Approved: 1-30-96

Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY

The meeting was called to order by Chairperson Tim Emert at 10:00 a.m. on January 18, 1996 in Room 514-S of the Capitol.

All members were present except: Senator Feleciano (excused)

Senator Moran (excused)

Committee staff present: Michael Heim, Legislative Research Department

Jerry Donaldson, Legislative Research Department

Gordon Self, Revisor of Statutes Janice Brasher, Committee Secretary

Conferees appearing before the committee:

Mr. Ron Smith, Kansas Bar Association Mr. Randy Hearrell, Judicial Council

Judge Sam Bruner

Mr. John House, Attorney, SRS

Others attending: See attached list

The Chair called the meeting to order at 10:10 a.m.

Bill Introductions:

Mr. Ron Smith, Kansas Bar Association requested that two bills be introduced. The first proposed bill deals with the division of "good will" for professionals in divorce property settlements. The conferee stated that this would reverse the decision in the case *Powell v Powell*. (Attachment 1)

The second bill requested by the conferee came from the KBA Alternative Dispute Resolution Section with the help of the Judicial Council. The conferee explained that this bill would insure that the mediation process is protected by statute against compulsory process so that mediators are not forced to divulge information learned in the mediation process in litigation in another forum.(Attachment 1)

Motion was made by Senator Martin, second by Senator Reynolds to introduce as committee bills both of Mr. Smith's requests. The motion carried.

SB 469--Related to the care and treatment of the mentally ill

The Chair introduced Mr. Randy Hearrell who explained that the Care and Treatment Committee of the Judicial Council was given the charge to review the care and treatment act for mentally ill persons. The objectives were to reorganize the act, make it easier to understand, make recommendations for revisions necessary as a result of mental health reform, K.S.A. 39-1601 et seq. in 1990. The Committee suggested some substantive amendments to the act as a result of this review. The conferee referred to a list of members on the Care and Treatment Committee. (Attachment 2)

Mr. Hearrell introduced the participants in the panel presentation of <u>SB 469</u> as Judge Sam Bruner, Chair of the Care and Treatment Committee assigned to review the care and treatment act for mentally ill persons, and Mr. John House, Attorney with the SRS who served on the Committee. Judge Bruner referred to the written material containing the full general comments by the Standing Advisory Committee to the Judicial Council for care and treatment law proposed and prepared for this bill. (Attachment 3)

Judge Bruner explained that the most recent major revision of the current treatment and mental illness law occurred in 1990 with the mental health reform bill. The conferee stated that **SB** 469 is the next effort to review mental health reform legislation passed in 1990. The conferee stated that the proposals in **SB** 469 having been exposed to public hearings conducted by the Care and Treatment Committee held at the Judicial

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY, Room 514-S Statehouse, at 10:00 a.m. on January 18, 1996.

Council level. The conferee stated that the Committee met with the Kansas Advocacy and Protective Services representatives for about a day and some of that group's recommendations were included. The conferee stated that eighty or ninety copies of the draft were distributed to clinicians around the state. The conferee stated that the proposed legislation is to completely replace the current code, rather than to make individual amendments to the current act.

Mr. John House, Judicial Council, SRS explained that while most of the changes **SB** 469 makes to current code, Article 29 of K.S.A. Chapter 59 are technical changes, there are however, several substantive changes.

Judge Bruner discussed the eleven substantive changes as listed on the written material. The conferee stated this bill would amend in Section 2 the current definition of "mental illness" by making a distinction between a "mentally ill person" and a "mentally ill person subject to involuntary commitment for care and treatment." Another change would make certain that the person seeking voluntary admission has the capacity to do so by requiring that the head of a treatment facility makes that determination.

The third change made by this bill would allow a guardian who has obtained prior authority to admit his or her ward to a psychiatric treatment facility as a "voluntary" patient without having to obtain an additional court hearing subject to the discretion of the head of the facility. The conferee stated that this was a significant change and was discussed with Advocacy and Protection Services members. The conferee stated that this provision would be beneficial for persons who have cyclical mental illness.

Mr. House commented that guardians would be the substitute decision maker in these cases.

In response to the Chair's question, Judge Bruner stated that currently there is no problem with an individual obtaining routine mental treatment, but an individual can not be admitted to a psychiatric treatment facility without an additional court hearing.

Judge Bruner stated that the recommendation in the bill would give law enforcement officers the authority to take a person suspected of being a mentally ill person into custody upon "reasonable belief" after investigation rather than requiring "personal observation." The conferee stated that observation as a criteria was difficult to adhere to since the law enforcement officers are most likely summoned after the crisis/incident's occurrence. This provision would allow them to collect information from people at the site. This recommended change was brought to the Advisory Committee's attention by law enforcement officers. This provision would also allow the law enforcement officers to return the individual to the place where they were taken into custody and/or another appropriate place if the medical professional determines they are not eligible to be taken to a treatment facility. The conferee stated that this provision protects the law enforcement officer from civil liability during the transportation of that individual.

Judge Bruner stated that under this bill the provision allowing a court ordered investigation into the "character" of the proposed patient was deleted. The conferee explained that general experience was that this statute was not being used. The conferee discussed the next item of change concerning the authorization of a continuance of trial in order that a jury may be assembled in cases where a patient requests a jury trial. Mr. House commented that a jury trial could not be accommodated in the time allowed under current law due to a conflict with jury law.

Judge Bruner explained other substantive changes contained in this legislation as listed:

- Making mandatory a due process hearing upon the revocation of a previously issued order for outpatient treatment which require that the patient be moved to inpatient status.
- Placing a limitation on the court's authority to transfer the venue of a trial from the county in which involuntary commitment proceedings began.
- Deleting from statute the provision for "conditional release" from treatment.
- Requiring the sheriff of the county in which a treatment facility is located to be notified of an involuntary patients's unauthorized absence from a facility.
- Requiring that patients placed in restraint or seclusion be checked every 15 minutes, as opposed to once per hour under current law.

Mr. John House offered some general comments stating that the Advisory Committee was very careful to put parallel provision in this legislation that allow for the option of outpatient treatment. The conferee stated that

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY, Room 514-S Statehouse, at 10:00 a.m. on January 18, 1996.

much time was spent trying to make the language simple and understandable.

Judge Bruner commented that the use of outpatient alternatives have been very encouraging, and that he would like to see them used in drug and alcohol treatment cases statutorily.

Discussion followed concerning the proposed amendments contained in **SB** 469.

In response to Senator Vancrum question, Mr. House stated that Kansas is rather unique in that a specific element, "lack of capacity to make an informed decision concerning treatment" is required for involuntary commitment.

Judge Bruner referred to lines 30, 31, and 32 and stated that there is a change in the statute that was not highlighted. The conferee stated that certain mental conditions have been added that can not be used for involuntary commitments. The conferee continued by stating that **SB** 469 is an expansion over current Kansas law to prohibit involuntary commitment for the treatment of mental illness, for instances with regard to mentally retarded individuals, or with regard to alzheimer victims, etc. The conferee noted that the language immediately preceding that change in the statute, line 29, states, "whose diagnoses is not solely one of the following." Judge Bruner related that duel diagnoses frequently occur. The conferee concluded by stating that this section is an expansion of current law.

