Approved: 3-30-98
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 16, 1998 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Robin Kempf, Legislative Research Department
Norman Furse, Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Ron Hein, Mental Health Credentialing Coalition
Ellen Piekalkiewicz, Director, Association of Community Mental Health Centers
James L. Germer, Director, Kansas Advocacy and protective Services

Others attending: See attached list

Hearing on Sub HB 2630 - Qualified mental health professionals defined and HCR 5042 - Establishing a task force on providers of mental health

Ron Hein, legislative counsel for the Mental Health Credentialing Coalition, testified before the Committee in support of **Sub HB 2630** which adds licensed marriage and family therapists and licensed professional counselors to the definition of qualified mental health professional as used in the Care and Treatment Act for Mentally Ill Persons. Mr. Hein noted that concerns may be expressed that some licensed Professional Counselors and Licensed Marriage and Family Therapists do not have the qualifications that the Community Mental Health Centers are looking for in an employee. He responded to these concerns by stating that the bill is not mandatory in any sense and simply permits the CMHCs to employ LMFTs and LPCs, and if the CMHC have any concerns with any specific individual, they would not be required to hire such an individual. He pointed out that under existing law, psychiatric nurses and masters level social workers are already included as QMHPs which was noted in his written testimony. Mr. Hein also expressed support for **HCR 5042** which would establish a 13 member task force of providers of mental health services to study the laws, rules and regulations relating to the providing of treatment for persons with mental disorders. The task force would make preliminary recommendations to the 1999 legislature and final recommendations to the 2000 legislature.(See Attachment 1) Committee discussion related to qualifications of LPCs and LMFTs, the reimbursement issue, and whether final recommendations of the task force should be made to the legislature in two years or one.

Ellen Piekalkiewicz, Association of Community Mental Health Centers of Kansas, Inc., commented that members of the Association have discussed **Sub HB 2630** at length and have a concern whether all FMTs and PCS are employable as Qualified Mental Health Professionals, since it is unclear whether MFTs and PCS have the appropriate educational preparation to prepare them to perform the QMHP function. Ms. Piekalkiewicz also pointed out that the Association supports a provision in the bill which would clarify that patients at Larned State Hospital with dangerous behaviors or charged or convicted of felony crimes would be treated in the State Security at Larned State Hospital instead of with the general psychiatric population. Reservation was also expressed about language in **HCR 5042** which appears to deal more with scope of business than what the charge of the task force should be, which is scope of practice as noted in her written testimony. (Attachment 2)

James L. Germer, Kansas Advocacy and Protective Services, Inc., expressed support for the intent of **HCR 5042** and suggested that consumers be represented on the task force. Mr. Germer also submitted a 32 page document to the Committee that offered some suggestions for possible legislative study relating to mental health services. (Attachment 3) Five amendments were also proposed to **Sub HB 2630** that related to: due process protection to voluntary patients, require that patients charged or convicted with felony crimes may not be maintained outside of the State Security Hospital, notice that persons transferred from one state hospital to another be entitled to a hearing, information be made available to the patients who would be subject to a transfer to the Security Behavioral Ward, and establishing a maximum census on SBW by SRS in the 18-20 patient range as outlined in his written testimony. (Attachment 4) Comparison of Masters Level Mental Health Professions was submitted by Chip Wheelen, Kansas Psychiatric Society, (Attachment 5)

The Committee briefly discussed both **Sub HB 2630** and the Resolution, but no action was taken until the House floor amendments on **Sub HB 2630** could be reviewed.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 17, 1998.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-16-98

NAME	REPRESENTING
Chip Wheelen	Ks Psychiatric Soc.
Susan Linn	Ks. Psychological Assoc.
Jim Germer	Ks. Adv. & Prot. Servs
Michelle Arl.	" " " "
Rick Guthrie	Health Midwest
J Mann	KAMP / BSRB
David Gilstrap	KAMP / MHCC
Dave Lord	KAMFT / MHCC
Jon Jordan	SRS-MH+DD
Carrie Reecht	Brad Smoot
Dawn Reed	KSNA
Whitney Damron	KS Psychological Assn.
Lyn Vonne Kinnitt	KBA

HEIN AND WEIR, CHARTERED

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Ronald R. Hein
Stephen P. Weir
Susan Baker Anderson

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
TESTIMONY RE: Sub. HB 2630 and HCR 5042
Presented by Ronald R. Hein
on behalf of the
MENTAL HEALTH CREDENTIALING COALITION
March 16, 1998

Madam Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Mental Health Credentialing Coalition (MHCC). The Coalition is comprised of three organizations and their members: Kansas Association for Marriage and Family Therapy (KAMFT); Kansas Association of Masters Level Psychologists (KAMP); and the Kansas Counseling Association/Kansas Mental Health Counselors Association (KCA/KMHCA).

As originally introduced, HB 2630 provided for changes regarding statutes relating to Licensed Masters Level Psychologists (LMLPs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs). The original bill also contained the section which is now Sub. HB 2630, which provides that Licensed Professional Counselors and Licensed Marriage and Family Therapists shall be included within the definition of Qualified Mental Health Professional (QMHP) in K.S.A. 59-2946. As such, those professionals must act under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

The other portions of original HB 2630, which were removed from the bill when the Substitute will was reported to the House floor, had caused quite a bit of controversy. There was a full hearing with proponents and opponents, as well as two subcommittee hearings to attempt to come to some agreement on the issues raised, but to no avail on those controversial issues.

The subcommittee concluded that there was agreement between all the parties regarding the amendment that is now set out in Sub. HB 2630. Therefore, the subcommittee recommended, and the House committee concurred, that the bill should be amended to include only the agreed-to portion of the bill.

Although there are no opponents to Sub. HB 2630, the Association of Community Mental Health Centers of Kansas, while not opposing the bill, will, I believe, make some comments regarding the employability of certain Marriage and Family Therapists and Professional Counselors. You will hear from their representative in a few minutes.

Senate Public Health and Welfare
Date: 3-16-98
Attachment No. 1

The MHCC recognizes that some LPCs and LMFTs may not have the qualifications that the CMHCs are looking for in an employee. There are still LMFTs and LPCs who have not had courses in psychopathology or psycho-diagnostics or perhaps other courses that the CMHCs might require prior to being hired.

There are two responses to these concerns.

First, the bill is not mandatory in any sense, and simply permits the CMHCs to employ LMFTs and LPCs. In short, if the CMHC has any concern with any specific individual, they will not be required to hire such an individual.

Secondly, under existing law, psychiatric nurses and masters level social workers are already included as QMHPs. The concerns of the CMHCs with regards to the employability of LMFTs and LPCs would be equally true of certain psychiatric nurses and licensed masters level social workers.

Sub. HB 2630 does not mandate anybody to be hired by CMHCs, but by designating LPCs and LMFTs to be QMHPs permits the CMHCs to hire LPCs and LMFTs if they desire to do so.

Ironically, HB 2630 as originally introduced would have corrected that problem by making all LMFTs and all LPCs meet that requirement to be licensed. But since that requirement of the original bill did not pass, the other two responses address the situation today.

The subcommittee studying HB 2630 also recommended that HCR 5042 be introduced and passed. That resolution provides for the creation of a task force to look at some of the mental health issues that were raised by HB 2630 as it was originally introduced, as well as to look at other issues relating to the existing statutes concerning mental health services. The scope of the task force is set out in lines 15-31 of HCR 5042.

The makeup of the committee is set out in the resolution, and consists of two legislators appointed by the President of the Senate, two by the Speaker of the House, one by the Senate Minority Leader, one by the House Minority Leader, and seven individuals appointed by the Legislative Coordinating Council. Of the seven people appointed by the Legislative Coordinating Council, there is one representative of each of the professions regulated by the Behavioral Sciences Regulatory Board (BSRB), namely marriage and family therapists, professional counselors, psychologists, masters level psychologists, and social workers. In addition to those five individuals, there is a psychiatrist on the task force, and a representative of the managed care industry.

Two of the members representing the five BSRB licensed professions shall be engaged in teaching in the profession for which they are licensed. In addition, one of the seven members appointed by the LCC shall be a representative of a community mental health center.

The task force is to file an interim report before the 1999 Legislature, and is to submit a final report and recommendations to the year 2000 Legislature.

The MHCC would request that the committee approve Sub. HB 2630 and HCR 5042 for passage.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

Submitted by Ron Hein

QMHP

EXHIBIT 2

	NURSE	MSW	LMLP	LSCSW	PC	MFT	PSYCHOLOGIST
	Psychiatric Nurse	Master Social Worker	Masters Level Psychologist	Specialist Clinical Social Worker	Professional Counselor	Marriage and Family Therapist	Psychologist
Ph.D.					NO	NO	**YES (No Direction)**
MA + 4,000 Hours*			**YES (With Direction)**	**YES (With Direction)**	NO	NO	
MA + 2,000 Hours*			**YES** (With Direction)**				
M.A.		**YES (With Direction)**					
B.A.	**YES (With Direction)**						
H.S.							

* Hours of supervised postgraduate experience
**HB 2630 increases post graduate supervised experience requirement to 4,000 hours.

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Association of Community
Mental Health Centers of Kansas, Inc.
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Testimony on Substitute for H.B. 2630 and HCR 5042

Senate Public Health and Welfare Committee
March 16, 1998

I am Ellen Piekalkiewicz, Director of Policy and Planning, representing the 30 licensed Community Mental Health Centers (CMHCs). CMHCs are the county's legally delegated authorities to manage Mental Health care in Kansas. CMHCs function as the local mental health authorities. As such, the Kansas public mental health system is a relationship of shared governance between two governmental entities, the state and the counties.

Substitute for H.B. 2630 would allow CMHCs to hire licensed Marriage and Family Therapists (MFTs) and licensed Professional Counselors (PCS) as Qualified Mental Health Professionals (QMHP). A QMHP is defined in K.S.A. 59-2946 as a physician or psychologist who is employed by a CMHC or who is providing services as a physician or psychologist under a contract with a CMHC, or a registered masters level psychologist 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 CMHC and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a CMHC.

