Approved: April 26, 1996
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Chairperson Michael R. O'Neal at 12:45 a.m. on March 21, 1996 in Room 313-S of the Capitol.

All members were present except:
Representative Britt Nichols - Absent
Representative Ed Pugh - Absent
Representative Doug Spangler - Absent
Representative Dee Yoh - Absent

Committee staff present: Jerry Donaldson, Legislative Research Department
Jill Wolters, Revisor of Statutes
Cindy Wulfkuhle, Committee Secretary

Others attending: See attached list

Representative Grant made a motion to withdraw **SB 523** from the table. Representative Mays seconded the motion. The motion carried.

SB 523 - statute of limitations relating to actions by corporations or associations against its officers or directors

Representative Grant made a motion to report **SB 523** favorably for passage. Representative Ruff seconded the motion. The motion carried. Representative Miller requested he be recorded as abstaining.

SB 469 - enacting the care and treatment act for mentally ill persons

Chairman O'Neal explained that in the past pedophilia, under the DSM III manual, has not been considered a mental illness. However, DSM IV has classified pedophilia as a mental disorder. (Attachment 1) He suggested that the committee place the "fix" for the sex predator act into the bill and provided the committee with a balloon amendment. (Attachment 2)

Jill Wolters explained that the balloon amendment would redefine what a "mentally ill person" is; would have two types of mentally ill persons subject to involuntary commitment and added the definition of a sexually violent offense. She stated that the balloon should have an attachment that would clarify that the people who meet the definition of a sexually violent person would be segregated from the other mentally ill population.

Representative Snowbarger made a motion to adopt the balloon amendment. Representative Miller seconded the motion. The motion carried.

Representative Miller made a motion to adopt a balloon amendment that would clarify the definition of law enforcement officer for the care & treatment act. (Attachment 3) Representative Adkins seconded the motion. The motion carried.

Jill Wolters told the committee that "christian science" should be capitalized on page 10, line 12 & pg 24, line 38.

Representative Adkins made a motion to amend in staffs technical amendments. Representative Haley seconded the motion. The motion carried.

Representative Garner made a motion to amend line 33 to read "qualified mental health profession designated by the head of a mental health facility". Representative Adkins seconded the motion. The motion carried.

Representative Adkins made a motion to report **SB 469** favorably for passage as amended. Representative Miller seconded the motion. The motion carried.

SB 299 - allowing county or district attorney to collect administrative handling cost from maker or drawer of bad checks

Representative Mays made a motion to amend the bill back to the original language and amend in provisions of **HB 3039** - requiring attorney fees to be paid in civil worthless check actions. Representative Grant seconded the motion. The motion carried.

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY, Room 313 S Statehouse, at 12:45 p.m. on March 21, 1996.

Representative Garner made a motion to strike lines 9 & 10 in **HB 3039**. Representative Pauls seconded the motion. The motion carried.

Representative Mays made a motion to report **SB 299** favorably for passage as amended. Representative Adkins seconded the motion. The motion carried.

The committee meeting adjourned at 2:00 p.m. The next meeting is scheduled for March 26, 1996.

HOUSE JUDICIARY COMMITTEE GUEST LIST

DATE: March 21, 96

NAME	REPRESENTING
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
JOHN HOUSE	JUD. COUNCIL / SRS
Nancy Lindberg	Atty Gen
Julie Meyer	KS. Sentencing Comm
REBECCA WOODMAN	KS Sent. Comm.
BARB TOMBS	KS SENT COMM
Jan Johnson	Dept of Corrections
Paul Shelby	OJA
Jerry Sloan	"
Kelly Kultala	KTLA
Whitney Damron	Kansas Bar Assn.
Bill McGreevy	

Richard Irons
DAGAZ
5816 SW 35th Street
Topeka, Kansas 66614

Dagaz

March 18, 1996

Senator Bob Vancrum
State Capitol

Dear Senator Vancrum:

I have recently moved to Kansas, to take the position of associate program director of the Alcohol and Drug Abuse Recovery Program at the Menninger Clinic. I have had extensive experience in the evaluation and treatment of professional sexual misconduct and sexual offense. At some time in the future, I would be willing to more formally introduce myself and provide you with a summary of my credentials and curriculum vitae for review.

I was asked by Mr. Bob Schmidt to FAX you this letter in support of legislation which might better define the appropriateness for certain sex offenders to be released into the community. I am sure you are aware of the reasons for this appeal.

