MINUTES

SENATE COMMITTEE ON WAYS AND MEANS

September 24, 1993
Room 123-S -- Statehouse

Members Present

Senator Gus Bogina, Chairperson
Senator Alicia Salisbury, Vice-Chairperson
Senator Dick Rock, Ranking Minority Member
Senator Jerry Karr
Senator Barbara Lawrence
Senator Steve Morris
Senator Marge Petty
Senator Bob Vancrum

Members Absent

Senator Bill Brady
Senator Dave Kerr
Senator Jerry Moran

Staff Present

Alan Conroy, Kansas Legislative Research Department
Kathy Porter, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office

Conferees

Secretary Donna Whiteman, Social and Rehabilitation Services
Harry Allen, Superintendent, Youth Center at Topeka
Dennis Beitz, Executive Director, Breakthrough House, Topeka
Eunice Ruttinger, Shawnee Community Mental Health Center
Reverend Barry Feaker, Director, Topeka Rescue Mission
Reverend Roger Neff, Director, Salina Rescue Mission
Reverend Gene Price, Director, Wichita Rescue Mission
Roxanna Lindquist, Administrative Director, Support Program for Independent Responsible Individuals in Transition, Inc., Ottawa
Nancy Knight, Social Worker and Placement Specialist, Adult Service, Osawatomie State Hospital
Laurie Rupert, Wyandotte County Mental Health Center Liaison to Osawatomie State Hospital

Brenda Weed, Wyandotte County Mental Health Center Case Manager
Janet Wilson, Social Worker, Adolescent Service, Topeka State Hospital
Yvonne Brown, Community Outreach Director, Metropolitan Lutheran Ministries, Kansas City, Kansas and Wyandotte County
Renita Rathke, Homeless Coordinator, Community Action, Inc., Topeka
Louise Hays, Keredel Community Residence, Topeka
Sheriff Cliff Hacker, Lyon County, President, Kansas Peace Officers Association
Sergeant Doug Hanna, Topeka Police Department

Morning Session

Senator Gus Bogina, Chairperson, called the meeting to order at 9:12 a.m., and welcomed the guests present (Attachment 1). Chairperson Bogina said that the agenda would include the issues of continuum of care in the mental health system and mental health reform and how it impacts local communities and the people providing services in Kansas communities.

Kathy Porter, Kansas Legislative Research Department, reviewed a staff memorandum detailing some of the major provisions of the Mental Health Reform Act. Also reviewed was information on the difficulties inherent in discharge planning (Attachment 2). Chairperson Bogina remarked that he would like to have discussion during the coming Committee meetings on whether community mental health services are in place prior to discharge of patients from mental health hospitals.

Dennis Beitz, Executive Director, Breakthrough House, Topeka, presented an overview of his organization and a review of mental health reform. Mr. Beitz said that improvement is needed in funding psychosocial services other than Mental Health Centers. He stressed that there is a major problem with out-of-county consumers needing services, but selecting not to return to their county of origin (Attachment 3). Senator Salisbury requested Mr. Beitz provide information on the priorities for the Center's $450,000 annual budget, and whether revenues are directed toward specific programs.

Eunice Ruttinger, Shawnee Community Mental Health Center, explained that the five goals of Mental Health Reform are to: (1) reduce the number of hospital beds in state institutions, (2) screen all admissions into the state hospital, (3) assist with and participate in discharge planning, (4) involve families and consumers in planning services, and (5) review the role of the Secretary of Social and Rehabilitation Services in overseeing and reviewing plans for future mental health services and reform.

Reverend Barry Feaker, Topeka Rescue Mission, briefed the Committee on the history and purpose of the Mission and said that they attempt to reintegrate people back into community living if possible, and institutional living, if necessary. In the last seven years, over 12,000 individuals have stayed at least one night at the Mission. There are around 230 people who have been barred from the Mission, many due to having displayed symptoms of mental illness, threatening staff, and occupants. Reverend Feaker related several situations in which Mission staff attempted to help people who had been released from State Mental Hospitals. Responding to a question from the Chair, Reverend Feaker said that when Mission staff encounter individuals with suicidal or homicidal tendencies, the Shawnee Community Mental Health Center has provided good cooperation. However, the Mission staff feels that transporting persons to the mental health center against their will presents a legal issue.

Senators Karr and Salisbury voiced their concern with the issue of discharge planning, whether the Topeka Rescue Mission is an appropriate release destination. The Committee discussed court order procedures for releasing patients from mental hospitals and Senator Salisbury requested that a representative from the courts appear at a future Committee meeting.

Reverend Roger Neff, Director, Salina Rescue Mission, said that his agency deals mainly with men and that there are many frustrations in rescue mission work. Reverend Neff explained that his mission has had problems due to confidentiality and with getting information from state mental hospitals regarding men he said were "dumped" in Salina. He reported on the McKinley Homeless Act, which provides partial federal funding for housing. Responding to a question, Reverend Neff said that, according to the bus company, bus tickets to Salina for seven men who arrived at the Mission were paid for with state funds.

Reverend Gene Price, Director, Wichita Rescue Mission, reported that from 10 to 30 percent of his clients have mental illnesses and that some have been released from mental hospitals in other states. He said that the Mission's objective is to help the homeless and destitute, but they find themselves spending increasingly more time policing and disciplining the homeless mentally ill. Reverend Price asked that organizations such as his be notified when the mentally ill are released in their areas.

Roxanna Lindquist, Administrative Director, Support Program for Independent Responsible Individuals in Transition Inc., (SPIRIT), Ottawa, explained the activities of her organization. She said that the largest portion of their funding comes from an SRS grant (Attachment 4). In response to a question from Senator Salisbury, Ms. Lindquist replied that changes are needed to increase openness in the confidentiality laws.

The Chair announced that the meeting would recess for lunch.

Afternoon Session

Chairperson Bogina reconvened the meeting at 1:40 p.m., and called for continued discussion on mental health services continuum of care.