The Chair stated that since there was another conferee who has requested some amendments and wished to express comments, there will be another hearing scheduled for <u>SB 469</u>.

The Chair called to the attention of Committee members written testimony of Wendy McFarland, ACLU expressing opposition to <u>HB 2310</u> which was heard on January 17, 1996.

The Chair adjourned the meeting.

The next meeting is scheduled for January 23, 1996.

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: 1-18-96

	NAME	REPRESENTING	
	Radym, Heavell	Judicial Council	
	Kerth R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PABLICATION FOR KANSAS	
	JOHN LOUSE	Indie Donnif / SRS	7
	Shery Dies	Kanas Advocacys) Protectures	Nicos
	Church Hernand	MH-5R5	
	Deather Gray	Jen-Larris office	
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	JAM LBRUNER	JUDICIAL GOUNSEL	
	Sin Clark	KCDAA	,
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Memorandum

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Debra Prideaux, Communications Director

> Ron Smith General Counsel

Art Thompson, IOLTA Director TO:

Hon. Tim Emert, Chair,

Members, Senate Judiciary Committee

FROM:

Ron Smith, General Counsel

SUBJ:

1. Division of Good Will in Professional Divorce Actions

2. Confidentiality Of Mediation Processes

DATE:

January 18, 1996

On behalf of the KBA we would like introduction of two bills for later hearings.

Legislation to allow division of the good will of a professional practice is requested by the KBA Family Law Section. A proposed amendment to KSA 23-201(b) is attached that accomplishes this recommendation. The amendment reverses the decision in *Powell v. Powell*, 231 Kan. 456, 648 P.2d 218 (1982). Kansas has a minority position on this topic that the Family Law Section would like to discuss with you for public policy purposes.

The second request comes from the KBA Alternative Dispute Resolution Section with the help and interest of the Office of Judicial Administration. We would like to insure that the mediation and conciliation process is protected by statute against compulsory process so that mediators are not forced to divulge information learned in the mediation process in litigation in another forum. There is need to insure that there are certain exceptions to this blanket immunity from compelled process, such as reporting of future crimes or past crimes, or child abuse, that sort of thing. Those matters can be reviewed when the bill is discussed. Our ADR Section will provide testimony at that time.

We would ask for these two bill introductions. Thank you.

enc/ Goodwill confidentiality

Senate Judies
1-18-96
Attach #1

Amended as follows:

23.201. Married persons; separate property; marital property. (a) The property, real and personal, which any person in this state may own at the time of the person's marriage, and the rents, issues, profits or proceeds thereof, and any real, personal or mixed property which shall come to a person by descent, devise or bequest, and the rents, issues, profits or proceeds thereof, or by gift from any person except the person's spouse, shall remain the person's sole and separate property, notwithstanding the marriage, and not be subject to the disposal of the person's spouse or liable for the spouse's debts.

(b) All property owned by married persons, including the present value of any vested or unvested military retirement pay, or professional goodwill to the extent that it is marketable for that particular professional, whether described in subsection (a) or acquired by either spouse after marriage, and whether held individually or by the spouses in some form of co-ownership, such as joint tenancy or tenancy in common, shall become marital property at the time of commencement by one spouse against the other of an action in which a final decree is entered for divorce, separate maintenance, or annulment. Each spouse has a common ownership in marital property which vests at the time of commencement of such action, the extent of the vested interest to be determined and finalized by the court, pursuant to K.S.A. 60-1610 and amendments thereto.

#3

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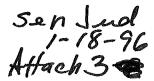
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GENERAL COMMENT TO THE REVISED ACT

The Care and Treatment Advisory Committee of the Judicial Council was given the charge to review the care and treatment act for mentally ill persons (Article 29 of K.S.A. Chapter 59). The objectives were to: (1) reorganize the act in a more logical order, making it easier to understand and use; (2) make recommendations for revisions necessary as a result of the implementation of mental health reform brought on by the passage of K.S.A. 39-1601 et seq. in 1990; and (3) suggest such substantive amendments to the act as the committee deemed advisable. The members of the committee contributed many hours to this project. The committee met 16 times and carefully reviewed, considered and re-considered each section of the act. The result of the committee's work is the following proposed draft.

The proposal is to completely replace the current code with this revision rather than to attempt to make all the individual amendments to the current act which would be required to achieve this same result. This proposed draft does not significantly deport from the main themes of the current law, and many parts of a majority of the sections of this draft are verbatim or nearly verbatim copied from the current law; however, every section of the current act would have to be amended in, at least, some fashion in order to come to this same result. Many sections of the current act have been moved within the order of the act to follow in sequence of how mental illness cases actually proceed through the court system. Other sections were broken up into two or more separate sections in order to group related matters into their own sections. Because of all these changes from the current format, the committee, upon recommendation from the revisor of statutes, has proposed to simply substitute this new "clean" draft for the current code. It is hoped this will avoid confusion, both in considering the proposal, and, if enacted,



in assisting persons who must use the law to be able to follow all of the changed language.

Most of the amendments this draft makes to the current code are technical in nature. They are intended to clarify the existing act's meaning and intent, or to expand the current act's procedures to also apply to outpatient as well as inpatient proceedings. The committee has proposed a few substantive changes which the committee believes strengthen the act in ways beneficial to patients. Specific comments explaining the committee's intent follow each section and call attention to the changes made from the current act.

Among the changes that have been made within this proposal are that cross references have been included so related sections can be easily reviewed when using a particular section. The committee has attempted to eliminate the "legalese" and relabeled the pleadings to use more commonly understood terms. The sections that require computation of time have also been clarified.

Due to the completion of the phased implementation of mental health reform, several repeated technical changes were necessary. For example, the phrase "... if there are one or more participating mental health centers located in the catchment area ..." has been deleted because every county is now within the service area of a participating mental health center. The required screenings and statements mandated in phase by the reform act are now universally required. The language restricting admissions to a state psychiatric hospital that reads "... unless a written statement from a qualified mental health professional authorizing ... has been filed with the court" has been standardized wherever possible.

The committee placed great emphasis on making the act consistent with the intent of mental health reform, which emphasizes community-based care and outpatient oriented treatment whenever feasible. The committee is convinced that as resources are diverted to community treatment providers rather than to state hospitals, courts will more often be presented with cases in which a person with a known history of mental illness will be brought before the court in circumstances in which an outpatient treatment order is appropriate. Specific language has been added to guide proceedings through circumstances in which a patient is treated as an outpatient, subject to court orders, where previously the patient would have been admitted to a state hospital.

