Approved 4/27/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

6:20 a.m./p.m. on March 28, 1990 in room 522S of the Capitol.

All members were present except:

Committee staff present:

Norman Furse, Revisor's Office
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Sandra Nash, Committee Secretary

Conferees appearing before the committee:

The Chairman called the meeting to order, recalling John Peterson to appear.

Mr. Peterson said that he did note meantime in regards to amendment number 3, addition on page 15, line 19, we're adding the term "or psychologist" that are in the list of amendments proposed by the Community Mental Health Center Association. They're proposing adding to that same line "who can be supervising different individuals working at a center." They had proposed adding for a registered nurse who has a specialty in psychiatric nursing. So I would certainly think, if you are going to add that amendment, the addition of the term psychologist would be appropriate.

Staff Furse asked if social workers supervised by psychologists?

Mr. Peterson said under their licensing law, they are not. Practitioners are supervised by physicians or psychologists. This is seeking in the term the individual who can sign off on that. So actually my amendment is liberalizing, the number of people getting closer to what a social worker can do in the real word if they were to qualify. Clearly the bill sets a definition "Qualified Mental Health Professional" separate and apart from those practitioners and their licensing requirements.

Staff Furse said the answer is that social workers are not ordinarily supervised by psychologists.

Mr. Peterson said he thought they very often are.

Staff Furse asked about master social workers.

Mr. Peterson said no. Master level psychologists are as a matter of statute.

Staff Furse said he was going to ask if Mr. Peterson's amendment related to both to master level psychologists and social workers, but he understood from what Mr. Peterson said that it does.

Mr. Peterson said he believed it did.

Staff Furse said in Section 29 there is an amendment which is proposing adding in a number of hospitals, physicians, colleges, etc., in referring patients back and forth. Is this intented just to relate to referral to state institutions or does it have the meaning broader than that.

Mr. Peterson said the language in that section relates to the treatment pursuant to an outpatient order. And decisions to release individuals in treatment. As you are aware, the individuals who are committed may be admitted to any treatment facility, which is a defined term and includes

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

private psychologists, psychiatrists, private hospitals. So, yes, you may well have. Regardless of how exclusive you make that, the court is still going to be committing people, on occasion, to regular hospitals and to other outpatient situations. My only thoought on it, it should have the same standards of care as you are providing in this Section 29 in state hospitals and community mental health centers.

Staff Furse said the testimony the Committee has received with respect to Community Mental Health Centers is that they are going to be undertaking additional duties and responsibilities under this bill. Is that true of other groups that you are suggesting, and does this bill provide them with any additional duties that they don't have today.

Mr. Peterson said no, that he doesn't feel the gate-keeping function as being much of a important role in terms of the delivery of services. I see what a gate-keeper is doing, as you are aware of the gate-keeper is not the person who renders the medical, psychological opinion as to whether or not a person is in need of care and treatment, whether an individual is mentally ill. Basically, what they are suppose to be doing is evaluating the community services that are available, determining whether an individual, given his or her condition, can be treated in a local community. Whether they need to be signed off on that they can go to a state hospital. I view that as a separate function from that of providing additional actual services. One of my biggest concerns as this comes down over the next four or five years, that you will end up being as the community mental health centers go to providing more services in the community, closer to the citizens where they reside, their going to build new facilities new hospitals, instead of utilizing the resources that are already in the community, whether they're private practitioners or hospitals that already exist. So I hope that there will be some coordination, some use. I don't think there is, going back to your question, I don't think there is a justification in changing the standard of negligence because someone is going to be serving as a gate-keeper. I don't feel that section as limited to the gate-keeper function. I believe that section changes the standard of care for providing treatment a person pursuant to an order for outpatient treatment, for example. Having nothing to do whether or not they are a gate-keeper, whether or not they are providing additional services.

Staff Correll said as she reads the bill, Sections 1 through 11 created a new act, and then the bill also amends the act relating to the determination of mental illness, which is a separate act. I don't find the terms physician or psychologist defined for the purposes of Section 1 through 11. She asked if she was missing something. You have simply used the term psychologist. And as you are using it here, it appears not be defined. She said, where he is inserting the word psychologist, it would be defined. But it is not defined for any of the first part of the bill, the first 11 sections. Nor is the term physician. Do you have some definition that you want to refer to a licensed psychologist.

Mr. Peterson said he wouldn't have a definition that would be in variance to the definition that's in the other section. Or you could insert into the other act, you could use the terminology "licensed psychologist."

Staff Correll said when she looks back, she doesn't find the term defined. We define a qualified mental health professional to mean a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or

psychologist under contract with a participating mental health center.

Staff Furse said it is on Page 14, Line 12.

Senator Reilly said asked if Tirrell was a psychologist?

Mr. Peterson said a Ph.D.

Senator Reilly asked if he was a member of your organization.

Mr. Peterson said he was but he was not appearing on behalf of the organization tho.

Senator Reilly asked if Dr. Tirrell had discussed any of these other provisions of the bill in concept and body of the bill with you at all. How many others are there concerned?

Mr. Peterson said no. He said he is familiar with some of the general concerns. My attempt at this point was to try to offer some, I don't recall hearing that he proposed any specific amendments other than an overall concern, but obviously, some of that concern was directed toward the creation of a system that, I believe, these proposed amendments, deal with. Number one, by giving SRS some flexibility to contract to with an entity, a hospital or other entity, other than a community mental health center. And secondly, by allowing a private practitioner whose already treating a patient to refer that patient to a state hospital, subject to the state hospital's accepting a patient. Those deal with, some of the points, he raised.

Senator Reilly said what he was trying to get out, was the professional psychologist association involved in discussing some of these issues, in terms of all of these things that were brought up. And there is a very interesting number of questions on the line. Did they sign off on the bill in order to take of some of the flaws of the bill. In order to insure that your professional psychologists have input in what is taking place as far as the process in concerned.

Mr. Peterson said he didn't follow the Senator in reference to an agreed upon sign off on the bill.

Senator Reilly said he only recently leafed through what Dr. Tirrell said. And he indicated a number of concerns. Are there other people like that? Are they concerned about the flawed language of the bill and the fact that they may or may not be part of the process allowing referrals to the state hospitals.

Mr. Peterson said he thinks a good number, a high majority of the members, of the association, and you also had testimony submitted to you from the Kansas Psychological Association which is a much larger association than mine, that also expressed concerns. I think a good number have concerns about the total lack of involvement or potential of any involvement for private practitioners, whether they be physicians or psychologists.

Senator Reilly asked if that holds true for your's and the other group?

Mr. Peterson said yes.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 522S, Statehouse, at 6:20 a.m./p.m. on March 28, 1990, 19__.

The Chairman called the next opponent, Corrina Hartman, Self-Help Resources & Development, Inc. She said she has three different perspectives because she could look at this bill as a service provider of a facility that she volunteers in, as a taxpayer and as a consumer. She said she is representative of people that fall through the cracks of the system. Ms. Hartman explained the Self-Help program and then listed the reason they were an opponent to H.B. 2586: 1) the monopoly of the mental health system, 2) The gate-keeping conflict of interest, 3) only a physician can do mental health evaluations, 4) right of freedom of choice denied, 5) private sector is left out.(Attachment 1)

The Chairman called the Committee's attention to the letter from Linda Sebastian, Associate Director of Nursing at the Menniner Clinic. (Attachment 2)

The Chairman called the opponent, Bob Frey, The Trial Lawyers Association. Mr. Frey spoke in opposition of Section 29 of the bill and requested that this amendment be removed.(Attachment 3) He stated Section 29 is contrary to the interests of the mentally ill and the citizens of the State of Kansas. If this section were adopted, there would be no liability, which is wrong. The Kansas Tort Claims Act already limits the liability of the State of Kansas. Mr. Frey said he would like to be say if you gave this responsibility to the Mental Health Centers, they would do a perfect job, they would make every decision correctly, they would not forget to do something, they would not mislay papers, they would not simply deny someone the proper treatment because they didn't have enough money or they didn't care. But the fact is that's going to happen. I don't think any of us are naive enough to believe that folks out there who are wanting this responsibility are so good at it, that they're not going to make mistakes and cause some harm. The responsibility for that harm, if it comes from negligence on their part, should be their responsibility.

Senator Reilly asked who had recommended Section 29.

Mr. Frey said it was his understanding that Mr. Rein did.

Senator Reilly said the state has the responsibility to warn if they are releasing someone and they have knowledge the person would or possibly do harm to an individual and the threats. Do they have the duty to warn.

Mr. Frey said the common law is what we are talking about. There is nothing in the statutes that says you have to inform. But under the decisions that have come down through the courts, the responsibility does lie. Now, if you don't know, the law isn't going to be unreasonable here. But if you actually have knowledge, known threats, you have a duty to warn.

Senator Reilly asked if that was the same for the Correctional Institutions.

Mr. Frey said in the case of the Correctional Institutions, the matter has been brought before the courts as well. And, the courts in that particular instance, the case of the individual at Lansing which resulted in someone being killed or severly injured by an escaped prisoner, other than the police were aware of the fact the prisoner had escaped and was out in the community, and they failed to notify the local police departments of his escape and of the dangerous characteristics of this person, the courts found liability.

Senator Walker said if Osawatomie State Hospital release a patient that had made threats against a person and then went out and carried

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 522S Statehouse, at 6:20 a.m./p.m. on March 28, 1990

out those threats. And the community hadn't been informed. Would it be gross negligence?

Mr. Frey said he isn't sure it would be gross negligence. Gross or Wanton Negligence usually require some specific or actual intent on the person to have caused the injury.

Staff Correll said the section that follows this, relates to saying that even in the case of a court-ordered admission, if the state facility does not have space, the courts are to be notified that the person is to be put on a waiting list. Do you see any potential liability for the state?

Mr. Frey said he hadn't really studied that.

Senator Hayden said in the case in Wichita where the guy shot the gal on the highway, and killed a person there. He had been in an alleged drug environment as far as mental health care.

Mr. Frey said he only read what was in the newspapers but as he recalled, that was right.

Senator Hayden asked if there was a liability present on somebody, some provider of services for that act?

Mr. Frey said yes.

Senator Hayden said under this deal there would not be?

Mr. Frey said yes.

Senator Hayden irrespective to the burden of the structure of the gate-keeper or after the gate-keeper, there would be no liability.