Nancy Knight, Social Worker and Placement Specialist, Adult Service, Osawatomie State Hospital, explained the discharge process and admissions policy at the Hospital. She said that family involvement is considered when releasing a patient into the community and that a client's diagnosis may limit services available to them. Ms. Knight responded to questions and said that limited resources in rural areas and inadequate funding for client services are also problems.

Laurie Rupert, Wyandotte County Mental Health Center Case Manager to Osawatomie State Hospital, reported that the Center has a homeless case management project and works with the homeless shelters in Wyandotte County. Results of this project have shown a marked decrease in the number of mentally ill persons in the shelters in the last three years.

Brenda Weed, Case Manager, Wyandotte County Mental Health Center, said that more community resources should be made available for some of the mentally ill who need assistance coming out of a nursing home setting. Ms. Weed said that she has worked in the mental health systems in Iowa and Oregon and believes the Kansas system to be far superior to the systems in those states.

Janet Wilson, Social Worker, Adolescent Service, Topeka State Hospital, discussed the changes at the Hospital which were implemented as a result of the Mental Health Reform Act. She also reviewed problems encountered in the discharge planning process (Attachment 5). In response to a question from the Chairperson, Ms. Wilson said that the two gaps in the system are: (1) channeling federal funding for services to fit patients who are both mentally ill and mentally retarded, and (2) a greater need for cooperation with the correctional program to address the needs of conduct disordered youth.

Yvonne Brown, Community Outreach Director, Metropolitan Lutheran Ministries, Kansas City, Kansas, and Wyandotte County, said that when she began her job 17 years ago there were many re-integration programs in place to help those with drug and mental problems, but the programs have been greatly reduced due to budget cuts. Ms. Brown said that they get many street people with mental health problems in the Ministries' offices and their case managers aid those people in a timely manner. She also addressed the needs in Wyandotte County for adequate income, affordable housing, and available transportation.

Renita Rathke, Homeless Coordinator, Community Action, Inc., Topeka, said that she is frustrated with the confidentiality law when trying to work with homeless people who exhibit symptoms of mental illness. Ms. Rathke also said that there are difficulties in obtaining housing for clients being released from mental hospitals because of the reluctance of landlords to rent to those who may be destructive due to not staying on their medication.

Louise Hays, Keredel Community Residence, stated that they have not seen any change since the beginning of Mental Health Reform and that their experience with emergency services has not been good. Ms. Hays explained the positive impact the Residence has had on their clients and said that one of the greatest needs of the mentally ill is more affordable and suitable housing with intensive case management (Attachment 6). Senator Karr remarked that the Keredel Community Residence is a classic example of what should be done by all communities and that Ms. Hays' testimony was an inspiration.

Sheriff Cliff Hacker, Lyon County, President of the Kansas Peace Officers Association, presented the perspective of the Peace Officers Association. He stated that the system is becoming overloaded due in part to the increased number of clients served at the Mental Health Center in Emporia. Potential problems are seen by the officers in situations in which people who are under some type of action for protective custody for care and treatment must be picked up and taken to an appropriate facility, sometimes as far away as Dodge City. An increasing amount of time is spent by peace officers transporting these clients, who can legally sign themselves in and out of a mental health hospital. In response to a question, Sheriff Hacker said that rural law offices, which are usually short of staff, find it a hardship to handle and transport the mentally ill.

Sergeant Doug Hanna, Topeka Police Department, said that the Topeka Police take into account the surroundings, such as the home environment, when determining whether a person is considered to be a danger to themselves or others. Transporting the mentally ill is more of an inconvenience for the Topeka Police Department than a problem due to the local availability of mental health services and hospital care. Sergeant Hanna responded to questions and suggested that there be some type of implied consent to deal with post release situations from state institutions and state-funded institutions, using an ID card that could give police helpful information.

Harry Allen, Superintendent, Youth Center at Topeka (YCAT), said that currently YCAT is safe for students and staff, the program is state of the art, juveniles are given good basic care, the training is outstanding, and personnel practices have vastly improved. He also said that they hope to be accredited by the American Correctional Association in March, 1994 (Attachment 7). When asked by the

Chair whether he thought the average ten-month stay for juvenile offenders was sufficient, Superintendent Allen said that rehabilitation was rarely possible in that length of time. Responding to a question from Senator Salisbury, he said that the boot camp concept would be good for some students but would not be a good idea for the serious offenders and would probably fail in the long run. He was questioned about the recent shooting death of a YCAT counselor and the subsequent arrest of a resident who had not returned from a pass, and the placement of students in Topeka schools.

Secretary Donna Whiteman, Social and Rehabilitation Services (SRS), said that under current Kansas law, prosecutors can certify 16-year-olds as adults for felony offenses and that county prosecutors across the state are using this in response to violent crimes occurring in their counties. Also, they can be certified as aggravated juvenile delinquents who would allow prosecutors to access the adult system. Secretary Whiteman reported that around 90 percent of YCAT students have drug or alcohol problems which SRS plans to address.

The Committee discussed rehabilitating hard core offenders and implementing a tracking system for offenders. Senator Petty requested that SRS and Topeka State Hospital submit data in chart form on what services are available and where interventions are occurring with very young offenders. Senator Lawrence suggested that schools also be included in the study group.

Chairperson Bogina adjourned the meeting at 4:48 p.m.

