Approved 4/4/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

4:20 ~~a~~p.m./p.m. on ~~March~~ 27, 19 90 in room 522-S of the Capitol.

All members were present except:

Committee staff present:

Norman Furse, Revisor's Office
Sandra Nash, Committee Secretary

Conferees appearing before the committee:

The Chairman called the Committee to order, calling its attention to H.B. 2586.

The Chairman called the first proponent, Dr. George Getz, Superintendent of Larned State Hospital. Dr. Getz said he was appearing in support of H.B. 2586, because they believe that the mental health services should be developed and delivered within, or as near as possible to the patient's home community.(Attachment 1)

The Chairman called the next proponent, Representative Arthur Douville. Representatiave Douville said he was appearing in support of H.B. 2586 because we need to address the screening process involved in the placement of the mentally ill in our state institutions and their return to the local community and also the needs of the mentally ill. He felt this bill did both(Attachment 2) Representative Douville said that community mental health services are defined to include approximately 21 different services, including housing, dental and medical care and other support services.

Representative Douville said on Page 3 of the act, subsection (g), it says the Secretary shall adopt rules and regulations for targeted populations which provide that no person shall be inappropriately denied necessary mental health services. Now that imposes a direct obligation upon the secretary of SRS. Also imposes a direct obligation upon the state of Kansas. A lawsuit is being brought against SRS on behalf of foster children, where they're taking a position in the lawsuit that the proper services are not being rendered to foster children. And then they are quoting the language that we have written over a period of time which indicates that every person, every foster child, is entitled to certain things. It doesn't say anything about subject to appropriations or anything else. The real danger in that, is first of all that creates an obligation and that is very difficult to get out and then what we have involved is the power of the judiciary over the purse. And what happens in that case is that action is brought by several individuals, for instance like the foster children, and you can apply the same rules with respect to children that have problems or any mentally ill person. What happens is, like the foster children, they come in and say they are represented by attorneys and say we are not getting proper care. Then the social workers come in and they say and they've even gone so far as to say that they want recognition because they're not able to do their duties because of the fact they do not have enough money and they do not have enough social workers, there's not enough case workers. So they say to the court, we're your friends, we want to help out with the problem and therefore the court says in view of the mandate and in view of the fact that we don't have enough social workers, we do not have enough appropriations. I, the court will say that this is what you have to do. And so we get a court determining how your money will be spent and the individuals acting as a legislative body, it's their job to determine how the money is to

be spent. Even that wouldn't be so bad, if in fact it was the state that was taking care of it. Then we could say, we the state caused the problem and therefore, we're going to have to respond to it. But if we pass this bill, then the question comes up to what extent can we mandate local units of government, and incidentally this is where you get into a conflict between the local mental health center and your board of county commissioners. Because on one hand your county commissioners only have a certain amount of money and on the other hand you got your social workers or your mental health center saying we don't have enough help or we don't have enough appropriations. We need more money. So there's a conflict and then the question comes up. And in all the discussion that we had this last summer, and I think a number of us asked this question, what extent are mandating all these services upon the local unit of government. Because they basically pay for it unless the state comes through. And second, to what extend is there a cost? And I don't recall what the exact figures are. I think we heard anywhere from $15 to $35 million. Now I know they start out here, no person shall be appropriately denied necessary mental health. How could anybody quarrel with these words. And that would apply to all individuals, whether they have mentally ill problems or rather they are mentally retarded, or children that are not mentally ill but are in need of services. So we have to allocate our money and the question comes up to what extent and I think all of us legislators say to ourselves, are we mandating anything upon the local units of government without appropriate money for them. And then if we say we made a decision what we're going to do it, but we're not going to give them the money, that's one thing. We don't say that. Now I think you could address it, and I was given this proposal by Dr. Harder, on page 5, line 13: adopt only those rules and regulations in policy which are within the acts of appropriations. That sounds pretty good and it would be adopted as another subsection (u). Now if you do it that way then you got a conflict between your two (g) and (u). And the question comes up is that the right way to approach it. Now there are two ways to approach this problem. In stead of number on page 5, line 10 and 11, dealing with adoption of such rules and regulations, include as part of that this problem of X number of appropriations and make it subject to acts of appropriations. I would rather, and I think the better approach, and this is what would hurt this language, but, if for instance on page 5(g): subject to the acts of appropriations, the Secretary shall adopt rules and regulations. In other words, subject to appropriations. Then there isn't any conflict between the different sections. And then you have narrowed it down and you said to the secretary unless you give us money we're not going to mandate that these local units of government put up these health centers and take care of the problems. I think if you address that problem and answer the question what have we mandated and what are the costs, then I think we've carried out our responsibility.

