowly tailored to those situations in which hospitalization is likely to help (14,15), not the open-ended standard found in the APA model law.

Finally, short-term institutional confinement will not provide the homeless with homes or the long-term community resources they need. After a hospitalization, the individual will still need housing, money, and outpatient treatment. No civil commitment law will eliminate these needs unless it proposes lifetime hospitalization (13,16–18).

Stromberg and Stone (1) thus have failed to identify any need for vastly expanding the scope of civil commitment. Nor have they considered the implications of the model law. Throughout the history of deinstitutionalization, state hospitals have tended to siphon off vast resources even though many patients have been discharged; this outcome has been to the detriment of community-based services (19,20). It is naive to expect a law that encourages families and therapists to seek commitment, thereby expanding the size and operating costs of state institutions, not to stifle financial and political interest

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in alternatives to hospitalization. And patients would suffer most.

The absence of fair procedures

Psychiatrists often complain that civil commitment procedures amount to time-consuming and inconvenient hurdles that must be jumped before their patients can receive the treatment they need. Commitment procedures, though, must be designed for hard cases as well as easy ones, for cases in which a person's past behavior is in dispute or in which medical judgments are subject to question. The clinician's goal, after all, is not just treatment, but compelled treatment. Therefore accomplishing the goal ought to be done in a way that is likely to resolve those disputes fairly. That is what due process of law is all about.

The APA has been remarkably successful recently in persuading the courts to equate due process of law with the exercise of medical judgment (21–23). The model law reflects the same orientation but carries it another step by granting psychiatrists the power to make decisions at all critical points in the commitment process and by truncating commitment procedures. The model law does not even require a judicial imprimatur as to the existence of probable cause for commitment for a full five days after emergency detention. At that hearing, the patient has no right to appointed counsel, and no set rules apply. When no emergency exists, the mere filing of a petition for commitment automatically triggers an order for a psychiatric examination. Even in a formal civil commitment hearing, there is no explicit right to cross-examine, to subpoena witnesses, or to rely on rules of evidence or traditional witness privileges.

One does not have to be a staunch civil libertarian to find these proposals disturbing and contrary to this society's deeply held values. Take, for example, the mandatory psychiatric examination that follows the filing of a petition. One cannot obtain a court order to repossess a stereo or a refrigerator simply by filing a claim for nonpayment; a judicial officer is required to make some determination concerning the facts (24–26). But suppose I have a dispute with my neighbor about a borrowed lawnmower and he thinks in good faith that I am acting irrationally and need psychiatric help. He goes to the courthouse and files a petition. The court automatically issues an order compelling me to undergo a psychiatric examination without reviewing the facts or particulars of the petition. According to Stromberg and Stone (1), the law protects against "unwarranted, meddlesome, or ill-motivated petitions" by allowing a person to submit a report by his own psychiatrist (Sec. 6.B.2.). That provision is small comfort to a person subject to such an order.

Consider, too, the reality of the hearing on emergency evaluation. The person has already been hospitalized for five days. He is probably on medication and may feel angry, resentful, and isolated from his community; he has no lawyer. Hospital representatives present his records and explain why he should be committed. According to Stromberg and Stone, "In this informal inquiry the court should engage in dialogue with the parties to learn the key facts bearing on probable cause." The problem is that in this setting the perspective least likely to be heard and given any credence is the patient's.

Other examples of the unfairness of hearing procedures abound. Evidentiary rules traditionally used to resolve disputes are lacking because, as Stromberg and Stone (1) explain in their commentary, "The ritualistic importing of these rules into the civil commitment process in recent years has ignored the fact that civil commitment has different goals, different substantive standards, and different rules from the criminal process." The rules of evidence that have been discarded, however, have nothing to do with standards, results, or goals, nor do they derive from the criminal process. They create a fair means of eliciting and deciding facts, while limiting intrusion into a person's life.

For example, the rule against hearsay evidence, which has been eliminated, was developed and has been maintained in civil law (along with appropriate exceptions, including ones for medical records and expert opinions) because it serves an important function: safeguarding the truth. A psychiatrist subject to a malpractice or disciplinary proceeding would rightly invoke the hearsay rule to prevent, for example, a patient from testifying that the doctor's secretary said that he was drunk when treating the patient. Surely the doctor would demand that any evidence of his drunkenness come from the secretary who claimed direct knowledge of it, and who could be cross-examined to ascertain the accuracy and truth of the testimony. The drafters do not explain why individuals who may be compelled to receive inpatient treatment should have less.

There are other flaws in the law too. The model law takes the physician out of the role of caregiver and casts him as judge. The psychiatrist is called upon not only to offer clinical judgment but also to determine whether a person behaved as alleged in a petition and who is telling the truth. Psychiatrists have often complained bitterly that the legal system has removed them from their accustomed roles of treater and healer (27). The model law, though, thrusts psychiatrists into the very role that they claim to abhor: gatekeepers of the institutions.

Finally, there is a question of the law's legitimacy. Regardless of the motivations of the parties involved and the inconvenience of the process, a free society loses something of great value in the absence of independent safeguards for someone whose liberty is at stake. The work of the therapist, providing treatment, will not be impeded by a fair commitment process, even if it is a nuisance. Indeed, by forcing out additional facts, suggesting alternatives to institutionalization,

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and assuring that the patient's viewpoint is fully aired, a fair commitment process will often enhance the therapist's goal. It is too bad the model law does not reflect these values.

Professional immunity

For an outsider, it is tempting to view the model law as a guild product, written simply to reduce society's control over psychiatric decisions. I have tried to resist that temptation, trying instead to analyze the proposals on their merits. But one provision of the model law, the extraordinary immunity granted professionals in all facets of institutional care, has made me suspicious. Measured by the standard Stromberg and Stone (1) themselves impose, that of "transcending the polemical debate between proponents of medical discretion and the legal activists who see civil liberties as the ultimate good," the model law is certainly a failure.

It contains a litany of patients' rights within the institution: the right to treatment, to a review of drug therapy and its side effects (though no right to refuse medication), to a healthful and humane environment, to receive visitors, to be free of compulsory labor, to be free of corporal punishment, and so forth. However, these rights are meaningless unless they are enforceable. Stromberg and Stone (1) acknowledge that enforcement of such rights through suits for malpractice, for other acts of negligence, or for constitutional violations should not be deterred by special immunity rules. Yet that is precisely what the model law does. It insulates physicians and all other employees of a treatment facility from liability for all "acts or omissions" relating to "admission, evaluation, care, and treatment" unless they are guilty of "willful misconduct" or "gross negligence," standards that are almost impossible to prove.

This immunity provision undercuts all of the law's rhetoric about the patient's protection against arbitrary treatment, overmedication, and even filth, suggesting that the concern of the model law is not the patient but the doctor. Stromberg and Stone assure us that the model law is not "an effort to advance the narrow interests of psychiatry." But in insulating the worst practitioners and worst institutions from liability, in derogating patients' due process protections, and in vastly expanding the grounds for compulsory hospitalization without any coherent justification, the law seems to serve no other interest. Society must face up to its responsibility to provide decent and humane treatment for those afflicted with chronic mental disorders, but the model law, if adopted by the states, is likely to impede progress toward that goal.

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Implications of Need-for-Treatment Laws: A Study of Washington State's Involuntary Treatment Act

Mary L. Durham, Ph.D.

In 1979 the State of Washington revised its civil commitment law to make it easier to hospitalize patients in need of care but not imminently dangerous to themselves or others. To assess the impact of the law, the author studied commitment patterns in Washington for two-year periods before and after the revised law went into effect. Results indicate that the number of involuntary commitments increased substantially after the law was revised, and the commitments were more likely to be based on grave disability rather than on dangerousness even if patients had engaged in violent behavior. However, the mental health system did not expand sufficiently to meet the needs of the increased patient population. Implications of Washington's experience for states considering passage of need-for-treatment legislation are discussed.

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In 1979, six years after the passage of narrow civil commitment standards based on dangerousness, Washington State implemented civil commitment legislation that represented a return to broader criteria emphasizing the need for treatment. Washington was one of the first states to make it easier to hospitalize patients in need of care but not imminently dangerous to themselves or others.

This article will discuss the Washington law and its similarities to the American Psychiatric Association's Model State Law on Civil Commitment of the Mentally Ill. Results of a study of the effects of Washington's 1979 law will be presented, and, based on the similarities between the 1979 law and APA's model law, implications for the passage of state laws emphasizing need for treatment will be discussed.

Washington's civil commitment law

Before 1973 Washington State civil commitment law allowed commitment of almost anyone believed by two physicians to be mentally ill and in need of care and treatment. In 1973 Washington passed the Involuntary Treatment Act, which was lauded as a civil libertarian model for commitment (1). The 1973 law limited commitment to an individual who "as a result of a mental disorder presents a likelihood of serious harm to others or himself or is gravely disabled" (2). "Likelihood of serious harm" was defined as behavior that threatened or attempted harm to self or others. Grave disability was defined as a "condition in which a person, as a result of a mental disorder, is in danger of serious physical harm resulting from a failure to provide for his essential human needs" (3). Com-

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mitment was not to be authorized if an individual could live outside an institution on his own or with the support of family or friends. The 1973 law also removed destruction of property as behavior for which a person might be involuntarily committed.