Edited by Kathy Porter

Approved by Committee on:

December 14, 1993
(Date)

SENATE WAYS AND MEANS COMMITTEE

DATE 9/24/93

NAME	ADDRESS	REPRESENTING
SHERYL SANDERS	TOPEKA	KS ALLIANCE FOR MENTALLY ILL
DAVID SOFFICIA	2700 W. 6TH ST. TOPEKA, KS	TOPEKA STATE HOSPITAL
Eunice Rettiger	2401 West 6th	Sheenee Community Mental Health Center
Trish Hampton	" "	" " " "
Randy Proctor	Topeka	MHRS/SRS
Esther M. Fitzgerald	P.O. Box 184 Towanda, Ks 67144	KMHAC Vice President
Jerry Larson	Topeka	Kansas Alliance for the Mentally Ill
Dennis Best	815 SW [illegible] Topeka, KS 66603	Breakthrough House, Inc.
Barry Teach	600 N. Kansas TOPEKA Ks. 66608	Topeka Rescue Mission
Ryan Neff	374 N. 13th Salina, Ks 67401	Salina Rescue Mission
Steve Price	130 N. ST. FRANCIS WICHITA, KS 67202	UNION RESCUE MISSION
Jan Resch	Osawatomie State Hospital	OSH
Doug Knight	Osawatomie State Hospital	OSH
Stephen K. Jones	Osawatomie State Hospital	OSH
Martin Hawver	[illegible]	Hawver's Capitol Report
John Peterson	Topeka	Ks Assn of Prof Psychologists
Lonny Lindquist	745 S PRINCETON OTTAWA KS.	SPIRIT KS. MENTAL ILLNESS AWARENESS COUNCIL
ROXANNA Lindquist	" "	SPIRIT

9/24/93

Senate Committee on Ways & Means
Attachment 1

MEMORANDUM

Kansas Legislative Research Department

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September 23, 1993

To: Senate Ways and Means Committee

Re: Mental Health Services Continuum of Care (Post-Institutional Release)

The Mental Health Reform Act, 1990 Sub. for H.B. 2586 (codified at K.S.A. 1992 Supp. 39-1601 *et seq.*), revised the Kansas mental health services delivery system by shifting the emphasis from a state hospital-based mental health services delivery system to a community-based services system. Among other provisions, the Mental Health Reform Act states that Kansas residents in need of mental health services are to receive the least restrictive treatment and most appropriate community-based care through coordinated utilization of the existing mental health centers and state mental health hospitals. (K.S.A. 1992 Supp. 39-1603 (i).)

Mental Health Reform Requires Both Pre-Admission Screening and Post-Release Planning

To avoid gaps in the service delivery system and to ensure continuity of care, the Mental Health Reform Act requires that persons in need of hospitalization in a state mental health hospital have contact with the existing system of community mental health centers both before entering a state hospital and before discharge from a state hospital. No person may be admitted to a state hospital without a written statement authorizing admission from a qualified mental health professional employed by or under contract with a participating mental health center. (K.S.A. 1992 Supp. 59-2905; 59-2908.) Mental health center screening is required prior to admission to a state hospital whether a patient is admitted either as a voluntary patient or as an involuntary patient. A voluntary patient may be admitted to a state hospital upon a finding that the person is in need of treatment in the facility. (K.S.A. 1992 Supp. 59-2905.) A person may be admitted as an involuntary patient upon a finding that the person is a mentally ill person and because of the illness is likely to cause harm to self or others if allowed to remain at liberty. (K.S.A. 1992 Supp. 59-2908; 59-2909.)

Similarly, no person shall be discharged from a state mental health hospital without receiving recommendations from the participating mental health center serving the area where the patient intends to reside. (K.S.A. 59-2907[a]; 59-2924[c].) In effect, this requires that a discharge or after-care plan be prepared before each patient is discharged from a state hospital. The Mental Health Reform Act does not specify what areas or services should be addressed in an after-care plan. Each plan would vary based upon the patient's needs and preferences, the services available in the area in which the patient intends to reside, and other factors. After-care plans could include all or part of the following elements: residential placement, peer support services, psycho-social

9/24/93
Senate Committee on
Ways & Means
Attachment 2

rehabilitation programs, medication check and other medical services, educational or vocational planning, case management services, financial support services, and other elements.

The majority of conferees appearing before the Committee today provide residential services, psycho-social and peer support services, and other community services. They will address the after-care planning process and the general mental health services delivery system from their perspectives. The conferees from Osawatomie and Topeka State Hospitals and Johnson County Community Mental Health Center will discuss how an after-care plan is developed and what elements may be included in an after-care plan.

Difficulties Inherent in Discharge Planning

Some of the conferees will also discuss difficulties which could be encountered in the development and implementation of after-care plans. One difficulty inherent in discharge planning is that, under some circumstances, little or no time may be allowed for discharge or after-care planning. Any voluntary patient who submits a written request for discharge must be released within three days of the request, excluding Saturdays, Sundays, and legal holidays. (K.S.A. 1992 Supp. 59-2907.) Patients who have been admitted on an involuntary basis may request a hearing to review status each 90 days during the first six months of treatment and every 180 days thereafter. If, after a hearing, the court determines that it has not been shown by clear and convincing evidence that the patient continues to be a mentally ill person, the court shall discharge the patient. (K.S.A. 1992 Supp. 59-2919a.) In such cases, the state hospital and community mental health center would have little or no opportunity to formulate an after-care plan. Additional difficulties beyond time constraints may be discussed by individual conferees.

The Impact of the Sentencing Guidelines Act on the Mental Health System

A related issue which has recently impacted the mental health services system is the release of Department of Corrections inmates from the Larned Correctional Mental Health Facility under the provisions of the Sentencing Guidelines Act. Because of the retroactive application of sentencing guidelines, certain of the Larned inmates will be eligible for early release under the Act. As of September 15, 1993, 67 of the 142 inmates at the Larned facility were eligible for retroactive application of the sentencing guidelines. Larned State Hospital is cooperating with the Larned Correctional Mental Health Facility staff in instituting civil commitment proceedings or formulating a post-release plan for those inmates determined to be in need of continued treatment. This issue will discussed by the Department of Corrections at the September 30 Senate Ways and Means Committee meeting.

Number of Patients Discharged from State Hospitals on an Annual Basis

The following chart notes the numbers of patients discharged directly from each of the four state mental health hospitals. The numbers noted do not include patients transferred between institutions, patients discharged on leave, or other special discharge circumstances.

The numbers noted could include repeat hospitalizations and do not include the number of persons receiving community services who have not been state hospital patients. However, the table would provide some indication of the number of discharge plans which must be formulated on an annual basis.

