Kansas

Mental Health in Kansas

Presented to Governor's Mental Health Task force

July 18, 2013

Why do we need a task force?

- Most Americans don't know signs of suicide, addiction or mental illness, what to do about them, or how to find help
- Behavioral health is as important as physical health
- Estimated that 1 in 5 individuals will be affected at some point in their life by a mental illness
- Research has demonstrated a strong relationship between adverse childhood experiences and both behavioral problems and substance use related behaviors

Prevalence of Mental Health and Substance Use

- First episode psychosis - 40,000 new cases of schizophrenia – delayed treatment/ life long disability
- 23 million people needing Substance Use treatment, 10 percent receiving care (28 million need diabetes care and 84 percent receiving care)
- Since 1980 600,000 died of AIDS, 3.3 million SUD
- 68% of adults with mental illness have medical condition and 29% with medical condition have mental health disorder - treatment primarily medication in primary care, poorly managed

Prevalence of Co-Occurring MH/SUD Disorders

- Approximately 8.9 million adults have co-occurring disorders; that is they have both a mental and substance use disorder
- Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.

Suicide Prevention

- According to 2010 statistics from the Kansas Department of Health and Environment (KDHE), suicide trailed only unintentional injuries as the second leading cause of death in Kansas for 15 to 44 year olds.
- The state's suicide rate of 13.38 deaths per 100,000 people exceeded the national average of 11.8 per 100,000 residents.

Risk and Protective Factors

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

Implications

- Behavioral health needs are often addressed independently or in isolation—when in fact evidence demonstrates that they share common risk and protective factors
- Shared risk and protective factors call for a concerted effort across multiple agencies and disciplines—utilizing a full continuum of efforts--*prevention, treatment, recovery*

- Behavioral Health Needs often times go unmet
- How can we bring communities together to realize they have a role to play
  - Engage multiple sectors
  - Change environments to support behavioral health, lessen stigma, increase awareness, and access

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) include verbal, physical, or sexual abuse, neglect, and family dysfunction (e.g., an incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation).

Verbal Abuse During Childhood	
Definition:	Verbal abuse during childhood includes adults/parents in the home swearing at, insulting, putting down, and/or psychologically abusing a child
Risk Factor for:	Verbal abuse during childhood is a risk factor for mental health problems[1, 3]; substance abuse[1, 3, 16]; personality disorders[2]; poor physical health[4]. In addition, the cumulative effect of multiple ACEs* (including verbal abuse) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age Group(s):	Youth (infancy through adolescence)
Potential Data Source & Example Questions:	BRFSS ACE/Q8. How often did a parent or adult in your home ever swear at you, insult you, or put you down? U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File: Children who are confirmed by child protective services as victims of maltreatment: psychological maltreatment (http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf)

Trauma: Child Physical Abuse	
Definition:	Physical abuse is non-accidental physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child, that is inflicted by a parent, caregiver, or other person who has responsibility for the child (Child Welfare Information Gateway)
Risk Factor for:	Physical abuse during childhood is a risk factor for depression[1, 18]; non-comorbid major depressive episode[14]; non-comorbid substance use disorder[19]; comorbid PTSD + major depressive episode[19]; comorbid PTSD + substance use disorder[19]; personality disorders[2]; persistence of mood, substance, and anxiety disorders[4]; substance abuse and mental health disorders[1, 3, 20-21]; poor mental and physical health[3-4]; substance use, abuse, and dependence[4]; alcohol, cocaine, or opioid dependence[3]; mood and anxiety disorders[1, 3, 22]; co-occurring disorders[18] . In addition, the cumulative effect of multiple ACEs* (physical abuse) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age Group(s):	Youth (infancy through adolescence)
Potential Data Source & Example Questions:	Behavioral Risk Factor Surveillance System (BRFSS): ACE/Q7. Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? (Do not include spanking) U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File: Children who are confirmed by child protective services as victims of maltreatment: physical abuse (http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf)