Following passage of the 1973 Involuntary Treatment Act, numerous groups attempted to revise and expand civil commitment authority. In contacts with legislators and the press, family and professional groups expressed their frustration at being unable to commit family members or clients to mental hospitals.

In 1978 a wealthy Seattle couple was killed by their 23-year-old next-door neighbor, who had only hours before been denied voluntary admission to a state mental hospital. The publicity surrounding the man's arrest and trial focused considerable attention on the difficulty the family had had in obtaining mental health services for their son. Public outcry over the murders applied pressure to legislators, who already had been considering broadening involuntary commitment authority.

In September 1979 the revised Involuntary Treatment Act went into effect. Although the 1979 act aimed to accomplish the same purposes as and to reaffirm the 1973 act, the criteria for commitment were broadened. The definition of gravely disabled was expanded, the destruction of property was reintroduced into the definition of likely to cause serious harm, specific conditions were provided for revoking conditional release, and spouses were allowed to testify against a person whose detention was sought.

It is important to note that the stringent procedural criteria established in the 1973 law to end indefinite commitments and shorten the length of hospital stays were maintained in the 1979 act. These criteria defined conditions under which 72-hour evaluation periods might occur followed, where appropriate, by commitments for 14 days and 90 days (both of which were nonrenewable) and for 180 days (which was renewable). Due process guarantees also remained unchanged.

Similarities to APA's model law

The most striking similarity between the Involuntary Treatment Act of 1979 and APA's model law is the intention of both to facilitate the commitment of community members who are believed to be in need of care and treatment. In addition to commitments based on dangerousness to self or others, both statutes allow commitments of individuals who cannot function independently in the community or who manifest deterioration of their physical or mental functioning. But Washington law focuses on commitment because of severe deterioration in mental functioning.

By expanding the definition of grave disability beyond commitment of persons who could not minimally satisfy "basic human needs" to those not satisfying "human needs of health and safety," Washington broadened its commitment authority. After 1979 families who had been able to sustain a patient's physical safety could claim that the mentally impaired person's essential health and safety needs could not be met outside a hospital.

Commitment of a client whose condition is deteriorating has been included in both statutes to address the problem of patients who function adequately in the community for short periods of time, generally 60 to 90 days, but who quickly deteriorate once they stop taking prescribed medications. Such a provision enhances the ability of family members and professionals to arrange for commitment before patients "hit bottom."

Study methodology

Data for the study were drawn from two sources for the period between September 1977, two years before the Involuntary Treatment Act went into effect, and September 1981, two years after the act went into effect. One source was a computerized data base consisting of all clients admitted to state mental hospitals. It contained information on each client's demographic characteristics, diagnoses, and admission and discharge history.

The second source of data was 3,750 individual client records randomly selected from the offices of involuntary commitment in two of Washington's largest counties: King County, which is predominantly Seattle, and Pierce County, which is predominantly Tacoma. From the individual client records, research staff compiled detailed information for a total of 8,100 referrals to the involuntary system, including 3,900 commitments.

Results

Commitment rate. Rubenstein (5) has noted that commitment criteria like those in APA's model law will inevitably result in more involuntary detentions. While an increase in the commitment rate may not be expressed as the legislative intent, need-for-treatment statutes do imply growth in the involuntary system. Legislation is intended to address treatment needs of community residents who have fallen through the cracks of more narrow, dangerousness-oriented commitment criteria. Unless types of patients who have been committed in the past are excluded from detention, such as patients who are dangerous but untreatable, the system will most likely grow unless mental hospitals are already filled to capacity and are unable to absorb additional clients.

Analysis of Washington State mental hospital admissions and discharges before and after implementation of the 1979 act indicated that involuntary admissions began to increase a full year before the law formally went into effect, suggesting a strong anticipation effect. An abrupt 45.2 percent statewide increase in involuntary commitments to state hospitals occurred in the four months after the act became law. In the year following the legal change, the absolute

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number of involuntary admissions increased by 91 percent.

It also appears that the abrupt increase in involuntary commitments immediately following implementation of the act cannot be attributed to acceleration of a "revolving door" of rapid admission, discharge, and readmission. Readmissions increased by less than 7 percent in the year between September 1979 and September 1980. However, first-time admissions rose from 47.3 to 63.2 percent of total admissions, and involuntary commitment of patients previously admitted voluntarily increased from 25.1 to 41.7 percent. Clearly, some of the increase in involuntary commitments is attributable to former voluntary patients who were readmitted on an involuntary basis.

Voluntary versus involuntary admissions. The increased commitment rate that resulted from the Involuntary Treatment Act of 1979 practically overwhelmed the mental health resources available in Washington. Staffing and bed space did not expand sufficiently to accommodate the influx of patients into the involuntary system (6).

Although Washington law encourages voluntary treatment whenever possible (7), state hospitals are not required to admit patients seeking voluntary mental health services. Lack of sufficient bed space therefore forced hospitals to give preference to involuntary patients.

The computerized data base of clients admitted to state mental hospitals indicated that as involuntary admissions increased following implementation of the law, voluntary admissions showed a concommitant but not offsetting decline. Two years before the act became effective, voluntary admissions accounted for half of all admissions to state mental institutions; by the middle of 1980, voluntary admissions accounted for 21 percent of total admissions.

Parens patriae. As a result of the expansion of commitment authority based on need for treatment, Washington State shifted from a system dominated by dangerousness criteria to a system dominated by *parens patriae* criteria. Unlike APA's model law, Washington law does not require that the patient have a treatable condition or lack the capacity to make an informed treatment decision.

As indicated by the individual client records from King and Pierce Counties, before 1979 grave disability held a slim lead as the criterion most often used for commitment. Following implementation of the revised Involuntary Treatment Act, use of the grave-disability criterion dramatically increased, accounting for three out of every four commitments by 1981. The use of dangerousness to others and dangerousness to self as the basis for detention decreased, involving only 29.7 percent and 25.7 percent of commitments, respectively.

Between 1977 and 1981 we also observed a growing tendency for mental health professionals to use the grave-disability criterion as the commitment authority for clients who engaged in violent behavior. Mental health professionals are not limited to using only a single type of commitment authority for detention. In 1977 danger to others was used as the commitment authority for 79 percent of cases involving violent behavior, and grave disability was used for 32.5 percent of such cases. By 1981 the grave-disability criterion was used for 65.1 percent of cases involving violent behavior and the dangerousness-to-others criterion was used for 60.7 percent of these cases. Our findings suggest that in Washington State patients were more likely to be admitted or readmitted as gravely disabled than dangerous even if they had engaged in violent behavior.

Conclusions

Revision of Washington State civil commitment statutes to accommodate a need-for-treatment approach to detention had several anticipated and unanticipated results. Commitment on the basis of grave disability was strengthened and the number of commitments increased. The mental health system was flooded with involuntary clients beyond its capacity to tend to their needs. In addition, voluntary patients—believed to be more receptive and amenable to mental health treatment—became only a small proportion of those who were admitted to state treatment facilities.

Many of the unintended consequences of the Involuntary Treatment Act might have been avoided by coordinating the expansion of commitment authority with a greater availability of resources to the mental health system. Since mental health resources are rarely if ever available in the quantity and quality needed, states adopting legislation patterned after APA's model law should carefully consider the direct and indirect consequences of decisions that affect the supply and demand of mental health services.

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APA's Model Commitment Law and the Need for Better Mental Health Services

Jack Zusman, M.D.

The author commends the American Psychiatric Association's model law on civil commitment as a practical document that is symbolic of psychiatry's concern about the quality of public mental health services. However, he believes that even the most progressive mental health laws have done little to ensure better or more responsive delivery of psychiatric services. Their effectiveness has been hampered by states' failure to provide funds for adequate services, lax interpretation and application of their provisions, and increasingly bureaucratic procedures resulting in impersonal treatment of patients. The author would strengthen the model law's section on patient advocacy, giving greater autonomy to advocates, and would extend legal authority for commitment to psychologists meeting specific qualifications.

I am very pleased to see the publication of the American Psychiatric Association's model commitment law (1). Development of a model law is a good way for experts in a field to share their wisdom with the legislators and citizens of each state. The model law represents the work and consultation of many individuals of varying interests and opinions. It incorporates much of the latest thinking of both clinicians and civil libertarians, two groups who are knowledgeable about inadequacies in existing commitment laws and who have taken the lead in criticizing those laws. Many elements of the model law have previously proven themselves as part of the mental health statutes of various states. In my opinion, the law will work and work well.