Number of Discharges from State Mental Health Hospitals

	FY 1991	FY 1992	FY 1993
Larned	1,280	1,295	1,240
Osawatomie	847	963	892
Rainbow	536	424	469
Topeka	609	629	601
TOTAL	3,272	3,311	3,202

Mental Health Reform Phased Schedule

It should be noted that Mental Health Reform was designed as a phased program, with three phases corresponding to the Osawatomie, Topeka, and Larned State Hospital catchment areas. Mental Health Reform, and the required discharge or after-care planning, began in the Osawatomie State Hospital catchment area on January 1, 1991, in the Topeka State Hospital catchment area on July 1, 1992, and in the Larned State Hospital catchment area on July 1, 1993.

93-7356/kp

SENATE WAYS AND MEANS COMMITTEE
SEPTEMBER 24, 1993

1. OVER VIEW OF BREAKTHROUGH HOUSE, INC.

Breakthrough House, Inc. was founded by former Topeka State patients and members of the Mental Health Association of Shawnee County in 1974. The program started meeting in consumers' homes and served 8 to 10 individuals. Today we have a have over 600 individuals we serve in our five programs (psychosocial clubhouse, housing, compeer, and pre-employment training). All programs use the non-clinical community support approach. There are no costs for most services.

Breakthrough became an affiliate of the Shawnee Community Mental Health Center in 1982. Most of our funding (64%) comes through the Center. The annual budget is a little over $450,000. There are 22 on our staff.

The mission of Breakthrough House, Inc. is to provide a satisfactory working, living, and social life for person with severe and persistent mental illness and help those individuals gain self esteem and be able to function as independently as feasibly possible in an appropriate community setting.

Admission requirements include being 18 years of age or older, living in Shawnee county, and recovering from a psychiatric illness. Consumers are expected to accept medical supervision, case management, participate in individually planned program of activities, and continue their medication when this is mutually agreed upon with their case manager.

2. REVIEW OF MENTAL HEALTH REFORM

We wish to stress that our comments will be made with the understanding that Mental Health Reform has only had a total of 86 days of being in effect for the adult population in this catchment area. Considering possible strengths and areas that need improvements are difficult to address. However, there are some indicators and areas that will be addressed.

A. Strengths

1. The concept of reducing beds at Topeka State Hospital is positive and necessary.
2. Reform is allowing hospital patients to become consumers of mental health services as "community residents."
3. The five goals of Mental Health Reform are attainable and should be kept.
4. Mental Health Centers serving as the "gate keepers" to the front door of the state hospitals is a good approach. This approach has worked will with Breakthrough being an affiliate of the Mental Health Center.
5. The idea of "community based" services for the consumer are important to maintain.
6. The involvement of family members and consumers in all areas is a strength that should be maintained and is strongly supported.

9/24/93
Senate Committee on
Ways + Means
Attachment 3

;eas That Need Improvement

1. There needs to be a process where some of the Mental Health Reform funding is channeled to psychosocial services other than Mental Health Centers. There is currently no process for this to occur. We do wish to emphasize this can be accomplished through agreements with the local Mental Health Centers. We are currently discussing this possibility with the Shawnee Community Mental Health Center. We also wish to relate that through the Mental Health Center's efforts Breakthrough was able to receive Shawnee County funding of $71,000 for 1994.
2. There needs to be more money so more services can be provided. Money needs to be "designated" for specific programs such as Compeer, medication assistance, employment training, etc.
3. Psychosocial programs need to be involved in the pre-release planning before discharge into the community. This also needs to include more flexibility in the area of releases of confidential information that is used in this process
4. There is a problem of out of county consumers needing services, but selecting not to return to their county of origin. Although this is their decision the fact remains they still are in need of services.

3. QUESTIONS AND ANSWERS

TESTIMONY
GIVEN BY
ROXANNA LINDQUIST
ADMINISTRATIVE DIRECTOR
OF SPIRIT

Thank you, ladies and gentlemen of the Senate, for allowing me to testify before you today, on the subject of what happens to a Mentally Ill homeless person when they are fighting institutionalization. First, I wish to tell you a little about SPIRIT, a consumer run alternative program, some of what we do, how we do it, and why. I am going to use three examples in doing so.

The first example will be of an individual in a State Hospital, where the State Hospital could not fight state, or (state vs. state) and SPIRIT was called in as an intermediator and advocate for this patient.

In November of 1992, we at the SPIRIT office received a call, that a patient at Osawatomie State Hospital was in risk of losing all his worldly goods, including a 1989 Ford pick-up truck. The individual I am about to tell you about was picked up on I-70 highway, just outside of Junction City. This individual was taken to court and court ordered into the State Hospital in Topeka. All his worldly belongings were in his pick-up, which was towed and impounded in Junction City. The court date was in September, about the 18th or 19th, he was admitted to Topeka State Hopsital the next day. Topeka State Hospital was not made aware that this individual even had property in impound. Within a month, heavily medicated, this individual was transferred to Osawatomie State Hopsital, where the doctors began decreasing his medication. With the decrease in medication, this individual started remembering his personal belongings and truck. The social worker on his ward tried and then the Director of Social Services for the hospital, tried to retrieve this individuals belongings, but to no avail.

9/24/93

Senate Committee on Ways + Means

Attachment 4

Letters and phone calls had been made to both the Junction City Impound Lot, and Mayor's office, with no one understanding this individuals plight. The Director of Social Services at Osawatomie State Hospital called our office, to ask if there was anything we might do to help. We imformed the Director, knowing SPIRIT'S motto, we don't have problems just challenges, we would try, and would contact her by the end of the week. Upon hanging up, I contacted a Major Bratta, a commander of the State Highway Patrol, in Topeka. Major Bratta was unware of the situation, but told me he would make a few calls. An hour later Major Bratta called back, and said that the Impound Lot would at least talk to us, and wished us luck. Called and talked to the owner of the Impound Lot, he said that the impound fees totaled over $1500.00. I began to tell him the situation of this individual, and within minutes, he lowered the fees to $300.00. I told him I would get back to him, after I called the hospital to verify that this individual had this kind of resources. The Director, was very pleased and assured us, the individual did have that much he could use. She wondered how we would retrieve the truck and belongings, from Junction City, I explained that our Board of Executives would be meeting that evening, to work out that detail, and would contact her in the next day or so. At that emergency meeting of SPIRIT, it was voted to rent a tow-bar and supply the gas and truck to tow the impounded truck back from Junction City to the Osawatomie State Hospital grounds. SPIRIT would use it's fundraising monies for this endeavor. The plan went well and by the third of December, this individual had his possessions back.