The primary duty of a QMHP working within a CMHC is to conduct Mental Health Reform screens (see Care and Treatment for Mentally Ill Persons, K.S.A. 59-2944) to determine whether an individual requires admission to a state hospital. During that screening evaluation, the QMHP must determine the following:

- Is the person being screened, "mentally ill," i.e. is the person "suffering from a mental disorder which is manifested by a clinically significant behavioral or psychological syndrome or pattern and associated with either a painful symptom or an impairment in one or more area of function and involving substantial behavioral, psychological or biological dysfunction, to the extent that the person is in need of treatment."
- Does the person "lack the capacity to make informed decisions concerning treatment."
- Is the person "likely to cause harm to self or others," i.e., "is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property ...."

Senate Public Health & Welfare
Date: 3-16-98
Attachment No. 2

Members of the Association of Community Mental Health Centers have discussed substitute for H.B. 2630 at length and have a concern whether all MFTs and PCS are employable as QMHPs, since it is unclear whether MFTs and PCS have the appropriate educational preparation to prepare them to perform the QMHP function.

The original bill, H.B. 2630, contained a provision requiring the Behavioral Sciences Regulatory Board (BSRB) to determine whether applicants for MFT and PC licenses were competent in the diagnosis of mental disorders. The provision required the BSRB to adopt rules and regulations to determine competency through curriculum requirements and examination proficiency.

Substitute for H.B. 2630 also includes a provision which would clarify that patients at Larned State Hospital with dangerous behaviors or charged or convicted of felony crimes will be treated in the State Security at Larned State Hospital instead of with the general psychiatric population. The Association of CMHCs supports this provision since it is intended to ensure protection and safety of staff and patients.

++

HCR 5042 establishes a task force to study the law and rules and regulations relating to the provision of treatment for persons with mental disorders and to review specifically the scope of practice of various professions licensed by the BSRB. The Association of CMHCs recognize the need for such a study and requested that one of the professionals on the task force represent the CMHCs. We do have reservations about the last part of the charge for the task force which reads, "to study referral patterns among providers and multi-disciplinary approaches to delivering mental health services. This language appears to deal more with scope of business than what the charge of the task force should be, which is scope of practice.

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James Germer, Executive Director

March 16, 1998

To: Senate Committee on Public Health and Welfare

From: James L. Germer, Director, Kansas Advocacy and Protective Services, Inc. (KAPS)

Re: HCR 5042

Members of the Committee:

I am the Director of Kansas Advocacy and Protective Services, Inc. The purpose of my testimony is to assure that any task force or other interim study group that is put together to study mental health issues involve consumers, family members and advocates. We believe that the mental health reform law contemplates the intense involvement of consumer advocates at all levels in this process. It is our understanding that only the involvement of service providers has been contemplated thus far, not the involvement of consumer groups, or for that matter, SRS representatives.

However, consumers have much to say about mental health services, and they are "in sync" in what they are saying. Attached to this Memorandum is a 32 page document that we put together by listening long and hard to what individuals with mental illness, family members and grass-roots advocacy groups have to say about mental health services and supports in Kansas. It includes some suggestions for possible legislative and regulatory activity. I will not read it now, but would strongly urge that anyone seriously interested in this subject read it thoroughly.

Sincerely,

James L. Germer, J.D.
Director

Senate Public Health & Welfare
Date: 3-16-98
Attachment No. 3

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DRAFT

Kansas Advocacy and Protective Services, Inc.
GENERAL COMMENTS ON MENTAL HEALTH ISSUES

March 16, 1998 draft
By James Germer, KAPS' Director

These comments update KAPS' General Comments dated October, 1997, which have been widely disseminated. These comments represent the perspective of KAPS' staff regarding the present status of Mental Health (MH) services in Kansas.

These comments were gathered primarily by listening to what mental health consumers and consumer-based advocacy groups have to say. We find a clear general consensus on the great majority of these matters; and although at this time this document remains in draft form, KAPS' staff believes that there will be very little disagreement on any of the matters covered and we should be receive official confirmation from all of the entities listed below very soon (Confirmation has already been received from many of them). The bottom line is that the beliefs that unite us far outweigh any differences.

The groups who were involved include:

NAMI - KS (National Alliance for persons with Mental Illness - Kansas)
KMIAC - Kansas Mental Illness Awareness Council
MHAK - Mental Health Association of Kansas
Keys for Networking
Families Together
Spirit, Inc.
Spirit 3
Breakthrough House - Topeka
Breakthrough Club - Wichita
KAPS' PAIMI (Protection and Advocacy for Individuals with Mental Illness) Advisory Council

Additionally, these groups thank to the Kansas University School of Social Welfare - Office of Social Policy Analysis, who provided technical assistance.

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INDEX

I. PROCESS ISSUES

The Big Picture

Mental Health Reform in Kansas must be accomplished in a collaborative fashion with all involved stakeholders working together, with consumers of mental health centers sharing the leading role. There must be open, vigorous, respectful debate, with this question in mind: "How will our decisions improve the lives of individuals with mental illness in Kansas?"

Weekly stakeholder meetings

We continue to believe that these Friday morning weekly meetings of the mental health advocates are of critical importance. For mental health Reform in Kansas to be accomplished, the following must be borne in mind:

1. There must be collaboration among ALL involved stakeholders. This includes consumers of mental health services, family members, advocacy groups and agencies, service providers, mental health professionals, scholars, the legislature, SRS, state entities, and the general public.

2. Consumers of Mental Health Services must at least share the leading role.

3. We can learn from the past, but must act for the future.

4. There must be open, vigorous, and respectful debate among all stakeholders.

5. Issues, not personalities, should be debated.

6. There must be responsiveness and follow-through for assigned tasks.

7. All stakeholders must keep this question foremost in mind:

   "How will our decisions improve the lives of individuals with mental illness in Kansas?"

II. WHO IS A "CONSUMER" OF MENTAL HEALTH SERVICES?

This is really two questions.
(1) First, who are consumers of mental health services for purposes of identification with the movement for rights and opportunities? Who is the mental health advocacy community? It is important that this be a broad coalition.
(2) Second, who are consumers of mental health services for purposes of ensuring representation on CMHC boards of individuals in the targeted population as the Kansas legislature has suggested? This will be a much smaller group.

(1) Who are consumers for purposes of defining the advocacy movement?

There are many different types of "consumers" who get help through community mental health centers. There are people who may need temporary services from a CMHC who do not have axis I diagnoses, but may have a functional impairment which substantially interferes with or limits one or more major life activities. Consumers may be persons who have been emotionally or sexually abused and need to work through issues. Persons may seek help for alcohol or drug dependency. Children's mental health issues vary from adults' mental health issues. There are family members - often called secondary consumers - of persons with mental illness. **In short, there are many different kinds of consumers, and it is very important that we not rank them in terms of importance or "sincerity" to the advocacy movement.** We are all important.

Because of the stigma still strongly attached to mental illness, there is no incentive in admitting that one has a mental illness, and therefore no reason to question the sincerity of anyone who admits it. However, individuals who use the mental health system, whether they have a diagnosable mental illness or not, can still help advocate for improving the lives of persons with mental illness and seek to reduce the stigma. For that matter, so can people with mental illnesses who for various valid reasons may not wish to proclaim it. For that matter, so can family members, friends, professionals, legislators, and anybody else who is interested in improving the lives of persons with mental illness and reducing the stigma. the important thing is that actual consumers - people who have "been there" - share the leading role. **The simple, bottom line: those of us who want to see improvement in the lives of persons with mental illness must work together.**

(2) Which consumers of mental health services are members of the "Target Population" for purposes of ensuring representation on CMHC boards?

The Kansas legislature has correctly noted that the individuals who are most in need of help, i.e., the "targeted population", should be specifically represented on CMHC Boards. That is, we believe, as does KU in the study cited below, that the legislature intended that adults with severe and persistent mental illness or who are at risk of requiring institutional care be represented, as well as family members of children with severe emotional disturbance.

Obviously, CMHCs should have all types of consumers represented on either their board or advisory council. However, the legislature found it important, and we certainly agree, that those most in need of services have the greatest need for representation.

The 1995 KU study quoted above indicates at page 55 that:

> The phrase "consumers of mental health services" is not defined [in the mental health act of 1991] and thus, has been interpreted diversely. The targeted population for those most in need of mental health services is defined by the legislature as "*adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care*." From this, many people assumed when mandating consumer and family representation on governing boards, the legislature was speaking of this population. However, some CMHCs do not have consumers from the targeted population on their governing boards. Instead, they may have individuals who have been in some less intensive form of counseling or have had short term psychotherapy. Clearly, the intent of the reform act needs clarification.

(Emphasis in original - also note that on the following page (56) the observation is made that CMHC consumers usually do not even know who this representative is.)

For purposes of defining board representation, we believe that a good definition of "consumers" is provided by the Mental Health Reform Act as it refers to the "targeted population." According to K.S.A. 39-1602, the term "targeted population" means:

> the population group designated by rules and regulations of the secretary as most in need of mental health services which are funded, in whole or in part, by state or other public funding sources, which group shall include adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care.

Therefore, boards should have those **"consumers"** who are part of the **"targeted population"**, which in turn means:

-(I) adults with severe and persistent mental illness

-(II) severely emotionally disturbed children and adolescents, and

-(III) other individuals at risk of requiring institutional care.

Two of the above three terms *are* defined in Kansas regulations (See Kansas Administrative Regulations - K.A.R. - 30-60-2):

(I) Adult with severe and persistent mental illness means one who:

(1) Has a severe disability resulting from mental illness evidenced by the fact that the person has:

(A) Required inpatient hospitalization for psychiatric care and treatment than outpatient more than once in their lifetime; or

(B) experienced at least one episode of disability requiring continuous, structured, supportive residential care, other than in-patient hospitalization, lasting for at least two months;
and

(2) has impaired functioning evidenced by at least two of the following, occurring on either a continuous or intermittent basis over a two year period of time:

(A) Being unemployed, being employed only in a sheltered setting, or having markedly limited work skills and a poor work history;

(B) requiring public financial assistance form their out-of-hospital maintenance and being unable to procure such assistance without help;

(C) showing severe inability to establish or maintain a personal social support system;

(D) requiring help in basic living skills; or

(E) exhibiting inappropriate social behavior which results in a demand for intervention by either the mental health or judicial systems.