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But having granted that the development of the model commitment law is an important and positive step, I admit that I am not sure how much good it will do in the long run. In this paper, I explain some of my doubts about the usefulness of mental health laws in general in improving services and the usefulness of the model law in particular. I view the issues from the perspective of a user of progressive mental health laws in New York, California, and Florida. The experiences of these states with their laws suggest what the model law's practical effects will be.

Practical strengths

The detail in which the model law was drafted indicates that it is intended to be a practical document. For example, a very important but often neglected problem for individuals who are involuntarily hospitalized unexpectedly is the care of their property until they return home. Thus Section 4.A.3. deals with this problem by requiring the police officer involved to take steps to protect the property.

As another example, the model law does not assume—as many laws have in the past—that an individual either is or is not mentally ill and that the differentiation can be made easily by an expert. Instead the law is responsive to the difficulty of the decision by specifying what level of certainty must be attained at specific steps of the commitment process; probable cause is required at some points, clear and convincing evidence at others. The Supreme Court's emphasis on the need for such specificity has been instrumental in this development.

The drafters of the model law have recognized California's problems with its 72-hour initial evaluation period and thus they have incorporated a 14-day evaluation period instead. The model law also reflects recognition that involuntary hospitalization does not necessarily mean inability to make decisions or loss of any legal rights. The law specifies that psychiatric treatment can be given under certain conditions without consent but that nonpsychiatric medical treatment can be given only with consent or through the use of other appropriate legal procedures. Each of the practical features I have mentioned is an indication of the sensitivity and experience of the clinicians and legal administrators who participated in the drafting process.

Symbolic significance

The model law and the work that went into it are very positive symbols of the concern of the psychiatric profession with delivery and quality of public mental health services. Expressions of this concern have been all too few in recent years, given the deteriorating state of public psychiatric services

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and the nationwide attention that APA can command. As the national group representing the "senior" mental health service profession, APA has an obligation to monitor and express its concern about the conditions under which patients are treated. Such activities can only increase public respect for psychiatry and for all the mental health professions. APA needs to make clear dramatically and repeatedly that its concerns are far wider than the economic well-being of its members.

In a less positive symbolic sense, a state mental health law represents only the care a state claims to hope to provide and the way in which it hopes to provide that care. But mental health laws do not provide funding or create the service units necessary to comply with the law. Merely passing a very forward-looking mental health law—but doing no more—is a very easy way for a state to claim to be aiming for the best care while spending no more than a fraction of what the best care would cost. It can take credit for having good intentions while being fairly certain that few if any challengers will ask what its intentions really are.

Impact on services

Even when a state government actually intends to improve services in part through an effective, modern mental health law, the law may not accomplish what its authors and legislators have envisioned. A mental health law is not a plan for delivering services nor does it exert a very specific influence over the way patients are hospitalized. My experience suggests that no matter how clear or detailed a law is, judges, police, attorneys, and bureaucrats often ignore or have no knowledge of its fine points. These officials, especially judges, who are often not accountable to anyone, routinely do what they think is best for the patient or what they think the law intends without regard to what the law really says.

This laxity is illustrated by Florida's mental health law, the Baker Act, which until 1984 did not provide for involuntary admission of suicidal individuals. To a student of mental health laws, that was a glaring omission. Yet in practice, the pattern of involuntary admissions in Florida seemed to be about the same as in states where danger to self was a cause for involuntary hospitalization. Regardless of what the drafters of the Baker Act intended (or at least what they wrote), the law was applied in a common-sense manner. Even the brochure published by the Florida Mental Health Association on the provisions of the Baker Act stated incorrectly that a patient's being "likely to injure himself" was a criterion for involuntary admission.

Similarly, requirements that the least restrictive treatment alternative be used or that patients be examined promptly after admission have often not been strictly adhered to in cities and towns far removed from the state capitals. No one should assume that by passing a law, states can effect radical changes in the quality of care or the means by which care is provided. Monitoring and enforcing mental health laws are a low priority for most states. Most individuals whose care is affected by mental health laws do not have the interest or the money to sue over apparent violations of their rights. And because there are not large numbers of attorneys expert in mental health law, a potential litigant cannot easily find a competent lawyer to take his case, let alone one who is both competent and willing to work for little or no payment.

Application in the real world

Several factors will affect the application of the law in the real world. First, although teasing out the subtle meanings of a law is bread and butter for attorneys and judges, my experience has been that the subtleties are lost when the law is applied in the community. Particularly in mental health law, few cases reach the appellate level where the law's intricacies are examined.

Furthermore, laws related to broad community interests should be written very generally to encompass a multitude of situations and to balance a wide variety of concerns. Mental health laws must address not only the welfare of the mentally ill but also the welfare of those who appear to be mentally ill but actually are not and those mistakenly incarcerated as mentally ill; the welfare of the families of the mentally ill; the welfare of the members of the community who may be endangered or annoyed by the mentally ill; the welfare of the state's taxpayers who will have to support the service system; and the welfare of the individuals employed within the service system whose income and well-being are at stake.

It should be self-evident that no law can ensure the right outcome for everyone involved in every situation. That dissatisfied parties complain about a law, quote horror stories about its results—such as allowing persons to "die with their rights on"—or declare that a law is useless is par for the course. Indeed my own opinion is that we should not search for the best law, but rather for the one that is the least harmful to the interests of the most people.

Second, although mental health laws are necessary, their application begins an inevitably damaging chain of events. To deal with large numbers of people affected by the law, states resort to high-volume, low-cost bureaucracies. The bureaucracies treat people impersonally, as numbers to be processed as efficiently as possible. Efficiency means that individual needs, preferences, and feelings are ignored, which can be seriously damaging to persons made fragile by mental illness.

Finally, laws do not ensure adequate care, as illustrated by the application of the Lanterman-Petris-Short Act, one of the most modern mental health laws for its time, in Los Angeles County, one

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of the richest counties in one of the richest states in the country. I can unequivocally state that under that law during the seven years (1975 to 1982) I worked in Los Angeles, the average care provided by public mental health services did not attain the quality that any of us would want for ourselves or members of our families. Facilities were overcrowded, regimented, noisy, dirty, and understaffed. Salaries paid the top professionals were too low to command their full interest and commitment, and psychiatric staff often viewed their public service positions as stepping-stones to something else or as income supplements that would no longer be needed when private practices expanded sufficiently.

Patient advocacy

In practice, then, one of our concerns has to be the protection of those helpless individuals in need of the support and services provided by the law from the deleterious effects of bureaucratic processing. This protection can come from effective patient advocacy.

A number of states have had a good deal of experience with patient advocacy. In California and in some parts of New York, advocacy has been viewed not as a legal service but as a service for solving problems that may have a legal component or whose solutions may need some legal backing. That approach is very different from the strictly legal approach in which the individual is represented by an attorney only at hearings or for the purpose of investigating violations of legally determined rights. A problem-solving advocate serves as a bridge between the patient and the facility, interpreting the needs and objectives of each to the other.

Advocacy of this sort seems to work best when there is legal authority in the background to guarantee access to the patient and ensure that the advocate's voice is heard by the facility. The advocate, though a bureaucrat, has the responsibility of being an antidote to the bureaucracy, assuring that the patient's individual differences and preferences are respected.

The inclusion of a section on advocacy in the model law is a very positive step, but the section is sketchy. The authors apparently envisioned patient advocacy primarily as a means of resolving grievances. The operation of the advocacy service is left to each state or perhaps to each individual facility. This approach is unfortunate because, given the choice, most facilities will establish a service that is an integral part of their facilities' clinical operations. A major role for the advocate in such services will be to suppress problems for the facilities. Though debate about the relative effectiveness of outside (externally funded and supervised) or inside advocates remains unsettled, there surely is a point beyond which further inside affiliation becomes an impossible obstacle to effective advocacy.

I would have preferred therefore that the model law had established a statewide advocacy service that could either carry out front-line advocacy in all institutions or could provide advocates to consult, train staff in protection of patients, and monitor the services of each institution; the choice would be left to the state. I would also have preferred that if separate advocates for each facility were provided, the advocates report directly to the facility administrator, be conversant with the laws regarding rights of patients, and not have additional part-time clinical duties. If several facilities had no need for a full-time advocate, they could share one full-time advocate rather than assign advocacy to staff as a part-time additional duty.

Effective advocacy can do much to soften the deleterious aspects of bureaucratic handling, which can never be overcome completely. Advocacy should be built into every mental health law and should be supported by those concerned with the quality of psychiatric care, even though there will be times when a good advocate will considerably complicate the work of a good clinician. The clinician must be consoled by the thought that a single case is not the measure of the program. The overall good achieved in many cases outweighs the problems in a few cases.

An unwise provision

One final aspect of the model law with which I strongly disagree is its authorization of nonpsychiatric physicians but not psychologists to certify the need for emergency psychiatric treatment and to participate in other legal proceedings involved in the civil commitment process. Aside from the facts that the provision is against the trend, is likely to be ignored by states, and inflames our fellow mental health professionals with whom we should be working, the action is completely wrong.