Pedophilia is a defined mental disorder that is classified in the DSM IV [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition]. As a mental disorder, it requires considerable expert treatment and assessment to determine the risk that the release of a convicted violent pedophilic offender may have for the public. In addition there are a number of other sexual disorders defined as paraphilias that may also be associated with violent sexual assaults. All of these disorders may be complicated by characterologic pathology, also defined in this same reference standard [DSM IV], which may be present. The most serious of these include narcissistic and antisocial personality disorders.

If I can be of further assistance to you and the people of my new home state as this matter is being considered for legislation, please feel free to contact me at this address or through the Menninger Clinic.

Sincerely,

Richard Irons, M.D.
913 273 2428

Behavior Healthcare Services

House Judiciary
3-21-96
Attachment 1

SRS: VIOLENT SEXUAL PREDATOR TREATMENT PROGRAM

PROGRAMS, PROCESSES AND TREATMENT
Vol. I No. 1
OCTOBER 1995

SPTP: Mission, Goals and Objectives

In March of 1995 the SRS SPTP Unit adopted the following Mission Statement, Statement of Purpose and Operational Goals:

MISSION STATEMENT

"The Unit mission of the SRS Sexual Predator Treatment Program is to ensure the safe, secure, and humane care of residents committed to the control and treatment of the Secretary of Social and Rehabilitation Services and to strive to assure that we provide residents an opportunity to receive treatment and a behavioral education that could lead to their court ordered discharge and/or release."

STATEMENT OF PURPOSE: The Sexual Predator Treatment Program Unit protects the public through secure and humane treatment of court committed residents to its custody. The program allows Residents to obtain treatment, gain skills and insight into their behavior that support a non-predatory and nonviolent life upon court ordered release to the community.

SRS SPTP GOALS

1. To provide a safe and secure commitment confinement for the residents, public and staff.
2. To provide treatment opportunities and behavioral education activities for residents.
3. To maintain positive facility/unit living and work environments.
4. To manage human, equipment, and fiscal resources responsibly.
5. To maintain cooperative working relationships with the external environment.

To achieve the goals mentioned above, the first order of business for the Treatment Unit was to research, design, develop and produce a "state-of-the-art" treatment procedure design that would encompass the wide variety of therapy needs of individuals committed to the SPTP program. "State-of-the-art" program design and development do not specifically infer an agreed upon and/or universally accepted set of approaches for: assessment, evaluation, and treatment paradigm(s). That such approaches exist in some coherent form is not true. Articles published over the last twenty years of the research have been presented in anecdotal form and/or lacking in the rigor generally associated with scientifically valid and reliable analysis efforts. Personnel, philosophical and policy preferences seem to have interfered with research design, focus and occasionally even the analysis of data.

State-of-the-art does imply: 1) a relevant, scheduled application of treatment modalities attuned to the immediate behavioral needs of the residents in treatment; 2) numerous needs assessment to be conducted on an individual and group foundation to include "life" socio-psychological development," civil and criminal records, previous treatment efforts and their efficacy; and current individual dynamics; 3) a realistically planned schedule of treatment modalities that would be attuned to the individual's program progress; 4) an ongoing evaluation of individual, group and program treatment efforts for effectiveness and efficiencies; and 5) the development and use of a set of program standards to measure the ability of the program to meet its stated goals and objectives.

CONTENTS

The state-of-the art for the SRS: SPTP Unit has been implemented by the acquisition of staff, tests, materials, instruments, supplies, equipment, treatment modalities, program packages, policy creation, the development of standards of program operations and evaluation supported by sufficient funding, a coherent mission statement, and a set of phase process distinctions for civilly committed residents.

For a general perspective the following ten (10) treatment modalities have been chosen from a list of fifty (50) which we may provide to individual residents (group or individual treatment efforts) in the SRS: SPTP Unit.: Denier's Group, Anger/Aggression Management, Sex Education--Removing Personal Myths and Mis-Information, Impulse Control, Cycle of Violence, Pre-Assault/Assault Cycle Management, Thinking Errors Elimination, Victim Empathy, Situational Perception Training, Pro-Social Life/Leisure Time Training.

We individually assess SPTP program components, individual residents, treatment efforts, and endeavors of the residents to change, learn, and apply non-assaultive, non-aggressive pro-social skills.