Senator Hayden asked if he would explain the wide variance of cost--$15 to 35 million.

Representative Douville said he didn't think anybody knows. Here's the problem. People have said to him don't worry about the cost. The cost is not to be acted upon, is not to be determiend. I think we have to ask ourselves. If we are talking about cost. If we are talking about 21 different things including medical and dental care and housing services, employment services, you are talking about million dollars. And if we are willing to appropriate the money, I think that's great. But I think before we start mandating some, we ought to take a look at what we are doing with respect to appropriations. And I know if I wasn't a member of this legislature and I simply was concerned with mental health, I would be saying let's go ahead. Damn the torpedos, full-speed ahead. But, as a legislator, I can't say that.

The Chairman called the next proponent, Representative Gary Blumenthal.

Representative Blumenthal said he wanted to discuss some of the provisions of the bill and also share with the committee some of the discussion which took place this summer on the interim committee. And also share some of the discussion on the House side regarding this bill. The purpose of the bill is to unite the state hospital system and the local community mental health center systems so that we are delivering appropriate mental health services to individuals who need those services. We have heard a significant number of testimony in regard to whether people are inappropriately placed in mental hospitals or not. The bill will allow the appropriate people to be placed in mental hospitals and to allow community mental health centers to see that we have in place, a program that will enable people to be treated in the community at much less cost in the long run.

Representative Blumenthal said there will be some upfront cost of this bill in terms of putting in place appropriate strengthening and structuring for the targeted populations of an adequate community support program. However, in the long run, you have two choices. One is to simply do nothing and pay year after year in significant increases of operating state hospitals and facing decertification of state hospitals because of inappropriately placed individuals. Or you have an opportunity through the enactment of the bill to redirect our efforts and redirect those dollars back into the community. In the long run we will be saving state dollars verses what we would have been investing back into the state hospital.

Representative Blumenthal said regarding Representative Douville's concern regarding page 3(g), he did not believe that this is a direct obligation upon the legislature. A concern he has heard from some members of the Committee is regarding private practitioners and whether private practitioners should be able to make direct admissions to the state hospitals. We explore this issue in the interim committee and they studied the private practitioner substituting for the community mental health center in the gate-keeping function. And the committee concluded that it would destroy the concepts of the bill.

The Chairman called the next proponent, Howard Snyder, the Kansas Alliance for the Mentally Ill, Kansas AMI.

Mr. Snyder testified he is in favor of the bill because he has a mentally ill son who is 31 years old and feels there should be a better system that would provide for community care of individuals instead of in an institution. (Attachment 3)