Finally, several substantive changes to the act are recommended by the committee:

- 1. Amendment of the current definition of "mental illness" with a distinction made between a "mentally ill person" and a "mentally ill person subject to involuntary commitment for care and treatment" (59-2902a); See 2 1 Bill
- 2. The requirement that the head of a treatment facility make a determination that a person seeking voluntary admission has the capacity to do so (59-2905); See (5)
- 3. Allowance for a guardian who has obtained prior authority to admit his or her ward as a "voluntary" patient to a psychiatric treatment facility and to do so without an additional court hearing, subject to the authority of the head of the treatment facility to divert that patient to another less restrictive treatment, if appropriate (59-2905);
- 4. Authority of law enforcement officers to take a person suspected of being a mentally ill person into custody upon "reasonable belief" after investigation, rather than requiring personal observation. Language was also added to allow law enforcement officers to return the person to the place where they were taken into custody or to some other appropriate place if the medical professionals determine it not appropriate to detain the person further at a treatment facility (59-2908);
- 5. The deletion of the provision allowing a court to order an investigation into the "character" of a proposed patient (59-2914);

(iii)

1	6.	Provisions are added to allow for continuance of the trial in order		
2 3 4		that a jury may be assembled when the patient requests a jury trial (59-2914, 59-2916, 59-2916b and 59-2917);		
5 6 7 8 9	7.	A provision is added for a mandatory due process hearing upon the revocation of a previously issued order for outpatient treatment which requires that the patient be moved to inpatient status (59-2918a);		
10 11 12 13	8.	A limitation is placed upon the court's authority to transfer venue from the county in which involuntary commitment proceedings began (59-2922);		
14 15 16	9.	The deletion of the provision for "conditional release" from treatment (59-2924);		
17 18 19 20	10.	A provision is added for the sheriff of the county in which a treatment facility is located to be notified of an involuntary patient's unauthorized absence from a facility (59-2926); and		
21 22 23 24	11.	Amended the requirement that patients placed in restraint or seclusion must be checked every 15 minutes, as opposed to once per hour (59-2928).		
25 26	The c	committee's rationale for each of these proposed changes is explained in the		
27	comment following that section.			

ARTICLE 29 - CARE AND TREATMENT FOR MENTALLY ILL PERSONS

New Sec. 1. (previously 59-2901)

3 COMMENT

The inclusionary references to 59-2943 and 59-2944 have been deleted since those sections as separate sections are eliminated and have been incorporated into the main body of the act. The title of the act is amended to include the term "care and treatment", which the committee finds is commonly used by persons referring to this act. This, however, should not be interpreted to mean that any less emphasis is intended upon the "treatment" purpose of commitment under the act.

New Sec. 2. (previously 59-2902)

2 COMMENT

The definitions section is rewritten to alphabetize definitions to aid the reader in finding specific definitions. Definitions of terms or phrases used within a definition are "stacked" following that term to facilitate quick and easy reference.

Definitions containing substantive changes are:

- (1) "Conditional release", found currently at 59-2902(a) is deleted since provisions for conditional release were deleted from the act. See the comment to section 28;
- (2) "Mentally ill person", found currently at 59-2902(h) is rewritten and is separate from the new term "mentally ill person subject to involuntary commitment for care and treatment." The changes require that there are certain mentally ill persons who should not be subject to involuntary proceedings to restrict their liberty;
- (3) "Mentally ill person subject to involuntary commitment for care and treatment" has been added. The intent is to separate the criteria that must be met before a person who is suffering from a mental illness may be involuntarily forced to accept treatment. In the current definition of "severe mental disorder", found at 59-2902(o), conditions caused by the use of chemical substances and antisocial personality are excluded from the legal definition. The committee expanded upon that list by naming disorders which are generally professionally recognized as unresponsive to psychiatric treatment. The "lacks capacity to make an informed decision concerning treatment" element is basically unchanged from current law, found at 59-2902(e). The "likely to cause harm to self or others" element is essentially the same as currently found at 59-2902(g) with the addition of the balancing of interests test set out by Suzuki v. Yuen, 617 F.2d 173 (9th Cir.) (1980). The committee believes that inclusion of the test in the

act is required under due process;

- (4) "Qualified mental health professional" is clarified to refer to professionals employed by or under contract with a participating mental health center. Current language does not make this restriction clear. Also clarified is the provision that professionals of less than an M.D., D.O. or Ph.D. psychologist, who are functioning as a qualified mental health professional ("QMHP"), are supervised in this function by an M.D., D.O. or Ph.D. psychologist employed by or under contract to a participating mental health center. The committee notes that some participating mental health centers may contract with a psychiatrist only for medical consultations;
- (5) "Restraints" and "seclusion", currently found at 59-2902(m) and (n) respectively, are deleted from this section and moved to the section concerning that subject matter (section 33) for ease in reference; and
- (6) The statutory definitions of the various state hospitals' catchment areas, currently found at 59-2902(bb), (cc), (dd) and generically at (ee), are deleted. These definitions were added to the act at the time mental health reform was enacted and were necessitated because of the phased-in manner of reform. Since that process has now been accomplished, these references and the phrases associated with phased reform appearing throughout the act have been deleted as no longer necessary. The committee is also aware that the catchment areas for each hospital may need to change over time as populations and resources shift and the committee believes that the ability to make these changes should be left to the secretary of social and rehabilitation services.

1	New	Sec.	3.
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3 COMMENT

This new section is added because the committee became aware of inconsistent interpretations of statutory time periods as calculated under the existing act. This section is intended to make such calculations consistent with K.S.A. 60-206 in the Kansas code of civil procedure.

New Sec. 4. (previously 59-2903, 59-2930, 59-2933 and 59-2938)

3 COMMENT

The committee understands that the last three of those sections, which are presently located at the end of the act, in conjunction are intended to provide that mentally ill persons do not automatically, by that fact alone, lose their civil rights. K.S.A. 59-2903 simply provides that persons held in custody at a treatment facility under authority of the act can legally be detained from their liberty.

The section is rewritten to clarify the general retention by patients of their civil rights and places that section near the beginning of the act as a policy statement, rather than leaving them at the end of the act which might make them seem as only an afterthought. The section is divided into two subsections: (a) the general statement of retained rights (taken from existing sections 59-2930, 2933 and 2938), but which provides that those persons held in custody under provisions of the act shall be subject in the exercise of their civil rights by the reasonable rules imposed by the treatment facility to maintain orderly operation (taken from existing section 59-2930); and (b) which provides that there is no implication or presumption that a patient under this act is a disabled person within the meaning of the guardianship and conservatorship act (taken from existing section 59-2933).

New Sec. 5. (previously 59-2905)

3 COMMENT

This section is rewritten to clarify the different circumstances under which a person may be admitted to a treatment facility as a voluntary patient. In addition, language is added in subsection (a) and as a part of new subsection (d) which requires the head of a treatment facility to determine that a person seeking voluntary admission as a patient has the capacity to make that decision. The committee notes that since lack of capacity to make decisions concerning the need for treatment is a specific element of our law with regard to commitment, the retention of such capacity must necessarily be an element of consenting to voluntary treatment. While the committee does not intend to discourage conversion of involuntary proceedings to voluntary care where the patient truly makes that decision, and hence adds subsection (d) to emphasize that point, the committee feels compelled to make provision for specific consideration of this element, particularly once it has been raised by the institution of involuntary proceedings.