Unlike so many quasi-intense treatment programs in both the public and private spheres, the SRS: SPTP progress and evaluation reports on the individual resident do not rely on their "self-reported" progress. The Unit through a process of testing instrumentalities will be able to assert "pre-treatment/intake assessment scores," pre/post-phase advancement assessment scores, pre/post-specific treatment modality scores, and sexual arousal veracity assessments.

Facts, statistics, information, validation and reliability of instrumentalities, *not best guess.*

The individual resident participates in the *community of treatment* which encompasses and permeates every waking hour of his or her time in the program. We measure the value of that involvement.

Attorneys of the Defense

Defense attorneys for persons who are or may be subject to Violent Sexual Predator Civil Commitment proceedings have contended a variety of what they believe to be the complex vagaries inherent in treatment efforts directed at violent sexual predators. Some of these legal frictions include:
1) treatment programs cannot successfully influence their client's behavior, 2) that a civil commitment to such a program is a "life sentence," and 3) no psychologist, psychiatrist or other treatment provider would ever decide that they should release a violent sex offender.

Defense attorneys will generally make these assertions with the best intent and interest of their client at heart. Their focus is necessary for their duty as a compensable agent for their customer.

Unfortunately, such assertions may not well serve the public information, the public interest, or the public's general understanding about the realities of violent sex offenders, the SRS: SPTP Unit, and the viability of the SRS treatment program.

We offer the following information as a counter to the misinforming assertions offered by the defense attorneys for violent sexual predators.

1. Treatment Programs Can Positively Influence Consumer/Offender's Behavior

To assume or assert otherwise is to conclude that human beings are not educable, trainable, or changeable. To state that treatment cannot positively affect their clients is to concede to hopelessness.

2. The SRS: Sexual Predator Treatment Program is not a "life sentence."

We have composed a program of relatively discreet process Phases through which a Resident can progress at his or her individualized pace. The pace of Phase advancement (from Intake to Exit) is predicated on voluntary treatment participation, measures of successful program completion, reliability and validity testing of Resident "self-reports" through scientific tests and instrumentalities, and a resident's genuine treatment unit "community progress." There are minimal Phase step periods.

Advancement, regression, progress, or deterioration is based on individual qualifying and quantified achievement. The fact remains that some persons may progress through the Phased program at optimal speed, while the progress of others may be at a slower pace due to their individual problematic performance (as related to their violent sexually predatory expressions).

3. Psychologists, psychiatrists, social workers and other treatment personnel employed and/or contracted by the SRS: SPTP Unit will not be making promises to the court.

These professionals will present to the courts of commitment the facts, information and materialities concerning the progress of the individual through the treatment program. Promises are not in the professional realm of either treatment providers or defense attorneys. However, quantifiable facts, reliable resident displayed competencies, phase evaluation statistical assertions and credibility of findings are in the realm of the SPTP treatment staff which will be provided to be delivered as evidence and testimony.

The judge or jury of the county of civil commitment is the trier of fact which will render a decision whether or not to maintain a resident in the SPTP Unit for continued treatment or release him or her back into the community.

Staffing, Care, Treatment, and Control

Staffing and Care:

As of October 2, 1995, we have filled most of the required staff positions. Staffing for the SPTP Unit includes: 1) on call psychiatrists for pharmaceutical needs of the residents, 2) one acting clinical director (Ph.D.), 3) one programs director, 4) one secretary, 5) one masters' level licenced psychologist, two social workers (one bachelor licenced, one master's licenced), two Activities staff (specialist and technician), two Forensic Therapist/Security Shift Supervisors, and ten Psychiatric Security Specialists.

SRS: Forensic Therapists and Psychiatric Security Specialists provide SPTP Unit internal security. Larned Correctional Mental Health Facility provides external off unit security (LCMHF) corrections officers.

Every non-support services staff member of the SPTP Unit receives and completes 80 clock hours of correctional facilities training prior to assuming their duties. In addition to the basic facility issues related training provided by LCMHF staff also receives Thirty-nine (39) hours of Basic Working with Sex Offenders Training, twenty (20) hours of Intermediate Training Staff Working with Sexual Predators and 6.5 hours of in-service self-paced training on "The Best Kept Secret: Child Sexual Abusers." Support services staff receives only the first eighty (80) hours training as provided by the facility. We will provide additional training and staff development within a staff member's duty domain and based on the program needs fulfillment as indicated in the satisfying of the SPTP Unit Mission Statement.