The Chairman called the next proponent, Tim Paul. He stated he was an attorney and he has MBA from Wichita State, a masters in Clinical Psychology. Also he has a physical defect which resulted in a chemical imbalance in my brain. I am a consumer of primary mental health care services. February 5 of this year I was hired by consumers to represent them in a new organization, The Kansas Mental Illness Awareness Council. It has been in existence for about six weeks. We had a board meeting yesterday that was interesting. We had at least one board member who is actively symptomatic, that is they were acting out during the course of the meeting. We have individuals who come to the board meetings who are adamant about no medications, cannot require medications, that's all they want to talk about. We have others that are adamant that you cannot force hospitalization on anyone. This is their key issue, that's what they want to talk about. It was my job to discuss with them substitute H.B. 2586 and have vote taken as to whether we were going to support it our not. We did support it in the House. There has been some changes and I wanted a new vote. My position is that the bill does not contain everything we as consumers would like to have. We didn't write it, we're not sponsoring it. But it

does contain a number of things which we as consumers are interested in. It lets consumers participate more in their treatment and it acknowledges the dignity of the individual consumer. Those things aren't done in some programs now. It's now become state law, it will occur in every program. Well, after about an hour and a half of debate, that vote was taken and we supported the bill unanimously by proclamation. You will hear or receive information from individual consumers during the course of the debate. Those people have key issues they are interested in and they are advancing them as individuals. Everyone of those people either was present or had a representative present yesterday when the council took its vote. I want to be very careful to distinguish for you. I'm speaking for a group of consumers. The people who are presenting testimony here, in writing or orally, are speaking as individuals, which is a difference. The last thing he wanted to point out, there are many good people on the Wellness Awareness Council. He said he has never met so many good people with so many good ideas. He said he was quite confident that they will be back next legilative session, making suggestions with things that we think will further improve the mental health system. He said there was one choice which has not been suggested today. The mental health retardation services, the different support programs, the council has done a tremendous amount of work on this bill. They suggested a program that phased in over several years. I would ask you to compare rational nature and maturity of that sort of a recommendation to what's happening in the criminal system where there is a federal judge who is telling what they will do and how much money they will spend. I don't believe that is the type of choice that should be made in dealing with mental health services.

The Chairman called the next proponent, Elta Hill, consumer.

Elta Hill said she was supporting H.B. 2586. She attends Class, Inc. in Wichita, Kansas. And she said she is supporting the bill because it allows us to be more involved in our treatment.

The Chairman called the next proponent, Chip Whelan, Kansas Medical Society and the Kansas Psychiatric Society. Mr. Whelan said that all psychiatrist are first physicians before they become specialist. A copy of the letter written by Mr. Whelan to the interim committee stating the qualifications of a medical doctor regarding whether a person should be admitted to a psychiatric hospital. Only a physician is qualified to diagnose organic disease that may be the basis of mental illness, may contribute to the person's mental illness, or may cause symptoms which indicate mental illness but are attributable to other causes.(Attachment 4)

Mr. Whelan asked for the Committee to be very cautious in amending the definition of "Qualifed Mental Health Professional." He also requested that the Committee consider amending new Section 5 which is found on page 6 to require that at least one member of the Governor's Mental Health Planning Council be a physician. Physician is appropriately defined, you don't need to say a person licensed to practice medicine. We think it is very important and you adopt the amendment prior to recommending the bill for passage.

The Committee adjourned at 5:05p.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3/27/90

~~3:30 p.m.~~ 4:20 p.m. Room 522S

(PLEASE PRINT)

NAME AND ADDRESS	ORGANIZATION
Carolyn Miller	MH/MR-SRS
Linda Sibley	MHRS
Sidonna Jones	MHRS
Jerry Larson	Ks. Alliance for the Mentally Ill
Dave Seaton	Mental Health Planning Council
Ka[illegible]z, D.V.M.	Larned State Hosp.
Al Romero	SRS/MHRS
Sonya Hammat	SRS/MH
Howard Snyder & Lou Snyder Ethel Hill 2607 W 4th Apt. 405 Wichita, Ks. 67203	Kansas Alliance for the Mentally Ill
Jim Paul 430 N Woodlawn Wichita, Ks 67208	Kansas Mental Illness Awareness Council
Larry Meikel	Mental Health Consortium, Inc.
Arlen W Daniels	Leg
Chip Wheeler	Ks Medical Soc.
Pamela Patterson	MH Consortium
Dave Romney	Harris News Service
Matt Tuell	AP
JoAnna M Unruh Larned Ks 716 West 7th	Kans Mental Health Planning Council
Chet Unruh Larned Kans 716 West 7th	