The second example is of an individual who is a native Kansan, who because of a family situation and his mental illness, could not function and live at home. When SPIRIT found this individual, he had been living in a rock quarry just outside our community, for about four months, with nothing but a makeshift tent and the clothes on his back. How he was eating, I am still not sure. He was brought to SPIRIT by a minister, who had talked to him after seeing him somewhere and told him what SPIRIT could do to help him. The individual then agreed to come to SPIRIT and did so. In the initial interview with this individual, we learned the he was a former consumer of Mental Health Services before Mental Health Reform, upon learning about Mental Health Reform, he wished to receive help again. We said that we could help him receive services if that was his wish. This individual had been off his medication for about a year due to lack of resources and no stable home life. He asked if there was anything SPIRIT could do to get him back on his meds, find him a place to live, and help him receive benefits that he felt were due him. We agreed that these were no stumbling blocks for SPIRIT as long as he wished for these things to take place. We invited him to stay at SPIRIT PLACE. We called an Emergency Evaluator at the clinic and also contacted the Emergency Homeless Disabilities Determination Unit in Topeka. It took a month and a half to bring everything together and secure a HUD Housing Certificate for this individual. This individual is now a Board Member of SPIRIT and an active member in the community.

The third example is of an individual that a Police Officer from Dodge City, knowing of us, called, asking if we could place this individual at SPIRIT PLACE. I informed him that I needed to speak directly with the individual as we would not even suggest that he stay at SPIRIT PLACE without his consent. The phone was handed to the individual who explained he was being charged with verbal assault and was in need of a place to stay for about a week to rest and get his thoughts together. I informed him we would drive to Dodge City to pick him up. I asked the officer if he could contact one of the churches to place him in a setting for that night as it would take till the next day to come and get him. This is something that was done. The next day on the way back from Dodge City, the individual was talking to himself quite a lot, but it wasn't until that evening that this individual started talking of killing everyone in SPIRIT PLACE. I noticed that there were many changes in voice, attitudes and personalities and needed to make a judgement call to a therapist at the Mental Health Clinic. Upon returning my call, I realized it was the Director of the Mental Health Clinic. Without releasing this individual's name, I began explaining his suicidal tendencies and his verbal actions. After this explanation, we asked if he would be willing to come in and see her the next morning at the clinic. He said he'd love to see her. The next morning, being Sunday, we met the Director outside the clinic where we sat at one of the picnic tables and talked. It was then agreed by all concerned including the individual that we try to locate his family. The individual also agreed and wanted help from the clinic. Upon trying to contact family in Virginia, through the town police station, we realized there had been a missing person report for this individual active for the last three years.

We will not attempt to go into his past anymore than this but stay stedfast on his improving progress. This Individual today is attending the C.S.P. (community support program) daily, SPIRIT PLACE Drop-in center about every other day and is also an active Board Member of SPIRIT. He has been living independently in the community for the last thirteen months, all charges in Dodge City were dropped when they realized this person had a mental illness.

These are just a few examples of sixty-three independent, responsible individuals SPIRIT has been instrumental in getting to live back in the community, in 1992. SPIRIT was started as a mutual support services program, open twenty four hours a day, with a Drop-In Center, Office and many activities such as camping, fishing, swimming and boating, fundraisers and a whole lot more that we can not even begin to cover.

Our biggest portion of funds come from a Grant from S.R.S, for the alternative self-help groups, but none of the examples above ever used grant funds. These individuals were funded by donations and fundraisers only, but not much revenue is made by fundraisers and donations and we need the State of Kansas to understand that these people need to be independent, with a little help. We don't need these people turning to crime in our communities, just in order to eat.

To tell you a little about how SPIRIT got started and I will be brief. Twenty eight years ago, I was training as a Basic Living Skills Instructor and became an Adult Foster Mother for the retarded in my home. I did this for seven years until my husband went into a State Hospital with a Mental Illness.

I did not understand the mentally ill at that time and needed much more education. Through the Welfare Dept. in the state where I was living, my home was made a temporary shelter for people with Mental Illness, who were homeless, and did this for about ten years, until my husband went into a coma because of his mental illness and remained in a catatonic comatose state for eight years. Upon moving to Kansas while he was in the catatonic comatose state at home, I continued to take in the homeless as much as possible. I have read in the medical libraries as many books on Mental Illness as I possibly could get my hands on. This does not make me a professional and I will never claim to be one. My only hope in this education, was to learn how to live around the mentally ill. I feel that I have accomplished this to the greatest extent, as I was told my husband would never come out of his catatonic comatose state and he did and is a very high functioning consumer. I also am a psychiatric survivor, as a doctor that was caring for my husband, before moving to Kansas, committed me through my depression and my vocal dislike of how my husband was being treated and I was court-committed for two months with eighteen electric shock treatments in-patient and nine out-patient. I could not have started SPIRIT without my husband's help and six months after his recovery from his catatonic comatose state, SPIRIT was born. I think that this will give you an insight to the dedication of all SPIRIT'S members, but we can't do it alone. State funding to help these consumers in their transitional period needs to be in place and that is why I have come before you today, and also why we have the name SUPPORT PROGRAM FOR INDEPENDENT RESPONSIBLE INDIVIDUALS IN TRANSITION.