II. Child or adolescent with severe emotional disabilities or disorders means one who:

(1) Is under:

(A) The age of 18; or

(B) the age of 21 and has been receiving services continuously since prior to becoming 18 years of age that require further continuity for maximum therapeutic benefit; and

(2) has severe behavioral, emotional or social disabilities evidenced by the fact that the person has:

(A) Experienced disruptions in academic or developmental progress, or in family or interpersonal relationships, to the point that the child or adolescent:

(i) is considered at risk for out-of-home placement; or

(ii) has been placed out of their home;

(B) experienced episodes of behavioral, emotional or social disability that:

(i) Have continued for an extended period of time; or

(ii) are judged, based on a specific diagnosis made by a qualified professional, likely to continue for an extended period of time;

(C) experience behavioral, emotional or social disabilities that cannot be attributed solely to physical, sensory or intellectual deficits; or

(D) frequently required intensive, well-coordinated, supportive services developed by an interdisciplinary team involving mental health professionals.

III. Other individuals at risk of requiring institutional care.

This term does not appear to be further defined in present SRS regulation; at least not in K.A.R. 30-60-2. Because of the fact that fewer people are being hospitalized these days, this term may need to be further defined. One possibility may be to clarify the definition as follows:

> *Other individuals at risk of requiring institutional care* means those individuals, who, without the use of appropriate community based mental health supports and services, including access to appropriate medication, would be at risk of requiring institutional care, or who probably would have needed traditional institutionally based care prior to the advent of better community supports and services.

This is important because individuals with significant mental illnesses who receive community based services and who may take medication for a psychiatric condition are still in the targeted population, even though they may never have been hospitalized or have received supported residential care.

Another possible definition for adults is taken from the Center for Mental health Services, 1993. (The Center for Mental Health Services, CMHS, is a federal agency within the Department of Health and Human Services.) It is as follows:

> 'Adults with Serious Mental Illness' are persons:
> Age 18 and over, (1) who currently or at any time during the past year, (2) have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R "V" codes, substance use disorders, and developmental disorder, which are excluded, unless they co-occur with another diagnosable serious mental illness.

Another option mentioned in our previous, October 1997 Summary of General Comments On Current Mental health Issues, is presented below. If the definition of "other individuals at risk of requiring institutional care" is sufficiently broad, perhaps no change in the definition of Adults with Severe and Persistent Mental Illness" (SEMI) will be necessary.

> In order to more fully assure for mental health treatment for adult individuals with severe and persistent mental illness (SEMI), another possibility is to change the language in state regulation - see K.A.R. 30-60-2(c)(1)(B). The term **"and"** appears between (c)(1)(B) and (c)(2). The present inclusion of the word "and" would seem to require that the consumer would have to have either received inpatient hospitalization more than once or received at least two months of residential care - in addition to the requirements of (c)(2) - before being found to be a member of the "target population" referred to in 30-60-2(b). In this area of decreasing use of psychiatric inpatient services, more and more individuals with SPMI are not going to meet the (c)(1) standards of having had inpatient treatment or at least 60 days residential treatment, but should still be in the target population. We had previously believed from talking with SRS representative in the past that the work "or" rather than "and" was in fact the standard. However, this does not in fact appear to be the case, and we believe that SRS in fact intended to use the term **"and"**.

IN SHORT:

WE ARE ALL ADVOCATES
MANY OF US ARE CONSUMER ADVOCATES
SOME OF US ARE MEMBERS OF THE "TARGETED POPULATION"

III. TENETS. We believe that the following tenets must be held in the forefront as we further improve mental health services in Kansas.

1. <u>In order to assure for appropriate mental health services, we must have a clear philosophy and vision with guiding principles.</u> There are several different possible sources in Kansans from which to draw a vision. They include:

1) Mental Health Reform Act, K.S.A. 39-1601 et seq., and accompanying regulations, see especially 30-60-50 *Client Rights*.

2) The K.U. School of Social Welfare noted in its *Topeka State Hospital Closure Evaluation: Interim Report* dated February 16, 1998 at page 5 that states that had successful closures of state hospitals all reported values including:

Preservation of personal dignity
Opportunities for growth and self-fulfillment
Entitlement to live in the least restrictive, most normal residential alternatives, and
The opportunity to receive the supports suited to individual needs

3) Of great importance is the SRS - Mental Health Services five year plan entitled *Outcomes for the 21st Century: Strategies for Enhancing the lives of Kansans with Mental Illness*, which contains SRS' Mission, Vision and Values statements for mental health services. It will be referenced throughout the following "Tenets."

2. <u>There must be a greater degree of consumer involvement in the design, provision and evaluation of services.</u> SRS indicates in its 5 year plan "Values" statement that "Individuals and families receiving services will be equal participants in goal setting, decision-making service planning, and outcomes" (see *Outcomes for the 21st Century*, page 2). Many individuals who are consumers of mental health services indicate a fear of becoming "too assertive" in advocating for themselves or family members because of fears - justified or not - that some form of retaliation might occur. **Obviously, this means that individuals with mental illness, including members of the targeted population, family members, and consumer advocacy groups should be heavily involved with any legislatively appointed groups, such as interim studies; and also very involved with any SRS work-groups that come together to study the issue, including managed mental health care issues.**

One further possible, partial remedy on the local level would be to strengthen the representation of individuals with mental illness who serve on the boards of CMHCs. State law requires that "the membership of the governing board shall include consumers of mental health services or representatives of mental health consumer groups and shall include family members of mentally ill persons." K.S.A. 19-4002(b). K.A.R. 30-60-25 only requires that the CMHC governing board "include at least one member who is or has been a consumer of mental health services" as well as one family member. Heavy consideration should be given to increasing the number of consumers - as well as family members - on CMHC governing boards. The mental health advocacy groups strongly believe that at least three slots are needed on boards of CMHCs: the two identified by statute and regulations (i.e., one member of the targeted class and one family member of the targeted class), plus another family member slot; in other words, the slots should be (1) one adults with SPMI, (2) one

parent of a child or adolescent with SED, and (3) one family member of an adult with SPMI. There should also be provision made to reasonably accommodate board members with mental illness or who are family members of individuals with mental illness by providing reasonable accommodations during the board meeting process. Some possible examples might be not scheduling meetings early in the mornings when the individual's medications make them groggy; or arranging for transportation if the medication regimen makes it difficult for the individual to drive; or to make sure a family member has enough notice of the meetings to arrange for respite care or attendant care. Another accommodation that might be of substantial importance would be to allow for the use of an alternate representative for individuals with mental illness in situations where due to the illness, or a change of medication, the individual is not able to attend meetings.

Second, the definition of "consumer" needs to be clarified, as indicated by the 1995 KU study quoted earlier in this document at page 4. It may be enough just to change K.A.R. 30-60-25 to state that "consumers of mental health services" means members of the "targeted population" as defined by K.S.A. 39-1602(a) and as further clarified in K.A.R. 30-60-2.

Third, in addition to strengthening the presence of consumers on CMHC boards of directors, strong consideration could also be given to establishing consumer advisory councils which would serve to provide technical assistance to CMHCs as they strive to better serve their constituency, and to also provide a place for consumers to bring their concerns. Each CMHC could establish this consumer advisory council, with the consumer advisory council chair serving as liaison to the CMHC board. The advisory council chair would also be a voting board member, and should be a consumer. This is similar to the advisory councils required by law for state protection and advocacy agencies such as KAPS.

The mental health advocacy groups also strongly believe that the same requirements for board representation and for advisory councils should also extend to any organizational entity that affiliates with a CMHC.

3. <u>We need to be willing to learn lessons from other states' experiences</u>

There is an old saying that goes something like "experience is best if you can get it second-hand." The KU School of Social Welfare reviewed the experiences of 5 other states which significantly downsized or closed state hospitals. *See* KU School of Social Welfare, Office for Social Policy Analysis, <u>Topeka State Hospital Closure Evaluation: Interim Report, February 16, 1998</u> (prepared under subcontract for the Center for Outcome Analysis), pages 5 and 6. With permission, that discussion is reproduced below:

> **<u>Summary of the Experience of Other States:</u>**
>
> **1. All of the states reported as having successfully closed or downsized state psychiatric hospitals began by developing a clear philosophy and vision with**

guiding principles to direct their systems change initiatives. The state mental health authorities reported values including preservation of personal dignity, opportunities for growth and self-fulfillment, entitlement to live in the least restrictive, most normal residential alternative, and the opportunity to receive the supports suited to individual needs.

2. In all of the states reviewed most, if not all, of the funding in the closed or downsized state hospital system was transferred and retained for community mental health services. The availability of resources to build the capacity of community support services was seen as critical to reducing the need for state hospital services. The flexibility of funding was also seen as important, so that local communities could use the funds to fill gaps in services in order to meet the unique needs of individual clients.

3. Development of alternative community services with sufficient capacity to serve former hospital patients and those in the community who are at risk of hospitalization, was viewed as a critical component of any hospital closure or down-sizing process. The configuration of community-based services developed in the states reviewed included several common, core services:

a) an aggressive crisis intervention system including 24 hour crisis phone lines, out-reach for in-home evaluations, crisis stabilization in small facilities, and one-to-one home crisis support for both adults and children;
b) an array of different types and intensities of case management services, from weekly case management service to assertive community treatment teams operating 24 hours a day;
c) individualized, wrap-around supports for children and families, with a point of accountability (usually a case manager) for coordination of services from various agencies;
d) residential services and supported housing options, from intensively staffed group homes to supported cooperative apartments for one or two adults, and therapeutic foster care for children;
e) expanded vocational, housing, and consumer self-help services to enhance rehabilitation and community integration; and
f) capacity for <u>local</u> inpatient hospitalization for both adults and children.

4. Only one of the five states reviewed continues to operate <u>any</u> children's state hospital beds (i.e.: New Hampshire operates one 20 bed state, acute care facility for children and adolescents.).

4. <u>Mental health services must be "person-centered," provide "wrap around services," and build on personal strengths.</u>

We commend SRS' 5 year plan "Values" statements that indicate that "services will be provided in a manner that shows respect for the dignity of the person served, building on personal strengths, and allowing consumers greater control of their own lives" and also that "services provided to children, families and adult consumers will be individualized to meet the unique needs and potential of each person, and implemented in a culturally sensitive manner" (see *Outcomes for the 21st Century*, page 1 - 2).