Trauma: Child Sexual Abuse	
Definition:	Any child sexual abuse, with or without intercourse (inappropriate/unwanted sexual touching, attempted intercourse, and/or completed intercourse)
Risk Factor for:	Sexual abuse during childhood is a risk factor for substance abuse or dependence[3, 18, 23]; depression [3, 18]; co-occurring disorders[18]; alcohol abuse or dependence[3-4]; suicidality[4]; alcohol, cocaine, or opioid dependence[18]; mood and anxiety disorders[18, 23]; psychopathology[3]; PTSD[3]; personality disorders[2] . In addition, the cumulative effect of multiple ACEs* (sexual abuse) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age Group(s):	Youth (infancy through adolescence)
Potential Data Source & Example Questions:	Behavioral Risk Factor Surveillance System (BRFSS): ACE/Q9. How often did anyone at least 5 years older than you or an adult, ever touch you sexually? ACE/Q10. How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually? U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File: Children who are confirmed by child protective services as victims of maltreatment: sexual abuse (http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf)

Neglect	
Definition:	Neglect can include, but is not limited to: being physically, emotionally, or medically neglected as a child
Risk Factor for:	Childhood neglect is a risk factor for mood disorders[23]; substance use disorders[23]; anxiety[23]; mental illness or mental health problems[20]; personality disorders[2]. In addition, the cumulative effect of multiple ACEs* (including childhood neglect) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age of Exposure:	Youth (Infancy through Adolescence)
	U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File: Children who are confirmed by child protective services as victims of maltreatment: neglect (http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf) Children who are confirmed by child protective services as victims of maltreatment: medical neglect (http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf)

Incarceration of a Parent or Family Member	
Definition:	One or more parents or another household family member incarcerated for any length of time during a person's childhood
Risk Factor for:	Incarceration of a parent of family member is a risk factor for mental, emotional, and behavioral health problems[1]; physical health problems[1]; elevated levels of alcohol and drug use[1]; and receiving mental health services[1] . In addition, the cumulative effect of multiple ACEs* (including incarceration of a household family member) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age of Exposure:	Youth (Infancy through Adolescence)
Potential Data Source & Example Questions:	Behavioral Risk Factor Surveillance System (BRFSS): ACE/Q4. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility? National Survey of Children's Health (NSCH): ACE5 Did [S.C.] ever live with a parent or guardian who served time in jail or prison after [S.C.] was born?

Family History of Mental Illness	
Definition:	Family history of mental illness can include, but is not limited to, exposure during childhood to: parental depression or depressive symptoms; parental modeling of anxiety; having blood relatives such as a parent or sibling with bipolar disorder; family history of personality disorders; parental psychopathology; parental emotional or behavioral problems; family history of mental health disorders; and family history of co-occurring disorders
Risk Factor for:	Family history of mental illness is a risk factor for mental illness or mental health problems[2]; bipolar disorder[2]; personality disorders[2]; depression; anxiety[23]; co-occurring disorders[1, 24]; substance use disorders[23]; mood disorders[23]. In addition, the cumulative effect of multiple ACEs* (including family history of mental illness) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age of Exposure:	Youth (Infancy through Adolescence)
Potential Data Source & Example Questions:	Behavioral Risk Factor Surveillance System (BRFSS): ACE/Q1. Did you live with anyone who was depressed, mentally ill, or suicidal? National Survey of Children's Health (NSCH): ACE8 Did [S.C.] ever live with anyone who was mentally ill or suicidal, or severely depressed for more than a couple of weeks? K9Q23 Would you say that, in general, ([S.C.]'s [MOTHER TYPE]/your) mental and emotional health is excellent, very good, good, fair, or poor? K9Q24 Would you say that, in general, ([S.C.]'s [FATHER TYPE]/your) mental and emotional health is excellent, very good, good, fair, or poor?