4-6

STATE OF KANSAS
JOAN FINNEY, GOVERNOR

SOCIAL & REHABILITATION SERVICES
DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

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January 26, 1993

Mr. and Mrs. Lonny Lindquist
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Ottawa, Kansas 66067

RE: Mr. John [redacted]

Dear Roxanne and Lonny,

I wanted to share with you both and with the organization of S.P.I.R.I.T. how appreciative, not only Mr. [redacted], but our hospital is that there are persons in the community who care so much about people in need. Your tremendous efforts in Mr. [redacted]s behalf were successful in reclaiming his personal property, his truck, from a towing and storage company which claimed to have over a $1,500 bill against Mr. [redacted]

For all of the expertise available within our system we were unable to obtain Mr. [redacted]s property for him, but a single phone call to you and the organization of S.P.I.R.I.T. proved successful and allowed Mr. [redacted] to have a very joyous Christmas holiday.

Your commitment to helping others in need was certainly prevalent in this situation as you even went so far as to travel to Junction City to secure Mr. [redacted]s property and return it to him at our hospital.

Although there is very little that I can do other than to offer you my gratitude for your assistance I would like very much to invite both of you to have lunch with me at your convenience.

Sincerely,

Thomas J. Vohs
Acting Superintendent

By: Martha J. Town, LSCSW, ACSW
Chief Social Worker

MT:llp

4-7

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TOPEKA STATE HOSPITAL

STATE COMPLEX WEST, 2700 WEST SIXTH, TOPEKA, KS 66606-1898

(913) 296-4596

DAVID A. SOFFERIN
SUPERINTENDENT

JOAN FINNEY
GOVERNOR

DONNA L. WHITEMAN
SECRETARY

September 23, 1993

RE: COMMITTEE TESTIMONY

I AM JANET WILSON, A SOCIAL WORKER ON THE ADOLESCENT PROGRAM AT TOPEKA STATE HOSPITAL. I COORDINATE SOCIAL WORK SERVICES ON THE ADOLESCENT PROGRAM AND ACT AS LIAISON WITH THE MENTAL HEALTH CENTERS IN OUR CATCHMENT AREA. I HAVE BEEN AT TOPEKA STATE HOSPITAL FOR 7 1/2 YEARS AND WITH THE SRS SYSTEM FOR 24 YEARS.

COMMUNITY MENTAL HEALTH REFORM WITH CHILDREN/ADOLESCENTS BEGAN WITH THE TOPEKA STATE HOSPITAL CATCHMENT AREA IN JULY 1992. WE WORKED CLOSELY WITH THE MENTAL HEALTH CENTERS TO DECREASE THE ADOLESCENT PROGRAM BY 20 BEDS, WHICH WAS ACCOMPLISHED IN FEBRUARY 1993. SINCE THAT TIME THE ADOLESCENT CENSUS HAS REMAINED AT CENSUS (51) OR BELOW. BOTH ADMISSIONS AND DISCHARGES ARE MORE CLOSELY PLANNED AND THOUGHT THROUGH SINCE THE

5

9/24/93
Senate Committee on
Ways + Means

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Attachment 5

CEPTION OF MENTAL HEALTH REFORM. GENERALLY ADMISSIONS ARE ONLY SOUGHT OUT AFTER ALL OTHER COMMUNITY RESOURCES ARE CONSIDERED INAPPROPRIATE OR EXHAUSTED. THERE ARE A FEW EXCEPTIONS WHERE AN ADOLESCENT HAS BEEN ADMITTED WHERE COMMUNITY SERVICES COULD HAVE BEEN EVALUATED MORE CLOSELY, BUT THIS IS THE EXCEPTION AND NOT THE RULE. TOPEKA STATE HOSPITAL IS GENERALLY NOT VIEWED AS A FIRST CHOICE FOR TREATMENT, BUT AS AN ALTERNATIVE THAT CAN BE USED WHEN COMMUNITY RESOURCES ARE NOT APPROPRIATE. COMMUNITY MENTAL HEALTH REFORM CAN BE LOOKED UPON AS A NEW WAY OF THINKING WHERE THE CHILDREN'S AND FAMILY'S NEEDS WITHIN THE COMMUNITY ARE TAKEN INTO ACCOUNT, RATHER THAN REMOVING THE CHILD FROM THE COMMUNITY AND DEFINING THE YOUTH AS THE ENTIRE PROBLEM.

ONCE A YOUTH IS ADMITTED TO TOPEKA STATE HOSPITAL MOST MENTAL HEALTH CENTERS ASSIGN A CASE MANAGER THAT WILL FOLLOW THE YOUTH'S CASE DURING AND POST HOSPITALIZATION. THESE CASE MANAGERS ATTEND THE TREATMENT PLANNING MEETING WHENEVER POSSIBLE AND/OR VISIT THE YOUTH AT LEAST ONCE A MONTH. THEY TRY TO KEEP INFORMED, SO WHEN DISCHARGE IS IMMINENT, AFTERCARE PLANS ARE CARRIED OUT EFFICIENTLY. DISCHARGE PLANNING IS CONSIDERED A PART OF THE TREATMENT PROCESS AND SHOULD NOT BE AN UNEXPECTED OR SURPRISE EVENT.