Please continue on next page.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE ____________________

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Steven Kraske	K.C. Star
Corrina Hartman 801 S. Harrison #635 Olathe, Ks 66061	Self-Help Resources and Development, Inc.
Denis Kelly P.O. Box 891 Olathe KS 66061	LINC

Department of Social and Rehabilitation Services

Testimony before
The Senate Public Health & Welfare Committee

Regarding

House Bill 2586

on

March 27, 1990

Dr. George Getz
Superintendent
Larned State Hospital

presented on behalf of:

Al Nemec, Commissioner
Mental Health and Retardation Services
Department of Social and Rehabilitation Services
Telephone (913) 296-3773

SP H+W
Attachment 1
3/27/90

I am appearing today to be on record in support of substitute for House Bill 2586. The staff at Larned State Hospital agrees with and supports the philosophy, intent, and principles included in the proposed legislation. Indeed, since the inception of the community mental health movement, we have supported the philosophy that mental health services, when feasible, should be developed and delivered within, or as near as possible to the patient's home community.

This afternoon I will not elaborate on the role of state psychiatric hospitals in the continuum of mental health services since Norma Stephens covered that issue quite adequately this morning.

I would like to mention that we at Larned work very productively and pleasantly with the mental health centers in our catchment area. Our staff will continue to work cooperatively with them in expanding mental health services in the communities of western Kansas.

STATE OF KANSAS

ARTHUR DOUVILLE
REPRESENTATIVE, TWENTIETH DISTRICT
JOHNSON COUNTY
9600 WOODSON
OVERLAND PARK, KANSAS 66207-2844

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: LABOR AND INDUSTRY
MEMBER: FEDERAL AND STATE AFFAIRS
JUDICIARY
INTERSTATE COOPERATION

March 27, 1990

COMMENTS BEFORE SENATE PUBLIC HEALTH & WELFARE COMMITTEE
Senator Roy Ehrlich, Chairman

From Representative Arthur Douville
Substitute HB 2586

No question but that we need to address the screening process involved in the placement of the mentally ill in our state institutions and their return to the local community. No question but we need to also address, generally, the needs of the mentally ill. Substitute HB 2586 does address both of these needs and, certainly, much work and thought has gone into the writing of this bill.

The bill does, in detail, set out what is meant by the words "community based mental health services". Approximately 21 different services, including housing, medical and dental care and other support services.

The Secretary of Social and Rehabilitative Services has been given tremendously broad powers to ensure the delivery of the designated services to a target population which can extend to "any individual at risk of requiring institutional care". That power includes the right to withhold funds if there is not full compliance with the orders and directives of the Secretary.

A number of concerns were raised that I'm not too sure were fully answered as the bill made its way through the summer hearings and the House process. Those concerns involve cost and who was to pick up those costs. The staunch advocates of this bill took the position that costs really weren't involved, in so far as the passage of this bill was concerned, as that would be taken care of by Appropriations plus the requirement by the local units of government to also address the problem. The trouble with this approach is that the language in new section 3(g) mandates that every member of the targeted population is entitled to all of the 21 services outlined. Every right or entitlement carries with it a corresponding duty on someone to live up to that right. Presently, there is in Topeka, and also in Wichita, lawsuits in which the language used in the statute creating a right has been used as a basis for requesting the courts to enforce those rights. The social workers are then in an adversarial position with respect to the agency charged with the responsibility of furnishing those services. Applying those cases to the mental health situation would mean that suits could be brought against the local mental

SP H & W
Attachment 2
3/27/90

health care centers and then the mental health care centers would be placed in a position of saying to the courts that sufficient monies are not available and that more facilities, more case workers and more money is necessary and then we get in a position of the courts determining the allocation of funds instead of the legislative branch. Language has been suggested to this committee to take care of this particular section. I have no problem with the language suggested, but do not feel that it should be made a separate subsection as then there can be a conflict in the subsections and the courts might say that the overriding paragraph should be the one that mandates the entitlement of every service indicated.