Person centered approaches which utilize wrap-around services make it easier for children with severe emotional disturbances to be raised by their natural parents, instead of having to reside outside the home in foster care. Consumers must have the opportunity for home and community based services wherever possible, and children with emotional disturbances should be raised by their natural parents, with adequate services and supports, wherever possible.

Although for many consumers and professionals (including the many who are *both*) this "person-centered" approach seems second nature, its implementation is by no means even remotely secured at this juncture.

Person centered planning could be based on the DD regulations that are already in existence. There are many protection in the DD regulations that should be converted to the mental health system, where applicable. People who have been involved on the DD side should be called upon to present their expertise and input into how some of the lessons learned there could apply to the mental health side. Sherry Diel of KAPS and Jane Rhys of the State DD Council have made initial efforts in working on this, but have since had to devote their full attention to the DD regulations, which have come up for review. However, we would like to see a work-group continue this process. Kari Ramos with KAPS has had extensive experience with setting up wrap-around services for children and families, and Keys for Networking would also have particular expertise in this area. Information gained from the consumer satisfaction survey should also be helpful.

5. <u>Consumers must have "choice" as to service providers and services provided.</u>

Inherent in this person-centered approach is the concept of *choice*. Consumers should have maximum input in the decision of what services they receive, or who their case manager is. In order to assist with consumer choice, durable powers of attorney for health care needs have worked well in many areas across the country. Some states, notably California, have separate statutes that deal with durable powers of attorney for health care needs. Kansas statutes (K.S.A. 58-625 et seq.) do talk about durable powers of attorney for health care decisions, including treatment of mental conditions (K.S.A. 58-629). One principle advantage in using these instruments is that the consumer's wishes are followed in the event of intense psychiatric need. What may have worked well for the individual consumer in the past can be put into the instrument so that all involved with the individual's mental health care will be aware, and the individual has a better chance of receiving individualized, appropriate care in the case of intense psychiatric need. This approach has been very underutilized in Kansas.

However, better use of durable powers of attorneys is only a partial answer. Consumers appear to have little choice under the present funding system because there is little competition among service providers.

6. <u>Services and funding must accompany the consumer.</u>

The location where the consumer lives, or wishes to live, should not govern what community based services the consumer receives. If a consumer is receiving appropriate services in one locality, but wishes to re-locate to another locality within the state, comparable services should be available. We are concerned that the following SRS policy may be mis-interpreted:

> An individual's residence...determines the State Mental Health Hospital catchment area to which he/she belongs. *An exception to this is a person who is residing in a facility in a particular county to receive mental health services because appropriate services are not available in his/her home county. Such individual's residence would be that of his/her primary county of residence prior to entering the facility.* (emphasis added.)

Perhaps this is not the intent, but this policy has been construed to mean that a community mental health center (CMHC) can deny services to a person who moved to its service area because services provided in that particular CMHC area are not available in the consumer's previous service area. It should be clarified that the individual's "residence" in this policy only affects the individual's state hospital catchment area, not the individual's ability to obtain mental health services in the individual's new locality.

Consumers should be able to "vote with their feet". If one area of the state is not providing sufficient and appropriate services, and another is, then both the services and funding should follow the consumer.

7. <u>Outreach efforts must be intensified.</u>

In too many instances, providers of mental health services are either not willing or not able to provide for intensive outreach efforts, especially to the homeless mentally ill. Due to the nature of their mental illness, individuals may not always be able to always make appointments or go to the mental health center to obtain assistance. For services and supports to really be effective, it is imperative that they follow the consumer, and are provided in places where they are needed by the consumer, not in places chosen for the sole convenience of the provider. Outreach must be a vital part of this process.

8. <u>Both the State and the local community mental health centers must be held accountable for the services provided.</u>

The clear consensus of opinion in this state among all stakeholders is that there is an inequality of community mental health services across the state, i.e., that there are gaps in services.

The University of Kansas School of Social Welfare, Office of Social Policy Analysis prepared a study that was published in February of 1995 entitled: *Kansas Mental Health Reform, progress as Promised.* We highly recommend it to your reading. On page 78 of this study it is noted:

> While CMHC catchment areas are each quite unique with major differences in terms of populations, geographic area covered, affluence, demand for service, availability of housing, etc., *the variability is too broad to be ignored in terms of availability of service and willingness to deliver a wide array of service aimed at a broad range of consumer needs. Basic, realistic standards need to be established for a minimal level of expected, community service.* (Emphasis added.)

The study goes on to say - and this is consistent with information received by KAPS - on page 79 that

> Review of state hospital records revealed consumers with stable symptoms and minimal functional or social disabilities who were referred to NF's MH [*Nursing Facilities for Mental Health*], sometimes against their expressed desire. *In other areas of the state, the same individuals would have been discharged into normal community settings with supportive services.* (Emphasis added.)

While we are encouraged by the performance measures in the newer SRS/CMHC contracts, we still do not believe these performance measures go far enough, especially in this era of increased accountability for services outcomes. In this regard, we believe that strong consideration should be given by SRS to re-visiting the mandatory and optional services listed in K.A.R. 30-60-60 through 30-60-75. Of particular importance is the issue of aggressive outreach. Outreach is critical because persons may stop seeking services as a function of their disability. Indications are that outreach efforts are ineffective, if not non-existent, in many parts of the state (see Tenet 7 for further discussion on outreach).

We believe that the State and CMHCs should be responsible for assuring that all appropriate and needed community mental health services be provided that are included in the children and adult templates of services issued by SRS. (the templates are set forth two paragraphs below). We are definitely NOT pleased that these templates were not incorporated into the annual contracts with the CMHCs as was first anticipated. We hope that this oversight is soon corrected. Moreover, we have not yet been able to even ascertain what community services are presently being provided by each individual CMHC. We have made inquiry with SRS, and request to be provided with any such information forthwith.

While we do not want to encumber CMHCs with burdensome paperwork, some very basic information needs to be tracked. In this regard, we agree with KU's assessment that "the ability to track clients through the system should be improved", including the development of "statewide standardized data collection and statistical reporting procedures" as well as "procedures which would

routinely use valid and reliable data sets to evaluate the system" (id., at 81). See also K.S.A. 39-1603(n) and (o).

We strongly believe that the following services as listed in the adult and children's templates should be tracked for each CMHC:

COMMUNITY-BASED RESOURCES AND SERVICES
TO KEEP ADULTS OUT OF STATE HOSPITALS

COMMUNITY SUPPORT SERVICES
- Case Management
-Housing
-Vocational
-Attendant Care
-Psychosocial Rehabilitation
-Partial Hospital/Day Treatment
-Psychiatric (Medical Services)
-Alcohol and Drug Treatment/Regional Dual Diagnosis
-MI/Substance Abuse Treatment

CRISIS SERVICES
-Crisis Case Management
-Non-Hospital Crisis Beds
-24 Hour Emergency Services/Mobile Crisis Teams
-Short Term Local Inpatient Hospitalization
-Acute Care Residential Treatment Services

These adult services are further defined as follows:

COMMUNITY SUPPORT SERVICES

Case Management: The primary Community Support Service through which consumers, with their case manager's assistance, identify strengths and goals and develop personal plans for achieving these goals. Typical goals may include staying out of the hospital, obtaining employment and maintaining independent housing. this service assists people in avoiding crises by anticipating events and personal cycles that have led to crises in the past.

Housing: As a part of the case management plan, consumers are assisted to obtain community housing which the choose and can afford. To increase consumer choices, mental health centered work with other community agencies to apply for state and federal funds for housing development, rent, and other living subsidies.

Vocational: As part of the case management plan, consumers are assisted in choosing, getting, and keeping competitive employment. Mental health centers, in conjunction with Kansas Rehabilitation Services, offer job training, search and placement services, as well as job coaching and other services to help consumers enter, re-enter, and remain in the job market.

Attendant Care: As part of crisis resolution, attendants can stay with a consumer either at the consumer's house or in a temporary crisis bed arrangement while the consumer's crisis is resolved and his or her symptoms become responsive to medication.

Partial Hospital/Day Treatment: For consumers who are coming out of a crisis or acute care setting, a short term, structured day program may be an option. For other, more disabled consumers, these settings can provide training in Activities of Daily Living (ADLs), as well as a safe, secure environment in the community.

Psychosocial Rehabilitation: The term refers to a spectrum of community based treatment services designed to improve the individual's quality of life by strengthening individual life skills and developing environmental supports. the focus is on assisting consumers to assume responsibility in their lives and to function as actively and independently as possible.

Psychiatric (Medical Services): This is access to a psychiatrist, nurse, medications, lab work, and psychological testing when necessary. Medication has proven to be effective in the treatment of severe mental illness and is one of the primary services traditionally provided by hospitals. When this access is in the community, hospitalization may be prevented.

Alcohol and Drug Treatment/Regional Dual Diagnosis MI/Substance Abuse: A significant percentage of people with mental illness also suffer from abuse of or addiction to alcohol and other substances. Successful treatment for these addictions, for people who are also challenged by mental illness, must be "carefrontive" rather than "confrontive." Traditional substance abuse treatment does not welcome people with mental illness, knowing that their programs are not effective with this population and indeed tend to worsen their psychiatric symptoms.

CRISIS SERVICES

Crisis Case Management: Crisis case management services, like regular case management services, are designed to assist individuals remain in their communities. Crisis case management services are however provided in acute emergency settings with an intense focus on stabilization symptoms and resolution of crisis.

Non-Hospital Crisis Beds: Short term stays in these settings provide an alternative to hospitalization for people who are experiencing acute psychiatric decompensation and/or a family life crisis that could result in hospitalization. Crisis beds may be provided in a hotel,

at the mental health center or elsewhere. The location is staffed continuously during the consumer's stay be case managers and/or attendant care providers, who provide crisis case management and medication as needed.

24 Hour Emergency Services/Mobile Crisis Teams: Required as part of the federal Mental Health Block Grant, emergency services respond to resolve situations in the least restrictive setting possible, as well as conduct screening for people going into the hospital or other crisis settings. This service may be most effective when provided in a mobile form, often as an adjunct to the police response in dangerous situations.