The problems caused by the admittedly deficient training of many persons called psychologists can be overcome by specifying in the law the qualifications that a psychologist must have to participate in the commitment process. Does anyone really believe that the average orthopedist or cardiologist has a better background in mental disease, mental health law, and mental health services than the average doctoral-level clinical psychologist? If psychiatry wishes to assert national leadership, it must make very clear that its actions are intended to further national interests, not only its own.

Despite being convinced that far more than a model law is needed to improve mental health services, I am glad the model law has been developed. I congratulate the authors on a very solid job.

Reference

1. Stromberg CD, Stone AA: A model state law on civil commitment of the mentally ill. Harvard Journal on Legislation 20:275–396, 1983

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APA's Model Law: A Commitment Code by and for Psychiatrists

David B. Wexler, J.D.

The author argues that the APA model law is seriously flawed because it lacks sufficient mechanisms for questioning the judgment of psychiatrists throughout the commitment process and for ensuring the best disposition of patients. By failing to provide for independent screening of commitment petitions, to mandate multiple psychiatric evaluations of respondents, to provide indigent respondents a free psychiatric examination to help them prepare for the commitment hearing, and to address the shortcomings of legal advocacy, the model law sets the stage for improper or unwarranted commitments. In addition, the law circumvents the rights of patients admitted on emergency status to refuse treatment throughout the entire evaluation period, which can last up to 14 days.

The American Psychiatric Association's Model State Law on Civil Commitment of the Mentally Ill, together with the unofficial but informative and revealing commentary by Stromberg and Stone (1), provides us with a great deal of food for thought. Stromberg and Stone regard the criteria for 30-day involuntary commitment and subsequent recommitments (Sec. 6.C.) as the heart of the model law, and many others will surely agree. I do not. I believe the particular commitment criteria are far less important than the various procedural and structural mechanisms that will determine, or at least influence, how a commitment code operates in practice. My principal concerns about the mechanisms of the APA model law are the subject of this paper.

Professor Wexler is Law College Association professor of law and professor of psychology at the University of Arizona, Tucson, Arizona 85721.

Major flaws in the law

Failure to provide for screening. Regardless of a code's particular substantive standard of commitment, its success both in locating the most appropriate treatment and in protecting a patient's liberty may well depend on whether it includes a statutory mechanism for screening commitment petitions. Screening should be required and should be done early in the commitment process by an agency or person thoroughly familiar with community facilities and programs. In a large number of cases, only a screening process is likely to locate the best dispositional alternative for the individual.

Take, for example, the rather routine case of an elderly disoriented man who, because he was prone to wander, was thought to be an appropriate candidate for state hospital commitment and an inappropriate candidate for a nursing home in his community—until a person familiar with the local scene mentioned a particular nursing home that happened to have a fence around it and that, therefore, would be sufficiently secure for that patient.

Screening was recommended by the President's Commission on Mental Health as an essential component of model commitment legislation (2). Yet, the model law, which purports to be comprehensive and contains even a severability clause (Sec. 20.B.), does not in any way provide for screening. Indeed, in supposedly routine nonemergency cases, screening should be essential. The model law, however, even allows a court to summon the person to submit to an evaluation by a private psychiatrist (Sec. 6.B.1.)—probably the professional least likely to know of viable community alternatives—and authorizes judicial commitment without any further psychiatric evaluation.

A possible explanation of the puzzling absence of a screening provision is that screening is typically performed by nonphysicians; the model law gives only physicians clinical authority to hospitalize, unwisely ignoring the critical role that can and should be played in the commitment process by nonphysicians (Sec. 4.B.).

Overreliance on a single psychiatric opinion. Closely related to the absence of a screening provision is the significance attached to a single psychiatrist's judgment about the need for commitment and treatment. In emergency cases, for example, a patient may be admitted to a facility for emergency evaluation and treatment if the examining psychiatrist (Sec. 4.D.2.) believes the emergency criteria are satisfied. A petition for 30-day commitment may then be filed by the treatment facility or by the next of kin (Sec. 6.A.2.). In nonemergency cases, "any interested adult" can petition for commitment (Sec. 6.A.1.), whereupon the court "shall" (even without making an independent determination?) issue a summons for the

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respondent to appear for an outpatient evaluation by a treatment-facility psychiatrist or by a private psychiatrist (Sec. 6.B.1.). If commitment appears warranted, a hearing on 30-day commitment will follow.

Because of the possibility of substantial psychiatric disagreement about diagnosis and treatment, some commitment codes require two psychiatric evaluations and may specify that the examinations be conducted independently (3). Under the model law, however, a single examination is sufficient. Indeed, whereas other commitment codes often specify that the psychiatrists testify "as to their personal examination of the patient" (3), the model law emphasizes that the hearing shall be informal and that "hearsay evidence may be received" (Sec. 6.D.5.); it does not even state absolutely that the psychiatric examiner testify in person.

No provision for an independent evaluation. Although the hearing is to be relatively informal, Section 6.D.1. of the model law requires the patient to be given advance notice of the hearing so that, according to Stromberg and Stone (1), he "can prepare for the hearing by arranging to be examined by his own psychiatrist and by conferring with counsel." Yet although the model law provides indigents with a right to free counsel, it does not, except through an optional provision (Sec. 6.D.3.), provide them the right to a free psychiatric examination. In their commentary, Stromberg and Stone (1) at best provide a lukewarm endorsement by explaining in a single sentence that Section 6.D.3. "also includes an optional provision by which the state can decide to provide indigent respondents one free psychiatric examination to help them in presenting their case."

In sharp contrast, lawyers experienced in representing patients at commitment hearings know—and learn from civil commitment trial manuals—that "the single most valuable person to testify on behalf of a client in a contested commitment situation is an independent expert" (4). For example, in one case, psychiatrists examined a respondent at the Veterans Administration general hospital in Tucson and recommended that he be committed for long-term hospitalization in an out-of-state VA psychiatric hospital 1,000 miles from his home. The patient's lawyer obtained a court order authorizing an examination of the patient by a psychiatrist aware of local treatment facilities. The psychiatrist concluded that the patient was a perfect candidate for treatment in a Tucson halfway house. The VA commitment petition was promptly withdrawn, and the patient was successfully and uneventfully treated in his community (5).

The right to an independent psychiatric examination is, of course, all the more important under a statute that fails to provide for screening of petitions and that requires only one psychiatric evaluation. Here again the model law fails to heed the advice of the President's Commission on Mental Health that model legislation include "the right to a retained or assigned independent mental health evaluation" (2).

Failure to address problems in legal representation of patients. Effective scrutiny of psychiatric judgments depends not only on the use of independent experts, but also on the advocacy efforts of attorneys representing respondents. Although Stromberg and Stone (1) recognize that "counsel frequently are poorly prepared to represent respondents," they—and the model law (Sec. 6.D.A.)—actually devote more attention to ensuring that the state's interest in commitment hearings is adequately represented by counsel than to ensuring adequate representation of respondents. Perhaps it is understandable that a model law drafted by the American Psychiatric Association would not specify duties and performance standards for the legal profession (3,6). Yet the poor performance of commitment counsel is a profound problem in mental health law. Any purportedly comprehensive "model" legislation should, with the input of the bar, address that problem.

By eschewing multiple psychiatric evaluations, by not mandating independent psychiatric evaluations, and by not addressing the problem of ineffective legal advocacy, the model law in effect allows psychiatric judgments to go unchallenged and to appear sound even in instances where they may not be. It is almost as though the drafters of the model law subscribe to the view recently expressed by the minister of health of Queensland, Australia, who, discussing proposed mental health legislation, said, "The conflict in expert opinion is not to be found in the basis of psychiatry or in medicine, but is the direct result of the principles of the adversarial system itself. I must protest again the denigration of the expert opinion of psychiatrists" (7).

If the judgment of a single psychiatrist can be faulty and if evaluation and hearing processes are not geared to expose that faulty judgment, the consequence may be improper or unwarranted commitment. Further, under the model law, the consequences of a commitment are more far-reaching than under prevailing commitment codes. Under the model law, when a respondent is found to warrant involuntary commitment, he is also found to lack the "capacity to make an informed decision concerning treatment" (Sec. 6.C.4.). Thus the commitment hearing in essence functions also as a limited guardianship hearing; commitment overrides not only a respondent's right to liberty, but his right to refuse treatment, principally psychotropic medication, as well.

Putting aside thorny questions about substituted judgment, I have no serious objection to the conceptual basis of overriding the right to refuse treatment in the context of a commitment hearing. But the right to refuse treatment, to quote Stromberg and Stone (1), is "perhaps the most incendiary issue in all of mental health law." That right should be overridden only after adherence to procedures that are designed to air, rather than conceal, possible disputes and dif-

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ferences of opinion concerning psychiatric judgment.