A substantive change is intended in subsection (b), paragraph (3) concerning admissions made by a legal guardian. Current law requires that before a guardian may authorize the admission of his or her ward to a treatment facility, he or she must obtain specific additional authority from the court which has jurisdiction over the guardianship. This requirement is satisfied by holding what amounts to a mental illness trial within the guardianship case each time the ward needs to be admitted. While this procedure is undoubtedly intended to protect wards from being improperly confined to a mental hospital upon the signature of their guardian alone, the committee believes that harm is adequately guarded against by the responsibility of the head of the treatment facility to discharge a patient when maximum benefit has been obtained (see

section 6), and by the right of any patient to file for a writ of habeas corpus (see section 4). The committee also notes the pre-admission mental health center screening requirements which are required before admission to a state hospital and also notes the existence of the protection and advocacy agency, one of whose purposes is to guard against violations of patients' rights (see K.S.A. 74-5515 and P.L. 99-319, and amendments thereto. [42 U.S.C. 10801 et seq.]) With all these safeguards in place, the committee believes the current provisions act as more of a hinderance than a help. The concept behind guardianship is to provide for a substitute decision-maker who is able to quickly act in the best interests of his or her ward. It is in the context of chronically mentally ill persons, whose pattern is that at some point they stop taking their medications, begin to deteriorate, and eventually fall to a level of illness requiring hospitalization, commitment to a hospital and all the legal proceedings attendant thereto, reestablishment of the taking of their medication, followed by rapid progress and re-stabilization allowing the patient to be released, that the committee believes the current legal process that requires a full trial cycle to be repeated each time deterioration sets in before assistance can be provided to be both inefficient and arguably hurtful to the patient, the patient's family and his or her community. The committee intends that a legal guardian should be able to show to the court with jurisdiction over the guardianship that this has been and is likely to be the future pattern the ward will follow, based upon both past experience and medical testimony, obtain continuing authority noted on their Letters of Guardianship to allow the guardian to admit the ward to a treatment facility without the necessity of repeated legal proceedings. The committee also notes that the guardian would always have the option of filing a petition within the guardianship case and having a judicial determination of the need for admission made, and would also construe the provisions of K.S.A. 59-3018a to require the periodic review required

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1 by section 25.

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Here, and throughout the act, the term "in loco parentis" is deleted and substituted by
the phrase "other person known to the head of the treatment facility to be interested in the care
and welfare of a minor patient." The committee believes this will clarify the meaning. The term
"legal guardian" has also been substituted throughout the act to clarify the intent to refer to
court-appointed guardians.

1	New Sec. 6. (previously 59-2906)
2	
3	COMMENT
4	The phrase "reached maximum benefit" is substituted for the existing phrase "no longer
5	advisable" because it is regularly used by clinical professionals.

New Sec. 7. (previously 59-2907)

3 COMMENT

This section is deleted in its entirety and rewritten. The content of subsection (a) remains the same. Current subsection (b) has been rewritten as new section 8. See the comment to that section.

Subsection (a) retains the option for a treatment facility to hold a voluntary patient, who has requested to be discharged, up to 3 working days to allow for consideration of whether or not to pursue involuntary commitment. The provision for input from a participating mental health center to a state psychiatric hospital's decision-making process has been enhanced by the requirement that oral or facsimile notice must immediately be given to that center so that more time is allowed for the center to make a recommendation.

Subsection (b) addresses the circumstances in which a "voluntary" patient is admitted upon the signature of some other person and the unique case of a 14- to 18-year-old minor acting on his or her own behalf. It is the intent of the committee that the person who signed the application for admission be the same person who makes the request for discharge.

New Sec. 8.

2 COMMENT

This new section is a rewrite of current subsection (b) of 59-2907. See the comment to section 7. Added is a provision which makes clear that the QMHP statement normally required whenever admission to a state psychiatric hospital is sought is not required in this instance. The committee's reasoning is that previously a QMHP statement would have had to have been obtained for a voluntary admission and because the commitment action is being sought by staff from the state hospital where the patient already is located pursuant to that QMHP statement, another statement is unnecessary. Furthermore, section 7 mandates the hospital to contact the participating mental health center and consider its recommendations if the patient requests discharge.

In what the committee expects will be a very rare case, when a participating center recommends discharge but the professional staff at the hospital believes so strongly that the patient should remain hospitalized that they wish to proceed in spite of the center's recommendation, the committee believes that the hospital's liability would not be relieved by the center's refusal to provide a statement. Accordingly, provision must be made for hospital staff to proceed without such a statement.

Similarly, in a case where a voluntary patient is not requesting discharge, but is refusing treatment, the committee believes the hospital's professional staff must be allowed to proceed. Because the center would previously have had to have provided a QMHP statement in order for the patient to have been admitted, the committee presumes the center intended for the patient to be provided treatment at that hospital and not just a place to stay. Requiring a second statement would therefore be duplicative.

New Sec. 9. (previously 59-2908)

COMMENT

This section is updated to reflect the changes of mental health reform. See the general comment. Minor changes are made for clarification. Three substantive changes are made:

- (1) The term "observation" is replaced with the term "investigation." The committee believes this is a more accurate description of what actually occurs in most cases. Law enforcement officers seldom actually have the opportunity to observe a person over an extended period of time so as to be able to say that what they personally saw causes them to believe someone is mentally ill. Rather, in the usual case the law enforcement officers are called to a scene, provided information by relatives, friends, members of the community, or professionals, and then draw their conclusions from a combination of their own observation and from these reports. However, the committee has heard stories of law enforcement officers believing their hands were tied under the present law because of a lack of personal observation and this fact leading to the necessity for repeated call-backs before action could be taken. The committee intends to authorize law enforcement officers to take action upon probable cause rather than requiring strict personal observation;
- (2) In the case of a person having been taken into custody by a law enforcement officer and transported to a treatment facility for the physician's or psychologist's examination, and then found not likely to be a "mentally ill person subject to involuntary commitment for care and treatment," provision has been made to allow the law enforcement officer to return the person to where they were originally picked up or to another appropriate place. The committee has heard of persons taken into custody, transported many miles in the middle of the night, and then

officers being put in the position, because they believed that the law does not authorize them to transport the person back to where they were picked up, of having to abandon these persons in a hospital emergency room or clinic without resources of their own to get back home. In those instances the committee understands the officers did go ahead and transport the person back to his or her home, but that they were concerned about their liability during that drive back across town or across several counties. This amendment is intended to protect the officer in that circumstance, and allows the officer the option to release the person in some other appropriate place if it would not be in the person's or some other person's best interests to have that person returned to their home, for example, in a domestic disturbance case; and

(3) In subsection (b), the burden to provide a place of detention until the law enforcement officer can make other arrangements is placed on the treatment facility which has determined the person in custody likely to be a "mentally ill person subject to involuntary commitment for care and treatment" but which declines to accept the person as a patient. The committee notes that treatment facilities are far more likely to have resources to detain such patients than are law enforcement officers in these circumstances, and that the period of time involved will be very short. The committee also understands the scenario addressed will occur only rarely. Generally, the place law enforcement officers will take a person will be the locally designated community hospital emergency room, and arrangements to cover just these types of cases will have been made in advance by and between the mental health centers, the local hospitals and the local law enforcement agencies. In those few cases where that is not the case the committee notes that section 37 provides for the assessment of the expenses of a treatment facility as costs. Accordingly, the committee believes the burden this change places upon the treatment facility is not undue.