Mr. Frey said correct, except if he was being treated by a private provider, one who charges fees for their services. The immunity doesn't extend to those folks. Which raises another question in our mind about the constitutionality, between one type of patient and victims entirely different than it would from another type of patient.

Senator Kanan asked if social workers were exempt.

Mr. Frey said no.

Senator Kanan asked if foster parents were exempt.

Mr. Frey said no.

The Chairman called the Committee's attention to the letter from the Attorney General's Office addressing Section 29. (Attachment 4)

The Chairman called the next opponent, Jeffery L. Neill. Mr. Neill said he was against the bill because it creates a monopoly and eliminates the right of freedom of choice for the patient. (Attachment 5)

The Chairman asked for data from SRS regarding the admissions to state hospitals, as requested by the Committee members. How many are through community base settings and how many private practitioners or how many through the court system.

Dr. Mani Lee of SRS said at the moment they do not have any exact data be he has a letter he would like to present to the Committee.

The Chairman agreed to allow Dr. Lee a couple minutes.

The Chairman said before Dr. Lee started, he wanted to know if they have the data on the admissions to state hospitals.

Dr. Lee said they don't have exact data on how many people from private practitioners but he would say that the majority of them would be served by community mental health centers and state hospitals.

The Chairman asked if he had nothing on the private practitioners.

Dr. Lee said a very small fraction of our clients would be covered by private practitioners.

The Chairman asked about the courts.

Dr. Lee said that roughly about 50% of our admissions are involuntary admissions. Dr. Lee stressed the reason for the concept of gate-keeping. (Attachment 6)

Senator Reilly said that the last comment from Mr. Rein that he wrote down was that this was certainly a bold and aggressive shift in treatment, and he said he would have to concur. This letter today reminds him a little of the battle fought around here regarding the restriction of admissions to colleges in the state. If he was reading between the lines correctly, Dr. Lee is saying that you do not want, under any conditions, private practitioners brought into this and not have the ability to admit patients to state hospitals. Where now, in the current situation, they may. The current policy is, of course, that the Kansas people pay to build and maintain by a 1.5 mill levy on their property taxes, which we're collecting. Isn't that a correct statement?

Dr. Lee said they did not want the private practitioners to be independent decision makers.

Senator Reilly said who are they going to go to?

Dr. Lee said is what they are proposing is that the mental health centers would have some kind of a working agreement with private practitioners and we would suppose that the centers would be willing to work with them.

Senator Reilly said you are supposing.

Dr. Lee said yes, they are pretty confident that it will happen. The centers would reach out to the private practitioners and make some kind of arrangement that they would assist in the screening process.

Staff Correll said the letter from Mr. Nemac which you presented does not seem to respond to the concerns of consumers, that they are losing the freedom of choice.

Dr. Lee said actually, as far as they are concerned, the consumers are not really losing the freedom of choice. They will gaining more programs, they will have more access.

Staff Correll said perhaps that will be the way you look at it, but is it not now true that a consumer of mental health services may ask to be admitted as a voluntary patient directly to the state institutions. And that will not be possible.

Dr. Lee said that is correct, it wouldn't be possible. We would want them to be screened by agency that knows the community resources.

Staff Correll said, so, infact, it would be correct what the consumers

are saying, that they are losing freedom of choice.

Dr. Lee said yes.

Senator Reilly asked Dr. Lee to walk him through the screening process.

Dr. Lee said any physician, any private practitioner, can say that a patient is in need of treatment. The final decision of whether somebody should stay at a state hospital or not, is made by a physician at the hospital. All the screening does is that the community mental health center staff verifies that the patient is in need of state hospital treatment and that there is no other alternative resources available in the community. So, if there are other available resources, and these people would be served in the community, which most clients would prefer. We asked one hundred people residing in state hospitals, 99% would say that they would like to go home and live in their community. If we can find ways to keep them in their own community, we are doing service for them.

Senator Reilly said he hadn't answered his question. What does the screening process entail. Who is going to be the screening person. You said an employee of the mental health center. Is that a social worker. Could that be a social worker.

Dr. Lee said it is the physician, a licensed psychologist, a licensed social worker, clinical social worker, licensed master social worker. And under the direction of or supervision of a physician. And, if there is an emergency, then these people would be contacted. And they would make contact with the client who these symtoms and decide whether the person could be managed in the community or should be further evaluated or treated at the state hosptial.

Senator Reilly said what he is question in the screening process is how long it would take and what is the procedures they would go through and what guidelines are there. This morning there was a comment that the screening process consisted of 15 minutes. What is the average time. I know what it takes to get a physical when I go in to see the doctor. What does it take?

Dr. Lee said the screen would take as little as 15 minutes or as long as two hours. Depending on the circumstances. If somebody is, screening is basically a clinical interview, somebody who has some expertise in interviewing a patient in terms of deciding whether somebody is mentally unstable, and to what degree.

Senator Reilly said if that were me I would like a doctor of psychology, or a psychiatrist, rather than others.

Dr. Lee said it is not the screening process that decides if they are mentally ill or not.

Senator Reilly said you are deciding whether or not I'm going to an institution. What services are there open for me.

Dr. Lee said if the screener believes that the screener is unable to evaluate the situation, then automatically that patient will go to the hospital.

Senator Reilly said in that catchment area.

Dr. Lee said right.

Senator Hayden asked Staff Furse to explain in lay language what

the Attorney General is saying. As I see it, he's saying Section 29 is not operable.

Staff Furse said it appeared to him that the reference the Attorney General was making was to the state hospitals inclusion in the section and was suggesting that that may not be appropriate to include state hospitals in this kind of exclusion for ordinary negligence.

Senator Hayden asked if the state hospitals were covered under the Tort Claims Act.

Staff Furse said he is not sure where we are right now with state hospitals.

Senator Hayden asked Dr. Lee if 29 was taken out, how would you deal with it.

Dr. Lee said the bill would still be workable. In psychiatry when we're dealing with mental illness, there is no guarantee that future predictiability is possible. The grave danger of being sued, the people involved in the system will be extremely careful about making treatment decisions. Section 29 is a provision to prevent people from staying very cautious and not doing anything.

Senator Hayden said in essense, what you're telling us, you are radifying what Bob Frey just said.

Dr. Lee said that is correct.

Senator Hayden said that if there is no chance for liability, you become a little looser.

Dr. Lee said and provide better care. It is our belief. Because there are people at Larned State Hospital who could be released but because of the laws involved, the doctors are very hesitant to make the discharge decisions. Also community programs will be very reluctant to take in some these people if there's being a lawsuit.

The Chairman called the Committee's attention to a letter from Penny Sue Johnson, an opponent. (Attachment 7)

The Chairman said the next committee meeting will be March 29, at 8:00a.m. The Committee adjourned at 7:03p.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3/28/90
p.m.

(PLEASE PRINT)

NAME AND ADDRESS	ORGANIZATION
Howard & Lou Snyder	Kansas Alliance for the Mentally Ill
Chet Unruh	
JoAnna Unruh Larned Ks	Kans MH Planning Council
Al Nemec Topeka	SRS/MH&RS
Terry Larson Topeka	Ks. Alliance for the Mentally Ill
[illegible] Olathe Ks	Self-Help Resources + Development Inc.
[illegible] Olathe ks.	Self-Help Res. + Dev. inc.
[illegible], POP, Ks. President	The Ks. Coalition, Inc.
Lori Class Topeka	KS Mental Health Assn.
Richard Morrissey	KDHE
John Peterson	Ks Assn Prof Psychology
Mari Lee	SRS / MHRS
I.M. Afraid "	MHRS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS

Please continue on next sheet.

To Public Health + Welfare Committee

This is a Statement to correct testamonie given to you by Tim Paul: 3/27/90

1) Tim made statement that he represented all Consumers. This is not true. He have not met and gotten a complete census of All Consumers/and group in the state of Kansas

2) at the Consumer steering council called Kansas Mental Illness awarness council I serve on that council as voting member. Statement was made that "all consumers there voted yes on this Bill." This is not true. I voted "No on HB 2586" and asked it to be noted in the minutes I did vote no. other consumers presents said we can not vote because we have Not read it and have no Knowledge of this Bill. We can't vote on it at this time - Also Amendments for the Bill were read at this meeting by two other Consumers.

Sincerely

Connie Hartman

SPH+W
Attachment
3/28/90

NASMHPD POSITION PAPER ON CONSUMER CONTRIBUTIONS TO MENTAL HEALTH SERVICE DELIVERY SYSTEMS

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that former mental patients/mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many arenas of the service delivery system. The significance of their unique contributions stems from expertise they have gained as recipients of mental health services, in addition to whatever formal education and credentials they may have.

Their contribution should be valued and sought in areas of program development, policy formation, program evaluation, quality assurance, system designs, education of mental health service providers, and the provision of direct services (as employees of the provider system). Therefore, expatients/consumers should be included in meaningful numbers in all of these activities. In order to maximize their potential contributions, their involvement should be supported in ways that promote dignity, respect, acceptance, integration, and choice. Support provided should include whatever financial, educational, or social assistance is required to enable their participation.

Additionally, client-operated self-help and mutual support services should be available in each locality as alternatives and adjuncts to existing mental health service delivery systems. State financial support should be provided to help ensure their viability and independence.

-- Developed by an Ad Hoc Committee on Consumer/Expatient Involvement meeting in Cambridge, Massachusetts, February 23, 1989

-- Approved by Executive Committee of Human Resource Division of NASMHPD on June 13, 1989, for consideration by the full membership of the NASMHPD Human Resource Division for action at its annual meeting in October, 1989, in Omaha, Nebraska.

-- Approved by NASMHPD Board 12/12/89, and by Membership on 12/13/89 at Winter Commissioners/Directors meeting.

Good Morning

Thank You for this opportunity to Speak with You today

I am Connie Hatman: Self-Help Resources & Development, Inc.
Developer/implemented program
was Coordinator/Ex Director for 2 years
am now caseworker of Self-Help

I serve on the National Board of Directors of NAPS - Spoke National to 612 Groups in 5 years

Self-Help - who are we? We are recognized as -
IRS - Social Welfare Agency (Self-Supportive)
Washington - Community Action Agency/Alternative
Nationally - Skill Development/Rehabilitation Center
HUD County - Transitional living/independent living Program for Homeless
City - Homeless Shelter/Clearing House Resource
State SRS - Consumer Run/Consumer Controlled Drop-N-Center
Local MH - Consumers

— We are Citizens/people who fell in the Cracks of the System - some refuse to use the traditional system others have been abused by this same System and others have been refused Services or Benefits they were entitled to receive and we Advocate for them all. we have one Center at Olathe - two other groups in the State have Chartered with us and this year we will be opening a center in Iola & Hays. our Total membership is 949 but only 417 use any type of Mental Health Services.