Provision for forcible treatment in emergency status. The incendiary issue of the right to refuse treatment, one of the greatest irritants to psychiatrists, is eclipsed by the model law in a conceptually and procedurally unsound way with regard to emergency treatment. The courts have recognized that patients can be forcibly medicated in genuine emergencies even in the absence of a determination of incompetency. While the courts continue to debate the definition and scope of the term emergency (1), the model law, in a major equivocation, regards all persons undergoing "emergency evaluation" as candidates for forcible treatment (Sec. 8.A.). Thus during the entire period of emergency evaluation, which can last up to 14 days (Sec. 4.A.), persons admitted pursuant to the emergency route may be treated against their will. In fact, the model law does not even specifically preclude the forcible administration of electroconvulsive therapy during the period of hospitalization preceding adjudication (Sec. 8.A.,8.C.).

The model law blunders badly (but cleverly?) in equating the status of being hospitalized pursuant to the emergency route with the volatile, individual emergency situations that form the basis of the judicially approved emergency exception to the right to refuse treatment. A patient may be admitted for involuntary emergency hospitalization only if the examining psychiatrist determines the patient is likely to cause or suffer certain serious harm and "immediate hospitalization is necessary to prevent such harm" (Sec. 4.D.2.). Yet, once hospitalized, many patients who posed a danger on the street will no longer present a risk of causing imminent harm. Such patients should not be subjected to involuntary medication during the evaluation period, but the model law authorizes such involuntary treatment.

Even genuine emergency admissions, therefore, often do not remain true emergency cases throughout the entire prehearing evaluation period. Further, in most jurisdictions, the emergency admission procedure is, for a variety of reasons, substantially overused. Many persons admitted under the emergency provision never present an actual emergency. Enactment of the model law would probably result in a substantial increase in the use of emergency admission procedures in nonemergency situations. That is because the model law would restrict the means of initiating the commitment process to two diametrically different options: an emergency route and a process involving a petition, a summons, and an outpatient evaluation (Sec. 6.B.1.).

My impression is that outpatient evaluation of patients is rarely if ever used in jurisdictions like Arizona that have such a procedure on the books (3). Ironically, then, a requirement for outpatient evaluation appears to be highly protective of patients' liberty, but it is in practice likely to result in funneling nonemergency cases into the emergency admission route. Perhaps the failure to include screening mechanisms in the model law is based on a realization that emergency admission is likely to be the only viable route of admission.

Cases of inappropriate emergency admission may well escape later challenge and detection. One reason is that at the preliminary hearing that must be held within five business days of emergency admission (Sec. 4.F.), the patient need not be provided with legal counsel (Sec. 14.A.). Persons inappropriately admitted and retained under the emergency provisions may, therefore, be deprived of both their right to liberty and their right to refuse treatment.

Under the model law, a voluntary patient may be treated without consent only in an emergency situation (Sec. 7.A.), which is defined in Section 3 as "a situation in which the patient exhibits substantial behavior that is self-destructive or assaultive, threatens significant damage to the property of others, or indicates that the patient is suffering extreme anxiety amounting to panic or sudden exacerbation of his severe mental disorder." The problem presented by the model law's position on forced treatment of patients admitted for emergency evaluation could be rectified if the concept of emergency situation in the law's section on voluntary admission were applied to emergency admissions as well. Nonconsensual treatment of even emergency route patients would be disallowed except in the event of an actual emergency.

As it stands, the model law "does not permit a treatment facility to vitiate a voluntary patient's general right to refuse treatment by routinely and inappropriately characterizing events as 'emergency situations,' " but it *does* permit a treatment facility to vitiate an involuntary patient's right to refuse treatment by that very device.

In its present form, the APA model law is sufficiently flawed to render it unacceptable for legislative enactment. Perhaps some of the labor that went into the law's development could be salvaged if the law were used as a springboard for launching a major multidisciplinary effort to draft a civil commitment law that is truly a model.

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7. Campbell IG: Proposed changes to the mental health and criminal justice systems in Queensland. Criminal Law Journal 7:179–206, 1983

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1-31-86

Kansas Psychiatric Society,

a District Branch of the American Psychiatric Association

P. O. BOX 829 • TOPEKA, KANSAS 66601 • (913) 232-5985

January 31, 1986

Testimony to Senate Judiciary Committee
Re: Substitute for H.B. 2050

Mr. Chairman and Members of the Committee:

I am Dr. Erv Janssen, a physician and psychiatrist practicing here in Topeka, and representing the Kansas Psychiatric Society as Chairman of the Legislative Committee.

In behalf of the Kansas Psychiatric Society, I want to speak in favor of this proposed legislation, feeling that the intent and substance of the Bill provides the opportunity for the humane and conscientious approach to the quality of psychiatric care we feel our fellow citizens should have made available to them. We realize that these are complex issues. The implementation of any statute is dependent upon the people who are involved. We hope that in a cooperative atmosphere where conscientious people are involved, that the availability of treatment will provide timely care while still maintaining the adequate legal protections for individuals.

I would offer one recommendation regarding those parts of the proposed statute pertaining to admission and discharge. It is my understanding that the current hospital laws of Kansas require admission and discharge decisions to be made by a physician. Thus, the chief medical officer or designate of the chief medical officer would be the responsible physician for making admission and discharge decisions. This would keep it internally consistent with our current Kansas statutes regarding hospital care.

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Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

January 31, 1986

Office Phone
913/233-7483

To: Senate Judiciary Committee

Re: Substitute for House Bill 2050

We often request amendments to bills during the legislative process which will allow those relying on spiritual means for healing to practice their religion freely. We try to limit our proposals so there will be no interference with the rights of others. With this in mind, I will address four areas of concern in this bill.

1. When the House Judiciary subcommittee held hearings on HB 2050, we requested a change in the proposed definition of "mentally ill person" to make the provision for those being treated by spiritual means alone for healing follow more closely the language of the present law. Our request was granted.

Having considered the bill further, we find that the broadened definition of "likely to cause harm to self or others" (lines 0058-0069) has the effect of considerably weakening the provision in lines 0085-0090. A person who refuses medical care could, quite easily, be found to fall within one or more of the conditions in the definition of "likely to cause harm to self or others."

The language of the present law, "is dangerous to self or others," provides greater protection for those being treated by spiritual means alone.

We request that the language of the present law be retained in lines 0085-0090 or that suitable language be found to make clear that a person will not be found "likely to cause harm to self or others" simply because he is being treated by spiritual means alone for healing.

2. The laws of several states provide that a person being treated by spiritual means alone may not be evaluated, detained, or treated involuntarily prior to the court finding probable cause to believe that the person is dangerous to self or others. We

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equest that a provision be included in this bill prohibiting treatment by a treatment facility before the court has found probable cause to believe that the person is dangerous to self or others in any case where the person is being treated by spiritual means alone. (Making the change suggested in 1., above, might remove the need for this change.)

3. We request that "minister of religion, including Christian Science practitioner," be inserted following "psychologist" in lines 0321 and 0337 (pg. 7) in the list of those who may be contacted by a person in custody or admitted to a treatment facility. For some, contacting a clergyman of choice could seem more important than contacting those presently on the list.

4. We do not ask that a patient admitted to a treatment facility voluntarily or pursuant to court order have the right to refuse treatment offered by the facility but we do request that the patient have the right to receive treatment by spiritual means and have access to a "minister of religion, including Christian Science practitioner" while being treated by a treatment facility. Perhaps this could be included in the patient's rights in Section 23 (pgs. 31-33).

I will be available and glad to work with you in resolving these issues.

Keith R. Landis
Committee on Publication
for Kansas

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REPORT TO THE SENATE JUDICIARY COMMITTEE HEARINGS ON HOUSE BILL 2050

Friday, January 31, 1985
10:00 - 11:00 a.m.

by
Susan Estelle Budd

Hospitalized:	Twice and deemed chronically mentally ill, 1967 - 1968.
Founding Member:	International Conference on Human Rights and against Psychiatric Oppression, 1972 to present.
Past Coordinator:	Project Acceptance of Lawrence, Kansas, 1980 - 1985.
Consultant:	To a variety of local, state and national mental health agencies and consumer's organizations including the National Institute of Mental Health (NIMH) - Community Support and Rehabilitation Branch (CSP), 1980 to present.
Special Presenter:	President's Symposium, American Psychiatric Association National Convention, Dallas, Texas, May, 1985.
Founding Member:	National Alliance of Mental Patients, 1985 to present.

In these hearings, I am representing myself and other consumers of mental health who might agree with me.

In 1976, the State of Kansas passed into law Senate Bill 239, which was then and is now one of the most progressive pieces of mental health legislation of any in the nation. It created the best possible balance between the rights of individuals to freedom of choice and the right of society to protection against behavior dangerous to its members whether inflicted by one's self upon their own person or upon the person of another. Now in 1986, ten years later, we appear to be attempting to set the clock back to the days of institutionalization proir to 1976. House Bill 2050 would allow for easier commitment to our inpatient facilities, greater control of the patient during hospitalization and after discharge and for commitment on an outpatient basis. This may sound beneficial to the patient on paper; but it in fact, builds a very unsafe system from which to ask for help. I am going on record as opposed to House Bill 2050. Here is why:

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To be mentally ill is to be terrified. As one who has been hospitalized, I can tell you of that terror. One feels that one does not fit - is not wanted by society, by family, friends, or community. One feels pushed to be as others want them to be. One may not be realistic in the same way that others might be realistic. One may be consumed in overwhelming frustration or anxiety. One may hear and see things that are not there. One may get profoundly depressed about things that they can not change or about things that one may not even be aware of. One feels inferior, helpless, unwanted.