New Sec. 10. (previously 59-2909)

COMMENT

This section is updated to reflect the changes of mental health reform. See the general comments. Minor changes are made for clarification. Four significant amendments are made:

- (1) In subsection (a) the term "order of protective custody" is stricken and replaced with the new term "ex parte emergency custody order." See the comments to sections 13, 14 and 15 for the reasons for this change;
- (2) The word "presented" has been added in the first lines of subsections (b) and (c), to make clear that a treatment facility may admit and detain only persons who are physically at the facility. The language currently found in subsection (d) [moved by the committee to subsection (c) and renumbered as (7)] which authorizes the head of a treatment facility to issue what could be termed a "citizens arrest warrant" is deleted. The committee understands this authority has rarely if every been used. The committee believes that such authority is not desirable. Law enforcement officers already have the authority under section 9, as amended, to take persons in the community into custody, after investigation, and so no need exists for this type of non-judicial order to be issued in order to get someone into protective custody. The committee has also heard that law enforcement officers are extremely wary of what their liability might be in executing such an order. Accordingly, the committee restricts the circumstances under which a treatment facility may detain someone to the situations of a court order having been issued or the proposed patient being presented at the facility and the person who brought the person to the facility being willing to sign that he or she will file the commitment petition the "next" day;
 - (3) In addition to the information already required by current law to be contained in the

application for an emergency admission, anything known about pending criminal charges is added. The requirement is added here in order to capture that information before it becomes "lost in the shuffle" and as an additional piece of information that may be helpful to the staff of the treatment facility which has just admitted this person in understanding what they are dealing with. This information has also been added to the required contents of the commitment petition (see section 13); and

(4) In subparagraph (c)(7), a QMHP has been added as a person who may sign the statement confirming that the person is likely to be a "mentally ill person subject to involuntary commitment for care and treatment". The committee notes that mental health reform was enacted to encourage people to seek assistance from their local mental health center. If they go there, they will likely be seen by a QMHP and screened. In the scenario presented by this subparagraph, if they have done so, they will have been diverted from a state psychiatric hospital to the private facility at which they now are present. The screening will have performed the function sought by the required statement and the committee intends not to require persons who have gone to a mental health center to be required to obtain a duplicate statement from some other physician or psychologist.

New Sec. 11. (previously 59-9210)

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3 COMMENT

This section as presently written is deleted in its entirety and rewritten. Subsection (a) is organized to clearly delineate the three things the treatment facility must immediately do upon an emergency admission to protect the rights of the patient. These three things come from the existing section. Provision for the patient's right to contact their personal physician, psychologist or minister of religion is not specifically cited, but is intended by the committee to be included in the reference to the rights provided for in section 34.

Subsection (b) is added to define who is included in the term "immediate family."

New Sec. 12. (previously 59-2911)

3 COMMENT

Only minor changes are made for clarification. The term "order of protective custody" is stricken and replaced with the new term "ex parte emergency custody order." See the comments to sections 13, 14b and 15c for the reasons for this change. The phrase "of the county where the person is present" is deleted to avoid confusion when the court in which the petition is filed is not in the county where the treatment facility is located, but is in the county of the patient's residence, and to encourage thinking not in terms of such venue change, but in terms of filing in the patient's home community. The committee believes this to be consistent with mental health reform.

New Sec. 13. (previously 59-2912 and 59-2913)

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COMMENT

The existing sections' language calling the pleading filed an "application" and the person filing the pleading the "applicant" is changed to the commonly used and understood terms "petition" and "petitioner".

Subsection (a) specifies the contents of a petition to determine whether or not someone is a "mentally ill person subject to involuntary commitment" as that phrase is used throughout the act. The section includes all the current requirements, some of which are rephrased and expanded to make the intent clearer. Added to those requirements, and specifically enumerated to make clearer that they are also required to be attached to the petition, are subparagraphs (8), (9) and (10). Subparagraph (8) is drawn from the unnumbered second paragraph of current section 59-2913. Subparagraph (9) is intended as a reminder and drawn from other provisions in the act regarding the attachment of a statement authorizing admission to a state psychiatric hospital from a qualified mental health professional if that is the proposed place of hospitalization. Subparagraph (10) is new, but drawn from sections 7 and 8 and is intended to make clearer to the court the exact circumstances under which the petition is filed in the case in which a voluntary patient is being proposed to be changed to involuntary status.

Subsection (b) specifies the additional information required if an ex parte emergency custody order is sought. The material is placed in its own subsection to make it easier to understand that the request is optional and distinct from the main function of the petition, which is solely to request a trial upon the merits of the claim that the person is a "mentally ill person subject to involuntary commitment for care and treatment." It is intended by the committee that this additional request and the required additional information may be combined into a single pleading. The material may also be placed in a separate pleading should the petitioner deem that more desirable.

Subsection (c) is added to clarify that the petitioner may also request a temporary custody order to provide for the holding of the proposed patient at a treatment facility until the trial of the case. It, too, is placed in its own subsection to make it clear that this request is optional and distinct from both the main function of the petition and any request for an ex parte emergency custody order.

It is expected that currently in most cases all three requests (the petition for a trial, the request for an ex parte emergency custody order, and a request for a temporary custody order—which can only be issued after a probable cause hearing has been held) will be made at the time of the filing of the case. However, through the provisions of sections 14b, 15c and 16b, it is intended to be clear that custody orders do not have to be sought in every case, and should not be sought if not appropriate, but if not sought at the time the petition is filed, may be sought later should a change of circumstances warrant.

New Sec. 14. (previously 59-2912)

3 COMMENT

This section, along with section 15, is a rewrite of existing section 59-2912 which has been deleted. In the existing section 59-2912, the term "protective custody order" (and provisions with regard thereto) is used in two separate contexts. Those contexts are more accurately described by the commonly used terms "ex parte emergency custody order" and "temporary custody order", and the rewrite uses these commonly understood terms. The two different contexts have been separately addressed by sections 14b and 15.

This section concerns ex parte emergency custody orders. Consistent with current law, this section provides for the court-ordered detention of persons alleged to be mentally ill subject to involuntary commitment for "two" days, subject to the same provisions set out in current section 59-2912, to allow for a probable cause hearing to be scheduled, noticed and held.

New	Sec	15.
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3 COMMENT

This is a new section and companion to new section 14. See the comment to section 14. This section concerns temporary custody orders. Consistent with current law, this section provides for the court-ordered detention of persons alleged to be mentally ill subject to involuntary commitment between, and after, the probable cause hearing and the trial of the case, subject to the same provisions concerning the probable cause hearing and detention set out in current section 59-2912.

Subsection (d) clarifies the options the court has following the probable cause hearing depending upon the evidence presented and the facts determined.

The committee expects that in a typical case there will be an immediate progression from investigation and emergency detention by law enforcement as provided for in sections 9 and 10, to filing of the petition provided for in section 13 (accompanied by a request for an ex parte emergency custody order and a request for a temporary custody order) the issuance of an ex parte emergency custody order valid for "two" days as provided for in section 14, and the holding of a probable cause hearing, followed by the issuance of a temporary custody order as provided for in section 15; however, the sections are worded to provide for and allow other scenarios as may occur.