— We are a Crisis Intervention Program Alternative Of Case management, Housing, job services, Skill Development, Drop-N-Center & Hot Line.

?ibility & Responsibility — Self & Family (Sometimes not accepted) & Normal World
- State for persons with M illness
- Whether they are rich or poor
- Quality Service
- All receive the Same Service

[Situation +]

Monopoly — Control of ones life

[Freedom of Choice]

- Skill Development
- Learning My Needs
- Goals & planning
- Individual Program Development
-

All people Need respect & Recognition

- CMHC - Consumers
- Private non-profit Consumers
- Some of the Street people
  who Sometimes won't use MH Transitional System
  past experiences, or been refused
- one on one peer counseling our Needs are reconized in a mutual understanding

Individual Needs

- of Individual
  using Community Resources
-

[Program Development]

Example: Oswatomie Catchment Area

1) Shawnee Mission Hospital evaluation

2) All Resources of Community offered Client choice.

3) all different Case Management Programs & support surrounded the client for that persons needs

4) that means using Alternative if that is that persons choice

Concerns of the Consumers "No to #B2586"

1) The Monopoly of the Mental Health System

2) The Gate Keeping - a conflict of Interest
   a. Receiving funds, deciding who gets funds, and then being a service provider
   b. If the county Commissioners become the Board - they are elected by the Community. How is the consumer represented on the Board

3) Only a physican - can only do mental health evaluation - No Case Workers or Professionals only Licensed Doctors.

4) Right of freedom of choice to pick your own Service provider, doctor, medication, etc. are all taken away from the clients by this Bill.

5) Private Sector is left out! Private-nonprofit Independent, and alternative mental Health Services will be monopolized if they want to recieve funds for there programs and they will then no longer controll there own programs

Sincerily,
Connie [illegible]

PERCEPTION OF CHANGE
by Corrina Hartman

Thesis Statement: Crisis and Poverty in the land of plenty will continue to destabilize the social economic fabric of our society unless we control the situation now.

Purpose: Today I want to share with you an idea, a change that is occurring in our traditional system for the betterment of mankind. Using the same goals mandated by federal law for Human Resources, which are to offer prevention services to reduce human suffering and cost. A change so overwhelming that it is perceived by some state agencies as a threat to their existence and to others as an answer to the problem, with results of overabundant success. Human Resources and Self-Help Resources and Development, Inc. working together seeking to expand and to improve the range of human services that foster the sound development of children, adults, youth, and families. This change is a grassroots movement which has been growing the last two years in social services, crisis intervention through Drop-n-Center and hot lines, crisis residential housing, job placement services, education services, advocacy and legal services, problem solving, motivation, and skill teaching workshops. A program which is serving over 7,000 individuals in over 612 Self-Help Centers (of all types of models) across the United States.

I am proud to say that I am recognized nationally for the development, Corporation, writing, and implementation of this program, that I am presenting to you today, in the last five years. I want to share with you today three advantages of this type of services for mankind. 1) The idea and services by peer workers using the self-help model, which was developed by the homeless, disabled, and indigent citizens of Kansas, who once lived on the streets but no longer do because of our own program. 2) Community resource network and cost effectiveness, because we get everyone in the community involved in the learning process. 3) Documented outcome data and Information on the first and only self-supportive Self-Help Center in the United States........which has been operating and providing services in Olathe, Kansas. With no assistance or support from the state social and rehabilitation services department or the states community support services dept.

First the idea and services, In general the state, county, and community all working together in the improvement of the quality of life for the homeless, mentally and physically disabled, and the poor. How would we do this you ask?....though a social and incentive work program to change income dependency from the state and federal government to the individual. I saw and understood clearly. That the nature of the Kansas SRS Dept. was to put and keep individuals in and dependent upon the Welfare and Mental Health system. That monopoly of individuals' lives is state administration and state department head mandated down to the agency workers, but not by federal law. Also, individuals who are not mental ill are wrongfully placed in mental health services because of lables placed on individuals by case workers. For example: if we can take one person off welfare or social security (SSI, SSD, SRS).......and put them back into the work forces as productive working tax paying citizens.....this is how the income dependency would switch from dependency to independence. (drawn example $5.50 an hour). I have handed out to you a list of Self-Helps Services. This is a long-term peer support program of problem solving, crisis intervention, and learning strategies that are taught to an individual at their own level of functioning and level of desire to grow. On the average it take one individual two

ye in this program, while he or she is working. The workers are all peer models....those who are life experienced, having successfully pulled themselves out, are now teaching someone with the same problem, through motivation, to do the same.

Secondly, Community resources in networking and the cost effectiveness of the Self-Help Program. The key is to get everyone involved.....the state, county, non-profit community agencies, churches, and individuals (through volunteer services). Finding all the resources available in that community. Everyone in the community working together for these individuals. Volunteers answering the hot-lines, working in the Drop-n-Center, giving the motivation seminars, and skill teaching workshops. The cost for one person to participate in the Self-Help program is only $600.00 per year...... ...1.65 per day.......24 hours crisis intervention services. Compared to Mental Health Centers CSP program which is $4,635.00 per year. The ICF mental health facility which is $10,560.00 per year... .. Osawatomie State Hospital which is $18,943.00 per year...... The federal mandated law idea is; to keep people in the community in the least restrictive and most cost effective community support program available. Which Self-Help Centers have done.....and best yet ....at no cost to you the tax payers, the state, and the federal government. We help with crisis transitional group homes, unsupervised living group homes, independent apts, and halfway houses. We help find them jobs in the community through our Job services or Job Coaches are available in our Vocational Rehabilitation Services. Education Dept helps with career setting goals......pell grants, workshops, conferences statewide and nationally. In our Health Dept referrals to services in the community and private doctors, also, community agencies that can help pay for their percription medication. Finally but not last, our Advocacy and Legal Services Dept helping those denied benefits that are eligible and lawyer services which mostly we have been handling civil right issues. Community individuals and agencies all working together, that is the key, removing stigma and labeling of individuals....all are equal.

Third, our data information services showing that just alone in the Olathe Center in the last two years over 893 individuals which were homeless, disabled, alcoholics, parolees, or poor; have been and are being served. We have only had to ask 9 to leave our program......They were looking for a free lunch......Self-Help is not a program that will be for everyone....it is a program for those who want to help themselves, who are ready to move on in a learning and growing process, who are willing to dream and reach for their goals. The Self-Help Programs across the United States have all been developed and serviced by the members themselves. Of all of the Centers the only one that is self-supportive is the center in Olathe, which I am the program developer. I believe we have accomplished and succeeded where the state has failed. In development, implementation, and cost effectiveness. We also asked to be a part of the system, but with respect to let us continue to run and control our own program. We also, believe we should be paid for our services due to the outcome of our program.....In one center, we have saved the state and tax payers over 6 million dollars in the last two years....these people are no longer dependent upon the system.....they are independent upon themselves. If you look at long term...this program after development of 30 centers who would be self-supportive....we would save the state, government, and tax payers.......over 180 million dollars a year.

With the idea of being self-supportive the idea of Investments Unlimited, Inc. was developed, working with Self Help Resources and Development Inc. in that instead of the profits going to an individual, the business profits go to self-help as unrestricted funds

providing the cash matches self-help needs to obtain other grant f... expansion of their services and salaries. This takes the financial hardship burden away from the states to have to come up with the matches. Also, having Self-Help certified as A Community Action Agency makes direct funding available at the federal level, thus not having to involved the state in the process, except in only their technical assistance and participation on our councils. This was done due to the states negligence, abuse, and neglect which has occurred to most of us in the membership role of Self-Help, and the states refusal to recognize and support our work and development that we have done.

Without the state, government, social, self-help, and humanitarian programs the problem of hunger, disease, poverty , and crisis of individuals will only worsen in this land of plenty, and will destabilize our social economic fabric of our society. So ask yourself this question! Will I except this change for the betterment of mankind and perceive that self-help is a answer to solving the problem, because of our already proven successful outcomes? We ask for your respect and financial support in the development of this program.

Thank you.......Do you have any Questions?

Enclosed with this presentation is legislation state testimonies given, position papers submitted to state SRS. [illegible]. HHS, and Human Resources, Self-Help's services paper, graph of our services working with the traditional system, and the bill we ask you to pass in our behalf.

Also, be advised we are recognized by the IRS as a 501 4 (c) A Social Welfare Agency. We are asking for certification as a Community Action Agency from Washington. We are certified as special workers by the labor board, and myself a job coach/job developer to work with the disabled.

Also, CHAP approved by HUD......and have been excepted for funding by Washington but the state would not sign the federal reassurances papers for us to receive the grants. We have been trying to get funding from the state to develop and completely set up this self-supportive program for two years.....with no assistance or exceptance from our state.

Several of our membership serve on state appointed task forces, boards, and national boards. We are involved state and national very strongly. Also, travel to other states paid as teachers and educators helping other groups who wanting to do the same as us and have received funds from their state in support.

Self-Help Resources & Development, Inc.

THE CENTER FOR SKILL DEVELOPMENT

A PHILOSOPHY STATEMENT

We believe that everything we do, think, and feel is purposeful to fulfill our internal needs. We also believe that we are not forced or compelled by the external environment to behave in any certain way. Instead, nearly everything we do, think, and feel is a choice. We make these choices based on the belief that they will help us get more of what we want. Sometimes in retrospect our choices appear rather foolish and even counter-productive to meeting our needs.

The Center for Skill Development's philosophy might be best exemplified by the familiar concept:

> If you give a hungry man a fish he can feed himself for the evening. If you teach him how to fish he can feed himself for the rest of his life.

With this philosophy as our inspiration we are no longer in the position of having to be temporary problem solvers for others. We do not merely discuss and administer rules and consequences. Our goal is to go beyond the level of other traditional approaches and teach new successful skills so that the same problems will not reoccur.

To achieve our goals we emphasize dialogue on a need level. The first step is to explore and define what we need. We then teach how our different behaviors either efficiently or inefficiently meet our needs. Finally (and most importantly) we teach specific skills which lead to more efficient need fulfillment. We work hard to live what we teach whether we are at work, a social gathering, or with our family or friends.