What is real, terrifyingly real, is the fear of those around you, their avoidance of you, the hushed telephone calls, the offer of a drive in the "country". If one believes that "a breath of fresh air" will make things better the first time, one will not believe it the next, because that "drive in the country" usually ends up at the state mental hospital. This commitment scenario represents what can happen if you are lucky, but, if you are not lucky, the sheriff or police appear at your door. They handcuff you and drag you away screaming. You may go to jail before you are taken to the hospital. At the hospital, you are seen as hysterical, paranoid, irrational. You are given medication, often against your will, to "calm you down" to "<u>make</u> you reasonable". And in all this time, not once has anyone soothed your fear or your anger by their understanding. You have never been asked if you are frightened. You have no time to process what is happening to you. If you express your fear or your indignation, you are only told that you are there because you need "help".

To help a person, to truly help them, we must build a system with a variety of options, whereby one feels in control of their treatment, whereby one does not experience the rejection of others or the stigma of being labelled "mentally ill". Yes, I have heard the complaints of families and professionals that they cannot get help for their loved ones and clients. I feel for them. But in all the years between 1976 and now, I have never seen anyone who truly needed to be <u>forced</u> into treatment <u>not</u> be committed. What I have seen, which makes my heart ache, is my peers going to the mental health system crying for help and being turned away. I have seen people ready to participate in therapy being told to go home. And so, over time, their desperation mounts until they slash a wrist or decompensate to a point of danger. And then, they are committed. After commitment, they are not participants in the treatment process. Rather treatment plans are negotiated on what staff feels is good for them. Discharge, medications, everything is decided by the staff. In the mental health system, we are often treated as though we are incompetent. Our dark, often symbolic, worlds are given no credence and thus, there is no way to communicate. In many facilities treating the long term mentally ill, there is no effort to engage the client in any of the many talk therapies available to "normal" people, the so called "walking worried". Nor is there any effort made to network mental health clients with the community at large and the natural support systems there in, like churches. Legislation of easier commitment is not the way to guarantee access to the mental health system.

Rather, I would ask you to study why the system is so unsafe that we, present and former patients fear it so, and I would ask that you as legislators demand that these things be corrected. I ask that you examine carefully the trends to consolidate all services, (vocational, housing and social support), given to long term mentally ill people under the auspices of the community mental health centers only. Please examine how this creates incredible dependency of consumers of mental health services on <u>one</u> provider of services leading to a severe limitation of available options, institutionalization within the community and isolation of the long-term mentally ill from the rest of the community within which they live. I ask that you look into some of the

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alternatives to the professionally run system that have sprung up around the country, like expatient run safe houses, drop-in-centers and mutual support groups like those in Berkeley, Boston, New York and Baltimore. I ask you to provide more funding for expatient run organizations in this state like the Coalition of Mental Health Consumers and Project Acceptance. I ask you to investigate what the Ohio State Department of Mental Health is doing to empower their consumers of mental health services in participating as equals with family members and mental health professionals in the design and implementation of programming. I ask that present and former mental patients be invited to participate on the SRS Advisory Board being proposed in Senate Bill 430. But most of all, I ask that you help us educate your constituency as to the nature of mental illness and as to the fact that the road back to health very much involves our acceptance into their community as family, friends, volunteers, employees, employers, landlords and most of all as equals. Most of us who are mentally ill desperately crave acceptance, understanding and a chance to contribute at whatever level we can. Please help us become participating members of your community.

FOR FURTHER INFORMATION CONTACT:

Kansas Coalition of Mental Health Consumers
(An advocacy and support group)
P.O. Box 4381
Overland Park, Kansas 66204
(913) 722-6733
Contact persons: Penny Johnson or Carol Ildza

Project Acceptance
(An expatient run alternative for support)
P.O. Box 187
Lawrence, Kansas 66044
(913) 843-4428 or (913) 842-6351
Contact person: Dixie Mitchell

Advocates for Freedom in Mental Health
(An advocacy and political action group)
1026 South 56th. Terrace
Kansas City, Kansas 66106
(913) 287-6498
Contact person: Sharon Jacobs

Susan Estelle (Su) Budd
P.O. Box 12821
Kansas City, Kansas 66112
(913) 334-3491

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1-31-86

BILL #2050

Madeline Hynes
410 North Roosevelt
Wichita, Kansas 67208
Sedgwick County

My name is Madeline Hynes and I am married with three children. I have lived in Sedgwick County for 13 1/2 years. I am a nurse. In 1970 I became ill with manic depression. This is a mental illness with a physical cause, due to a chemical imbalance in the brain. A person can suffer severe mood swings with this illness. They can either have severe depressions or manic attacks or both.

I was hospitalized at different intervals for a ten year period. I was a voluntary patient. In times of crisis I dreaded going into the hospital but I did accept treatment without force. I was lucky because my husband was financially able to have me treated in a private hospital, and supported me emotionally also. I had good aftercare. I have been completely well for five years and see my psychiatrist periodically.

One of the points about the bill that is most important to me is the provision for aftercare. The period between hospitalization and when the person is completely well and back community is very important. There must be a definite plan for adjustment to life in the community after hospitalization. And there must be people available to give them the help and support they need on a day to day basis. I cannot stress enough the vital important of patient education in regards to medication. A person must realize that they should take their drugs as directed, not just until they are feeling well.

Mentally ill patients need enormous support in their return to the community. They must be educated and informed about how to cope with the public's reaction to their illness.

I was very lucky to receive private hospitalization and good care when I was ill. I take this opportunity to speak for the many people who are suffering from mental illness and are not able to receive proper care. Hopefully Bill #2050 would make this possible for the people of Kansas.

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My name is Laura Cummings and I live at 1258 Burning Tree in Wichita.

Bill #2050 provides treatment for people who do not realize the severity of their illness, particularily those afflicted with a severe mental illness.

When we speak of our rights as a citizen in a free country, we also need restraints and laws in order for free people to be protected.

Do we really have the right to kill ourselves? To refuse medications when they are helpful to us? If a diabetic doesn't take his insulin, he will surely die... or an epileptic does not take his medication, he will have seizeres.

Why is it that we think we are infringing on a person's rights, if we give him treatment or medication? There should also be a follow-up treatment, so that these people are not allowed to regress.

Schizophrenia is a disease. It is just the same as having another disease such as leukemia. The magnitude of schizophrenia is exceeded only by the magnitude of our ignorance in dealing with it.

Because of society's perception, and through ignorance and neglect, it has become a living hell for the persons who are so afflicted with this disease...and also for their families.

We choose to turn our backs on these people by telling ourselves that we are taking away their rights by forcing treatment upon them.

I am very fortunate to be able to stand here in front of you today. I did not happen to be afflicted with schizophrenia, but I did suffer a nervous breakdown in which I was professionally treated. I was hospitalized and received psycho-therapy for ten years and because of this, I have an ongoing interest in mental health. Also I am a registered nurse with a degree in nursing.

After hospitalization and ten years of psycho-therapy, I am a reasonably well person.

The stigma of mental illness prevents so many people from getting help. Our society refuses to allow a person to be mentally sick and because of this, People are ashamed to admit their illness.

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Joan Navrat
204 North Belmont
Wichita, Kansas 67208
Sedgwick County

I spent a considerable amount of time on Wednesday analyzing carefully Bill 2050 and prepared to relate to you today in logical precise terms exactly why I support this very important piece of legislation regarding the mentally ill in our community.

It sounded alright when I read it to myself, but it didn't really tell how it is to live under our present laws with a loved one suffering mental illness.

The key word is suffering. For all our talk of bills, and rights and problem solving, we must look first to the people involved.

Our son, John, is 27 years old and has been diagnosed as paranoid schizophrenic. Schizophrenia is caused by a chemical impalance in the brain. It is a disease. We don't know why he has this disease, but he has been ill for about ten years. He hears voices which torment ridicule and harass his every constructive idea. He sometimes feels compelled to answer these voices, even though he has been taught that this is unacceptable. He forgets about personal hygiene and can go for months without changing clothes or bathing, if not constantly reminded. He cannotread, because he cannot focus his concentration. He cannot listen to music, because the devil speaks to him then. He cannot watch TV, the TV controlls his mind. He cannot eat when people watch, he can't touch wood. People are watching him and trying to kill him. Anyone can take advantage of him, and he even brings these people home with him. He has to give his money, his clothing and his meger possessions to appease these voices. Mostly he sits, sleeps and paces all day. He roams at night...I guess the spirits don't see him so clearly then. It's his safest time.