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COMMENT

This section is amended for clarity. Subsection (a) lists the preliminary orders and arrangements that must be made upon the filing of a petition to determine whether or not someone is a "mentally ill person subject to involuntary commitment for care and treatment". In current subparagraph (a)(1), the language with regard to continuances necessary because of the absence of the proposed patient is moved to subsection (b), which relates to continuances. Provision is added to allow for the extension of the time within which the trial must be held when a demand has been made for a jury trial. Since the time frame in these cases is so short to begin with, for the benefit of the patient, a request for a jury trial in most instances makes it impossible to stay within that time frame. Rather than extending the time frame for all cases, since jury requests are rare, the committee elected to extend out the time frame only in this circumstance. However, wanting to keep that extension as short as possible, the committee later added a provision in section 21 allowing the clerk to expedite the assembly of a jury panel by negating the requirement otherwise applicable that prospective jurors be given 20 days notice of the date they are to appear at the courthouse. This allowed the committee to provide that the trial must proceed within, at most, 30 days after the date the patient requests a jury trial. (See also the comment to section 21.) In current subparagraph (a)(2), the language with regard to the court recording why a proposed patient's presence is excused is deleted because it appears in, and the committee believes should more properly be found in, the sections setting out hearing procedures. See sections 15(c), 21(b), 23(g) and 25(e).

A substantive change is made by deleting entirely the language currently found in

subparagraph (a)(6) providing for a court-ordered investigation and report concerning a proposed patient's character, family relationships and past conduct. No member of the committee could recall that this provision has ever been used. It seems unnecessary since section 17 provides for a mental evaluation, which is the real issue before the court, and K.S.A. 59-3011, in the guardianship act, provides for this character, family relationships and past conduct investigation if that seems relevant to an issue in a guardianship proceeding. Since subparagraph (a)(7) allows for a mental illness petition and guardianship petition to be combined and heard at once, no need for an independent character investigation could be determined by the committee.

New Sec. 17. (previously 59-2914a)

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3 COMMENT

This section is amended for clarity. The language in current subsection (b) pertaining to the holding of a probable cause hearing in the circumstance of a proposed patient being at liberty (not subject to a temporary custody order) is moved to a new section, section 18, immediately following. See the comment to that new section.

New Sec. 18. (previously 59-2914a(b))

3 COMMENT

Material is moved to this new section to allow section 17 to deal with the mental evaluation itself and to reemphasize that custodial proceedings are not automatically required; and that alternative procedures are provided for and should be utilized where appropriate. The material in this new section provides for a probable cause hearing similar to the one which would otherwise have been held pursuant to section 15 had the petitioner requested that the proposed patient be held in custody pending the trial. This section allows for a proposed patient not in custody to request and have a hearing to determine whether or not sufficient evidence exists to suggest the person is a "mentally ill person subject to involuntary commitment for care and treatment" before the person is required to submit to a psychiatric evaluation.

New	Sec.	19.	(previously	59-2916)
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3 COMMENT

This section is amended for clarity. Subsection (b)(5) has been added to give the proposed patient notice that his or her trial may be delayed if he or she chooses to demand a jury trial, but that there is a limit on the length of the delay.

New Sec. 20. (previously 59-2918)

COMMENT

Material is moved to this location in the act because it more logically fits here. Though a patient's request for a continuance and order of referral could come at any time in the course of a case, it most logically and most often occurs after the probable cause hearing and before the trial. The committee relocates this section between the sections providing for the filing of the petition and the actions occurring at about that same time (sections 13, 14, 15, 16, 17, 18 and 19) and the section providing for the trial (21) for ease of reference and of locating it by persons using the act.

Three significant changes are made from the current language, though the committee does not consider them to be substantive changes to the current law:

- (1) Provision is currently made in subsection 59-2918(a) for the patient's request for a continuance and order of referral to be made in writing. Added is the requirement that this written request be acknowledged before a notary public or judge. The committee believes this added protection is desirable because of the due process rights the patient is, in effect, waiving, and as additional protection for the attorney appointed to represent the patient against a later claim by the patient that he or she had not desired to sign the request.
- (2) A new subparagraph (b) is added to clarify that an order for referral for short-term treatment waives a probable cause hearing if one has not already been held. The committee believes it makes no sense and would be a waste of time to allow a person to request and receive a continuance for short-term treatment, but then 90 days or more later come back into court and demand a hearing to determine if there is probable cause to hold them while a mental evaluation

is conducted. By this point, any mental evaluation would already have been completed and the case would have to be ready for trial.

- (3) Provision is added in subparagraph (c) that the court shall specifically set a new date and time for the hearing and trial that is being continued in order to allow for the referral, and that notice of that confirmed date and time be given to all interested parties. The committee believes this is probably already being done in most cases, but has heard that often the exact date and time were not being communicated, particularly to the treating facility, and that has led to confusion about when the facility's report is due.
- (4) Language similar to that in subsection 17(b) is added to the end of subsection (d) because the report prepared and filed by the treating facility at the end of the referral period is treated as supplemental to the mental evaluation report which likely was filed at least 90 days earlier. The committee intends the same parties who received the earlier mental evaluation should now receive the update report.

New Sec. 21. (previously 59-2917)

3 COMMENT

This section is amended for clarity. Provisions for the patient to be present at the trial, or the reasons the patient's presence has been requested to be waived and granted, currently found in subsection 59-2914(a)(2), are relocated here for ease of reference. The provisions for an order for treatment or dismissal of the case currently found in subsections (f), (g) and (h) are moved and rewritten as new section 22. See the comment to this new section.

As noted in the comment to section 16, in order for the continuance of a trial necessitated by a patient's demand for a jury trial to be held to no more than 30 days, the committee found it necessary to add a provision in paragraph (b) negating the requirement for the 20 day notice provided for in K.S.A. 43-166. The committee felt that since these trials are typically very short in duration, jurors would not be unduly burdened by receiving less than 20 days notice of their being summoned for jury duty.

New Sec. 22. (previously 59-2917(f), (g) and (h))

2 COMMENT

This section is amended for clarity and separated from what is now section 21 for ease of reference. New material appears in paragraph (b), but simply ties orders for treatment to the section providing for reviews and subsequent orders for treatment. The sentence concerning the participating mental health center being given responsibility for providing or securing treatment in paragraph (a) is significantly different from the language currently found in section 59-2917(f), but is based upon the belief by the committee that the intent of the current language is that the mental health center is to be the ultimate provider of treatment, if none other is available. This is made true because the centers, after reform, control who is and who is not authorized admission to a state psychiatric hospital (the former provider of last resort).

The current language specifies that if a QMHP denies authorization, the center the QMHP represents must accept responsibility to provide, or otherwise secure, treatment. The problem the committee finds with the current language is that no provision is made for the case of a petition being filed, the request being made for treatment at a state psychiatric hospital, but no QMHP screening ever having been performed. That leaves no center as the one responsible for the patient. While this scenario is probably unlikely to occur, it is a possibility. The new language implements the committee's understanding of the original intent to make mental health centers the "providers" of last resort. The committee understands that the identified participating mental health center may fulfill its duty by providing the necessary statement authorizing admission and treatment at a state psychiatric hospital and having the court reissue its order for treatment.

New Sec. 23. (previously 59-2918a)

3 COMMENT

This section is amended for clarity. Substantively added to the section are provisions for a mandatory due process hearing following the issuance of any ex parte emergency custody order revoking an outpatient treatment order and causing the patient to be detained. Such proceedings are required under the ruling made in G.T. v. Stone, 159 VT 607, 622 A.2d 491 (1992), and the committee finds the reasoning contained in this case equally applicable to Kansas. The intent is that such hearings should be held similar to the probable cause hearings required whenever temporary custody orders are sought. However, for those ex parte orders that only modify an existing outpatient order and allow the patient to continue on outpatient status, but with new conditions, the existing language is retained providing that if no party desires a hearing, none need be held and the ex parte order can become the final order.