Family History of Substance Use Disorders	
Definition:	Family history of substance use disorders can include, but is not limited to, exposure during childhood to: parental substance abuse; parental alcoholism; growing up in a household in which there is substance abuse; family drug behavior; parental and/or sibling modeling of drug/alcohol use
Risk Factor for:	Family history of substance abuse is a risk factor for lifetime alcohol use[25]; current alcohol use[25]; current binge drinking[25-26]; lifetime marijuana use[25]; current marijuana use[25]; increased alcohol and drug use between 7th and 9th grades[26]; early onset of drinking and persistence of alcohol use disorders[27]; alcohol, cocaine, or opioid dependence[3]; mood and anxiety disorders[3]; co-occurring disorders[1, 24]; substance abuse[1, 28-29]; non-comorbid major depressive episode[19]; non-comorbid substance use disorder[19]; comorbid PTSD + substance use disorder[19]; comorbid PTSD + major depressive episode[19]. In addition, the cumulative effect of multiple ACEs* (including family history of substance use disorders) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age of Exposure:	Youth (Infancy through Adolescence) and Young Adult
Potential Data Source & Example Questions:	Behavioral Risk Factor Surveillance System (BRFSS): ACE/Q2. Did you live with anyone who was a problem drinker or alcoholic? ACE/Q3. Did you live with anyone who used illegal street drugs or who abused prescription medications? National Survey of Children's Health (NSCH): ACE9 Did [S.C.] ever live with anyone who had a problem with alcohol or drugs? K9Q40 Does anyone living in your household use cigarettes, cigars, or pipe tobacco? K9Q41 Does anyone smoke inside [S.C.]'s home? U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File:

	Children with a alcohol abuse caregiver risk factor: http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf Children with a drug abuse caregiver risk factor: http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf

Family History of Co-Occurring Disorders	
Definition:	Family history of co-occurring or concurrent mental health and substance use disorders
Risk Factor for:	Family history of co-occurring disorders is a risk factor for co-occurring disorders[1, 24]; and higher rates of emotional or behavioral problems[30]. In addition, the cumulative effect of multiple ACEs* (including family history of co-occurring disorders) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age of Exposure:	Youth (Infancy through Adolescence) and Young Adult
Potential Data Source & Example Questions:	

Witnessing Domestic Violence[16]		
Definition:	Children witnessing their parents and/or other adults in the home abusing each other	
Risk Factor for:	Poor mental and physical health[4]; substance use, abuse and dependence[4]. In addition, the cumulative effect of multiple ACEs* (including witnessing domestic violence) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]	
Age Group(s):	Youth (infancy through adolescence)	
Potential Data Source & Example Questions:	BRFSS	
		ACE/Q6. How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?
	U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS) Child File	
		Children with a domestic violence caregiver risk factor: http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf

Parental Divorce/Separation (During Childhood)	
Definition:	Growing up with divorced or separated parents
Risk Factor for:	Alcohol dependence[3]; higher levels of mental, emotional, and behavioral problems[1, 20]; lower levels of success in developmental tasks[1]; physical health problems[1]; alcohol and drug use[1]; receiving mental health services[1]; depression[1]; personality disorders[2]; persistence of mood, substance, and anxiety disorders[23] . In addition, the cumulative effect of multiple ACEs* (including parental divorce or separation) is associated with depression[5-6], use of psychotropic drugs[7], hallucinations[8], suicidality[9], early initiation of alcohol use[10] alcohol abuse[11-12], illicit drug use[13], prescription drug use[14], early initiation of smoking [15] and smoking during adolescence and adulthood[15-17]
Age of Exposure:	Youth (Infancy through Adolescence)
Potential Data Source & Example Questions:	Behavioral Risk Factor Surveillance System (BRFSS): ACE/Q5. Were your parents separated or divorced? U.S. Census Bureau: Child Trends calculations of U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement. "America's Families and Living Arrangements". Tables C-2, C-3. Available at: http://www.census.gov/population/www/socdemo/hh-fam/.html

***For more information on the cumulative effect of ACEs, see CDC. Adverse childhood experiences reported by adults—five states, 2009. MMWR 2010;59(49): 1609-1613.**

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- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