We have tried everything...Psychiatrists, psychologists, extensive testing, social workers, A.A., alanon, Drug Abuse Centers, Vocational Rehabilitation, Job Training, in patient hospitalization, and out patient hospitalization (Day Hospital), group homes, satalite apartments, numerous independent living situations and finally now our son is back living at home with us again.

There is no continual care for people like our John. No one really cares what happens to him except for his family. Because he is free to walk out of any hospital, free to walk out of any supportative living situation, free to reject medication. He is also free to starve himself and to waste away in loneliness and self inflicted isolation.

You see the authorities have decided John is not a danger to himself or others. He cannot be committed for care. Nevermind that he cannot hold a job or make reasoned judgements about his safety or welfare.

Can we continue to abandon these suffering people in the pompus name of protecting their "rights"? I watch his cry for help echo across our nation. I want Kansas to do something positive for the Mentally Ill.

I hope Bill #2050 is a start...

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My name is Camille McGuire. I live in Wichita. I am here to testify in support of House Bill 2050. I would like to give you a brief report of the onset of my illness and how earlier treatment would have helped me and others.

In the beginning, I was in college. I was sure two boys were following me. One of my teachers asked me if I was getting help. I did not know she meant psychiatric help. I told her yes, as I was seeing a doctor for a physical problem. Then my family doctor said I needed a psychiatrist. I asked him why. He did not answer. When I left, the nurse told me about welfare. I called SRS and was told that I need not apply because I was a student and ineligible.

I could not concentrate. I could barely get any sleep at night. Things kept getting worse. I went to the dentist and he put a too-tall filling in my mouth. Well, I couldn't sleep. His office wouldn't rectify the situation. I caught a ride with a stranger and he tried to strangle me. I went back to my place and a neighbor raped me. I was having a nervous breakdown. I heard awful voices and wasn't functoining. It was Christmas Eve. I went to my family's. I thought I was dying and asked to go to the hopital. I became paranoid. I went downstairs to get a drink and, in my wild hallucination, thought the Mafia had surrounded the house and were going to kidnap me, send me to Alcatraz and make me sing all day long. Also, be their prostitute. I thought I could not go through with it. I'm desperate. I went down and took a few of a relative's pills. The next day, Christmas, I just cried. The next day my mother told me there was a hope and took me to the hospital. Well, I stayed there a month. My pills were making me vomit up every meal. Finally I refused my medication. The doctor took me off pink capsule lithium, which I am allergic to. I was released and depression set in so I volunteered to go to day hospital.

I got help too late. I had minor problems that escalated into a nervous breakdown. Of course, it came as a shock to me that I was mentally ill.

Over the years, I have become acquainted with many people with similar problems. I know of mentally ill persons today wandering the streets and eating out of trash cans. No provision has been made for their care. I saw classmates suffer years as social outcasts and no supportive person intervened and got them care. We have all known at least one person who didn't fit in and eventually was committed.....or worse was sent to prison, or was a victim of suicide.

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Bill No. 2050

LEGISLATIVE RESEARCH DEPARTMENT
SUMMARY OF ESTIMATED FISCAL IMPACT

March 26, 1985

Bill Status: As Amended by House Committee of the Whole

	FY 1985		FY 1986	
	State General Fund	All Other Funds	State General Fund	All Other Funds
Revenue	$ —	$ —	$ —	$ —
Expenditure	—	—	516,903	—

Short Title: Treatment Act for Mentally Ill Persons

H.B. 2050 amends existing law regarding the act for obtaining treatment for a mentally ill person. The bill would redefine a mentally ill person, make procedural changes in the hearing process leading to involuntary commitment, clarify outpatient treatment as a commitment option, grant immunity from civil liability to state psychiatric hospitals and their employees, except for gross and wanton negligence, and make other technical changes.

The passage of H.B. 2050 would expand the definition of a mentally ill person and the state's authority to divert patients to community alternatives. The Division of Mental Health and Retardation Services indicates the bill will have no impact on them, in that the expanded definition will be offset by the broadened authority.

The expanded definition of mentally ill persons would impact the Judicial Branch. The Office of Judicial Administrator has suggested that as many as 2,045 additional cases per year could be filed upon passage of this bill, resulting in the need for additional clerical and judicial time. Assuming 2,045 additional cases and a half day in hearing each additional case, the Office of Judicial Administrator anticipates that the passage of the bill would add over 1,000 days of in-court judge time throughout the state, the equivalent of five full-time judges. The addition of five new judges (at $51,417) and the necessary support staff (Official Court Reporter at $21,204 and Administrative Assistant at $14,376) would cost in salaries and fringe benefits $516,903. The addition of new judges would also incur a cost to the counties in office space and supplies.

In addition, passage of the bill would result in additional costs to community mental health centers, which are funded in part with state funds.

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The Honorable Joe Knopp, Chairperson
Committee on Judiciary
House of Representatives
Third Floor, Statehouse

Dear Representative Knopp:

SUBJECT: Fiscal Note for House Bill No. 2050 by Committee on Judiciary

In accordance with K.S.A. 75-3715a, the following fiscal note concerning House Bill No. 2050 is respectfully submitted to your committee.

House Bill No. 2050 amends existing law regarding the act for obtaining treatment for a mentally ill person. The bill would redefine a mentally ill person, make procedural changes in the hearing process leading to involuntary commitment, clarify out-patient treatment as a commitment option, grant immunity from civil liability to state psychiatric hospitals and their employees, except for gross and wanton negligence, and make other technical changes.

The passage of House Bill No. 2050 would expand the definition of a mentally ill person. It also broadens the states authority to divert patients to community alternatives. The Division of Mental Health and Retardation Services indicates the bill will have no impact on them, in that the expanded definition will be offset by the broadened authority.

The expanded definition of mentally ill persons would impact the Judicial Branch. The Office of Judicial Administrator has suggested that as many as 2,045 additional cases per year could be filed upon passage of this bill, resulting in the need for additional clerical and judicial time. The Office of Judicial Administrator reports such an increase in caseload would result in substantial delays in the hearing of civil litigation or necessitate the addition of judges and supporting staff. Assuming 2,045 additional cases and a half day in hearing each additional case, the Office of Judicial Administrator anticipates that the passage of the bill would add over 1,000 days of in-court judge time throughout the state, the equivalent of five full-time judges. The addition of five new judges (@ $51,417) and the necessary support staff (Official Court Reporter @ $21,204 and Administrative Assistant @ $14,376) would cost in salaries and fringe benefits $516,903. The addition of new judges would also incur a cost to the counties in office space and supplies.

As stated above, the passage of House Bill No. 2050 would broaden the state's authority to divert persons to community alternatives. The Association of Community Mental Health Centers of Kansas has indicated that the cost of serving these clients could be substantial, though no fiscal estimate has been provided. As community mental health centers currently receive state funding, any increase in community program costs could have fiscal implications for the state.

Alden K. Shields
Director of the Budget

AKS:RS:dj

1-31-86

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

West Tenth Professional Building
1119 West Tenth, Suite 2
Topeka, Kansas 66604-1105

Telephone
913-233-6323

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

HB2050

TESTIMONY OF MICHAEL BYINGTON

I come representing the above captioned agency. The Topeka Resource Center for the Handicapped works with many disabled consumers who from time to time come under the jurisdiction of the body of law covered in this bill.

Much of the body of law covered has not been reviewed by the Kansas Legislature in quite a number of years. It is thus appropriate that review is taking place. The House of Representatives has done a good job in its revision of the original bill. Nonetheless, I shall propose some additional amendments.

When an individual is in any kind of custody covered under the provisions of this act, it is noted that they may consult privately with an attorney, a personal physician or psychologist, and at least one member of the persons family. Added to this list of persons with whom private consultation rights are assured should be a licensed social worker and an advocate or case manager acting in their professional capacity as defined by an employing agency or facility. Many community support programs of mental health centers and many programs for independent living work on a case management model. Clients often develop a closer relationship with a case manager, advocate, or social worker than they do a physician, psychologist, or attorney. The case manager, advocate, or social worker is thus often in a better position to advise the client of his/her rights and consult concerning his/her needs initially than is any other professional. The right to privacy and confidentiality in such relationships should be assured and protected. Sections seven and 23 are two which need this wording added.

Also in reference to Sections seven and 23, the word "or" should be struck and replaced with the word "and" in reference to private consultation rights. A client should not have to choose between, for example, having the right to private consultation with a trusted physician or psychologist. The client should not have to choose between seeing an attorney or an advocate confidentially. He/she should be assured that all of these people may be seen confidentially.

In line 328, the word "or" should be changed to "and/or".A legal

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council and legal guardian are not always the same person, nor does having a legal guardian prohibit the individual's right to private consultation with legal council.

The sentence ending near the end of line 347 should have the following words added to it, " . . .from actual harm." Simply to say, " . . .to protect the person or others" is too general and all-encompassing.