There is one other problem that should be considered and that is the problem of secure detention centers for those who represent a danger to themselves or others or simply might not be controllable. Limitations are placed upon the use of jail facilities. Do each of the mental health centers have a secure detention facility or access to one that would meet the requirements of the act? If this information was furnished I was not aware of it. How can the screening process work if there isn't such a secure facility? The answer I heard was that the Secretary would not enter into a contract with a local mental health center until there was a secure facility. What is the significance of this? If there is no contract because there is no secure facility, then what happens? Several health care center employees indicated there was no real solution to the problem, or at least, so I understood. With the above areas resolved I would recommend passage of the bill.

Local units of government face substantial budgetary restraints and the uncertainty of the tax structure gives them little comfort. The question for the legislature is "are we mandating any obligation upon the local units of government without ensuring sufficient funds to carry out that mandate?"

Kansas Alliance For the
Mentally Ill
Kansas AMI
112 SW 6 St. Suite 305
Topeka, Kansas 66603
913-233-0755

My name is Howard Snyder, and I'm from Prairie Village. I'm testifying today as Past President of Kansas AMI, which is an organization of approximately 400 families across the state who have mentally ill family members. I was also a member of the Governor's Task Force on Mental Health Reform, and am presently a member of the Governor's Planning Council on Mental Health Services, and Chairman of the citizen governing board of Johnson County Mental Health Center.

The primary reason I am involved in these activities is that my 31 year old son, Howie, has been suffering from a brain disease-schizophrenia-since he was 19 years old, and a sophomore in college. The year before he was named top freshman in the school of geology. He had known since he was quite young that he wanted to be a geologist. Barring a miracle-he never will be a geologist. He is an eagle scout, was twice an exchange student in France, and was fluent in French. Today he is emotionally flat, does not talk, cannot concentrate or read, cannot drive car, and cannot work. For a year and a half in the mid 80s we lost track of him because he was a homeless person in Arizona. He became a homeless person because neither Kansas or Arizona provided the services that he needed in the way that he needed them.

In the attachment to this testimony, which I will not read, you will see comments on how fragmented the Kansas Mental Health System is from a user's viewpoint. This attachment was written one year ago, but very little has changed since then. The state hospital system is on one track, and community services are on another. The amount and quality of services varies widely across the state. We are still spending 80%± of our mental health service dollars in the 4 state hospitals while mentally ill people will spend 95% of their lives in their community. The state hospitals continue to be overcrowded, and continue to be in danger of decertification each year. Kansans continue to be housed in state hospitals because services in their communities are insufficient or not available. My son is presently in an ICFMH. He will need a structured group home, but there are insufficient group home beds in my area.

This bill is the result of at least 5 years of study by the legislature, SRS, the Governor's Task Force, the Dept. of Social Welfare of KU, mental health professionals, families, consumers and advocates. It has not been put together lightly, but with great amounts of time and energy exerted by many interested Kansans. A Legislative Post Audit report of 1988 pointed out serious gaps in our mental health service system. A national report rating the states in 1988 placed Kansas in 42nd place-an embarassing position. That report is biannual and will be published again in September, 1990.

HB 2586 is not complete reform - that would require all the funding necessary to establish all the services needed by mentally ill Kansans. It is a strong start on needed reform. It's passage will send a strong message that Kansas does care what happens to its citizens who are unfortunate enough to suffer mental illness. The families of the mentally ill in Kansas urge you to vote favorably for HB 2586.

The choices seem clear. Do nothing and perpetuate the problems of today-fragmented services; overcrowded hospitals; appropriating substantial additional general fund monies each year to keep the hospitals certified; keeping Kansans warehoused in hospitals because there are insufficient services in their communities; and continuing the uneconomic expenditure of state tax dollars for the most expensive and sometimes less effective inpatient treatment. Or-starting in this legislative session to solve these problems.