Short-Term Local Inpatient Hospitalization: Contracts between Mental Health Centers and local hospitals allow hospitalization for people who need a secure setting while medication management of the psychiatric symptoms is arranged. Because these are typically very short-term stays of less than a week, having the service available on a local basis enhances the consumer's ability to reintegrate in their communities.

Acute Care Residential Treatment Services: These are transitional living situations allowing people who are reintegrating to their community to become familiar with their social networks and received ADL training prior to moving to a less restrictive setting.

COMMUNITY-BASED RESOURCES AND SERVICES TO KEEP CHILDREN AND ADOLESCENTS OUT OF STATE HOSPITALS

-Case Management
-Attendant Care
-Respite Care
-Home-Based Therapy
-Medication Management
-Flexible Funds
-Therapeutic Foster Care
-Partial Hospital/Day Treatment
-Mobile Crisis/Emergency Services
-Residential Crisis/Stabilization Services
-Acute Care Treatment Program
-School Based/Liaison Services
-Sexual Abuse Treatment
-Alcohol/Drug Treatment
-parent/Family Advocacy

ESSENTIAL COMMUNITY BASED SERVICES/RESOURCES FOR CHILDREN AND ADOLESCENTS

1) **Case Management.** A core service for mental health reform and other initiatives designed to provide community based services. Case management in children's mental health performs direct service as well as service coordination and liaison. Services must comply with Kansas Case Management Standards. Case management services plans address major life domains for the child and family. The client and family is assisted in accessing needed medical, social, educational and other services. Crisis issues are dealt with and ongoing problem solving is accomplished. The service is targeted to youth with severe emotional disturbance.

2) **Attendant Care.** A one on one supervision and supportive service designed to help prevent out of home placement. This services can be used for crisis management as well as provide stability in community living on a longer term basis. Attendant care may be provided in the client's home or at varied sites throughout the community, including school settings. Attendant care is specifically designed to meet needs of the individual child. the service is targeted to youth with, or at risk of, severe emotional disturbance.

3) **Respite Care.** Provides short term and temporary direct care and supervision for youth. The primary purpose is relief to families of a child with serious emotional problems. The service is designed to help meet needs of primary caretakers as well as children. Respite care can be an in-home services, or provided in other community settings.

4) **Home-Based Therapy.** This service works with the entire family as the client. Home-based therapy is specifically designed to prevent hospitalization or other out of home placements. Therapy is conducted by approved mental health center staff, approved by a physician. The service is intensive and short term. Treatment plans and progress must be reviewed every 90 days and comply with Kansas Home Based Intervention Standards.

5) **Medication Management.** This involves physician assessment, review and approval of medications utilized in a youth's treatment plan. Medications can help with a variety of problems, including the youth's emotional and behavioral functioning. Effective medication management can help alleviate situational factors that may lead to disruption of the youth's and family's daily lives. Effective management of these factors helps prevent out of home placement.

6) **Flexible Funding.** Provides for needed services or resources not otherwise funded by traditional or categorical programs. Funds are used for specific needs usually considered as one time expenses. These funds can provide for crucial missing links in a service plan that help a family maintain daily living activities important to their well-being, and thus promotes their ability to stay together.

7) **Therapeutic Foster Care.** An intensive treatment service provided to a youth by a specially trained family. This typically involves the child living in the home of two parents. The services is targeted to youth with serious behavioral and/or emotional problems who are not able to live with their parents, or have no family. The service is receiving attention from community mental health centers as they look for viable placement options for children already hospitalized or at risk of long term hospitalization.

8) **Partial Hospital/Day Treatment.** Widely regarded as an important community resource by mental health centers, the service provides intensive support and treatment to youth. Typically the service hours match a school day. A variety of educational and treatment activities take place. The content of the plan varies with the need of the youth. The setting or facility may in fact resemble a school setting, in that the youth is part of a group supervised by a number of staff.

9) **Mobile Crisis/Emergency Services.** Typically this is a team of a qualified mental health clinician and a case manager/attendant care worker that responds to a youth/family crisis wherever the crisis occurs. For example, the team may go to a client's home. the team may also go to a school, jail, hospital, or any other location in the community.

10) **Residential Crisis/Stabilization Services.** A short term (24-72 hours) intervention in a facility where a youth goes to stay in time of a crisis or to help prevent potential crisis situations from getting worse. This service is used as a temporary solution. The ;youth should expect to return to their home or the setting appropriate to their needs. Many crises can be resolved in a short term, avoiding risk of longer out of home placement.

11) **Acute Care Treatment Program.** This service typically involves up to a two week intensive intervention in a psychiatric treatment facility. the youth may need observation, in-depth assessment, and time for appropriate treatment planning to be accomplished. The service is targeted for youth with severe emotional disturbance.

12) **School Based/Liaison Services.** Mental health services are provided to the youth in their school setting. Typically this involves attendant care or case management, although therapy may also be provided. In addition, school personnel are involved in the coordination of services so that needs from the school' perspectives may also be addressed.

13) **Sex Abuse Treatment.** A highly specialized and intensive therapy designed to work with youth and families. Sex abuse presents an extreme risk for emotional and physical harm. Out of home placement, including hospitalization, often is a serious consideration. Resolution of issues around sex abuse is essential for the youth and family.

14) **Alcohol/Drug Treatment.** Substance abuse and emotional disturbance are often linked, and youth experiencing both need intensive interventions. Mental Health resources for youth

with substance abuse problems are important to help manage family, education, social and perhaps legal factors.

15) **Parent/Family Advocacy.** Meeting families' needs for information and support in their work with service providers is essential. Parens need access to services and a voice in the planning of services. Very often families feel excluded, and ensuring their full involvement ca be and should be a responsibility of professionals working to ensure delivery of family centered services.

It is critical that consumers have input. It is their real life stories that factor in to data to collect. We are pleased that consumers are having direct involvement with the consumer satisfaction survey process, in conjunction with KU School of Social Welfare.

9. <u>Consumers must have adequate recourse to due process.</u>

K.S.A. section 39-1603(r) states that SRS is "to adopt rules and regulations to ensure the protection of persons receiving mental health services, which shall include an *appeal procedure at the state and local levels*" (emphasis added). K.A.R. 30-60-50(11) deals with complaints and grievances, but does not appear to include appeals at the state level, or even at the local level, because it only deals with the right of the CMHC client to make the complaint or grievance to the chief executive officer of the CMHC. Consumers who are already wary of making complaints may not wish to use this avenue because of fears of retaliation. We request that we be informed if in fact there are other provisions of which we are not currently aware that would address this issue. Strong consideration should be given to tying the appeals provisions in with the Kansas Administrative Procedures Act, K.S.A. 77-501 et seq.., or other similar mechanism.

It is of critical importance that consumers and their family members should not have to ask how to appeal. It must be up to the CMHC **(and affiliates or any other provider of mental health services)** to advise the consumer of the right to appeal at the time the adverse decision is made. Appeal rights should also be inserted in the consumer's handbook.

It would also be beneficial for consumers to have recourse to a more independent entity with which to lodge complaints or grievances, and to have assistance with the presentation of grievances to the CMHC. One possibility, a **consumer advisory council**, is discussed above in Tenet number 2, at page 9.

<u>10. Consumers of mental health services should have equal access to insurance coverage for major mental illnesses; that is: PARITY.</u>

"House Bill 2138 was introduced in 1997 and has carried over to 1998. As it is written, HB 2138 protects the current mental health mandates for disorders and conditions not provided for under the equal coverage proposal; and provides the same coverage for specified brain disorders, also called mental illness, as for any other illnesses, diseases and conditions.

The illnesses that would be covered equally, under HB 2138 are schizophrenia and related disorders; major affective or mood disorders, including depression and manic-depression; obsessive compulsive disorder; panic disorder; autism; attention deficit and attention deficit hyperactivity disorders; and borderline personality disorder.

The Kansas Insurance Department's (KID) impact study estimates a maximum premium increase of 2.76%. The University of Kansas Institute of Public Policy and Business Research analyzed the KID study and concluded that:

> Within today's insurance market, the 2.76% maximum increase estimate was probably correct.
> Under managed care contracts, increases would be negligible or non-existent.
> Passage of HB 2138 would likely hasten the move to managed care; however, the analysis noted that this will happen anyway. The only difference is when.
> Businesses will experience higher levels of productivity and fewer general expenses from employees benefitting from HB 2138 as they receive the treatment they need.
> Government would benefit by reduced demands on Medicaid, Medicare and Social Security.
>
> Estimates notwithstanding, the actual impact in states that have had equal coverage for several years is less than what their impact studies had projected.
>
> Other compelling reasons in support of equal coverage are: decreasing the number of adults and children entering the taxpayer supported public mental health system; it will save families from resource depletion and possibly even bankruptcy, and it will end the unjust discrimination against no-fault diseases of the brain."

Thanks to NAMI-KS, from which the above information was obtained.

The mental health community is in absolute agreement on parity. The only issue within the mental health community is really one of strategy: should we settle for nothing less than that ALL mental illnesses be covered, or, as we fight this battle, is it better to provide that at least *some* are covered rather than none? In either case, the end goal is to strive for total coverage for all mental illnesses.

11. <u>Individuals with mental illness have the right to have safe, affordable housing of the type and in the community of their choice.</u>

SRS has established a housing initiative. Much work needs to be done to support this initiative and to advocate for the removal of barriers to housing. Included are such things as supplementation of the Tenant Based Rental Assistance Program and individual subsidies.

12. <u>The "GAPS" plan should be supported.</u>

The Governor's Mental Health Planning Council studied perceived gaps in services, and made recommendations for closing the gaps for priority services. The following description of the "gaps" priorities is taken from testimony delivered to the Senate Ways and Means Committee by Howard Snyder on February 11, 1998. Mr. Snyder chaired the committee that studied the gaps in services.

A short version of the 4 priorities (housing, case management and attendant care, consumer run organizations and vocational services) follows:

Housing: Affordable and decent housing is very difficult to find for persons suffering with mental illness, who are automatically poor. Without a place to live, needed services cannot be provided. The recommendation is for $500,000 for a new Rental Assistance Program for persons whose incomes are too low to rent decent housing. Also, $250,000 for 110-140 persons to add up to $200.00 per month of additional income (SSI of $494.00 + $200.00 = $694.00) to aid low income persons to find housing in the open market.