Any notice referenced in HB2050 which is to be delivered to a person in custody should be in the form known to be best understood by the individual. This could mean that the notice would be explained orally as well as delivered in writing. It could also mean that the notice would need to be communicated in Braille, American sign language, or another language. These provisions need to be spelled out in the bill particularly in reference to Section 12.

Thank you for reviewing this testimony. If Committee members have questions, I may be contacted at the numbers on this letterhead.

XVII

1-31-86

JIM LAWING
ATTORNEY AT LAW

400 Farmers and Bankers Building
First at Market
Wichita, Kansas 67202-2181
316-267-2821

Senator Bob Frey
Senate Committee on Judiciary
State Capitol Building
Topeka, KS 66612

Re: Substitute for H.B. 2050

Dear Senator Frey

Please accept the comments in this letter which are directed toward the above bill as testimony I would give were it possible for me to appear before the Judiciary Committee when it holds hearings on this proposed piece of legislation.

As a member of the Legislature during 1975 and 1976 when extremely progressive legislation on mental health and mental patients' rights were passed, there is a natural reluctance on my part to see the bill changed. However, I note that certain social conditions, marked prominently by an increase of the number of Americans who are homeless, have now come to light which give rise to the need to amend the legislation of 10 years ago. For the most part, I believe it would be appropriate to pass the bill as it was sent to you by the House Committee of the Whole.

However, one portion of the definition of the phrase "likely to cause harm to self or others" goes too far. It proposes to return Kansas to the position it was in before 1975, when a person's conduct which threatened property gave the State cause to lock up the individual who was perceived to be such a threat. For that reason I would hope that the words "or substantial damage to another's property" can be deleted from Section 2(g)(1).

The reasons for taking this policy position are numerous. The threat to a person's property has often been used as an excuse for abusing the rights of individuals who are unpopular. Thoughtless statements that individuals have made are often taken out of context, and it would be easy to over-emphasize an angry remark. Furthermore, if the threat

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of property damage should be perceived to be real and massive enough to injure individuals, then that threat would be a sufficient justification for involuntary treatment under the present statute.

Two other proposed changes would be especially bad. The worst portion of the bill involves an attempt to take away the right of a patient to refuse medication. Since the whole purpose behind medication is to restore rationality to individuals who have lost it and to enlist mental patients in efforts made to restore them to competency, the concept of pushing unwanted medicine into a patient's system defies logic and experience. While short term changes of a dramatic nature are often realized by using psychotropic drugs which calm a distraught individual, the fact that the individual is already confined ought to be enough protection for society. Distraught people will eventually calm down on their own. Then, the professional ought to be in a position to discuss the individual's situation with him or her in a reasonable manner and get the patient's cooperation. Some people see the need to cooperate sooner than others, but eventually everybody who is locked up finds reason to cooperate with their captors and wardens. And legislators should not fail to keep one thing in mind: People who are being held for observation and care as mentally ill persons are just as much in jail as those who might have committed serious crimes. With the first step of protecting society already accomplished, there is no reason to take away the individual's self-respect by forcing him or her to ingest unwanted chemicals. If there is a good reason for this step, I have yet to see it.

Finally, I am worried about the ready admissability of all forms of hearsay. The Evidence Code already allows over 30 exceptions to the rule that prohibits hearsay testimony. I do not see any reason to go beyond the liberality of these exceptions. Otherwise, judicial proceedings will be nothing more than hearing gossip and receiving it as gospel.

There may be other items which more careful and prayerful study will expose to be iether badly needed or totally unnecessary. I only hope that the Senate gives this important bill the necessary thought. Kansas has a good reputation for treating mental patients in a manner consistent with their constitutional rights, and I hope the bill your committee recommends will advance this policy.

Very truly yours

Jim Lawing

January 28, 1986

XVIII

1-31-86

Kansas Advocacy & Protective Services for the Developmentally Disabled, Inc.

kaps

Suite 2, the Denholm Bldg.
513 Leavenworth
Manhattan, KS 66502
(913) 776-1541

TO: The Senate Judiciary Committee
Senator Robert G. Frey, Chairperson

RE: Substitute for H.B. 2050

DATE: January 30, 1986

KAPS assists Developmentally Disabled children and adults in gaining access to the rights and services to which they are entitled. We are a private, non-profit corporation created specifically to meet the protection and advocacy requirements of the Developmental Disabilities Act (PL 94-103 as amended). There are 54 such agencies in our states and territories.

In addition to casework, which is similar in all such protection and advocacy agencies, KAPS also operates the Kansas Guardianship Program. The KGP is a statewide service which recruits volunteers to act as guardians and conservators for persons who are dependent upon public support. Our agency provides training and a support structure for volunteers in the program, including a small monthly stipend to offset some expenses. Volunteers submit monthly written reports on their services on behalf of their wards/conservatees. More than 500 persons have been served through the program.

Our comments come out of these experiences. They are not intended to be comprehensive but will highlight our reaction to some of the proposed amendments to the Care and Treatment Act.

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In reviewing the Substitute for HB 2050, we note that a number of concerns previously expressed by KAPS were addressed by the House in the substitute bill. We very much appreciate the work done by the House and the consideration given to our suggestions.

The remarks we have prepared today deal with some questions not addressed in the substitute measure as well as additional questions or issues we feel deserve your consideration.

Page 2, line 82

We believe the phrase "lacks capacity to make an informed decision concerning treatment" could be difficult to establish. A person could be found likely to inflict substantial physical injury to the person's self, be substantially unable to provide for the person's basic needs or, if not treated, suffer, or continue to suffer, severe and abnormal mental, emotional or physical distress. If that person, however, could be expected to have the capacity to understand basically the nature and effects of hospitalization or treatment, and be able to engage in rational decision making regarding hospitalization or treatment, would that mean the individual could not be involuntarily admitted for treatment?

Page 5, lines 169 and 170

We question the use of the word "advisable" on line 169 and suggest that it be replaced by the word "needed". We also suggest that the words "prior to" be inserted between the words "notice" and "the discharge" on line 170 so that persons who care for the patient can be prepared to assist that person when he or she is discharged.

Page 6, line 209

It has been acknowledged that there are only rare occasions when voluntary patients want to refuse all reasonable treatment efforts. We see the possibility that the threat of an involuntary commitment could be held over persons' heads if they do not agree to accept a proposed treatment. We believe it unwise to risk discouraging persons who are in need of treatment from voluntarily admitting themselves and,therefore, suggest that (b) be deleted.

Page 9, line 321

We suggest that, following the word "family", language be added to include the guardian or person in loco parentis.

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Page 9, line 338

We suggest that reference to the guardian or person in loco parentis be added here also.

Page 13, lines 481-482

We find this language confusing and in need of clarification.

Page 15, beginning line 551

Would such an investigation allow for unlimited access to a person's records without the individual's permission? This raises the question of a possible violation of confidentiality. We are unclear as to the need for this section since a mental evaluation would be conducted to determine the individual's need for treatment.

Page 16, beginning line 598

We question the removal of the provision for a hearing. The proposed patient, who is not being held in custody, would presumably be required to undergo an evaluation and no longer be allowed to request a hearing on the issue of whether there is probable cause that he/she is a mentally ill person. It would appear a protection is being deleted without justification.

Page 23, line 195

We are unclear as to the meaning of the term "material noncompliance". Would it be more accurate to use words like "substantial" or "significant" noncompliance?

Page 27, line 332

We suggest that, following the word "attorney", reference be made to include the patient's guardian or person in loco parentis.

Page 29, line 387 to 394

This language would indicate that the head of the treatment facility must review and investigate all applications for involuntary admission and, if appropriate, divert patients to less restrictive treatment alternatives before further judicial proceedings occur whenever deemed appropriate. While we agree that diversionary planning might be appropriate and wise, we find this reference located in the section of the Act dealing with the discharge of patients to be confusing. We also could interpret the language as taking the determination of the need for an involuntary commitment somewhat out of the hands of the court.

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Page 30, lines 434 to 436

We would suggest that, if the patient has a guardian, the seven days notice of intent to discharge should also be given to that guardian.

Page 33, line 538

We suggest that the word "available" be changed to "provided". The restriction of a patient's rights is a serious matter and a statement of reasons for restrictions should be provided to the parent, guardian or person in loco parentis, not simply be available.

Page 35, beginning line 623

In general, we struggle with the issue of the right to refuse treatment. On one hand, we see the very real need for a mechanism to obtain treatment for those persons who are hurt and at risk and who, because of their illness, are unable to request or accept the treatment they need. We do, however, also know that some medications are terribly intrusive and have caused long-term damage to individuals. There are valid arguments and valid concerns on both sides of this issue which deserve serious consideration.

Page 50, lines 423 thru 427

The statements in (1) and (2) appear to be somewhat contradictory.

Page 52, lines 509 thru 515

We simply call your attention to this language because we feel somewhat uncomfortable with it. We suggest that it deserves clarification and consideration.

Respectfully submitted,

Joan Strickler
Executive Director

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