SPH+W
Attachment 3
3/27/90

Finally, the citizen governing board of the Johnson County Mental Health Center has authorized me to speak in favor of HB 2586, and urges its passage.

Howard Snyder

Howard Snyder

The Kansas Mental Health System
A User's Perspective on
Services for the Long Term Mentally Ill

I Fragmentation instead of integration.
- A. State hospitals are administered and programmed by the state-little involvement in community services.
- B. Private hospitals are not a part of the community support system.
- C. Mental Health Centers are licensed by the state, but locally administered and locally programmed.
- D. Community services vary widely from area to area-some very good, some only token.
- E. Private out patient providers, and public community providers generally don't coordinate their services.
- F. ICFs are not a part of the MH system.
- G. Income maintenance for the mentally ill is not a part of the MH system.
- H. Medicaid use by mentally ill persons is not a part of the MH system.
- I. There is no state housing authority, so there is no state housing plan.
- J. In the involuntary commitment process, legally trained people make medical decisions concerning a person's need for treatment.
- K. Discrimination against the mentally ill in work, housing and public accomodations is legally sanctioned by the state.
- L. Vocational Rehab offers few services beyond evaluation-and the evaluation is usually "not job ready," which was known up front.
- M. A person with mental illness must deal with a Social Security office, a SRS office, a MHC, a Voc Rehab office a local housing authority plus all the other agencies that we all must confront.
- N. A private outpatient provider may see someone 1 hour per week. What about the other 167 hours?

Comment: A system this fragmented is completely dependent on the creativity, communication skills, the desire to communicate and minimal concern about turf protection of of 100s of people.

Comment: We expect a person with disordered and disorganized thought processes to navigate through the maze of services. Those of us who have no thought disorder would have great difficulty.

II Money
- A. We spend $.80± of every MH dollar on in-patient treatment and $.20± on community services. Yet, mentally ill persons will spend 95% (at least) of their lives in their community, and only 5% in a hospital.
- B. Most insurance coverage is geared toward inpatient treatment.
- C. Latest NIMH figures show Kansas is 51st of all states and territories in per capita state spending for community MH services.
- D. Osawatomie State Hospital once had 1700 beds. It now has 325±. Of the 1400± beds closed, less than 500 have been replaced in the Osawatomie catchment area.
  1. Johnson and wyandotte Counties (500,000 population) have only 1 group home of 10 beds.
- E. Income maintenance is approximately $350 per month. How many of us could live on that. Minimum wage is $2800 per year more.
- F. If they earn more than $75 per month, they lose all their benefits-including the Medicaid card. The incentive is to <u>not</u> work.
- G. Until recently the state was passing up federal matching funds, because they were not willing to match.

Final comment: Many persons with mental illness are dumped on their aged families who then must be care givers, crisis managers, social life providers and case managers. All this with no training, and for no compensation.

Howard Snyder
February, 1989

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 26, 1990

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: House Bill 2586; Mental Health Reform Act

We appreciate this opportunity to endorse the concept embodied in HB 2586. We agree that the provision of mental health services at the community level is generally preferable to institutionalization. We would emphasize, however, that in some instances, treatment of a patient in a state psychiatric hospital environment is the most appropriate placement.

The provisions of HB 2586 are the product of a great deal of analysis and deliberation by interest groups as well as those who enact public policy. We generally agree with the wording of HB 2586, but wish to express concerns as to the composition of the Governor's Mental Health Services Planning Council. You will note in new section 5 that a simple majority of the Planning Council consists of members of the general public who are consumers of mental health services or family members of mentally ill persons. The balance of the Council consists primarily of representatives of state agencies and representatives of community mental health centers. Only one member is a representative of private mental health service providers. This one member could be any one of a number of professions.