Case Management: To serve an estimated 75% of adults with SPMI and 50% of children with SED, the recommendation is for an additional 175 case managers statewide at an estimated cost of $4,375,000. We also recommended $3,000,000 to expand attendant care services.

Consumer/Family Run Organizations: the existing consumer/family run groups are providing a variety of needed services in a very cost-effective manner. the recommendation is for funding 16 new groups at a cost in new money of $524,000.

Vocational Programs: Vocational opportunities are needed so that Kansans with mental illness have an opportunity to become productive tax paying citizens. the recommendation is for $75,000 to bring the total of federal match funds to $40,000, which will bring down federal funds of $1,477,934 for expanded vocational programs.

These are the recommendations for moving toward closing existing service gaps for Kansans that suffer from mental illness.

It is important that there be adequate funding for Housing, Case Management/Attendant Care, Consumer and Family Run Organizations, and Vocational programs, as recommended in the Plan. It is critically important to adequately support consumer and family-based advocacy groups such as the National Alliance for the Mentally Ill - Kansas (NAMI-KS), the Kansas Mental Illness Awareness Council (KMIAC), the Mental Health Association of Kansas, and other similar entities.

13. SRS' Initiatives for Home and Community Based Services (HCBS) Waivers for both adults and children with major mental illness should be supported.

SRS Commission on Mental Health and Retardation has already initiated a children's waiver, and is in the process of initiating a proposal to pursue and develop an HCBS waiver for adult individuals with major mental illnesses. According to a January release from Connie Hubbell, Commissioner of MHDD, the adult services "would most likely include: homemaker, personal care services, respite care, adult day care, home modifications, and alternative care facility services." Further, that

These services are identified in a Colorado waiver for individuals with major mental illness approved by the Health Care Financing Administration (HCFA) since 1995. Kansas will be using the Colorado waiver as a model for HCFA approval.

The MI waiver would be designed to assist those who have a current primary diagnosis of major mental illness or those with a chronic mental illness, who require community based services to prevent institutionalization. Thresholds for levels of care, services definitions, and reimbursement rates will be developed by committees composed of government, provider, and consumer representatives. The waiver will be developed in a time frame to be implemented on July 1, 1999.

These are exciting developments, and we commend them.

14. Support should be provided for other continuing SRS initiatives.

Other initiatives that we commend include the data-keeping or **Management Information System (MIS)** project. It is of critical importance that relevant data be tracked (data tracking is discussed in Tenet 8, above). Also, of continuing importance are initiatives that involve **juvenile justice**, the **Department of Corrections**, persons with **dual diagnoses of mental illness and substance abuse**, and services for **persons with dual diagnoses of mental illness and mental retardation.**

Regarding those **individuals with both mental illness and mental retardation,** many elements need to be worked out. For example, pursuant to SRS policy, the developmental disability system has the primary responsibility for coordination of services to persons with dual diagnoses. However, it was never intended that the mental health centers be relieved of the obligation to collaborate. It is also important that these individuals be served in the community wherever possible, and not by simply attempting to effect placement at the dual diagnosis unit at Parsons State Hospital. Definitions, or perhaps more specifically - interpretations of definitions - need to be clarified. This does NOT mean that we should move toward pigeon-holing or listing who is DD or who is MI by diagnoses, but rather that we have clear, understood, functional definitions. We believe that SRS' proposed Revised Policy and Procedures for Persons who are both Mentally Ill and Developmentally Disabled (February 10, 1998) is a good start.

15. There must be greater responsibility for persons residing in Nursing Facilities for Mental Health (Nfs/MH) and Residential Care Facilities (RCFs).

We are extremely concerned about the use of Nursing Facilities for Mental Health (NFs/MH) in situations where lesser restrictive, community based options are available for and desired by the individuals being served. This is an area where collaborative approaches should be used by all involved stakeholders in assuring for the rights of individuals to reside in the least restrictive setting.

At page 80 of its 1995 study cited above, KU makes some important recommendations with regard to NFs/MH. The report states:

d. Gatekeeping should be implemented for NF's MH.

e. Counties of responsibility should be designated for current residents which should then be responsible for assessing residents on the need for NFMH care.

f. Financial incentives should be established to provide community service to current or potential NFMH residents who do not have significant self care deficits or dangerous behaviors.

We applaud the steps currently being taken to include NF/MHs in the mental health picture, but much more needs to be done, especially in light of KU's findings on page 79 of its 1995 study that "(i)n the course of this evaluation, it became clear that the criteria for sending consumers to NF's MH from the state hospital has as much to do with the orientation of hospital and CMHC staff as it does with the functional abilities of the consumer." We still receive complaints regarding individuals at state hospitals who are required to accept NFMH placement as a condition of discharge, and seriously question the use of this "back-door" form of commitment to an NFMH.

Likewise, we have concern about the lack of oversight of residential care facilities, and advocate for stronger inspection and enforcement mechanisms.

III. SUMMARY

Having core values is important. What is it we really care about accomplishing? We must improve the system, with the result of improving the lives of individuals with mental illness.

We must look at the civil and human rights of the individuals receiving mental health services; we cannot simply look at cost alone. Full implementation of adequate community services may well by more expensive than traditional institutionally based care. However, our personal liberties are paramount, and the economical delivery of services is largely dependent upon the level of accountability of the State and service providers. The mental health system in Kansas has to be much more accountable. The savings to taxpayers comes through enhancing accountability, and through assuring that the services put in place actually improve the lives of those with mental illness.

Kansas can become a leader in the area of mental health services and supports. The tools, collaborative relationships and collective vision are all in place.

IV. SUMMARY OF NEEDED STATUTORY, REGULATORY AND POLICY CHANGES

Consumers and advocacy groups strongly urge the State to adopt Values and Guiding Principles in statute to govern the development of mental health services, such as the following:

AT 39-1601, et seq., the "MENTAL HEALTH REFORM ACT."

IT IS THE POLICY OF THE STATE OF KANSAS THAT:

1. Individuals and families receiving services, especially those who are members of the targeted population as defined in K.S.A. 39-1602, should be equal participants with advocacy groups and agencies, service providers, mental health professionals, scholars, the legislature, SRS, state entities, and the general public in the design, provision and evaluation of services. Services should be provided in a manner that shows respect for the dignity of the person served, building on personal strengths, and allowing consumers greater control of their own lives.

2. Consumers and family members should have choice as to service providers and services and supports provided, with adequate recourse to due process.

3. Visions we strongly hold for consumers of mental health services include: Preservation of personal dignity, opportunities for growth and self-fulfillment, entitlement to live in the least restrictive, most normal residential alternatives, and the opportunity to receive the supports that are culturally sensitive and suited to individual strengths, desires and needs.

4. Consumers and family members should be able to access services and supports from the providers of their choice that are affordable, available in the right amounts when and where needed, that are provided by a sufficient number of well-trained, responsive staff, and that are accessible statewide.

5. Community based services in all areas of the state should contain core services including, but not necessarily limited to, the following:

(a) an aggressive crisis intervention system including 24 hour crisis phone lines, out-reach for in-home evaluations, crisis stabilization in small facilities, and one-to-one home crisis support for both adults and children;

(b) an array of different types and intensities of case management services, from weekly case management service to comprehensive community treatment teams operating 24 hours a day;

(c) individualized, wrap-around supports for children and families, with a point of accountability for coordination of services from various agencies;

(d) residential services and supported housing options, from intensively staffed group homes to supported cooperative apartments for one or two adults, and therapeutic foster care for children;

(e) comprehensive vocational, housing, and consumer self-help services to enhance rehabilitation and community integration;

(f) capacity for local inpatient hospitalization for both adults and children; and

(g) intensive outreach efforts for homeless persons with mental illness.

REPRESENTATION ON GOVERNING BOARDS.

1. Amend K.S.A. 19-4002(b).

State law requires that "the membership of the governing board shall include consumers of mental health services or representatives of mental health consumer groups and shall include family members of mentally ill persons." K.S.A. 19-4002(b). The phrase "consumers of mental health services" is not defined in the mental health act of 1991. This statute should be amended to read: "the membership of the governing board *as well as the membership of the governing board of any entity having a governing board that affiliates with a community mental health center* shall include consumers of mental health services *who are members of the targeted population as defined by K.S.A. 39-1602(a)* [or] *and* representatives of mental health consumer groups and shall include family members of mentally ill persons *who are members of the targeted population.*

2. Amend K.A.R. 30-60-25.

K.A.R. 30-60-25 only requires that the CMHC governing board "include at least one member who is or has been a consumer of mental health services" as well as one family member. K.A.R. 30-60-25 should be changed to state that the CMHC governing board include one adult member of the targeted population, one family member of a child in the targeted population, and one family member of an adult in the targeted population, the term "targeted population" being defined by K.S.A. 39-1602(a) and further clarified in K.A.R. 30-60-2. It should also be established by regulation that this also applies to any entity with a board of directors that affiliates with a CMHC.

3. Reasonable accommodations for board members.

There should also be provision made - probably by regulation - to reasonably accommodate board members with mental illness or who are family members of individuals with mental illness by providing reasonable accommodations during the board meeting process. (Some possible examples might be not scheduling meetings early in the mornings when the individual's medications make them groggy; or arranging for transportation if the medication regimen makes it difficult for the individual to drive; or to make sure a family member has enough notice of the meetings to arrange for respite care or attendant care. Another accommodation that might be of substantial importance would be to allow for the use of an alternate representative for individuals with mental illness in situations where due to the illness, or a change of medication, the individual is not able to attend meetings.)

4. CMHC Affiliate Requirements.

The mental health advocacy groups also strongly believe that the same requirements for board representation should also extend to any organizational entity with a Board of Directors that affiliates with a CMHC.

ESTABLISHMENT OF CONSUMER ADVISORY COUNCILS.

1. For Community Mental Health Centers.

In addition to strengthening the presence of consumers on CMHC boards of directors, strong consideration should also be given to establishing consumer advisory councils which would serve to provide technical assistance to CMHCs as they strive to better serve their constituency, and to also provide a place for consumers to bring their concerns. Each CMHC could establish this consumer

advisory council, with the consumer advisory council chair serving as liaison to the CMHC board. The advisory council chair would also be a voting board member, and should be a consumer. This is similar to the advisory councils required by law for state protection and advocacy agencies such as KAPS.