Staff at the Larned State Hospital provides personnel services and the support services of acting clinical director and psychiatrist (LSH). As with the LCMHF inmates, LSH also provides the support services of meals and laundry to the SPTP residents. Prison Health Services (PHS) has provided medical services for residents through a contract entered into by the department of corrections and the department of social and rehabilitation services. A medical services contractor for LCMHF provides the 24-hour medical care/treatment of SRS: SPTP residents. Nurses, doctors, and other health care professionals are available to the SRS residents.

Residents and Unit Capacity:

As of October 2, 1995, seven (7) persons have been declared to be violent sexual predators by their respective courts of civil commitment. Each resident has a lengthy history of criminal (or civil) commitments, and numerous victims. Four (4) of the seven (7) have been admitted since June 1995. We have projected that by July 1997 more than thirty (30) persons will be committed to the Unit. The Unit at LCMHF has a capacity of 28. (Due to lack of storage space in the Unit and properties security areas, two rooms are being used for Unit supplies and Resident property storage space.)

The ages of the residents range from 23 to 72. All are white males, five (5) pedophile, two (2) with histories of violent rapist and pedophile offenses. The average age of a resident on the Unit as of October is 49.7 years old.

Some residents have previously received some variety of sex offender treatment programming prior to their commitment to the SRS: SPTP Unit. Most of the current residents, however, had either refused or were not successfully released from that prior treatment program.

In most of the previous programs measures of validity, reliability, veracity, integrity or fact were not used to explain the resident's level of participation, progress, or honesty other than as the resident reported of himself to the treatment provider.

Typically, no form of instrument or testing was used or attempted in those programs to demonstrate anything other than some therapist's best guess of treatment outcomes. In those instances the providers accepted the client's "feel good-feel better" statements as fact.

The SRS: SPTP Unit will be using approved principles of research, assessment, evaluation and operational measures to verify success or failure of the methodologies employed with Residents and the program's management.

Holistic Treatment

(24 hours a day, 7 days a week, 365 days a year)

It is the central tendency in most of the current set of treatment environments, either public or private, which offer treatment to sex offenders, violent sex offenders and/or sexually assaultive or abusive individuals to make unusual tradeoffs between public safety, philosophical perspectives of treatment and a secure/care-focused environment.

These tradeoffs occur because the principle ideology contends that if an organization protects the public then it cannot adequately treat the client group. Conversely, if an organization treats persons who have been dangerous and/or harmful to others, they cannot expect that organization to protect the public while the dangerous individual is under their care.

This philosophical tendency presumes the inability of either public or private treatment efforts to be able to successfully entertain or achieve dichotomous efforts. By this rationale, all human endeavor would have to be mono-bound: one choice per customer, each human being with only one skill, one piece of the information, one ability, one area of competence, one type of intelligence; only one type of knowledge or set of facts. The rest of the world would be unknowable, unavailable, and incomprehensible. Instead of having Unicycles we'd have UniBeings.

The SRS: SPTP Unit functions on the principle of myriad-goal orientation. Security of staff, residents and public is central. Appropriate treatment processes are identified and implemented.

The SRS: SPTP Unit does not constrain itself through a singular preference of philosophy, treatment modality, theory of process or doctrine. What works for the individual resident is the focus. Individuals "heal" at their own speed, through their own efforts, in their own time, one at a time.

To help in the progress that an individual might make the SPTP Unit does not allow for either an information or management gap to exist or develop between security staff and treatment staff. Because sex offenders/abusers as a "group" tend to the secretive (most offenses are by stealth and manipulation) the program prohibits secrets.

There are no secrets.

Security staff communicates with treatment staff. They have attended and supported treatment staff's individual and group sessions. Treatment staff communicates with and supports the efforts of the Security staff.

Treatment and Security staff attend weekly meetings for the purpose of sharing information regarding resident progress, problems, fixations, evasions, and process needs. All staff provides informed input in the staff meetings and assists the management of the program to devise response to the treatment, security, and care needs of the residents.

Every staff member is capable of contributing to the observation, care, treatment, assistance, development and improvement of the resident. The capacity to contribute effectively abides in the fact that each staff member is intimately familiar with each resident's case.

The ongoing training offered through the Unit Staff Development process has created, enhanced and supported the holistic treatment environment of the program.

In this manner: 1) residents are not able to triangulate staff; 2) residents are always in a state of treatment, the environmental milieu; 3) the focus of resident treatment program is reinforced by therapy staff and security staff; 4) security concerns and principles are consistently applied; and 5) optimal resident care is fostered.

