Chair Warren and members of the committee,

Thank you for the opportunity to provide testimony in support of House Bill 2353, which amends several statutes within the care and treatment act for mentally ill persons.

I am a district judge in the 16th Judicial District, comprising of Clark, Comanche, Ford, Gray, Kiowa and Meade counties. While my interest in this legislative proposal arises from my work as a judge, the positions I express in my testimony today reflect only my individual views and not the views of the judicial branch.

As part of my duties as district judge, I preside over proceedings pursuant to the care and treatment act for mentally ill persons. In Ford County, I oversee the Assisted Outpatient Treatment program (AOT), which is one of five pilot sites across the state established by the Kansas Department of Aging and Disability Services and receiving grant funding from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Generally, data supporting AOT indicates that individuals who have previously struggled to follow through with treatment are more likely to comply with treatment when they are under court order to do so.

While I support the entire bill, my testimony focuses on my support for the proposed amendments set forth in Section 3. Section 3 is crucial to the growth of AOT because it expands the bases upon which a court can order an individual to participate in outpatient treatment. Under the current version of K.S.A. 59-2967, a court may enter an order for outpatient treatment only upon finding that the individual is subject to involuntary inpatient treatment and further finding that the individual is likely to comply with an outpatient treatment order and that the patient will not likely be a danger to the community or be likely to cause harm to self or others.

HB 2353 allows for entry of an outpatient treatment order when (1) the individual will become subject to involuntary inpatient treatment in the foreseeable future without outpatient treatment and is only likely to attend outpatient treatment if there is a court order mandating such treatment; or (2) the individual, if left untreated, will reasonably experience an increase in symptoms that would result in the need for inpatient treatment in the foreseeable future and the mental illness has previously caused the individual to refuse needed community-based treatment.

Presently, individuals in our judicial district become participants in AOT following commitment to Larned State Hospital pursuant to a court order of involuntary inpatient treatment and the individual's subsequent release. In practice, individuals are frequently released at the discretion of the state hospital during the pendency of temporary orders issued pursuant to K.S.A. 59-2959(d)(1). In these instances, the course of inpatient treatment has stabilized the individual such that the individual no longer meets the statutory definition of a mentally ill person subject to involuntary commitment for care and treatment. Because the individual no longer meets the definition, the court now lacks the evidentiary basis required to enter an inpatient treatment order. And because the court must base an outpatient treatment order in part on the determination that an individual is subject to inpatient treatment, the court also lacks the evidentiary basis required to enter an outpatient treatment order.

Without court-ordered outpatient treatment, many individuals recently released from involuntary commitment often quickly become noncompliant with medication regimens and deteriorate to the point that subsequent involuntary commitments are necessary. This course of treatment is not only suboptimal for the individual's long-term recovery, but also strains state hospital resources. To break this cycle, the court in our judicial district conducts a hearing following release during which the court inquires whether the individual will participate in AOT voluntarily. Upon the individual's agreement, the court enters an outpatient treatment order based upon stipulation. So far, this approach has proven effective in getting individuals into AOT and thereby getting them needed community-based treatment for a time. The downside is that when individuals begin to backslide and reject services, the court has no recourse due to the voluntary nature of the individual's participation. This of course frustrates the core idea behind AOT that court-mandated treatment makes the difference.

The proposed changes in Section 3 remedy these issues. Because many of the individuals we serve in AOT have a long history of recurring mental illness and often multiple involuntary commitments, there is typically a strong evidentiary basis to support the requisite conclusions for outpatient treatment orders under the proposed changes. Once the court can begin regularly mandating outpatient treatment, it will be able to utilize the full potential of AOT for the benefit of individuals suffering from mental illness and the efficient use of state resources. In my experience so far with AOT, I am encouraged by the care and stability we can offer, and I am excited by the prospect of reaching more individuals under the proposed amendments within HB 2353.

I support House Bill 2353 and I ask the committee to pass favorably. Thank you again for the opportunity to provide testimony.

Andrew M. Stein