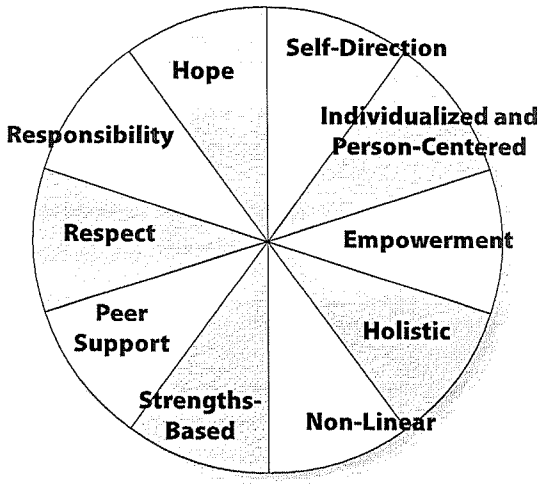
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Components of Recovery



Resources
www.samhsa.gov
National Mental Health Information Center
1-800-789-2647, 1-866-889-2647 (TDD)

NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Background

Recovery is cited, within *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, as the "single most important goal" for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

MENTAL HEALTH LAW: Kansas Overview

A Presentation to Members of
the Kansas Governor's Mental Health Task Force
July 18, 2013

Civil Commitment Before 1960

1. Hearings were perfunctory – A physician and his patient with few questions.
2. Need for Treatment.
3. No periodic judicial review – Committed until discharged by the Chief Medical Officer.
4. Commitment for all purposes – Once committed all decisions made by Chief Medical Officer.

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5. Whatever happened to Mary?
6. Annual Reports to the Legislature: Gallons of milk, acres of wheat, produce from the garden.
7. Funding!

Enter Kansas Senate Bill 26 in 1976

1. Dangerous as defined by Lessard v. Schmidt (WI, 1972); "Recent Overt Act of Violence."
2. Need for treatment was still part of the equation but most of the argument was on dangerousness.
3. Hearings with appointed counsel and genuine cross-examination.

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4. Periodic Judicial Review – every 90 days and the right to review hearings.
5. Clinical staff was not very fond of the new rules – judges and attorneys spelled trouble.

Larned State Hospital in 1977 when I arrived.

1. Only two distinct hospitals: Larned State Hospital and State Security Hospital.
2. LSH was one of four state psychiatric hospitals – LSH, TSH, OSH, RMHF (primarily children).
3. LSH served both committed and voluntary patients from Western Kansas.

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4. LSH had a *children's* inpatient program, an *adolescent* inpatient program, a *school*, and a *juvenile detention center* called Youth Center at Larned (YCAL). It also had an *inpatient alcohol and drug abuse* program (ADAS) on Jenkins Hill. None of these programs remain at LSH today.

5. LSH had a security behavioral ward (SBW) for committed patients from all four state psychiatric hospitals who had committed **acts of violence in the hospitals**. This program is still located at LSH but by a different name.

State Security Hospital.

1. SSH was contained in the Dillon Building which is now the SPTP.

2. SSH provided evaluation, care, and treatment for district courts and the Secretary of Corrections.

3. There were seven statutes which interfaced the **criminal justice system** and the **public mental health system**.

   a. K.S.A. 22-3301 (trial competency evaluation)

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b. K.S.A. 22-3303 (trial competency treatment not to exceed six months due to *Jackson v. Indiana*).
c. K.S.A. 22-3219 (insanity evaluation – NGRI).
d. **K.S.A. 22-3428 (NGRI treatment until no longer dangerous – antisocial personality disorder).**
e. K.S.A. 22-3429 (Pre-sentence evaluation).
f. K.S.A. 22-3430 (Treatment in *lieu* of sentencing).
g. K.S.A. 75-5209 (Administrative transfer from Department of Corrections for short-term treatment and return).
h. There was no Sexual Predator Treatment Program at LSH in 1977.

A Few of the Big Names

1. Dr. Thomas Szasz, a psychiatrist. (Mental illness is a convenient myth consisting of nothing more than the servant of social control over deviant behavior people don't like.) Quotes from Volume five of Perlin's treatise.
2. Bruce Ennis, a lawyer. His book, *Prisoners of Psychiatry*, was the first book many young attorneys in the 1970s most likely read on mental health law. (The very worst thing society can do to a person is curtail his liberty. It is much better to let a man live with his thought disorders than to take away his freedom.) Quotes from Volume five of Perlin's treatise.