****

SRS: Violent Sexual Predator
Treatment Program
% LCMHF
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N E W S L E T T E R

SRS: Violent Sexual Predator Treatment Program

Vol. 1 No. 2
January 1996

Programs, Processes, and Treatment

Comprehensive Treatment Planning

INSIDE

SRS: Violent Sexual Predator Treatment Program

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Treatment Planning Overview

The delivery of treatment services to sexual predators is a complex and distinctively specialized field. Unit staff who are involved in the therapeutic interventions with sexual predators on the SPTP Unit use their general therapeutic background, specialized training, and an understanding of the unique dynamics of the sexual predator to optimize the delivery of the treatment service.

Issues of planning, documentation, and evaluation are not merely luxuries, but a necessity for the establishment and continuation of quality treatment in the SRS program.

The SPTP Unit is dedicated to the importance of treatment planning, in rigorously plotting the course of treatment and continuous update evaluation of treatment techniques and interventions used. They then thoroughly implement this method of quality control.

The Individualized Treatment Programming and Goal Attainment Scaling in areas of individual Resident's needs are the quantitative tools of objectivity. The tools can be used to measure the efficiency and efficacy of the treatment and for measuring the progress of the Resident.

The treatment program for sexual predators uses a multi-modal intervention model that reflects on the complex and multi-determined causes of predatory sexual behavior.

As a responsible treatment planning effort then, the SRS: SPTP Unit efforts might best be defined as a remediation plan that, based on the sexual predator's identified history, problems, internal resources, needs, and/or deficiencies, uses the most effective, appropriate, and available methods to achieve the desired treatment goals.

Comprehensive Treatment Planning Advantages

Besides the advantage of comprehensive treatment planning allowing for the opportunity to focus on the most appropriate and effective interventions several other advantages exist:

***All staff and contracted clinical service providers who are directly involved with the treatment efforts of individual sexual predators are informed as to what treatment has been offered the Resident and can see documentation regarding the Resident's response to that treatment.**

***The plan can identify additional issues that are yet to be addressed or resolved.**

*Planning requires prioritization of efforts, and therefore some issues may receive attention only after we have addressed the most significant problematic areas.

*The plans provide for a logical and standardized basis of providing responses to the predator's treatment status to: the Resident, treatment personnel, treatment security personnel, and the courts.

*Staff accountability and professional quality assurance standards are enhanced.

*The planning system invites, encourages, and requires the clinical and security staff continuously to think of treatment needs and the objective goals of the Unit, and the Resident.

*An established treatment plan guides the clinical staff and Resident toward a series of treatment objectives.

* The planning continually refocuses all staff on the central concern and core issues of the Resident.

*Goal setting and scheduled reviews keep staff focused on realistic goals for group and individual treatment efforts.

*Planning provides an opportunity to trace the progress of the sexual predator on each goal throughout the treatment record.

*Meeting and treatment process notes in individual Resident files to trace Resident short and long-term progresses are available for team reviews.

*Periodic summaries of treatment intervention, coupled with the Resident's response(s) noted.

*Follow through of planning helps for a ready reference of an overview of the treatment.

As a Resident responds to the planned treatment and interventions, we revise the goals to reflect the responses. The treatment planning process is a standard operating procedure used regularly and modified as the need arises. In this fashion, treatment remains relevant, realistic, individual and focused toward the needs of the individual sexual predator.

Planning Prelude: Assessment

In the program we primarily base SPTP Unit treatment approaches on the following three assumptions:

1) That sex offenders and therefore sexual predators comprise a very heterogeneous population that single motivational, etiological factors, mental, psychological or psychiatric diagnosis cannot characterize. The classification schemes' and/or explanatory theories developed over the last fifteen years[1] have successfully argued that sex offenders/predators behavior is varied, complex, and multipli-determined. Therefore, any treatment effort must consider the specific factors pertinent to the individuals predatory history and the psychological characteristics of the individual.

2) Recent and contemporary treatment techniques can effectively treat some, but not all sex offenders. Recent research reviews demonstrate an increasing and encouraging success rate with certain types of child molesters and some types of rapists.[2]

3) Appropriate, adequate, and successful treatment involve a comprehensive and individually tailored treatment program that takes into consideration the acts committed, preference or targeting of victim, predator motivations, predator psychological characteristics, predator psychological and social development, cognition, deviant sexual arousal, social skills deficits, irrational beliefs and attitudes, anger, stress and life-crisis management, self-esteem problems and other areas that demand therapeutic interventions.