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3 COMMENT

Subsection (a) of this section is updated to reflect the changes of mental health reform, which make participating mental centers the "gatekeepers" to the state psychiatric hospitals. This subsection is now made consistent with the deletion of the statutorily defined catchment areas. See the comment to section 2.

Subsections (b) and (c) are rewrites of current sections 59-2944 (a) and (b), updated and amended for clarity and moved to this section for ease of reference.

New Sec. 25. (previously 59-2919a)

2 COMMENT

This section is amended for clarity and reorganized to follow the legal flow of review of a patient's status. Three significant changes are made from the current language, though the committee does not consider them to be substantive changes from the current law:

- (1) A requirement is added in subsection (b) that the patient's attorney must file with the court a specified statement if the patient does not wish a review hearing. The committee's intent is that this statement will clarify the record.
- (2) Provision is made in subsection (d) for review hearings to be held earlier than at the end of the 90 or 180-day treatment period, if that seems appropriate, and new orders entered. The committee intends that no patient who more properly could and should be transferred to outpatient treatment should have to continue in an inpatient treatment facility, merely because the 90 or 180-day period of time has not yet run. However, it is also the intent of the committee that not more than one such review hearing could be required to be held by the demand of a patient within each 90- or 180-day period. While nothing would prohibit a court from holding more than one such review hearing within those time frames, if that is felt necessary, the committee did not intend to burden courts with the necessity to hold hearings every time the patient felt like he or she wanted one.
- (3) In new subsection (e), the burden of proof is placed upon the petitioner, the county or district attorney or treatment facility to show that the patient continues to meet the legal criteria to be held involuntarily after each review. The committee believes this is clearly the current law in view of the U.S. Supreme Court's ruling in Foucha v. Louisiana, 504 U.S. 71, 118 L.Ed 2d 437 (1992).

New	Sec.	26.	(previously	59-2920)
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3 COMMENT

This section is amended for clarity. The word "may" is substituted for "shall" in the first sentence because the committee believes the intent of the current section is not to require that a court must utilize a relative to transport a patient.

New Sec. 27. (previously 59-2922)

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3 COMMENT

This section is amended for clarity. A substantive change is made in the first paragraph placing the burden upon the court in which the petition is filed to transfer venue within 2 days after the probable cause hearing or change venue only upon the showing of good cause. The committee's intent in this 2-day rule is to insure that the patient's due process right to a speedy trial is not delayed merely because of a last minute change of venue, which could have been done earlier, but if now done on the eve of trial only makes that trial logistically impossible to hold. This change is also made because the committee understands that the intent of mental health reform is to maintain more patients in their home communities and have services provided locally. As additional resources have and continue to be made available to local mental health centers, these centers have been and are becoming more able to provide for the detention and care and treatment of patients which previously would have had to have been sent to a state psychiatric hospital. The committee is also aware that at this time many patients still have to be sent to a state psychiatric hospital and when that involves the patient being sent long distances from where the case was originally filed, transfer of venue to the district court in the county where the hospital is located makes further proceedings much more convenient for the professional staff of the hospital. Transfer of venue negates transportation of the patient back to court, but it also means family and community witnesses must travel to the site of the new venue. The committee's intent in this section is to allow for transfers of venue that make good sense, but to encourage courts to keep venue in cases where inpatient treatment may be expected to be short term and outpatient follow up to be done back in the community. The committee's further intent is that the same court which hears the trial of a case and orders treatment should normally retain venue to hear the reviews.

Four other significant changes are made which the committee does not believe are substantive changes from current law:

- (1) The last sentence currently found at the end of the first paragraph has been stricken in its entirety, because the committee believes it was primarily intended to allow changes of venue sought because of pre-trial publicity or other circumstances that would make selecting an impartial jury impossible. The committee believes the provision for change of venue for good cause shown would cover any circumstances where the patient could show that he or she would not get a fair hearing.
- (2) Provision has been added in the second paragraph for facsimile transmission of records to make sure proceedings can be held with the least amount of delay in order to protect the patient's due process rights.
- (3) The language currently found at the end of the third paragraph referring to the order for a mental evaluation is stricken because the committee believes the earlier requirement that the receiving court proceed as if the petition had originally been filed there means for the receiving court to pick up and proceed in the case from the point the transferring court left it. The committee could see no reason why only this one preliminary order should be singled out, and found no evidence that receiving courts currently feel compelled to reissue custody orders without similar language being in the law saying that such is not necessary. Therefore, the committee concluded the language was unnecessary. It is not the committee's intent that this deletion should be construed as meaning that previously issued orders for the mental evaluation now need to be reissued.

(4) Provision was added at the end of the third paragraph to require a continuance of up
to 7 days to guarantee that notice of the new location at which a hearing, which had been
previously scheduled by a transferring court, will be given to interested parties and to allow for
scheduling problems created by a venue transfer. The committee believes such continuances are
already required by due process, but adds the language for clarity.

New Sec. 28. (previously 59-2924)

3 COMMENT

This section is amended for clarity. The provisions currently found in subsections (c) and (f) concerning discharge have been deleted in their entirety and moved to section 29 for ease of reference and so that the transfer provisions, which apply only to facilities operated by the secretary of social and rehabilitation services, can be located within their own section. See also the comment to section 29.

A substantive change is the deletion of current subsections (d) and (e) in their entirety. Those subsections provide for "conditional release" of patients from inpatient care. The committee finds that these provisions are not used by the state psychiatric hospitals in the eastern area of the state where mental health reform has been in place longer, and believes that use of these provisions will shortly be phased out at Larned State Hospital since mental health reform is in place there too. The committee finds that treatment facilities are wary of their liability for patients under conditional release. The committee concludes the better way to provide for continued supervision of patients who no longer require inpatient care is through orders for outpatient treatment. Such orders are now more regularly being used in the eastern area of the state where mental health reform has given the participating mental health centers the active role in the follow-up care of patients leaving the state hospitals and intends that the concept be universally applied.

New Sec. 29. (previously 59-2924(c))

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COMMENT

Subsection (a) is a rewrite of current subsection (c) of 59-2924. Subsection (b) is current subsection (f) of 59-2924. It is has been segregated into its own section for clarity and ease of reference (see comment to section 28). The last two sentences of current 59-2924(c) have been deleted. The committee determined that this language was added to the act as an earlier attempt at mental health reform. Since the adoption of screening and diversion by the mental health centers brought about by the 1990 reform act, the review and diversion by the head of a treatment facility has become unnecessary in cases involving a state psychiatric hospital. In most instances where a patient ends up in a private treatment facility they have gotten there by the screening and diversion occurring at the mental health center. In those few instances in which a patient arrives at a private treatment facility without having been screened at a mental health center, the general statutory directive of this section requiring the head of the treatment facility to discharge any patient who no longer needs care in that kind of a facility serves essentially the same purpose. The committee also notes the context of this section (involuntary commitments) means that a probable cause hearing would have been required to have been held within approximately 48 hours of when this screening and diversion was to have occurred and that that hearing provides considerable protection against a person being detained unnecessarily. The committee, therefore, concludes the current language is unnecessary and probably confusing and has deleted it. The committee does not intend for this to be construed to mean treatment facilities, upon admission, do not have any duty to review the necessity and appropriateness of a patient's admission nor to negate their professional ethical obligation to see to it that a patient receives only treatment which is necessary.