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3. Bill Rein, a less well-known lawyer. (In 1977, NAMI's Kansas forerunner, *Kansas Families for Mental Health*, was tired of hearing Szasz's mantra that mental illness was a myth. Kansas families had been told "civil commitment allows parents to commit their unpopular or underachieving adult children." "You laugh. That was real.") Quotes from: Issac, Rael Jean and Armat, Virginia C. *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (Free Press: New York, 1990) 267-268.

Where Does Mental Health Law Come From?

1. Primarily the Fourteenth Amendment to the U.S. Constitution, and only one small phrase from there: "**. . . nor shall any State deprive any person of life, liberty, or property, without due process of law; . . .**"
2. How can 17 words generate so much controversy and so many cases in the history of American jurisprudence?
3. What if the Fourteenth Amendment had said no state may deprive any person of life, liberty, or property *without first giving him a dish of ice cream?* (Pretty simple- how many dips do you want and what is your favorite flavor?)

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4. What if the Fourteenth Amendment had said no state may deprive any person of life, liberty, or property *without first offering him transportation to the country of his choice?* (Pretty simple again- here's your parachute, where do you want us to drop you?)

5. However, the Fourteenth Amendments says no state may deprive any person of life, liberty, or property without *due process of law*. (Not so simple- what's due process of law?)

What's Due Process of Law?

1. In the 1960s, a number of "poverty or low cost legal clinics" were established by young, idealistic attorneys. These attorneys accepted cases which were not profitable for most law firms. They handled housing complaints, consumer rights, criminal, juvenile, and other low fee producing cases. Among that mix was civil commitment.

2. Remember earlier we talked about how perfunctory civil commitment hearings were before the 1960s? "Doctor, do you believe the proposed patient needs psychiatric treatment?" "Your Honor, I have an order here. . ."

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3. This new group of attorneys had questions by the truck load. They eventually succeeded in convincing the U. S. Supreme Court that involuntary hospitalization results in a "massive curtailment of liberty." Therefore, the Fourteenth Amendment required **procedural** due process of law. And, unlike ice cream, procedural due process of law came in only one flavor:

   a) Notice
   b) Meaningful Hearing (personal presence, counsel, cross-examination)
   c) Compulsive process (the right to subpoena witnesses)

4. Impartial Finder of Fact (judge or jury).

So, due process means that certain legal procedures must go before a deprivation of life, liberty, or property? Not so fast!

1. Here is the problem these poverty law clinics faced. What if the state followed all of the right procedures, but nothing happened in the hospital? What good did that do their clients?

2. Enter Bruce Ennis and his book, *Prisoners of Psychiatry*. Ennis argued that due process meant more than following the right procedures. As important as procedural due process is, he saw a *quid pro quo* at work in involuntary anything- criminal or civil- when it came to life, liberty, or property. Procedures only got his clients part of the way to the city of "due process." (Continued on next slide)

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3. If a state deprived a person of liberty because it said the person needed treatment, then the state had to provide the treatment it said the person needed.

4. In other words, due process involved not only procedure but something substantive as well. In the case of involuntary commitment to a psychiatric hospital, that "something substantive" was treatment.

5. So, what's treatment?

Due process of law does come in more than one flavor.

1. There's ***procedural due process*** and then there's ***substantive due process***. And the same person gets to have both flavors in one bowl (or perhaps good climate and plenty of jobs in one parachute drop to use our earlier analogy).

2. Who gets to define treatment- the hospital's chief medical officer, the legislature, or the courts?

3. Somewhat like public education. Who gets to define education- local boards, state board, the legislature, or the courts?

1. Civil Commitment in Kansas underwent two phases of mental health reform in 1986 (HB 2050) and 1990 (the Mental Health Reform Act).