Some assessment issues which we address in the SRS: SPTP Units are:
-Natures of Specific Offense(s)
-Victim(s) Characteristics
-Antecedents of Offender's Crimes
(Of record and not of record)
-Previous Offenses (any criminal)
-Level of Psychopathology
-Developmental History
-Educational History
-Social History
-Sexual History, Experience and Knowledge
-Religious Beliefs
-Occupational History
-Level of Anger
-Level of Violent History
-Level of Responsibility and Ability To Empathize
-Cognitive Distortions about Men, Women and Children
-Sexual Arousal
-Social Skills
-Pscho-sociological tests results
-Assessment Procedure Results
-clinical
-psychological
-socio-psycho
-psychiatric

These assessment processes and others then provide a broad and comprehensive base of information used in generating effective treatment programming for the civilly committed Resident.

[1] Finkelhor 1984, Prentky, Cohn and Seghorn 1985, Carter and Baird 1986.

[2] Kelly 1982, Lanyon 1986, Becker and Blanchard 1978 and 1992, Hobson, Boland and Jamieson, 1985.

As Amended by Senate Committee

Session of 1996

SENATE BILL No. 469

By Committee on Judiciary

1-17

AN ACT enacting the care and treatment act for mentally ill persons; prescribing certain prohibited acts and providing penalties therefor; amending K.S.A. 22-3305, 22-3428, 22-4503, 28-170, 38-1505, 38-1614, 39-1602, 39-1610, 59-214, 59-2212, 59-3002, 59-3010, 59-3013, 59-3018a, 65-5603 and 76-12a10 and K.S.A. 1995 Supp. 12-1,109, 38-1513, 59-212, 65-5601, 75-5209 and 77-201 and repealing the existing sections; also repealing K.S.A. 59-2901, 59-2902, 59-2903, 59-2905, 59-2906, 59-2907, 59-2908, 59-2909, 59-2910, 59-2911, 59-2912, 59-2913, 59-2914, 59-2914a, 59-2916, 59-2916a, 59-2917, 59-2918, 59-2918a, 59-2919, 59-2919a, 59-2920, 59-2922, 59-2924, 59-2925, 59-2926, 59-2927, 59-2927a, 59-2928, 59-2929, 59-2930, 59-2931, 59-2932, 59-2933, 59-2934, 59-2936, 59-2937, 59-2938, 59-2939, 59-2940, 59-2941, 59-2943 and 59-2944.

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

New Section 1. The provisions of sections 1 through 42 and amendments thereto shall be known and may be cited as the care and treatment act for mentally ill persons.

New Sec. 2. When used in the care and treatment act for mentally ill persons:

(a) "Discharge" means the final and complete release from treatment, by either the head of a treatment facility acting pursuant to section 6 and amendments thereto or by an order of a court issued pursuant to section 29 and amendments thereto.

(b) "Head of a treatment facility" means the administrative director of a treatment facility or such person's designee.

(c) "Law enforcement officer" means any sheriff, regularly employed deputy sheriff, state highway patrol officer, regularly employed city police officer, law enforcement officer of any county law enforcement department or regularly employed police officer of any university, community college or haskell indian nations university, if such police officer of a university, community college or haskell indian nations university has completed not less than 320 hours of law enforcement instruction at the law enforcement training center or in a training program approved under

K.S.A. 74-5604a, and amendments thereto.

(d) (1) "Mental health center" means any community mental health center organized pursuant to the provisions of K.S.A. 19-4001 through 19-4015 and amendments thereto, or mental health clinic organized pursuant to the provisions of K.S.A. 65-211 through 65-215 and amendments thereto, or a mental health clinic organized as a not-for-profit or a for-profit corporation pursuant to K.S.A. 17-1701 through 17-1775 and amendments thereto or K.S.A. 17-6001 through 17-6010 and amendments thereto, and licensed in accordance with the provisions of K.S.A. 75-3307b and amendments thereto.

(2) "Participating mental health center" means a mental health center which has entered into a contract with the secretary of social and rehabilitation services pursuant to the provisions of K.S.A. 39-1601 through 39-1612 and amendments thereto.

(e) "Mentally ill person" means any person who is suffering from a severe mental disorder to the extent that such person is in need of treatment.

~~(1)~~ "Severe mental disorder" means a clinically significant behavioral or psychological syndrome or pattern associated with either a painful symptom or serious impairment in one or more important areas of functioning and involving substantial behavioral, psychological or biological dysfunction.