The Skill Development Theory for human success has evolved from cognitive, behavioristic, and humanistic approaches. We have taken what works best in each approach and have created a practical theory to help all people achieve more of what they really want.

Skill Development offers no magical answers or quick solutions. Developing skills is a process which requires intense work and a lifetime commitment to making improvements each day.

Copyright 1986

Skill Development:
A THERAPY MODEL

STAGE I*

Be friendly and listen empathically to presenting problems.

A. "What do you want?"
B "What do you really want?" (teach needs)
C. "What do you have now compared to what you want?"
D. "What are you doing to solve your problems?"
E. "Is what you are doing helping you enough?" (value judgement problems)

STAGE II*

Transition from problems to needs. Ask skill building questions.

A. Open-ended questions:
1. Usually begin with "What are you doing to fulfill a need(s)?"
2. Gives you information as to how the client is meeting his or her needs.

B. Closed-ended questions:
1. Usually begin with "Do you".
2. Gives the client specific information as to how he or she could more efficiently fulfill needs.

C. Questions that call for the client to make a value judgement about what they are doing or not doing and whether or not it is helping enough to fulfill his or her needs.

STAGE III*

Teach plan making skills.

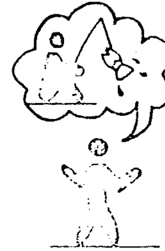
A. Initially you make the plan for the client.
B. Make plans together when client understands the plan sheet.
C. Client will make the plan when they understand the skill building process.

Have client write out the plan on the plan sheet.

Client checks that all eight criteria are met.

Counselor makes a commitment to support the client.

STAGE IV*



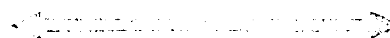
Ask for value judgement about the plan. (Does client think it is fulfilling a need(s)?)

Client internalizes the plan through describing specific steps of future action. (visualization)

Discuss long term consequences of building simple skills.

When appropriate discuss sabotage.

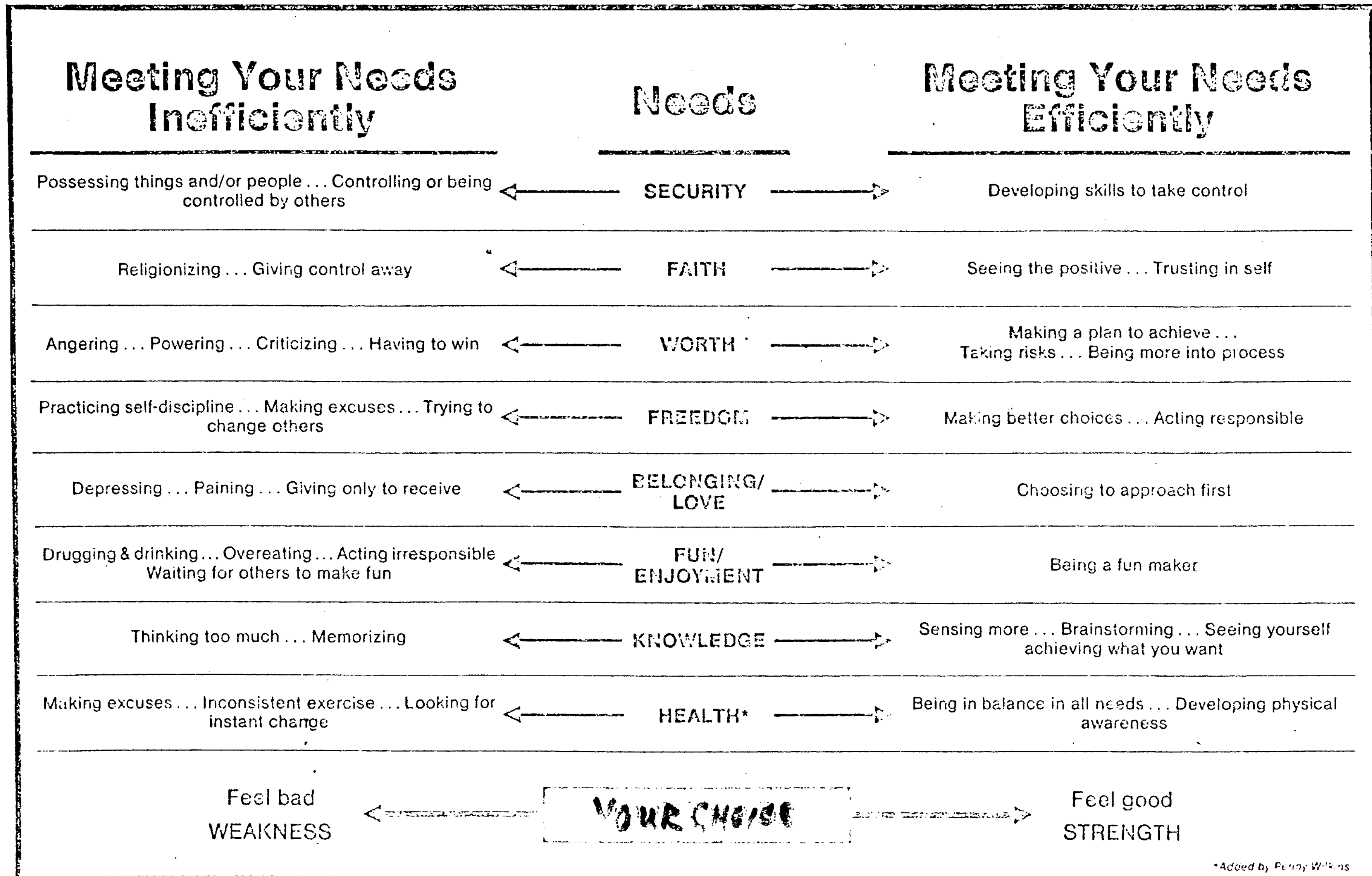
STAGE V

Inefficient Behavior	Client's Choice	Efficient Behavior
Few Alternatives		Many Alternatives
Negative Perceptions		Positive Perceptions

* Summarize between each stage and if appropriate between steps.

1-10

PSYCHOLOGICAL NEEDS:
CHOICES TO MEET THEM



Meeting Your Needs Inefficiently		Needs		Meeting Your Needs Efficiently
Possessing things and/or people . . . Controlling or being controlled by others	←	SECURITY	→	Developing skills to take control
Religionizing . . . Giving control away	←	FAITH	→	Seeing the positive . . . Trusting in self
Angering . . . Powering . . . Criticizing . . . Having to win	←	WORTH	→	Making a plan to achieve . . . Taking risks . . . Being more into process
Practicing self-discipline . . . Making excuses . . . Trying to change others	←	FREEDOM	→	Making better choices . . . Acting responsible
Depressing . . . Paining . . . Giving only to receive	←	BELONGING/ LOVE	→	Choosing to approach first
Drugging & drinking . . . Overeating . . . Acting irresponsible Waiting for others to make fun	←	FUN/ ENJOYMENT	→	Being a fun maker
Thinking too much . . . Memorizing	←	KNOWLEDGE	→	Sensing more . . . Brainstorming . . . Seeing yourself achieving what you want
Making excuses . . . Inconsistent exercise . . . Looking for instant change	←	HEALTH*	→	Being in balance in all needs . . . Developing physical awareness
Feel bad WEAKNESS	←	YOUR CHOICE	→	Feel good STRENGTH