2. HB 2050

   a. Changed the definition of dangerousness (often interpreted as a recent overt act of violence) to "lack of ability to make treatment decisions due to a thought disorder (not a personality disorder) which made it reasonably likely that the person would harm self, others, or the property of others. This was one of the main goals of Kansas Families for Mental Health.
   b. Authorized out-patient commitment orders.
   c. Clarified judicial review hearings by requiring an attorney-client discussion at least every 90 days.
   d. Began the process of melding CMHCs and state hospitals into one public mental health system.

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3. Comprehensive Mental Health Reform in 1990

   a. Made CMHCs the gatekeepers to public mental health system.
   b. Everyone had to be screened by a CMHC QMHP before accessing state hospitals.
   c. Established a free-flow of information between CMHCs and state hospitals.
   d. Carefully defined QMHPs (conflicts among private mental health professionals and CMHC screeners).
   e. Established a new state hospital/CMHC client privilege for the release of information not based upon who a client's therapist was- psychologist, social worker, physician, nurse.

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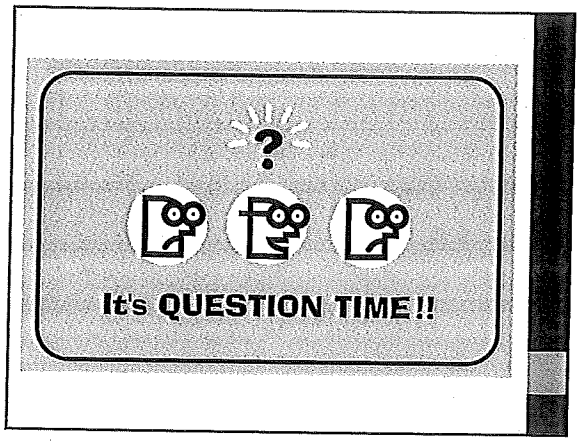
It's QUESTION TIME!!

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Gina Meier-Hummel, Commissioner

Sam Brownback, Governor

Behavioral Health Services:

July 1, 2012 through Governor Brownback's ERO SRS, Disability and Behavioral Health Services (DBHS) became part of Kansas Department for Aging and Disability Services. With this reorganization, also came the merger of mental health services (MH) and addiction and prevention services (AAPS). Behavioral Health Services (BHS) is now managed by one Director under the Commissioner of Community Services and Programs (CSP).

MH & Substance abuse = Director

Mental Health Services:

KDADS Behavioral Health Services program administers, manages, and oversees publicly funded community, residential, and inpatient psychiatric services and supports for those who do not have the means to pay, especially adults with a severe and persistent mental illness (SPMI) and children with a serious emotional disturbance (SED). Organizations providing these psychiatric services and supports include:

- Community Mental Health Centers (CMHCs);
- State Mental Health Hospitals;
- Private practitioners;
- Nursing Facilities for Mental Health;
- Psychiatric Residential Treatment Facilities;
- Private Community Hospital Psychiatric Programs funded by Kansas Department of Health and Environment Health Care Finance;
- Residential Care Facilities (RCF);
- Consumer Run Organizations and Other Support Groups;
- Housing Programs; and
- Pharmacy Benefit Manager.

Current issues facing Kansas' public mental health system and current initiatives include:

- Development of regional recovery support centers intended to enhance successful outreach and engagement of individuals who have behavioral health disabilities and have not entered the mental health system through traditional means;
- State Mental Health Hospitals routinely serve patients who might be better served in alternate levels of care; Efforts are underway to redesign services at Rainbow MHF to provide for some of these needed services;
- CMHCs must triage the persons without the means to pay for treatment services, focusing on serving persons with an SPMI/SED and those experiencing a mental health crisis; this could leave a gap for people who need brief intervention and support.
- Improving the infrastructure to treat individuals with co-occurring mental health and substance use disorders;

- Coordination between physical and mental health treatment needs to be improved so persons with co-occurring chronic physical illnesses and mental illness experience improved wellness and health while reducing the physical health care costs of these persons;
- Ensuring mental health medication prescribing practices, especially for children in state custody and on the SED Home and Community Based Services Waiver, are well managed and evidence based;
- Monitoring the use of residential psychiatric treatment for children and adults to ensure those who need these services receive them and those who can be safely and effectively served in community-based settings immediately receive the community services they need;
- Increase and improve the use of evidenced based practices and better measure quality of life outcomes.