DISCHARGE PLANNING IS A CONTINUOUS PROCESS. WHILE THE YOUTH IS IN THE HOSPITAL THE CASE MANAGER MEETS WITH THE FAMILY AND DETERMINES WHAT IS NEEDED FOR SUCCESSFUL REUNIFICATION. IF A FAMILY REFUSES THESE SERVICES

OM THE MENTAL HEALTH CENTER, THEN THE CASE MANAGER MAY NEED . . INVOLVE THE SRS SOCIAL WORKER AND/OR COURT OFFICIALS. AT TIMES A FAMILY MAY NOT BE AVAILABLE, SO THE CASE MANAGER MAY NEED TO WORK WITH THE SRS WORKER IN THESE INSTANCES ALSO. HOME VISITS TAKE PLACE TO MONITOR THE YOUTH'S READJUSTMENT TO THE HOME AND PROVIDES AN OPPORTUNITY FOR THE CASE MANAGER TO IDENTIFY THE SPECIFIC SERVICES NEEDED. VARIOUS SERVICES THAT ARE AVAILABLE THROUGH THE MENTAL HEALTH CENTERS ARE CASE MANAGEMENT, INDIVIDUAL THERAPY, FAMILY THERAPY, GROUP COUNSELING, ATTENDANT CARE, RESPITE CARE, MEDICAL FOLLOW UP, AND SUBSTANCE ABUSE COUNSELING. OTHER IDENTIFIED SERVICES THAT CAN BE TARGETED IN THE COMMUNITY ARE SPECIALIZED EDUCATIONAL SERVICES, SRS FAMILY PRESERVATION SERVICES, CORRECTIONAL PROGRAMS, AND CONTRACTING WITH PRIVATE PROVIDERS. IN SETTING UP DISCHARGE PLANS WE HAVE ALSO UTILIZED FINANCIAL COUNSELORS, HOUSING AUTHORITY SPECIALISTS, SCHOOL NURSES, NUTRITIONISTS, THE YMCA, BIG BROTHER-BIG SISTER, AND CLERGY. ONCE PLANS ARE SET AND THE HOME VISITS ARE GOING WELL, THEN A DISCHARGE DATE IS SET. SOMETIMES THIS PROCESS WILL TAKE A MONTH, BUT AT OTHER TIMES IT MAY ONLY TAKE A FEW DAYS. AT TIMES AN EXTENDED TEMPORARY "TRIAL" VISIT IN THE HOME MAY BE UTILIZED TO ASSURE THAT ALL OF THE AFTERCARE ARRANGEMENTS ARE CARRIED OUT SMOOTHLY.

PROBLEMS OCCUR WHEN THE DISCHARGES ARE NOT ANTICIPATED OR COME ABOUT SOONER THAN EXPECTED AT COURT REVIEWS. THESE UNEXPECTED DISCHARGES ARE NOT THE NORM, BUT STILL THEY CAN HAPPEN WHEN THE COURT DETERMINES THAT INPATIENT TREATMENT IS NO LONGER INDICATED.

SUCH SITUATIONS, USUALLY THE YOUTH RETURNS HOME WITHOUT AS MU[illegible] PLANNING OR COORDINATION AS DESIRED. IT CAN BE DIFFICULT IN SUCH INSTANCES FOR THE MENTAL HEALTH CENTER TO ACCURATELY IDENTIFY AND IMPLEMENT SERVICES WHEN SUFFICIENT NOTICE OF DISCHARGE HAS NOT BEEN AVAILABLE. IN THESE SITUATIONS HOME VISITS HAVE ALSO NOT BEEN SCHEDULED AS FREQUENTLY, SO SERVICES HAVE NOT BEEN EFFECTIVELY TRIED BEFORE DISCHARGE. WHEN THE YOUTH HAS NO FAMILY RESOURCE TO RETURN TO, OR IF AFTERCARE PLANS NEED TO BE FINE TUNED, THEN AN EMERGENCY FOSTER CARE OR EMERGENCY GROUP HOME SETTING MUST BE SOUGHT OUT.

OTHER PROBLEMS WITH DISCHARGE OCCUR WHEN THE IDENTIFIED SERVICES AND RESOURCES ARE NOT AVAILABLE IN THE COMMUNITY. SOME OF THESE MAY INCLUDE ATTENDANT CARE (HIRING AND TRAINING OF STAFF), MEDICAL FOLLOW UP, AND RESPITE CARE. WHEN THE FAMILY IS NOT DEEMED A VIABLE ALTERNATIVE FOR PLACEMENT, THEN THERE IS OFTEN VERY LIMITED FOSTER CARE AND GROUP HOME BEDS. IN MANY OF THESE CASES THE YOUTH HAS AN EXTENSIVE HISTORY OF ACTING OUT AND A "REPUTATION" THAT MANY PROGRAMS ARE NOT WILLING TO CONSIDER. ONE CAN UNDERSTAND WHY A PARTICULAR GROUP HOME MAY CHOOSE TO ACCEPT A YOUTH WITH LESS BEHAVIOR PROBLEMS FOR THE SAME AMOUNT OF REIMBURSEMENT, RATHER THAN CONSIDER A YOUTH WHO POTENTIALLY MAY DISRUPT THE "NORMAL" FUNCTIONING OF THE OTHER INDIVIDUALS IN THE PROGRAM.

ADDITIONAL PROBLEMS THAT WE MAY ENCOUNTER ARE LIMITED FINANCIAL RESOURCES TO PAY FOR SUCH SPECIALIZED SERVICES. IF THE FAMILY OR YOUTH HAS

MEDICAL CARD, THEN REIMBURSEMENT IS NOT A MAJOR ISSUE. HOWEVER, IF THE FAMILY IS NOT ABLE OR WILLING TO PAY FOR THE NEEDED SERVICES, THEN DISCHARGE PLANNING BECOMES MORE DIFFICULT. OFTEN THESE FAMILIES DO NOT QUALIFY FOR SUPPLEMENTAL SECURITY INCOME (SSI) AND THEIR PRIVATE INSURANCE WILL NOT REIMBURSE CASE MANAGEMENT, ATTENDANT CARE, OR RESPITE. SUCH SERVICES CAN USUALLY BE ACCESSED EVENTUALLY, BUT ONLY AFTER THE FAMILY AGREES TO PURCHASE THESE SERVICES AT CONSIDERABLE EXPENSE TO THE FAMILY, OR THE MENTAL HEALTH CENTER PURSUES MANY AVENUES TO AVAIL THEMSELVES TO SPECIALIZED FUNDS.