*Added by Penny Wilkins

SELF-HELP RESOURCES AND DEVELOPMENT CENTER

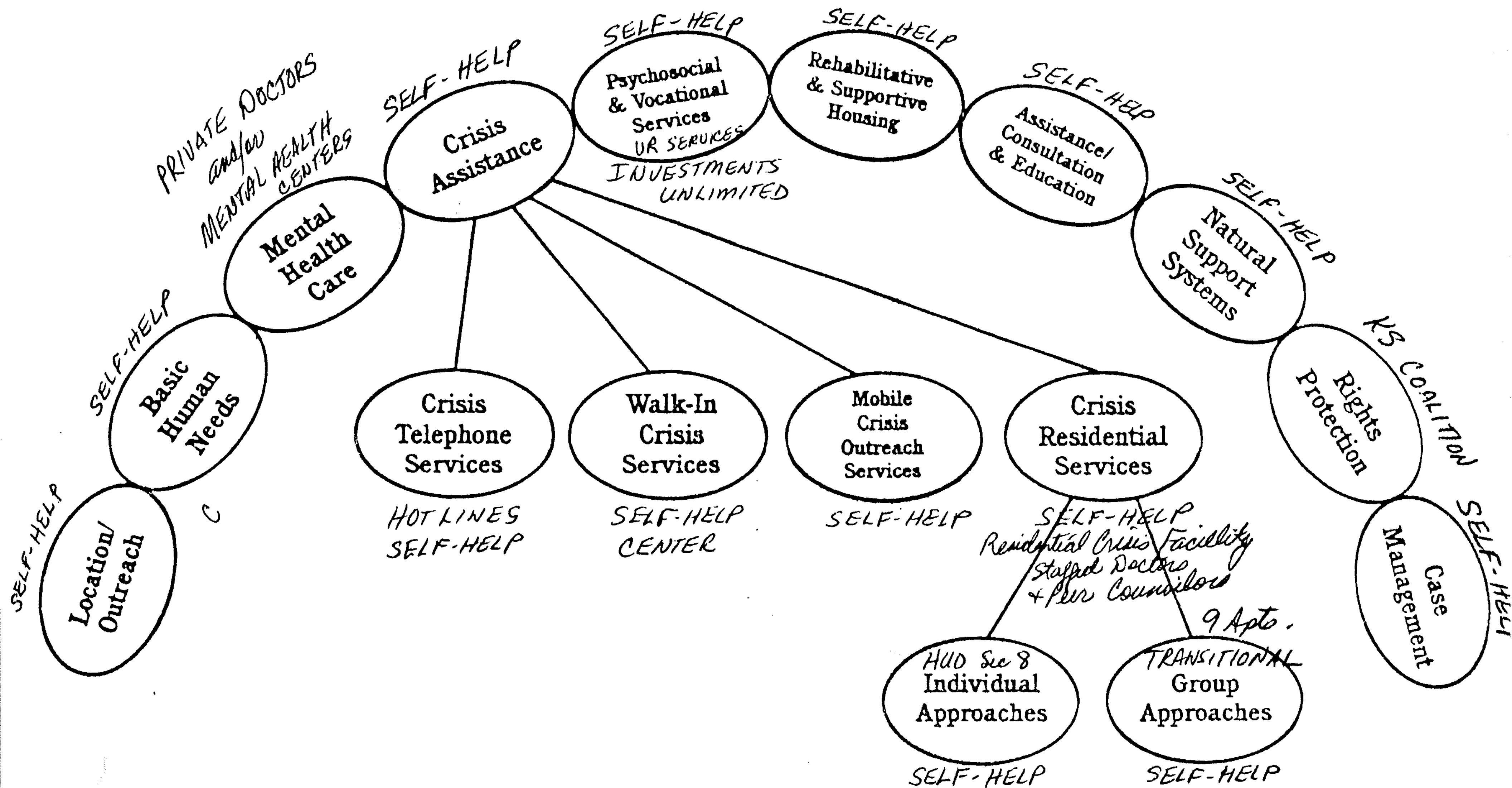
SUMMARY OF PROGRAMS AND SERVICES

SERVICE AREA/PROGRAMS	DESCRIPTION
CRISIS AND RECEPTION	
Daytime Crisis/hot lines	Responds to caller's initial request for service, and provides intake appointment or referral. Also Mobile Unit.
Drop-n-center	Provides crisis assessment, intervention, and referral if hospitalization services are needed 8:00 a.m. to 5:00 p.m.
After Hours	Provides crisis intervention, assessment, on call doctors, counselors, and volunteers; thru center and hot line in 24 Hours programs, Mobile Unit.
Residential Services	Community support System
COMMUNITY SUPPORT SERVICES	
Residential	Maintains a continuum of residential service options including Self-Help emergency shelters 10, Creative Living apartments 52 (transitional), Creative Estates 48(Supervised Independant Apartments), over 830 living in Apartments and on their own - unsupervised
Crisis Residential Service	Provides a range of services designed to maintain approximately 20 crisis intervention clients in a community setting and decrease rehospitalization. Services include: 1) housing during a crisis, short-term, acute treatment and support services, serving individuals. 2) case management, 24 hour treatment, and rehabilitation services; 3) clients are resident, daily activities. Staffing Psychiatrist/Director

Phychosocial Activities	Self-Help Center, L I N C , Compeer, and others. Coffeehouse, Supper Club, Card night/Bingo, Dollhouse Project, Bowling Club, Sewing Club, Arts and Crafts, Baseball Team, Tennis Club, and Movie night, and Natural Support Groups.
Work Activity Center	(Jobs Sites - On the Job training, Support Job Coaches) Answering Service, Greenhouse Creative Writting,Project hire, Lawn/garden Care, Day Care, and Janitor/maid Services, & Crafts
Basic Human Needs	Food, Clothing, Shelter.
Rights and Protection	Advocates, Workshops/Education
COMMUNITY EDUCATION/OUTREACH	Provides Presentations,courses, and workshops to individuals, professionals, & organizations to promote positive mental health programs and rehabilitation support. Includes a series of weekend workshops to assist individuals to effectively cope with Stress management Programs Conferences, Motivation and Basic Skill Workshops.
CONTRACT SERVICES	
Mental Health Care	Referals Psychiatric Doctors Referals Mental Health Center Referals Catholic Service
Health Care	Referals Johnson County health Department, Referals to PHD's
Accounting CPA	Provides program budgeting, financial management & grant writting and reporting.
Clerical	Secretarial, client records, and clerical support functions
Program Evaluation	Provides federal, state,county, grant & Center management serv. and accountability reports.

TABLE 1

RELATIONSHIP OF CRISIS RESIDENTIAL SERVICES TO COMMUNITY SUPPORT SYSTEM



Ap... ed by the Self-Help Resources and Development, Inc. Board of Directors and membership at the Center Olathe, Kansas 11-10-89

POSITION PAPER

STATE OF KANSAS LINE ITEM FUNDING IN REVOLVING FUNDS FOR SELF-HELP RESOURCES AND DEVELOPMENT, INC. PROGRAMS AND CENTERS
Headquarters; 316 South Cherry Olathe, Kansas 66061
501 4 (c) Social Welfare and Crisis Intervention Agency

A. NEED/BACKGROUND

The CSS concept recognizes that traditional Mental Health Services alone are not enough. The concept includes the entire array of services, support, and opportunities needed by a person in order to function within the community, including services to address basic human needs, housing needs, and rehabilitative needs. Accordingly, the CSS concept delineates 10 essential components that are needed to provide adequate opportunities and services for persons with long-term mental illness. The CSS concept is not based upon nay one model but draws upon elements of the medical model, rehabilitation model, and social support model in an attempt to consider the comprehensive needs of persons with long-term mental illness. Each community should have arrangements to perform the following 10 functions, through Self-Help programs, community resources, private mental health providers, and community mental health centers all working together. Because Self-Help serves clients who have been refused services by the traditional system, clients who have been abused by the traditional system and refuse to return, and clients who have fell in the cracks of the traditional system, this population is underserved. Also, populations from the physically disabled, homeless, and alcoholics are inaproperpately placed into mental health services who are not mentally ill. Which if Self-Help was not here would be some of the individuals who fall in the cracks of the traditional system to the life of the streets due to no other community programs. Which long-term street residents can become then participants of mental health services. It makes more since that Self-Helps crisis intervention program can divert that crisis and unnessasy expenses. We also added one more component of physical health care, in crisis.

LOCATION OF CLIENT/OUTREACH - Locate clients, reach out to inform them of available services thru peer counseling, and assure their access to needed services, and community resources by arranging for transportation, if necessary, or by taking the services to the client.

ASSISTANCE IN MEETING BASIC HUMAN NEEDS - food, clothing, emergency shelter, and shelter.

MENTAL HEALTH CARE - Contract services through Private Psychiatric Doctors, Community Mental Health Centers, and Catholic Services.

PHYSICAL HEALTH CARE - Contract services through Private Doctors, County Hospitals, and County Health Depts.

CRISIS ASSISTANCE Through 24 hour crisis intervention hot-line services, walk-in crisis services through 24 hour drop-n-centers, mobile crisis outreach services through hot-line (taking services to them), and peer model case management. We have developed a crisis residential service through short-term, acute treatment and support services, serving individuals. Case management. 24 hour supervision, and rehabilitation services. Clients are residents and have daily activities, problem

1-15

solving, stress management and chores. All Doctors on call, with live-
di or, and several volunteers.

PSYCHOSOCIAL AND VOCATIONAL SERVICES - Workshops, support groups, training, presentations, courses, coping shill training, stress management programs, problem solving, time management, goal and career planning, crisis intervention programs. Providing peer models, preventing isolation, and clients interacting in the normal community. Communicative skills, public speaking, conferences, seminars, work habits, grooming, and job seeking skills, and more.

REHABILITATIVE/SUPPORTIVE HOUSING - Transitional, supervised independent, adults family homes, group homes, unsupervised independent living, charted Oxford group homes, and boarding homes.

ASSISTANCE/CONSULTATION AND EDUCATION - Networking with professionals, agencies, other self-help and consumers groups locally, state wide, and nationally. Supporting, listening, and teaching each other. Furthering clients education and career in schooling, conferences, workshops, seminars, and colleges. Problem solving together and respecting each others choices and opinions. Helping clients learn about positive risk taking, shopping, personal care, health care, limit setting, community resources, and public transportation. Education to families, employers, and community about the physically disabled, mentally ill, alcoholics, and the homeless as productive working citizens and how they can support them.

NATURAL SUPPORT SYSTEMS - Individual one-on-one support to promote integration and prevent hospitalization. Contact with people and supportive friends outside of treatment and the center. Normalized community activity. Just plain old "friends helping friends".

RIGHTS AND PROTECTION SERVICES - Protection and Advocate training through workshops and hands on experiences. Teaching clients about the system and how it works. Helping advocate for those who have not learned about the system and their rights. Lawyer referral resources.

CASE MANAGEMENT - Person or team designated to provide services and support to each individual clients. Assist in obtaining financial assistance or financial independence, medical services, housing, employment, education, and other resources available in the community to help meet basic human needs. Assistance in selecting and acquiring other community resources and activities and providing help in meeting the client's program goals and objectives. Assistance in problem solving, support, and guidance of all the resources and alternatives, but the choice is the clients. These staff positions are held by peer workers only.

B. RECOMMENDATION

Funding for existing and new Self-Help Programs is needed immediately. New efforts to sustain clients in community settings have resulted in a great demand for Self-Help services. It is estimated that if stable funding can be accomplished, the number of clients served will (10) ten times during the next year. Self-Help has been unable to secure any grants, and we are growing faster than we ever imagined. Provision of ongoing services and needed expansion will require a stable governmental funding source for set-up, first years salaries, and development only of each Self-Help Center. After that the program is self-supportive financially. Currently, Self-Help must compete on the state level with other services for mental health block grants, Stewart B. McKinney grants, HUD grants, and special purpose funds which have been reduced. SRS Director of Community Mental

Heal Services, Sec. of SRS, and State CSP Director for Kansas have indicated that stable funding for Self-Help cannot be accomplished in this setting. A more effective funding mechanism would be to pursue a separate State of Kansas Budget line item for Self-Help Resources and Development, Inc.. Funding is available at the Federal level, for the different services Self-Help provides, mostly through the Stewart B. Mckinney Act. Programs should be eligible for a first year loan out of the revolving fund to set up, develop, and salaries. Second year eligible for a match level of 75% from the revolving funds to 25% match from each Self-Help Center. The third year 50% revolving funds to 50% Self-Help funds, and the Forth year 25% revolving funds to 75% Self-Help funds. Each Center on the fifth year will be totally self-supportive. Development and set-up of three centers a year with 30 centers established at the end of ten years, with the understanding that each Self-Help Center pays back money given the first five years at 20% at the beginning of sixth year and 20% back the seventh, eighth, ninth, and tenth. At the end of the tenth year the state would be paid back all funds given to develop and establish each and every Self-Help Center, meaning the centers established in the tenth year (3 centers) would only be in the first phase of the revolving funds process which will become final ten years after their establishment. This is a ten phase funding process for each Self-Help Center established. Annual cost per client is $600 (for this 24 hour crisis intervention program, open 7 days a week, at $1.64 per day per client). the estimated cost of each Self-Help Center serving 1,000 clients, for each Center is $600,000 for the first five years, which would be paid back the following five years of its operation, total $125,000 each year. Establishing three Centers a year would mean $1,800,000.00 placed in revolving funds the first year, second year, third year, fourth year, and fifth year. At the beginning of the sixth year, seventh, eighth, ninth, and tenth year only $600,000.00 would be placed a year into the revolving funds line item. The first 15 Centers would be paying back replenishing funds into the line item for the last 15 Center to be established. Making a total of $12,000,000.00 placed in the revolving funds over a ten year period, all being paid back to the state in the revolving fund, back to the state in the following ten years, which the establishment of the 30 Centers would be up and operating serving over 30,000 clients in Kansas. All Self-Help Centers would be totally self-supportive in a Social Welfare Agency, Community Action Agency, and crisis intervention program. Since all money is paid back there will be no cost to the state, federal, or tax payers for the operation and service of this program after the tenth year of operation. Recommended action is that Self-Help Resources and Development, Inc. and other groups which seek to improve community conditions for the long-term mentally ill, physically disabled, homeless, and poor; immediately begin working toward legislative consideration and approval of a Self-Help line item in the State of Kansas Budget to be administered by the Dept of Human Resources at the level above to sustain the continued growth of Self-Help programs throughout Kansas.