Substance Use Services:

KDADS Behavioral Health Services provides and monitors a system of care for the treatment of Substance Use Disorders (SUDs) that is customer/community focused, outcome driven and consists of a network of providers who are focused on best practices. Additionally, BHS promotes prevention and recovery in Kansas communities through the mobilization of community coalitions and partnerships. BHS supports communities in understanding the extent and cause of substance abuse problems and helps citizens take action to reduce and prevent them. Since the passing of SB 66 in 2007, which designated 2.0 percent of the state proceeds from expanded gaming activities to be made available to treat problem gambling and other addictions, BHS has worked to heighten awareness of and treatment services to problem gamblers in Kansas.

Treatment services provided by BHS providers include:

- Acute Detoxification Treatment
- Alcohol and Drug Assessment and Referral Programs
- Alcohol and Drug Safety Action Programs
- Case Management Services
- Crisis Intervention
- Early Intervention/Interim Treatment
- Inpatient Treatment
- Intensive Outpatient Treatment
- Intermediate Treatment
- Medication Assisted Treatment
- Opioid Maintenance Outpatient Treatment
- Outpatient Treatment
- Peer Mentoring
- Person Centered Case Management
- Reintegration Treatment
- Social Detoxification
- Therapeutic Community Treatment
- Problem Gambling Treatment

Current issues facing Kansas' SUD treatment system and current initiatives include:

- Information technology system for the network is outdated and efforts are underway to convert such system to an updated platform;
- Implementing targeted workforce development initiatives that focus on recovery and peer mentoring;
- Implementing screening, brief intervention, and treatment in primary health;
- Creating awareness about pathological gambling as an addiction and how to treat such addictions; and
- Creating coalitions in communities to support prevention of risk factors associated with substance use.

State Mental Health Hospitals

SMHHs provide inpatient psychiatric treatment to all persons approved for admission to state psychiatric hospitals as provided for in Mental Health Reform statute, K.S.A. 39-1601. Community Mental Health Centers are the designated "gatekeepers" that perform a "screening" function to determine if individuals can be evaluated and/or treated in the community or should be referred to the appropriate state psychiatric hospital for treatment and/or evaluation. Kansas' three state mental health hospitals, Larned State Hospital, Osawatomie State Hospital and Rainbow Mental Health Facility as provided for in K.S.A. 59-2945 "Care and Treatment for Mentally Ill Persons, currently have the capacity to serve an average daily census of approximately 302 persons in their general psychiatric services programs.

Hospital and Home
VISION:

Consumers experience recovery and satisfaction with themselves, their world, and their dreams/aspirations by living safe healthy self-determined lives in their community as evidenced by continuity in maintaining and enhancing their homes, occupation, financial stability, & personal relationships.

MISSION:
The Hospital and Home Transformation Team will recommend action steps for the purpose of improving access to an array of mental health services and supports that promote recovery and community integration.

Some of the most significant work of the Hospital and Home Team has been the review of admission data for the state mental health hospitals. The data revealed significant variability in state mental health hospital admission rates from various areas across the state. The data suggests that this variability may be occurring for one or more of the following reasons:

- Variability in how individual screeners determine danger to self or others;
- Variability in the availability of regional inpatient mental health treatment services;
- Variability in the rates of homelessness;
- Variability in the amount and type of available mental health services in different areas of the state;
- Variability in how CMHCs serve persons in crisis whom they have not previously served; and
- Variability in the amount and type of available services and supports for persons with other complex needs such as mental retardation, traumatic brain injury, elderly with difficult behavior challenges, substance abuse, etc.

In Fiscal Year 2013, KDADS contracted with Mercer Government Human Services Consulting to conduct an actuarial analysis of hospital and community based services utilization and to offer observations on State Hospital and Medicaid service utilization variances across the state. The results of this study validated the variability suggested above.