BRIEFLY I WILL MENTION OTHER "GLITCHES" OR PROBLEMS THAT OCCUR WITHIN THE DISCHARGE PLANNING PROCESS. THERE ARE LONG WAITING LISTS FOR SRS FAMILY PRESERVATION SERVICES, AN OVERLOAD OF THE JUVENILE OFFENDER SYSTEM WHERE CONDUCT DISORDERED YOUTH CANNOT BE TREATED IN THE CORRECTIONAL SYSTEM, THE SCHOOL SYSTEMS HAVE DIFFICULTY ACCESSING THE APPROPRIATE SERVICES FOR "PROBLEM YOUTH", AND DUALLY DIAGNOSED (MENTALLY RETARDED/MENTALLY ILL) YOUTH CANNOT ACCESS THE NEEDED SERVICES IN THE COMMUNITY. HOWEVER, MENTAL HEALTH REFORM HAS ADDRESSED MANY PROBLEMS IN A MANNER THAT IS MORE CONDUCIVE TOWARDS CONSUMER/FAMILY NEEDS. IN DOING SO THE MENTAL HEALTH CENTERS AND STATE HOSPITAL HAVE COME CLOSE TOGETHER IN MEETING THE CONSUMER NEEDS. MENTAL HEALTH REFORM HAS ALSO IDENTIFIED THE "WEAK LINKS" OR SERVICE GAPS WITHIN THE SYSTEM THAT WILL HOPEFULLY BE EVALUATED MORE CLOSELY IN THE FUTURE.

.ANK YOU FOR PROVIDING ME AN OPPORTUNITY TO ADDRESS THE COMMITTEE.

Louise Hayes, Owner and Administrator of Keredel Community Residence.

We have not seen any change since the beginning of Mental Health Reform. We have one resident who was discharged through the Mental Health Center's partial hospitalization program in 1985 and has had assigned case managers since then. Other residents see a private psychiatrist for medication. Another State Hospital patient has just moved into our home this week.

Most of our residents have lived in our home for many years. They like a safe and secure place to live - a place they can call home. Most have house duties and enjoy being with people. Their medication is supervised and plenty of good food provided. They all would like to have case managers but the waiting list is long in this county. We would like to have a social worker or case manager for the house if not for each resident. Each person needs someone to call or someone to talk to when depressed or under stress or just as a friend who cares.

Our experience with emergency services has not been good. One resident became very angry, violent and threatened everyone including the paid staff. Emergency services said he did not need to go to the State Hospital. We could not take him back so he was diverted to the Rescue Mission where he stayed for at least a year.

We have an apartment house with three apartments but the medication is supervised and meals are provided at the group home. One of the greatest needs of the mentally ill is more affordable and suitable housing with intensive case management.

9/24/93
Senate Committee on
Ways & Means
Attachment 6

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

Senate Committee on Ways and Means

September 24, 1993

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SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

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Youth Center Mission Statement

The mission of the Kansas Youth Centers is to provide juvenile correctional programs with a blended mission of care, habilitation, treatment and public safety, which assures:

- Protection of the safety of youth, staff and the public
- Youth come to understand the predictable connections between behavior and consequences and that they can control what happens to them by controlling their behavior.
- Realistic treatment and programming for youth and their families.
- Protection of the legal and civil rights of youth.
- Spiritual, moral, physical, intellectual and social needs of youth are met.
- Constructive training aimed at habilitation and re-establishment of youth in society.

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TESTIMONY

Mr. Chairman, Members of the Senate Ways and Means Committee, before I respond to your questions, I feel it is necessary to provide you some background to my credentials which caused me to be selected in June, 1989, as Superintendent of the Youth Center of Topeka. I also would like to provide you a brief assessment of the progress made at the facility since June, 1989.

9/24/93
Senate Committee on
Ways & Means
Attachment 7

First of all, I have a BS Degree in Education from Seton Hall University in New Jersey and a Master of Arts Degree in Corrections/Criminology from Sam Houston State University. I retired from the United States Army in June, 1989, as a Military Police Officer in the grade of full Colonel. I spent twenty-four of those years in various law enforcement and correctional assignments. My first two years was spent as an Armored Officer commanding a Reconnaissance Company. I have commanded at the platoon, company, and battalion level, and served in many different law enforcement and correctional staff positions. From 1977 - 1980, I was on the Headquarters Department of the Army staff in the Pentagon and served as Chief, Army Corrections Branch with the responsibility of developing policy for the U.S. Army Correctional System. In 1980, I was selected to command a Military Police Battalion at Fort Riley, Kansas, composed of youthful military offenders. Our job was to attempt to change their attitude/behavior through a highly structured discipline program. If we were not successful with these soldiers, they were then given a dishonorable discharge. I served in this capacity for three years. The ages and types of offenses of the students of the Youth Center and the Correctional Battalion were comparable. I am people oriented; I believe in consensus organizations and I realize that staff working together make the organization.

When I became Superintendent at the Youth Center, the facility was in bad shape. The Legislative Post Audit Committee gave it a letter grade of F for its lack of good management, poor safety/security policies/procedures, inadequate training programs, and poor record keeping procedures. Morale was very low. Today, I would give the facility a B+. The facility is basically safe for juvenile and staff, the program is state of the art, juveniles are given good basic care, staff are held accountable for their actions, training is outstanding, and personnel practices have vastly improved. Gang activity and theft among students in now negligible as a result of our standard dress policy. Staff morale is better. I feel we have been successful because we improved the quality of all aspects of the facility and program. It was anticipated by the Commissioner of Youth/Adult Services it would take five years to turn the Youth Center into a good training school. I am at the beginning of my fifth year and believe we are on target. As a result of an American Correctional Association's assessment last August, they stated, "The program and operation of the Youth Center is equal to, if not better than, similarly operated facilities across the nation. The strength of the Youth Center's present operation lies in its evolution not its revolution." We are presently seeking accreditation by the American Correctional Association. I hope to accomplish that goal in March, 1994. This goal was not achievable a few years ago but now the Youth Center at Topeka has the ability to make it happen.

Thank you!

Harold Allen, Superintendent
Youth Center at Topeka
Department of Social and
Rehabilitation Services

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