CAPITAL TIMES 2/7/90

Patrick Irick (left) and Barb Hennings are members of a group to assert the rights of people diagnosed as mentally ill.

Capital Times photos by Rich Rygh

Helping yourself pays off

Mentally ill find self-support groups can ease pai

By BARBARA MULHERN
Capital Times Staff Writer

Barb Hennings has been in and out of psychiatric hospitals for years.

Hennings, who has had several diagnoses for her illness, says she spent three of her teen-age years hospitalized and has been a patient at Mendota Mental Health Institute 37 times.

Over the past few years, Hennings has been thinking more and more about how she can help not only herself but others with mental illnesses as well. So she's poured her energies into the mental health consumer movement — a movement that's beginning to grow statewide.

"It's a scary thing to be identified as a mental health consumer in a place where you want to live and have a job. But there's such a need and so few dollars. And there are certain things consumers can do for each other that professionals can't do because they haven't been there," Hennings said.

"It's necessary for people to stand together to assert their rights as adult citizens. I believe if you don't assert your rights, you don't have them," said Bruce Perron, coordinator of Peer Connection, a Madison-based mental health, consumer-operated telephone line.

"I see this as a civil rights movement. It's our right to be treated as adult citizens and to utilize the services we feel we need," he said.

Hennings, Perron, Patrick Irick, Betty Blaska and a woman who asked not to be identified met with a reporter to talk about the importance of mental health consumers being advocates for their own rights.

Blaska, who says she's been a psychiatric "survivor" for 20 years, and Irick, who was diagnosed with a mental illness in 1981, are working for the Wisconsin Coalition for Advocacy on a statewide consumer-operated services demonstration project.

The project, funded by the National Institute of Mental Health, is aimed at strengthening the mental health consumer movement in Wisconsin.

Among the project's specific goals are to train consumers and to provide funding for consumer-run support groups, drop-in centers or telephone counseling lines.

Other goals locally are to establish a consumer-run "safe house" — where people who are having problems could come — increase consumer membership on state and county mental health services committees and set up support groups for hospital psychiatric wards.

"People have been speaking for our interests as if we can't speak for ourselves," Blaska said. "This is continuing the stigma of mental illness. We want to be dependent on ourselves — not on hospitals or community support programs."

Irick, who says the overall goal of the movement is to give consumers choices, is concerned about the "dehumanization that goes on" when a person is labeled mentally ill.

"I'm always hearing of people who are being diagnosed and are receiving medications th don't really help them recover," Irick said. "They stabilize them and give them the sha and glassy eyes."

"They keep them quiet," Hennings added.

According to Hennings, much of the groun work for the movement was laid by people with physical and developmental disabilitie who realized that the more informed they were, the more they could be involved in th own treatment plans.

"Because of our illness involving our min we haven't been allowed to be involved," sh said.

All of those interviewed said becoming pa of the consumer movement has helped them realize how much they can accomplish, des their illnesses, which are often cyclical.

"When I was working for the state it didn do anything for me personally. But since I' become involved in the consumer movemer my manic and depressive cycles have even out," Irick said.

"It's helped me have a sense of self-estee Hennings said. "I always felt I had to be w first before I could help somebody. Now I' realized I don't have to. It's helped my sens being a person with something to give."

People interested in the mental health co sumer movement can call Irick at 266-849 Blaska at 266-3576. The number for the Pe Connection telephone counseling line is 258 9848.

1-18

March 27, 1990

Dear Senator Erlich and Members of Public Health
and Welfare Committee:

I am writing in response to the testimony on March 26, 1990, of Pat Johnson, Executive Administrator of the Kansas State Board of Nursing.

Specific reference is made to her request not to delete Section 4(e)(2) in regard to site surveys. I am the providership coordinator at the "nationally known institution" that objected to site visits. Mrs. Johnson's testimony made reference to the fact that I was "threatened" by site visits and that there were "several major deficiencies" with our continuing education providership.

I take exception to her comments. The major deficiencies were relatively minor and I refer you to the attached testimony I gave. The area of disagreement that I specifically objected to in her site visits was the issue of bibliographies. I went through a very long, expensive and time-consuming appeal process with the Board of Nursing and its Continuing Education Committee. The conclusion was that the Board and the Continuing Education Committee agreed with my position about bibliographies. So much for "major deficiencies."

I was not threatened by Mrs. Johnson's visits; they were meaningless. She has made four visits, not three, to our institution. I don't think she would have visited us that often if we were in Garden City.

The other issue she did not mention was that site visits were unannounced. No other accrediting body makes unannounced visits and I refer you to attached testimony by Dr. John Homlish.

I urge you not to reinstate Section 4(e)(2). The procedures and criteria are not clear and I believe there is discrimination involved in making decisions about who will be surveyed. The Kansas State Board of Nursing has better uses for its budgetary resources.

Sincerely,

Linda Sebastian

Linda Sebastian, RN, MN
Associate Director of Nursing

amw

Attachments

The Menninger Clinic
Box 829
Topeka, KS 66601 0829
913 273 7500

SPH&W
Attachment 2
3/28/90

Testimony for HB 3022
February 26, 1990

Public Health and Welfare Committee

My name is Linda Sebastian. I am Associate Director of Nursing at the Menninger Clinic. I am responsible for nursing education in the adult and children's hospitals at Menningers. We have a long-term providership for continuing education for RN's and LMHT's and I serve as providership coordinator.

I am speaking in opposition to Section 4(e)(2) (Survey of continuing nursing education providers).

Mrs. Pat Johnson, education specialist at the Kansas State Board of Nursing, has visited our facility four times since January 1989.

The first visit was made January 6, 1989, followed by a visit January 20, 1989, as the program she was auditing was a two-part series. I did not know she was coming. In fact, there was no statutory authority for her to be there. She informed me, when I inquired, that the Continuing Education Committee of the Kansas State Board of Nursing had directed her to visit all providerships. This is not in the provisions of the statutes and there was no budgetary allotment. The Appropriations Committee had specifically indicated that they wanted the Board of Nursing to allocate their resources for other more important issues.

So not only was Mrs. Johnson's visit unauthorized, but she did not have the criteria for her visits established. I did not receive the criteria for visits until after her visit.

During the first visit in January, Mrs. Johnson criticized us because she felt our program was specific to our institution. I took her remarks under advisement and have more narrowly defined what we can offer as CE credit.

The visit in June was to a program offered by our Division of Continuing Education which offers national workshops at least 2-3 times a month. Menninger's Division of Continuing Education is nationally recognized for their excellent educational programs. At this workshop, there was a break in procedures due to a new coordinator and there were not specific objectives for nurses. Never mind the fact that the content was excellent, we were to be subjected to yet another visit. I quote Mrs. Johnson's letter to me of June 21, 1989:

> "I was very impressed with your speaker, Saul Scheidlinger. As a psychotherapy group theorist, he had a lot to offer as to both theory and clinical application."

John Homlish, Director of Division of Continuing Education, wrote to Mrs. Johnson accepting responsibility for the lapse and stated that it is not usual practice.

Yet another issue was raised during this site visit -- the issue of having nursing references on bibliographies. The speaker was a nationally known authority on the subject of group psychotherapy -- he is not a nurse. This is

not a field in which nursing has done a lot of writing. Psychiatric practice is multidisciplinary and all disciplines can learn from each other. Not understanding this issue, Mrs. Johnson required that I add nursing references to all bibliographies. I believe this is unethical and unnecessary. We had national speakers who presented that had written many books and journal articles and were the authority on their topics, yet I had to do a literature search and find at least two or three or four nursing references --never mind that they were irrelevant --and provide them for nurses. This was very expensive and time consuming on my part. In fact, I was beginning to consider dropping our CE providership because the requirements were so extensive.

The requirements of nursing references on bibliographies was appealed at the CE Committee of KSBN. I have written repeatedly, asking for clarification of the appeal process and have never received information on the process, and I note that the proposed changes still do not specify the appeal process for providers.

As a result of our questioning, the CE Committee finally conceded that since psychiatric nursing has such a multidisciplinary focus, perhaps we don't have to do this redundant literature search after all. Evidently I still have to have "some" nursing references, but it is unclear to me what the criteria are.

As a providership coordinator, I have found that the requirements from the site visits are redundant and meaningless and do not insure quality.

Additionally, I find the unannounced aspect of site visits to be unprofessional, demeaning and unacceptable. Other accrediting bodies inform us of their upcoming visits. If site visits are going to occur, I believe the following should be required:

1. Notice of date of visit
2. Purpose of visit - what criteria will be used

The purpose of KSBN is to protect the public. I know that they are behind on disciplinary matters regarding licensees who are a danger to the public. Quite frankly, I question the wisdom of funding site visits to CE providers when the fundamental purpose of the board is not being maintained. I also question the necessity of such intense surveillance, especially when the criteria is vague, inconsistent, and capricious.

I urge you to strike Section 4(e)(2) and disallow site visits except when clearly indicated. They are unnecessary bureaucratic requirements. If the KSBN persists in requiring meaningless busy work for providership coordinators, the cost of CE programs for RN's will increase and the providership will stop offering CE programs because of the unreasonable demands.

Testimony for H. B. 3022

Public Health and Welfare Committee

My name is John Stephen Homlish. I am director of continuing education at Menninger. I also hold a faculty position in Medical Ethics in the Karl Menninger School of Psychiatry and Mental Health Sciences and also hold the position of Adjunct Professor of Nursing Ethics at St.Mary of the Plains College of Nursing, Stormont-Vail Campus.