Attached to this statement is a copy of our letter to the Chairman of the interim Committee which studied this issue during 1989. This letter was written after the public hearings were concluded in response to the question as to the qualifications of a physician to diagnose and treat mental illness. The question was asked by the Chairman of this Committee who knew the answer to the question when he asked it, but recognized the need to provide the Committee with a reminder. We believe this letter substantiates the argument that at least one person licensed to practice medicine and surgery should be a member of the Council. We respectfully request that you adopt an appropriate amendment to HB 2586 before recommending it for passage.

Thank you for considering our concerns.

CW:lg

Attachment

SPH+W
Attachment 4
3/27/90

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

October 23, 1989

The Honorable David J. Heinemann
Chairman
1989 Special Committee on Corrections/Mental Health
via
Kathy Porter
Kansas Legislative Research Department
545-N, Statehouse
Topeka, Kansas 66612

Dear Representative Heinemann:

During the Committee's discussion of proposal number 17 on October 12, 1989, Senator Roy Ehrlich requested that the Kansas Medical Society submit a statement as to "whether a medical doctor is qualified" to make decisions to determine whether a person should be admitted to a psychiatric hospital. I believe Senator Ehrlich's question was asked because of the various statutory requirements that a statement be obtained from a licensed physician or a licensed psychologist before a person may be admitted for treatment of mental illness.

The simple answer to the question is yes; a medical doctor is qualified to make decisions regarding whether a person should be admitted to a psychiatric hospital. Furthermore, physicians (persons licensed to practice medicine and surgery) are the professionals most qualified to diagnose and treat mental illness.

Perhaps the question arises because of similarity between the terms psychiatrist and psychologist. A psychiatrist is a physician licensed to practice medicine and surgery, whereas a psychologist is not a medical doctor.

We sometimes oversimplify or minimize the complexity of mental illness. Emotional disturbances or psychological disorders can be symptoms of mental illness but may also be the result of other illnesses. For example, a person who abuses drugs may demonstrate psychotic behavior that resembles mental illness until he or she is detoxified. The same thing can happen to a person who takes multiple, legitimately prescribed medications. The side effects of medication can produce behavior that appears symptomatic of mental illness.

There are also common maladies which may result in aberrant behavior, delusional thinking, confusion, or other symptoms resembling those of mental illness. For example, hypothyroidism (deficiency of thyroid activity) can create the appearance of mental illness (typically depression) when the disorder is actually a glandular dysfunction. A more common example of a misleading symptom would be hallucinations caused by fever associated with an infection. A physician is the professional with the most extensive training and experience to make these differential diagnoses.

4-2

It is for these reasons that any person who demonstrates symptoms of mental illness should receive the benefit of a medical diagnosis prior to undergoing any kind of therapy program. This, of course, includes admission to a psychiatric hospital. Only a physician is trained and qualified to diagnose organic disease that may be the basis of mental illness, may contribute to the person's mental illness, or may cause symptoms which indicate mental illness but are attributable to other causes.

Another important point; psychiatrists are medical doctors or doctors of osteopathy who have completed post-graduate medical education training specializing in psychiatry. They are psychiatric physicians licensed to practice medicine and surgery who have successfully completed educational curricula and clinical training that far exceeds the preparation that any other category of mental health professional receives. To reiterate, all too often, members of the general public confuse the term psychiatrist with the term psychologist. The psychologist is not medically trained. This misleading similarity in terms is unfortunate.

Finally, I should explain that Kansas does not license physicians based upon their medical specialty. Instead, we license persons who are qualified to practice medicine and surgery and we call them physicians. This is why in statutory construction you find the term physician, when in practical application it is likely to be a psychiatrist who provides a medical diagnosis.

Thank you for this opportunity to clarify a very important question.

Respectfully yours,

Chip Wheelen
Director of Public Affairs

CW:lg

cc: Donald R. Brada, M.D.
President, Kansas Psychiatric Society