2. For CMHC Affiliates.
The mental health advocacy groups also strongly believe that the same requirements for advisory councils should also extend to any organizational entity that affiliates with a CMHC that has its own Board of Directors.

RESIDENCE POLICIES MUST BE CLARIFIED.
The following SRS policy:

> An individual's residence...determines the State Mental Health Hospital catchment area to which he/she belongs. *An exception to this is a person who is residing in a facility in a particular county to receive mental health services because appropriate services are not available in his/her home county. Such individual's residence would be that of his/her primary county of residence prior to entering the facility.* (emphasis added.)

Should be revised as follows:

> An individual's residence...determines the State Mental Health Hospital catchment area to which he/she belongs. An exception to this is a person who is residing in ~~a~~ *any* facility, *including but not necessarily limited to Nursing Facilities for Mental Health, Residential Care Facilities, Consumer Run Facilities, and Board and Care homes*, in a particular county to receive mental health services because appropriate services are not available in his/her home county. Such individual's residence would be that of his/her primary county of residence prior to entering the facility.
>
> *The individual's "residence" in this policy only affects the individual's state hospital catchment area, not the individual's ability to obtain mental health services in the individual's new locality. Where a consumer has changed counties because appropriate services were not available in his/her home county, the home county provider shall continue to be responsible for payment for the services and supports.*

TRACKING OF CORE SERVICES
Whether through contract with SRS or by legal/regulatory changes, CMHCs should be responsible for assuring that all appropriate and needed community mental health services be provided that are included in the children and adult templates of services issued by SRS, **especially for members of the targeted population**. Further, these services should be "tracked" through the MIS or Management Information System that is being implemented.

COMMUNITY-BASED RESOURCES AND SERVICES TO KEEP ADULTS OUT OF STATE HOSPITALS

COMMUNITY SUPPORT SERVICES

- Case Management
-Housing
-Vocational
-Attendant Care
-Psychosocial Rehabilitation
-Partial Hospital/Day Treatment
-Psychiatric (Medical Services)
-Alcohol and Drug Treatment/Regional Dual Diagnosis
MI/Substance Abuse Treatment

CRISIS SERVICES

-Crisis Case Management
-Non-Hospital Crisis Beds
-24 Hour Emergency Services/Mobile Crisis Teams
-Short Term Local Inpatient Hospitalization
-Acute Care Residential Treatment Services

COMMUNITY-BASED RESOURCES AND SERVICES TO KEEP CHILDREN AND ADOLESCENTS OUT OF STATE HOSPITALS

-Case Management
-Attendant Care
-Respite Care
-Home-Based Therapy
-Medication Management
-Flexible Funds
-Therapeutic Foster Care
-Partial Hospital/Day Treatment
-Mobile Crisis/Emergency Services
-Residential Crisis/Stabilization Services
-Acute Care Treatment Program
-School Based/Liaison Services
-Sexual Abuse Treatment
-Alcohol/Drug Treatment
-parent/Family Advocacy

Additionally, it is of critical importance that there be a system in place to thoroughly track the numbers, locations, and home residences of individuals who are homeless, in nursing facilities, in MR/DD state hospitals, in jails, and in prisons.

REVIEW AND AMEND K.A.R. 30-60-60 THROUGH 30-60-75, and K.A.R. 30-61-15.
Strong consideration should be given by SRS to re-visiting the mandatory and optional services listed in K.A.R. 30-60-60 through 30-60-75, and incorporating the requirement that the CMHC must provide all of the services that are listed on the Adult and Children's Templates set forth above to the targeted population, and also including aggressive outreach (see K.A.R. 30-61-15, which would look a lot better with the *"may"*s and *"where feasible"*s stricken).

AMEND K.A.R. 30-60-2 DEALING WITH THE DEFINITION OF TARGETED POPULATION.
K.A.R. 30-60-2 should be amended to include "Other individuals at risk of requiring institutional care", which is part of the definition of "targeted population" as defined by K.S.A. 39-1602(a).
One possibility may be to clarify the definition as follows:

> *Other individuals at risk of requiring institutional care* means those individuals, who, without the use of appropriate community based mental health supports and services, including access to appropriate medication, would be at risk of requiring institutional care, or who probably would have needed traditional institutionally based care prior to the advent of better community supports and services.

ESTABLISHMENT OF WORK-GROUPS
1. A work group should be started to look at how the DD regulations that deal with strengths planning, including the elements of service portability and choice, could be applied to mental health.
Person centered planning could be based on the DD regulations that are already in existence. We will seek involvement of those who worked on the DD regulations.

2. A work group should be started to look at how durable powers of attorney for health care decisions could be used to streamline mental health treatment.
Kansas statutes (K.S.A. 58-625 et seq.) do talk about durable powers of attorney for health care decisions, including treatment of mental conditions (K.S.A. 58-629). One principle advantage in using these instruments is that the consumer's wishes are followed in the event of intense psychiatric need. Ron Pavelka with KAPS would be a good resource for this group.

3. A work group should be started to look at managed care issues.
Managed care is neither inherently "good" or "bad", but is clearly the trend. It is absolutely *essential* that consumers and consumer-advocacy groups have intense involvement with the development and delivery of managed care systems *on all levels*, and that these groups help assure for appropriate remedies to reduce the risk of inappropriate service delivery.

4. A work group should be started to look at the Definition of the Targeted Population.
See discussion on pages 4 - 8 above for more information on the "targeted population."

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James Germer, Executive Director

TO: Senate Committee on Public Health and Welfare
FROM: Kansas Advocacy and Protective Services
RE: Substitute for House Bill No. 2630
DATE: March 16, 1998

The primary responsibility of KAPS is to provide advocacy services for persons with disabilities. Through the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, KAPS staff are regularly in contact with persons with mental illness whom the proposed revisions to KSA 76-1305, 1306, and 1307 would directly affect.

As we understand the proposed changes in the law, their practical impact would be to make two substantial changes to the categories of patients who could be subject to a transfer to the Security Behavior Ward(SBW) at Larned State Hospital. Under current law, voluntary state hospital patients may not be transferred to SBW. The proposed changes to the law remove this prohibition. Additionally, patients are now subject to transfer to SBW only if they display dangerous behaviors, or are a security risk. The proposed revisions to KSA 76-1306 create another category of patients who may be moved to SBW- patients charged with or convicted of felony crimes.

The transfer of a patient to SBW is a serious matter, with potential long term consequences. SBW is an extremely structured setting, located in a building surrounded by security fencing. An SBW patient's freedoms are substantially restricted. While patients in "open grounds" units may eventually be granted privileges such as grounds passes, SBW patients never attain such freedoms. Once assigned to SBW, patients may find it difficult to be discharged from SBW. For example, a current KAPS client has been on SBW for more than eight years.

Because of the potential impact on the persons who might be transferred to SBW, any attempt to broaden the admission criteria must be deliberately considered. From discussions with SRS personnel, it seems that the motivation for the proposed change is to add greater flexibility to the Commissioner's power to transfer patients to SBW. On its face, amending the statute should not lead to increased SBW admissions, but such a result could be an eventual consequence of taking such an action.

In this regard, some historic information is important. In the early 1990's, 30 or more patients were typically housed on SBW. Perhaps in part because this population is difficult to manage, major problems were evident. In fact, in one instance, one SBW patient murdered another. One

of the recommendations made after a review of the SBW program related to a reduction in the census on SBW. For some time, the census on SBW was in the 16-18 range. More recently, however, the number of patients on SBW has gradually increased. During the first week of March, SBW had 21 patients. In our view, statutory changes that could lead to an increased census on SBW must be approached with caution.

KAPS staff suggest the following revisions that would, from an advocacy perspective, improve this statutory framework:

1) In order to provide due process protections to voluntary patients, the bill should be revised to require that an involuntary commitment petition be filed in the cases of such patients who refuse reasonable treatment efforts.

2) In the case of persons "charged with or convicted of felony crimes," probable cause to conclude that they may not be maintained outside of the State Security Hospital should be required.

3) KSA 59-2972 provides that persons transferred from one state hospital to another are entitled to a hearing. The law should be amended to provide that a notice to that effect made available to the patient. This notice is currently sent only to a family member or guardian.

4)The notice provided for in KSA 76-1307(b) should be made available to the patient who would be subject to a transfer to SBW, and the notice should include information about how to contact KAPS.

5) In what may be more of an administrative matter, SRS may want to consider establishing a maximum census on SBW in the 18-20 patient range.

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institution ~~or~~; (2) that the patient ~~or person~~ is a security risk; *or (3) that the patient is charged or convicted of felony crimes* and, therefore, is unable to receive proper care or treatment in a facility other than the state security hospital. Any patient ~~or person~~ transferred to the state security hospital under this section shall be assigned quarters separate from those individuals who have been transferred from penal institutions or committed thereto by courts under the Kansas code of criminal procedure.

[Sec. 4. K.S.A. 76-1307 is hereby amended to read as follows: 76-1307. (a) Any patient ~~or person~~ transferred to the state security hospital by the secretary of social and rehabilitation services from an institution under the supervision of the secretary of social and rehabilitation services shall: (1) Be assigned quarters separate from those individuals who have been transferred from correctional institutions or committed to the state security hospital by courts pursuant to the Kansas code of criminal procedure; and (2) remain subject to the same statutory provisions applicable to the patient ~~or person~~ at the institution from which the patient ~~or person~~ was transferred and in addition shall abide by and be subject to all the rules and regulations of the state security hospital not inconsistent with such statutory provisions.

[(b) The next of kin and guardian, if one has been appointed, of the patient ~~or person~~ transferred to the state security hospital by the secretary of social and rehabilitation services under K.S.A. 76-1306 *and amendments thereto* shall be notified of the transfer. If the patient ~~or person~~ was committed to the *sending* institution ~~from which the patient or person is being transferred~~ by a court, notice of the transfer shall be sent to the committing court. The notice of transfer shall be given within a reasonable time after the date of the transfer.]