My testimony in opposition to H. B. 3022, section 4 (E) (2) (Survey of Continuing Nursing Education Providers), should in no way be construed or interpreted as officially representing the stated or intended positions of Menninger, St. Mary of the Plains, or Stormont-Vail Hospital.

I am here at the request of Linda Sebastian, Associate Director of Nursing at the Menninger Clinic, and because I have reacted negatively through correspondence to the KSNB's practice of unannounced cite visits.

1). First, I am entirely in support of quality control in matters related to professional education, particularly, in matters pertinent to continuing education as they relate to re-licensure and recertification. In my view, the purpose of continuing health care education is the maintenance and improvement of professional knowledge of skills toward the goal of competent care of patients.

2). Second, it is the responsibility of accrediting organization to see to it that providers meet the clear standards established for professional education programs.

Typically, following initial approval as a continuing health care education provider, accrediting organizations leave it to the organization, and a locally designated director to design and present programs, as well as assure the maintenance of accrediting standards. Frequently, accrediting organization require an annual report and summary of programs - as in the cases of the the American Psychological Association, the Kansas Behavioral Sciences Regulatory Board, the National Board of Certified Counselors and the Kansas Board of Nursing. Accrediting periods range from two to six years.

The annual reports are structured to help providers evaluate the quality of their programs and allow the certifying organization to review compliance - and to suggest or require alterations where compliance is in question.

3). Three, with the exception of the Kansas Board of Nursing, no accrediting organization that I am familiar with, uses unannounced cite visits as a method for assuring compliance.

If an accrediting organization has concerns about the quality of a provider's programs, they express those concerns in writing and conduct an open inquiry to determine that organization's suitability to continue as an approved provider of continuing education.

Except in situations where serious violations are suspected and documented, cite visits are used only as a means of furthering research into needs assessments, uses of various teaching methodologies or other educationally related matters.

4). Finally, conducting approved continuing health care education is founded on mutual professional respect between accrediting bodies and local providers. An atmosphere of mutual regard and trust allows the accrediting and providing organizations to work toward the common goals of presenting programs for the ultimate improvement of patient care.

H. B. 3022, Section 4, E, paragraph 2 lends itself to distrust, implied spying and a taint of sneakiness which undermines the tradition of professionalism which those of us in the field hold in high regard.

Paragraph 2 is vague, establishes no clear criteria for cite visits and gives the impression that the cite visitor is looking for trouble.

I am opposed to any stipulation which allows the current practice of unannounced visits to continue

.
I also encourage the drafters of Bill 3022, to make specific the conditions under which announced cite visits are permitted. I suggest that the following stipulations are included: (A) In circumstances where non-compliance is documented. (B) In instances where legitimate research is being conducted.

In my opinion, these conditions work toward the professionalism and trust needed to conduct high quality programs.

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RICHARD H. MASON
EXECUTIVE DIRECTOR

TESTIMONY
of the
KANSAS TRIAL LAWYERS ASSOCIATION
before the
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

March 28, 1990

HB 2586

I. Introduction

The effect of New Section 29 of HB 2586 is, absent a showing of gross and wanton negligence, to (1) immunize the state psychiatric hospitals and participating mental health centers and their employees from any liability for failing to warn or notify persons that a person who is a danger to himself or others or mental ill has not been admitted, or has been transferred or discharged and (2) to immunize these same health care institutions from any liability for refusing admission, discharging or conditionally releasing or providing treatment to a person who is a danger to himself or others or mentally ill. State psychiatric hospitals and participating mental health centers are their employees are given the right to be negligent without concern that they will be accountable under civil law for injury caused to their patients or third persons. New Section 29 is contrary to the interests of the mentally ill and the citizens of the State of Kansas.

II. Discussion

Our common law system of civil justice provides that if a person is negligent and this conduct is the proximate cause of an injury to another, then the injured person has the right to obtain a decision by a jury of his peers on the question of liability and damages. Except when immunized by legislation, the common law principle that a person should not be negligent generally applies to all conduct in our society. We expect auto mechanics, building contractors, plumbers, lawyers, manufacturers, farmers, insurance agents, etc., to operate their businesses and perform services in a reasonable and competent manner. If they are negligent and cause injury, we expect them to pay damages or defend their conduct before a judge and jury. The civil justice system is both a deterrent to negligent conduct and a means for obtaining compensation for those injured by another's negligence. State psychiatric hospitals and participating mental health centers and their employees should not be immunized from accountability for negligent conduct any more than auto mechanics, insurance agents, airplane pilots, lawyers or doctors.

SPH&W
Attachment #3
3/28/90

A. New Section 29 Condones the Death or Serious Injury of the Mentally Ill Caused by Negligent Conduct.

New Section 29 provides that a mentally ill person who is injured or dies because of a negligent discharge, conditional release, decision regarding treatment, or refusal to admit has no right to seek damages in the civil justice system. The mentally ill who are discharged and suffer injury or die because of lost paperwork, computer entry errors, inadequately trained staff, a wrong medical judgement, or numerous other negligent acts are denied the right to seek compensation. In effect, if New Section 29 is enacted we make second class citizens out of the mentally ill of the State of Kansas, who have no choice except treatment in state psychiatric hospitals and participating mental health centers. Those of us who can afford private treatment for family members and loved ones wouldn't tolerate their injury or death because of negligent discharge or conditional release and would demand the right to compensation on their behalf. We should require state psychiatric hospitals and participating mental health centers to meet the same standards of conduct as private institutions and permit those patients injured because of negligent discharge, conditional release, refusal to admit or decisions regarding treatment the same right as private patients to seek compensation through the civil justice system.

One measure of our humanity is the manner in which we treat the most unfortunate among us. Perhaps none among us are more burdened than those who are poor and mentally ill. We know that in the past we have failed to provide them a mental health care system that is adequately staffed and funded and probably will continue to do so in the future. When the mental health system we provide acts negligently and injures its patients, the least we can do as citizens of the State of Kansas is accept responsibility for this negligence, and grant access to the civil justice system and the right to seek compensation.

B. New Section 29 Condones the Negligent Failure to Provide Notice Upon Release of a Person Who Is A Danger to Himself or Others or Mentally Ill.

Rarely a day goes by without a violent act being committed by a person who has a long history of mental illness and previously has been determined to be a danger to himself or others. Hopefully, the decisions of state psychiatric hospitals and participating mental health centers to admit, treat and discharge will not be made negligently and those who are a danger to themselves or others will be treated and not released until their illness is controlled. However, when public mental health institutions are treating a patient who is a danger to others and they have acquired knowledge of a risk of injury to an identifiable person or group, then notice or warning should be given when the patient is not admitted, transferred or discharged. Failure to send paperwork in a timely fashion, losing a patient's file, computer error, inadequate administrative procedures or other acts of negligence that result in the failure to provide notice or warning should not be immunized from liability.

The family of the dangerous patient, health care providers who have treated him, police officers who have detained him, or judges who have committed him all may be the specific and identified targets of delusions and aggression. We should not tolerate our public health care system's negligent failure to warn such people that they may be at risk of harm because a person who is a known danger to them has been released. Correspondingly, as citizens of the State of Kansas, we should accept responsibility for negligent failure to provide notice or warning and grant such injured persons the right to seek damages through the civil justice system.

C. The Kansas Tort Claims Act Already Limits the Liability of the State of Kansas.

The Tort Claims Act of the State of Kansas exists both to grant the citizens of the State of Kansas the right to recover damages for injuries caused to them by the State and its agents and employees and to limit the circumstances in which damages may be recovered and the amount recoverable. Generally, when the conduct of the State, its employees and agents is negligent and comparable in nature to that of a private citizen, there is no restriction on the circumstances of recovery. In other words, the State will be liable for the negligence of its truck drivers just as a private employer, while the circumstances in which a police officer is liable differ significantly from those in which a private security officer will be liable.

The employees of State psychiatric hospitals and participating mental health centers should be providing health care in accordance with the same standards that exist for private institutions. To paraphrase our Supreme Court in Durflinger v. Artiles, 234 Kansas 484, 492 (1983), when it quoted a decision of the Michigan Supreme Court -- All mental health professionals, whether employed by a state institution or private facility, are subject to exercise competent, professional judgment in all aspects of treatment of their patients, including the decision to discharge a patient from custodial care.

Through our legislature, we, the citizens of the State of Kansas, have said that if we are injured by the negligence of a truck driver employed by the state, we should be able to recover damages pursuant to the Kansas Tort Claims Act. The Durflinger decision recognized our right to recover damages if we are injured by negligent treatment, including discharge, by state mental health professionals and there is no overriding public policy reason that justifies immunizing certain negligent conduct by such persons from civil liability pursuant to the Kansas Tort Claims Act.

D. The Existence of Potential Liability for Negligent Conduct Is a Positive Effect.

Unfortunately, all of us are not motivated and dedicated to performing at all times to the best of our abilities. Sometimes we are lazy, forgetful, sloppy and just plain make mistakes that easily could have been avoided. Simply put -- we are negligent. When we do make

mistakes, we have a tendency to blame others, instead of accepting responsibility and making the effort not to be negligent. Being sued for negligence may be a negative motivational factor for an individual, but it is a positive one for society, because we benefit when each of us performs his job competently and free of negligence. As citizens of the State of Kansas we benefit when all employees of state and local government perform their jobs competently and without error. We should retain the present principles of liability for state hospitals and participating mental health centers in order to motivate the employees of those institutions and ourselves to insist on competency and professionalism in all phases of treatment and decision making. It is naive to conclude that freeing negligent conduct from civil liability will result in less negligence. Only better training, supervision and a stronger sense of professionalism and responsibility will reduce negligence in the public mental health care system.

E. Civil Lawsuits for Negligence Have Not Crippled the Public Mental Health System.

The Durflinger decision in 1983 recognized that public employees who are providing professional services to the mentally ill may be liable for negligence in their treatment, including the discharge of the patient. Yet, the Kansas Reports are not full of cases brought against employees of state hospitals or local mental health centers. Furthermore, the Kansas Supreme Court has yet to be called upon to answer the specific question it declined to answer in Durflinger as to whether a mental health professional may be liable for failure to warn a person known to be at risk of injury because of the danger posed by a patient. Despite the lack of litigation and damage awards for negligent admission, transfer, discharge, notice and warning, it is now proposed that civil liability be eliminated for such negligence.