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3 COMMENT

This section is amended for clarity. The phrase "unless there has been issued a superseding inpatient or outpatient treatment order not being discharged by this notice" has been added to prevent a misinterpretation of the word "discharge" from causing the case to be terminated prematurely. The committee intends section 29 and this section to be read together, and to continue the current concept that a patient should be released from commitment and court orders as soon as the patient is no longer in need of treatment, regardless of the fact that the last court order would legally extend the patient's commitment an additional length of time. When the patient is ready for release from treatment, the head of the last treatment facility to which the patient has been committed should do so, pursuant to section 29 and send a notice of that discharge to the court pursuant to this section, which will terminate the proceedings. This rule applies to both inpatient and outpatient treatment facilities. The committee is concerned about the use of the term "discharge." While the committee intends for this term to apply only to the final discharge and release from treatment, the committee fears the term "discharge" is so commonly used by treatment facilities to mean release from their care, even though the patient may be actually transferring to another provider, that notices of these non-terminating "discharges" will be sent to the court. This is not thought to be bad in itself because it helps to keep the record straight. However, as the committee expects more and more often patients to move from inpatient to outpatient care in succession, but recognizes that notices from the inpatient facility will likely lag behind the issuance of the outpatient order, meaning that the notice from the inpatient facility will be filed second in time to the outpatient order, the

- committee was concerned that a misinterpretation of that notice or a strictly technical reading of the section could cause termination of the case when it should not be.
- The provisions concerning notice of conditional release are deleted because of the deletion of the provisions for conditional release in section 28. See the comment to section 28.

New Sec. 31. (previously 59-2926)

3 COMMENT

This section is amended for clarity. A substantive change is made by the requirement added that the head of the treatment facility must notify the local county sheriff of an AWOL patient and request his or her return, in place of the current language which authorizes a "citizen's arrest warrant." The committee has heard that law enforcement officers are wary of their liability in executing such a "warrant." The committee believes the better solution to an AWOL patient is for the treatment facility to notify the sheriff and allow the sheriff to communicate with other law enforcement agencies, as necessary, and to utilize their existing authority to either take a dangerous person into custody or to execute the court's order for treatment. The committee also believes this requirement places an undue burden on the treatment facility to meet its obligation.

The provisions currently found in subsection (b) are deleted in their entirety. The committee believes the authority recited in this subsection is inherent in the whole of the act, provided for by the statutes which generally provide the authority of the secretary, or the secretary's designee, as head of a state treatment facility, to make rules and regulations as are contemplated in section 4, and equally applicable to other treatment facilities. The committee believes the language is unnecessary, but intends that its deletion should not be construed as any diminishment of the secretary's authority.

New Sec. 32. (previously 59-2927a)

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3 COMMENT

This section is amended and restructured for clarity. Subsection (d) is a rewrite of what is currently section 59-2916a, which is moved to this section to combine the medication provisions into one section. The committee found that having provisions concerning the administration of medications in two separate sections was inconvenient and confusing. The committee adds language to require a report be submitted to the court prior to any hearing if mind altering or participation-affecting medications have been administered within 2 days of the hearing. By not specifying any particular form that report must be in, the committee allows for that report to be submitted either in writing or orally presented immediately prior to the hearing. Current language is amended to provide that any examination concerning whether the administration of medications has due process implications should occur prior to the hearing. If the court determines adverse affect, the court may grant a reasonable continuance as it deems appropriate to resolve any medication issues and is required to order the administration of these medications discontinued until the hearing can be held, unless these medications are found necessary to sustain life or protect persons, in which case, since they cannot be discontinued, the hearing must proceed.

New Sec. 33. (previously 59-2928)

3 COMMENT

This section is amended for clarity. Provisions concerning licensed adult care homes are deleted. The committee believes they are inappropriately placed in this act and should be placed within the adult care act. The definitions currently found in subsections (m) and (n) of 59-2902 are relocated here for ease of reference.

A substantive change is made in the length of time a patient may be left in restraint or seclusion without monitoring the patient's condition from 1 hour to 15 minutes. The committee believes that the shorter time period is far better clinical practice. The committee believes the additional burden this requirement places on treatment facilities is far outweighed by the protection afforded to the patient's health and safety. The committee understands the current practice at the state psychiatric hospital is to check on patients in restraint or seclusion between every 5 and 15 minutes, depending upon circumstances, and the committee intends to apply at least the longer standard to every type of treatment facility. Of course, this maximum allowable standard should not be interpreted to negate the necessity for shorter intervals as may be medically indicated, nor to prohibit a treatment facility from establishing within its own policies a requirement for shorter intervals.

1	New Sec. 34. (previously 59-2929)
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3	COMMENT
4	This section is amended for clarity. The language added to subparagraph (a)(5) is a
5	rewrite of current section 59-2943. Subparagraph (a)(12) is a rewrite of current section 59-
6	2927.

New Sec. 35. (previously 59-2931)

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COMMENT

This section is amended for clarity. The reference to the "applicant" ("petitioner" as the act has been amended by the committee) in subparagraph (a)(5) is deleted because the committee believes the law does not intend the petitioner to forever have access to the patient's records, but is intended to have access to only so much information as is necessary to prosecute the case. The committee believes that the provisions of (a)(7) cover this need, or it may be provided for by an order issued pursuant to (a)(4).

1	New Sec. 36. (previously 59-2932)
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3	COMMENT
4	This section is revised only by amending the term "application" to read "petition" as that
5	term has been substituted into this draft.

1	New Sec. 37. (previously 59-2934)
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3	COMMENT
4	This section is amended only slightly for clarity.

1	New Sec. 38. (previously 59-2936)
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3	COMMENT
4	This section is amended and restructured for clarity.
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1 New Sec. 39. (previously 59-2937)

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3 COMMENT

This section is amended only slightly to conform to the amended act.

1	New Sec. 40. (previously 59-2939)
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3	COMMENT
4	This section is amended only slightly for clarity.
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1	New Sec. 41. (previously 59-2940)
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3	COMMENT
4	This section is amended for clarity and consistency with the amended act
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1	New Sec. 42. (previously 59-2941)
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3	COMMENT
4	This section is amended only slightly for clarity.

New Sec. 43. (previously 65-5601)

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3 COMMENT

Though not a part of the care and treatment act, Article 56 of chapter 65 has been reviewed by the committee because it is referenced in section 59-2931 and made integral to it. The definitions section was amended in subsection (h) to delete the reference to Norton state hospital since it is no longer in operation.

New Sec. 44. (previously 65-5603)

3 COMMENT

Subparagraph (a)(13) is amended for clarity and consistency with the concept of mental health reform. Subparagraph (a)(14) is added because the committee has heard that many requests for such information are regularly made to the state psychiatric hospitals, which would like to provide this information but report that they can find no current exception which would allow for them to do so. The committee believes no good reason exists why such an exception should not be added.