~~(2)~~ "Treatment" means any service intended to promote the mental health of the patient and rendered by a qualified professional, licensed or certified by the state to provide such service as an independent practitioner or under the supervision of such practitioner.

(f) "Mentally ill person subject to involuntary commitment for care and treatment" means a mentally ill person who also lacks capacity to make an informed decision concerning treatment, is likely to cause harm to self or others, and whose diagnosis is not solely one of the following mental disorders: Alcohol or chemical substance abuse; antisocial personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

~~(1)~~ "Lacks capacity to make an informed decision concerning treatment" means that the person, by reason of the person's mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by an inability to weigh the possible risks and benefits.

~~(2)~~ "Likely to cause harm to self or others" means that the person:

(a) Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage

2-2

(1)
: (A)
; or
(B) mental condition that has resulted in the commission of an act that would constitute a sexually violent offense
(2)
(3)
: (A)
(1)
, as defined in subparagraph (e)(1)(A),
; or
(B) a mentally ill person, as defined in subparagraph (e)(1)(B), who presents a continuing threat of harm to self or others
(2)
(3)

chologist or a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

(l) "Direction" means monitoring and oversight including regular, periodic evaluation of services.

(2) "Licensed master social worker" means a person licensed as a master social worker by the behavioral sciences regulatory board under K.S.A. 65-6301 through 65-6318 and amendments thereto.

(3) "Licensed specialist social worker" means a person licensed in a social work practice specialty by the behavioral sciences regulatory board under K.S.A. 65-6301 through 65-6318 and amendments thereto.

(4) "Registered masters level psychologist" means a person registered as a registered masters level psychologist by the behavioral sciences regulatory board under K.S.A. 74-5361 through 74-5373 and amendments thereto.

(5) "Registered nurse" means a person licensed as a registered professional nurse by the board of nursing under K.S.A. 65-1113 through 65-1164 and amendments thereto.

(k) "Secretary" means the secretary of social and rehabilitation services.

(l) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility or Topeka state hospital.

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

(n) The terms defined in K.S.A. 59-3002 and amendments thereto shall have the meanings provided by that section. Insert attached subsection.

New Sec. 3. In computing the date upon or by which any act must be done or hearing held by under provisions of this article, the day on which an act or event occurred and from which a designated period of time is to be calculated shall not be included, but the last day in a designated period of time shall be included unless that day falls on a Saturday, Sunday or legal holiday, in which case the next day which is not a Saturday, Sunday or legal holiday shall be considered to be the last day.

New Sec. 4. (a) The fact that a person may have voluntarily accepted any form of psychiatric treatment, or become subject to a court order entered under authority of this act, shall not be construed to mean that such person shall have lost any civil right they otherwise would have as a resident or citizen, any property right or their legal capacity, except as

2-3

(o) "Sexually violent offense" means:

(A) Rape, K.S.A. 21-3502, and amendments thereto;

(B) indecent liberties with a child, K.S.A. 21-3503, and amendments thereto;

(C) aggravated indecent liberties with a child, K.S.A. 21-3504, and amendments thereto;

(D) criminal sodomy, subsection (a)(2) and (a)(3) of K.S.A. 21-3505 and amendments thereto;

(E) aggravated criminal sodomy, K.S.A. 21-3506, and amendments thereto;

(F) indecent solicitation of a child, K.S.A. 21-3510, and amendments thereto;

(G) aggravated indecent solicitation of a child, K.S.A. 21-3511, and amendments thereto;

(H) sexual exploitation of a child, K.S.A. 21-3516, and amendments thereto;

(I) aggravated sexual battery, K.S.A. 21-3518, and amendments thereto;

(J) any conviction for a felony offense in effect at any time prior to the effective date of this act, that is comparable to a sexually violent offense as defined in subparagraphs (A) through (I), or any federal or other state conviction for a felony offense that under the laws of this state would be a sexually violent Offense as defined in this section;

(K) an attempt, conspiracy or criminal solicitation, as defined in K.S.A. 21-3301, 21-3302, 21-3303, and amendments thereto, of a sexually violent offense as defined in this section; or

(L) any act which at the time of sentencing for the offense has been determined beyond a reasonable doubt to have been sexually motivated. As used in this subparagraph, "sexually motivated" means that one of the purposes for which the defendant committed the crime was for the purpose of the defendant's sexual gratification.