If the public mental health system was being overwhelmed by claims for negligence in admission, transfer or discharge of patients and the failure to give notice or warning, and the citizens of Kansas decided to accept this level of incompetency and prohibit compensation to the injured, then the only choice would be New Section 29. Fortunately, our public mental health system has not deteriorated to that point and we should not penalize those injured by the negligence of its employees by denying them access to the civil justice system.

III. Conclusion

Those who are poor and mentally ill have few if any advocates and defenders. It will be easy to enact New Section 29 and provide that if they are injured because of a negligent decision regarding admission, transfer, treatment or discharge, it's simply their tough luck. The rest of us can forget about them, as we all too often have done in the past. We should not forget about our mentally ill, but, instead should insist that they have the same rights as those of us with private health insurance or other resources. We should insist that those health care providers who treat them do so without negligence and

provide in our laws that if the patients of our public institutions are injured because of negligence, they have the same rights for a remedy as any other citizen.

Furthermore, we should not immunize the negligent failure to warn or give proper notice of the discharge or release of a person who is a danger to himself or others, or is otherwise mentally ill. We should accept responsibility in our public health system for the mentally ill, including all of its acts of negligence, and reject New Section 29.

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March 28, 1990

The Honorable Roy Ehrlich
State Senator
State Capitol, Room 138-N
Topeka, Kansas 66612

Re: House Bill 2586

Dear Senator Ehrlich:

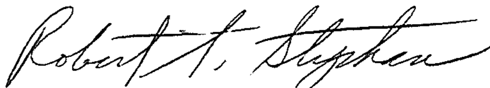
I just noted on page 34 of the above referenced bill in New Section 29, a provision that exempts from liability those in the state psychiatric hospital who refuse to admit or discharge an individual, except for gross or wanton negligence. I am sure this bill grows out of some recent cases that have found those at state psychiatric hospital civilly responsible for the release of an individual when psychiatric and mental reports indicated that the individual should be retained.

It is my opinion that there should be no greater degree of negligence in regard to liability in such cases than that which is presently utilized. In like manner, I do not favor a change in the degree of negligence for court ordered out-patient treatment as set out in New Section 29.I appreciate the problem involved insofar as litigation is concerned, but I think we have to do all that we can to promote a high degree of care in our psychiatric hospitals. If the medical and psychiatric reports indicate that an individual should remain confined and someone allows that individual to leave, then they should face civil liability on the same standard of evidence as is now applied and that should not be enlarged.

SPH + W
Attachment 4
3/28/90

I believe this provision would be a disservice to those victims who may suffer as a result of a negligent release of an individual. Your consideration of this matter will be appreciated.

Sincerely,



Robert T. Stephan
Attorney General

RTS:bls

NO

Kill House Bill 2586

Funds are only good for 3 years! Mental health + S.R.S. believe in the monaply. After 3 years fund will be cut off again. This monoply has to stop now.

The right to fill in for private doctors can not be taken out of the fredom to choose. All of us has this right. Half of the people will end up on the streets then the police has the right to take them to mental health. This is not the rights of people. They need alternitives for other programs not with S.R.S. or mental health.

This gate keeping to control the monoply, to force almost anyone to keep people in this system that stinks. We the people will have to show more support of alternitive programs. The secretary can not be alowd to control. Funds are being kept from the commuties that want to help find Jobs and pay taxes.

SPH+W
Attachment 5
3/28/90

I have the right for protective custody. We the people have that right. The Constitusion right will be voilated. I want to reserve that right because I know they can't take that from me. We the people have to protect this bill or someday you will be over druged or possibly locked up in a room not able to talk to anyone. (This closed door Called, Seclusion)

The right to choose doctors out of mental health. Those in mental health only want a big check as long as they follow this bill. Doctors will loose at 3 years when funds will be cut again. There is nothing in this bill to make the system self-supportive.

Self-Help resources
and Devepement
Pres of Board Dir.

Jeffery L. Neill

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, 915 S.W. Harrison, Topeka, Kansas 66612

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Mental Health &
Retardation Services
Fifth Floor
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Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABRIEL FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

March 28, 1990

The Honorable Roy Ehrlich
Kansas Senate
Statehouse, Room 138-N
Topeka, Kansas 66612

Dear Senator Ehrlich:

The concept of gatekeeping/screening was conceived as a service to help in our effort to unify our public mental health system which has been criticized for its fragmentation and lack of coordination.

The decision to designate community mental health centers as gatekeepers was made after a long and difficult deliberation by numerous individuals who are concerned about the public mental health delivery system. They include legislators, consumer and family members, state officials, community mental health providers, private practitioners, specifically, Dr. Don Brada who is the president of Kansas Psychiatric Society and an executive board member of Kansas Medical Society, and a member of the Governor's Task Force on Mental Health Reform and other concerned citizens. I would like to point out again that the legislative interim committee concurred with the decision and made a specific recommendation regarding this issue. The inclusion of private practitioners who do not have some working agreement with this designated gatekeepers--CMHC's--would nullify our efforts of unifying our public mental health system. The private practitioners are capable of making treatment decisions, but often they are not equipped with information that would assist them in determining if a patient is in need of treatment at a State psychiatric facility. They often do not have intimate knowledge of what is available in the community and what CMHC staff can do to deter admissions.

SPH&W
Attachment 6
3/28/90

Although Mr. Peterson argued that only a few number of patients are involved with private practitioners, the same argument could be used as to why private practitioners should not be included as gatekeepers. If we allow exceptions, the purpose of the fail safe system is defeated. I would like to remind Mr. Chairman and the members of the Committee that we are talking about those persons most in need. They are mostly people with severe and persistent mental illness who are usually indigent, meaning private insurance is not available, and therefore are in need of treatment provided by the public mental health system.

We believe that the majority of these individuals are being served either by state hospitals or community mental health centers and only a fraction of these individuals are being served by the private practitioners.

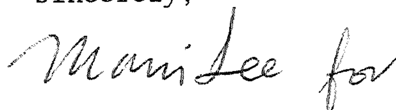
We strongly urge you not to include private practitioners as independent screeners.

As pointed out by many individuals who testified before you, we are certain that local CMHC's will be more than willing to work with private practitioners in arranging a reasonable working relationship in which they would be involved in screening in concert with the community mental health centers.

For the same reasons listed above, we cannot support the proposed amendment to include "other treatment facility" in the definition of "participating mental health center".

We are not opposed to the proposed amendment on page 34 which extends the provision of immunity from liability to "hospitals licensed under KSA 65-425 or 75-3307b, physicians and psychologists."

Sincerely,



Al Nemec
Commissioner

ALN:ML:ees

TO: PUBLIC HEALTH & WELFARE, KANSAS LEGISLATURE
REF: HB 2586(HB 2577,2578,2579 & substitute)
FROM: Penny Sue Johnson, The Kansas Coalition, Inc.

March 28, 1990

It is both mixed and somewhat painful to stand here today. Since 1983 this administrator and health advocate has appeared before respective committee' regarding SRS' and contract providers. Not one of us is pardoned from the deepening rein of terror by its administration and even regulator practices todate no matter what health care label they exclaim Kansas citizens to fall under.

Yes; I did say rein of terror and being a degreed public administrator who serves on both the CSP Advisory Council and the KAPS Advisory Council for Kansans... frankly as a responsible leader I must recommend killing this bill. The issues are far reaching whether one looks at the lack of legislative and judicial oversite or even when thouroughly examined the basic "due process" provisions for Kansas citizens being served have been excluded. Then to take issues a bit farther the mental health industry is not qualified to offer comprehensive medical services and should be limited to voluntary, choic and information and referral services regarding matters such as judicial right and wrong tests, financial estates, recreation, housing, physical rehabilatation, educational testing-retraining, but most of all regarding legal questions of competency, or the legal question whether one lackssubstantial capacity and to exclaim poverty as illness simply this administrator is not

SPH&W
Attachment 7
3/28/90

going to listen any to the drug talk, to the non performance or lack of community involement by even mental health private providers or community mental health centers trying to cloud our thinking to believe they have all the answers-for each of us who have dared to come here today know a closed secluded offering of services admist complex systems and complex needs is destined to fail leaving each of us even as providers hopeless. Then we could look into the future at the present rate of community disgust and see high cost court battles and even more taxpayer revolt and as representatives and leaders its up to each of you to base dicisions on more than a single industry' opinion which in its proposal only wants more victims, long term research victims and clearly as proposed here never intents to restore one fellow Kansan to their rightful place in community.

Finally; we have to address the force issues, the marked overdrugging, and the fact that even those working and recovered are being held back by case managers and yes even doctors from full-time employment and educational opportunity and futures as productive Kansans. The disregard for individual citizens beliefs, values, and goals-simply there is no excuse. To SRS and their contractee' if you can't listen, believe in, aid, offer assistance without force or drugging competent Kansans then the collective responsible response with our tax dime is in fact we don't want you or need

you or your contractee' including community mental health centers serving Kansans who are trying to restart their lives; and to the anti-trust and monopoly violators related to this mess I am confident you'll be delt with and for every person who has conspired against this peace loving advocate and other advocates I dare to say someday too you'll stand before destiny. Too I must applaud the "911" network, judges, chambers of commerce, and alternative providers both public and private for in KANSAS"the buck stoppes here!" and to the politically violent gang behavior porported by even Kansas current mental health system perhaps each of you need to be in community re-training programs so you can learn how to be respectful to the Kansans you serve, for Kansas law throughout is clear to be poor is not nuts or ill or imcompetent and with some 400-500 schools of thought on what treatment means let us stand firm against this bills rein of terror against Kansans and insist that no Kansan be incarcerated or subjected to involuntary servitude in the name of even mental health. Priority consumer calls is for jobs, equitable pay, hours- there need by no drug pushing in this advocates mind or continous funeral processions because a system like SRS continues to be mere lip service and too this administrator realizes even many of SRS' employee' are afraid to speak out for they have watched evem loyal peaceful advocates such as Johnson, Hartman, Neill, Budd, and Jacobs who have dared to clamor and be responsible citizens, administrators, and educators be victimized for being of different professional opinion, different schools

of thought and who have dared to dismiss ill gotten unprofessional violent health care providers including psychiatrists, psychologists, and others including social workers; yes even community mental health centers which is the goodness of current Kansas law. Again its this professionals opinion that this bill should be killed along with others noted on page one and our current law although imperfect as any legislation at least offers some hope to us all or whatever school of thought you come from.

Thank You,

Your loyal administrator & advocate