Sec. ~~2~~ [5]. K.S.A. [76-1305, 76-1306 and 76-1307 and K.S.A.] 1997 Supp. 59-2946 ~~is~~ [are] hereby repealed.

Sec. ~~3~~ [6]. This act shall take effect and be in force from and after its publication in the statute book.

And there is probable cause to believe that the ~~person~~ patient may not be maintained outside of the State security hospital

and the patient him or herself

uch order, if not in the county of resi- of the proposed patient, shall transmit to strict court in the county of residence of the posed patient a statement of any court costs curred by the county of the district court issuing uch order and a certified copy of all pleadings and orders in the case.

Any district court to which venue is transferred shall proceed in the case as if the petition had been originally filed therein and shall cause notice of the change of venue to be given to the persons named in and in the same manner as provided for in K.S.A. 1996 Supp. 59-2963 and amendments thereto. In the event that notice of a change of location of a hearing due to a change of venue cannot be served at least 48 hours prior to any hearing previously scheduled by the transferring court or because of scheduling conflicts the hearing can not be held by the receiving court on the previously scheduled date, then the receiving court shall continue the hearing for up to seven full working days to allow adequate time for notice to be given and the hearing held.

Any district court to which venue is transferred, if not in the county of residence of the patient, shall transmit a statement of any court costs incurred and a certified copy of all pleadings and orders in the case to the district court in the county of the residence of the patient.

History: L. 1996, ch. 167, § 27; Apr. 18.

59-2972. Transfer by secretary of social and rehabilitation services. (a) The secretary of social and rehabilitation services or the secretary's designee may transfer any patient from any state psychiatric hospital under the secretary's control to any other state psychiatric hospital whenever the secretary or the secretary's designee considers it to be in the best interests of the patient. Except in the case of an emergency, the patient's spouse or nearest relative or legal guardian, if one has been appointed, shall be notified of the transfer, and notice shall be sent to the committing court not less than 14 days before the proposed transfer. The notice shall name the hospital to which the patient is proposed to be transferred to and state that, upon request of the spouse or nearest relative or legal guardian, an opportunity for a hearing on the proposed transfer will be provided by the secretary of social and rehabilitation services prior to such transfer.

(b) The secretary of social and rehabilitation services or the designee of the secretary may transfer any involuntary patient from any state psychiatric hospital to any state institution for the mentally retarded whenever the secretary of social and rehabilitation services or the designee of the secretary considers it to be in the best interests of the patient. Any patient transferred as provided for in this subsection shall remain subject to the same statutory provisions as were applicable at the psychiatric hospital from which the patient was transferred and in addition thereto shall abide by and be subject to all the rules and regulations of the retardation institution to which the patient has been transferred. Except in the case of an emergency, the patient's spouse or nearest relative or legal guardian, if one has been appointed, shall be notified of the transfer, and notice shall be sent to the committing court not less than 14 days before the proposed transfer. The notice shall name the institution to which the patient is proposed to be transferred to and state that, upon request of the spouse or nearest relative or legal guardian, an opportunity for a hearing on the proposed transfer will be provided by the secretary of social and rehabilitation services prior to such transfer. No patient shall be transferred from a state psychiatric hospital to a state institution for the mentally retarded unless the superintendent of the receiving institution has found, pursuant to K.S.A. 76-12b01 through 76-12b11 and amendments thereto, that the patient is mentally retarded and in need of care and training and that placement in the institution is the least restrictive alternative available. Nothing in this subsection shall prevent the secretary of social and rehabilitation services or the designee of the secretary from allowing a patient at a state psychiatric hospital to be admitted as a voluntary resident to a state institution for the mentally retarded, or from then discharging such person from the state psychiatric hospital pursuant to K.S.A. 1996 Supp. 59-2973 and amendments thereto, as may be appropriate.

History: L. 1996, ch. 167, § 28; Apr. 18.

59-2973. Discharge. (a) When any proposed patient or involuntary patient has been admitted to any treatment facility pursuant to K.S.A. 1996 Supp. 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967 and amendments thereto, the head of the treatment facility shall discharge and release the patient when the patient is no longer in need of treatment, except that no patient shall be discharged from a state psychiatric hospital without the hospital receiving and considering

Such notice shall also be provided to the patient being transferred

Comparison of Masters Level Mental Health Professions

by C. Wheelen, Kansas Psychiatric Society
Feb. 1998

Masters of Social Work

K.S.A. 65-6302. Definitions.

(b) "Social work practice" means the professional activity of helping individuals, groups or communities enhance or restore their capacity for physical, social and economic functioning and the professional application of social work values, principles and techniques in areas such as psychotherapy, social service administration, social planning, social work consultation and social work research to one or more of the following ends: Helping people obtain tangible services; counseling with individuals, families and groups; helping communities or groups provide or improve social and health services; and participating in relevant social action. The practice of social work requires knowledge of human development and behavior; of social, economic and cultural institutions and forces; and of the interaction of all these factors. Social work practice includes the teaching practicum courses in social work.

(c) "Psychotherapy" means the use of psychological and social methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation to acquire greater human realization of psychosocial potential and adaptation; to modify internal and external conditions which affect individuals, groups or communities in respect to behavior, emotions and thinking, in respect to their intra-personal and inter-personal processes. Forms of psychotherapy include but are not restricted to individual psychotherapy, conjoint marital therapy, family therapy and group psychotherapy.

K.S.A. 65-6319.

(a) The following licensed social workers may diagnose mental disorders classified in the diagnostic manuals commonly used as a part of accepted social work practice: (1) A licensed specialist clinical social worker, and (2) a licensed master social worker who performs diagnoses of mental disorders within the course of employment by a licensed community mental health center, a state facility authorized to provide psychotherapeutic services or a not-for-profit entity approved under subsection (c) of section 501 of the internal revenue code when such licensed master social worker is **under the direction of (i) a person licensed to practice medicine and surgery**, (ii) a licensed psychologist, or (iii) a licensed specialist clinical social worker.

(b) Nothing in this section shall be construed to authorize a licensed social worker who under subsection (a) may diagnose mental disorders classified in the diagnostic manuals commonly used as a part of accepted social work practice to provide direction for registered masters level psychologists under K.S.A. 74-5362 and amendments thereto.

(c) This section shall be part of and supplemental to the provisions of article 63 of chapter 65 of the Kansas Statutes Annotated and acts amendatory of the provisions thereof and supplemental thereto.

Masters Psychologists

K.S.A. 74-5302. Definitions.

(a) "Practice of psychology" means the application of principles of learning, motivation, perception, thinking and emotional relationships to problems of behavior adjustment, group relations and behavior modification, by persons trained in psychology. The application of such principles includes, but is not restricted to, counseling and the use of psychological remedial measures with persons, in groups or individually, having adjustment or emotional problems in the areas of work, family, school and personal relationships; measuring and testing personality, intelligence, aptitudes, public opinion, attitudes and skills; the teaching of such subject matter; and the conducting of research on problems relating to human behavior, except that **in all cases involving the care of the sick and ill as defined by the laws of this state, the primary responsibility devolves upon those licensed under the Kansas healing arts act.**

(continued, page 2)

Masters Psychologists (continued)

K.S.A. 74-5362.

Any person who is licensed under the provisions of this act as a licensed masters level psychologist shall have the right to practice only insofar as such practice is part of the duties of such person's paid position and is performed solely on behalf of the employer, **so long as such practice is under the direction of a person licensed to practice medicine and surgery** or a person licensed to provide mental health services as an independent practitioner and whose licensure allows for the diagnosis and treatment of psychological disorders. A licensed masters level psychologist may use the title licensed masters level psychologist and the abbreviation LMLP but may not use the title licensed psychologist or psychologist.

Professional Counselors

K.S.A. 65-5802. Definitions.

(b) "Practice of professional counseling" means assisting an individual or group for a fee, monetary or otherwise, through counseling, assessment, consultation and referral.

(c) "Professional counseling" means to assist an individual or group to develop understanding of personal strengths and weaknesses, to restructure concepts and feelings, to define goals and to plan actions as these are related to personal, social, educational and career development and adjustment.

(d) "Assessment" means selecting, administering, scoring and interpreting instruments designed to describe an individual's aptitudes, abilities, achievements, interests and personal characteristics.

(e) "Consultation" means the application of principles, methods and techniques of the practice of counseling to assist in solving current or potential problems of individuals or groups in relation to a third party.

(f) "Referral" means the evaluation of information to identify problems and to determine the advisability of referral to other practitioners.

Marriage and Family Therapists

K.S.A. 65-6402. Definitions.

(b) "Marriage and family therapy" means the assessment and treatment of cognitive, affective or behavioral problems within the context of marital and family systems.

(c) " Licensed marriage and family therapist" means a person who engages in the practice of marriage and family therapy and is licensed under this act.

Bold phrases = emphasis added to stress physician direction and collaboration with mental health professionals who may diagnose or treat patients with mental disorders.

The Qualified Mental Health Professional

by C. Wheelen, Kansas Psychiatric Society
Feb. 1998

The role of a QMHP under the Treatment Act for the Mentally Ill is to screen patients for purposes of determining whether the patient should be admitted to a state psychiatric hospital or can be served in the local community. The purpose is, of course, to avoid admissions to state hospitals whenever community resources are adequate.

K.S.A. 59-2949 from the Treatment Act for the Mentally Ill includes the following:

> (a) A mentally ill person may be admitted to a treatment facility as a voluntary patient when there are available accommodations and the head of the treatment facility determines such person is in need of treatment therein, and that the person has the capacity to consent to treatment, except that no such person shall be admitted to a state psychiatric hospital without a written statement from a qualified mental health professional authorizing such admission.

In addition, the term "screening" is defined under K.S.A. 39-1602 (Mental Health Reform Act) as follows:

> (h) "Screening" means the process performed by a participating community mental health center, pursuant to a contract entered into with the secretary under K.S.A. 39-1610 and amendments thereto, to determine whether a person, under either voluntary or involuntary procedures, can be evaluated or treated, or can be both evaluated and treated, in the community or should be referred to the appropriate state psychiatric hospital for such treatment or evaluation or for both treatment and evaluation.

The QMHP does not perform a diagnosis but instead evaluates the patient to determine whether the patient should be sent to a state psychiatric hospital, a community hospital, a community mental health center, or other services.