As Amended by Senate Committee

Session of 1996

SENATE BILL No. 469

By Committee on Judiciary

1-17

AN ACT enacting the care and treatment act for mentally ill persons; prescribing certain prohibited acts and providing penalties therefor; amending K.S.A. 22-3305, 22-3428, 22-4503, 28-170, 38-1505, 38-1614, 39-1602, 39-1610, 59-214, 59-2212, 59-3002, 59-3010, 59-3013, 59-3018a, 65-5603 and 76-12a10 and K.S.A. 1995 Supp. 12-1,109, 38-1513, 59-212, 65-5601, 75-5209 and 77-201 and repealing the existing sections; also repealing K.S.A. 59-2901, 59-2902, 59-2903, 59-2905, 59-2906, 59-2907, 59-2908, 59-2909, 59-2910, 59-2911, 59-2912, 59-2913, 59-2914, 59-2914a, 59-2916, 59-2916a, 59-2917, 59-2918, 59-2918a, 59-2919, 59-2919a, 59-2920, 59-2922, 59-2924, 59-2925, 59-2926, 59-2927, 59-2927a, 59-2928, 59-2929, 59-2930, 59-2931, 59-2932, 59-2933, 59-2934, 59-2936, 59-2937, 59-2938, 59-2939, 59-2940, 59-2941, 59-2943 and 59-2944.

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

New Section 1. The provisions of sections 1 through 42 and amendments thereto shall be known and may be cited as the care and treatment act for mentally ill persons.

New Sec. 2. When used in the care and treatment act for mentally ill persons:

(a) "Discharge" means the final and complete release from treatment, by either the head of a treatment facility acting pursuant to section 6 and amendments thereto or by an order of a court issued pursuant to section 29 and amendments thereto.

(b) "Head of a treatment facility" means the administrative director of a treatment facility or such person's designee.

(c) "Law enforcement officer" ~~means any sheriff, regularly employed~~ deputy sheriff, state highway patrol officer, regularly employed ~~city~~ police officer, law enforcement officer of any county ~~law enforcement~~ department or regularly employed police ~~officer of~~ any university, community college or haskell indian ~~nations~~ university, if such police officer of a university, ~~community~~ college or haskell indian nations university has ~~completed not~~ less than 320 hours of law enforcement instruction at the ~~law enforcement training center or in a training program approved under~~

shall have the meaning ascribed to it in K.S.A. 22-2202,

KSA 22-2202

(13) "Law enforcement officer" means any person who by virtue of office or public employment is vested by law with a duty to maintain public order or to make arrests for violation of the laws of the state of Kansas or ordinances of any municipality thereof or with a duty to maintain or assert custody or supervision over persons accused or convicted of crime, and includes court services officers, parole officers and directors, security personnel and keepers of correctional institutions, jails or other institutions for the detention of persons accused or convicted of crime, while acting within the scope of their authority.

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~~K.S.A. 74-5604a,~~ and amendments thereto.

(d) (1) "Mental health center" means any community mental health center organized pursuant to the provisions of K.S.A. 19-4001 through 19-4015 and amendments thereto, or mental health clinic organized pursuant to the provisions of K.S.A. 65-211 through 65-215 and amendments thereto, or a mental health clinic organized as a not-for-profit or a for-profit corporation pursuant to K.S.A. 17-1701 through 17-1775 and amendments thereto or K.S.A. 17-6001 through 17-6010 and amendments thereto, and licensed in accordance with the provisions of K.S.A. 75-3307b and amendments thereto.

(2) "Participating mental health center" means a mental health center which has entered into a contract with the secretary of social and rehabilitation services pursuant to the provisions of K.S.A. 39-1601 through 39-1612 and amendments thereto.

(e) "Mentally ill person" means any person who is suffering from a severe mental disorder to the extent that such person is in need of treatment.

(1) "Severe mental disorder" means a clinically significant behavioral or psychological syndrome or pattern associated with either a painful symptom or serious impairment in one or more important areas of functioning and involving substantial behavioral, psychological or biological dysfunction.

(2) "Treatment" means any service intended to promote the mental health of the patient and rendered by a qualified professional, licensed or certified by the state to provide such service as an independent practitioner or under the supervision of such practitioner.

(f) "Mentally ill person subject to involuntary commitment for care and treatment" means a mentally ill person who also lacks capacity to make an informed decision concerning treatment, is likely to cause harm to self or others, and whose diagnosis is not solely one of the following mental disorders: Alcohol or chemical substance abuse; antisocial personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

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

(2) "Likely to cause harm to self or others" means that the person: (a) Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage