

SESSION OF 2017

**CONFERENCE COMMITTEE REPORT BRIEF  
SENATE SUBSTITUTE FOR HOUSE BILL NO. 2053**

As Agreed to April 5, 2017

**Brief\***

Senate Sub. for HB 2053 would create the Crisis Intervention Act (Act) and amend law related to mental health to reflect the provisions of the Act, as follows.

***Crisis Intervention Act***

*Definitions*

For purposes of the Act, the bill would define “crisis intervention center” (center) to mean an entity licensed by the Kansas Department for Aging and Disability Services (KDADS) that is open 24 hours a day, 365 days a year, equipped to serve voluntary and involuntary individuals in crisis due to mental illness, substance abuse, or a co-occurring condition, and that uses certified peer specialists. “Crisis intervention center service area” would be defined as the counties to which the crisis intervention center has agreed to provide service. The bill also would define “behavioral health professional,” “head of a crisis intervention center,” “law enforcement officer,” “licensed addiction counselor,” “physician,” “psychologist,” “qualified mental health professional,” “treatment,” “domestic partner,” “physician assistant,” “immediate family,” “restraints,” and “seclusion.”

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\*Conference committee report briefs are prepared by the Legislative Research Department and do not express legislative intent. No summary is prepared when the report is an agreement to disagree. Conference committee report briefs may be accessed on the Internet at <http://www.kslegislature.org/kldr>

### *Effect on Rights*

The Act would state that the fact a person has been detained for emergency observation and treatment (EOT) under the Act could not be construed to mean the person has lost any civil right, property right, or legal capacity, except as specified in any court order or as limited by the Act or reasonable policies the head of a center may, for good cause, find necessary to make for the orderly operation of the facility. No person in custody under the Act could be denied the right to apply for a writ of *habeas corpus*. No judicial action taken as part of the 48-hour court review [described below] would constitute a finding by the court. There would be no implication or presumption that a patient under the Act is, for that reason alone, a person in need of a guardian or conservator, or both, under the Act for Obtaining a Guardian or a Conservator, or Both.

### *Effect on Voluntary Admission*

The Act would state it could not be construed to prohibit a person with capacity from applying for admission as a voluntary patient to a center, and any person desiring to do so would be given an opportunity to consult with the person's attorney prior to applying. If the head of the center accepts the application and admits the person as a voluntary patient, the head of the center would have to provide written notification to the person's legal guardian, if known.

### *Custody and Transportation by Law Enforcement Officer*

The bill would allow any law enforcement officer (LEO) who takes a person into custody under the Care and Treatment Act for Mentally Ill Persons or the Care and Treatment Act for Persons with an Alcohol or Substance Abuse Problem to transport such person to a center if the LEO is in a crisis intervention center service area. The center could not refuse to accept any person brought by an LEO for

evaluation if the LEO's jurisdiction is in the center's service area. If the LEO is not in a center service area or chooses not to transport the person to a center, the LEO would have to follow the procedures under the Care and Treatment Act for Persons with an Alcohol or Substance Abuse Problem or the Care and Treatment Act for Mentally Ill Persons.

*Admission and Detention Upon Application by Law Enforcement Officer*

The Act would allow a center to admit and detain any person 18 years of age or older who is presented for EOT upon the written application of an LEO. Such application would be made on a form set forth or approved by the Secretary for Aging and Disability Services (Secretary). The Act would specify certain information to be included in the application, including the applicant's belief (and factual circumstances supporting that belief and under which the person was taken into custody) that the person may be a mentally ill person or person with an alcohol or substance abuse problem (or co-occurring conditions) subject to involuntary commitment under the care and treatment acts for such persons and that, due to such problem or condition, is likely to cause harm to self or others if not immediately detained.

The original application would be kept in the regular course of business with the law enforcement agency and a copy would be provided to the center and to the patient.

*Admission and Detention Upon Application by Adult*

The Act would allow a center to evaluate, admit, and detain any person 18 years of age or older who is presented for EOT upon the written application of any adult. Such application would be made on a form set forth or approved by the Secretary. The Act would specify certain information to be included in the application, including the applicant's belief

(and factual circumstances supporting that belief and under which the person was taken into custody) that the person may be a mentally ill person or person with an alcohol or substance abuse problem (or co-occurring conditions) subject to involuntary commitment under the care and treatment acts for such persons and that, due to such problem or condition, is likely to cause harm to self or others if not immediately detained.

The original application would be kept by the applicant and a copy would be provided to the center and to the patient.

#### *Evaluation, Court Review, Discharge, and Further Placement*

The head of the center would be required to evaluate a person admitted under the Act within four hours of admission to determine whether the person is likely to be a mentally ill person or a person with an alcohol and substance abuse problem subject to involuntary commitment under the care and treatment acts for such persons and whether, due to such problem or condition, the person is likely to cause harm to self or others if not immediately detained. The head of the center would be required to inquire whether the person has a wellness recovery action plan or psychiatric advance directive.

The Act would require evaluation of a person admitted under the Act by a behavioral health professional not later than 23 hours after admission and again not later than 48 hours after admission to determine whether the person continues to meet the criteria described in the paragraph above. The 23-hour evaluation would have to be conducted by a different professional than the professional who conducted the initial evaluation.

Within 48 hours of admission, if the head of the center determines the person continues to meet the criteria above, the head of the center would be required to file an affidavit to

that effect for review by the district court in the county where the center is located. The affidavit would have to include or be accompanied by the written application for EOT, information about the person's original admission, the care and treatment provided, and the factual circumstances supporting the evaluating professional's opinion that the person meets the criteria described above. After reviewing the affidavit and accompanying information, the court would have to order the release of the person or order that the person may continue to be detained and treated at the center, subject to the limitations described below.

The head of the center would be required to discharge a person admitted under the Act at any time the person no longer meets the criteria described above, and not later than 72 hours after admission, unless the head of the center determines the person continues to meet the criteria described above, in which case the head of the center would be required to immediately file a petition under the appropriate care and treatment act and find appropriate placement for the person (including community hospitals equipped to take involuntary commitments or the designated state hospital). If the 72-hour period ends after 5 p.m., the Act would require such petition be filed by the close of business of the first day thereafter that the district court is open.

The center would be required to make reasonable accommodations for the person's transportation upon discharge from the center.

#### *Requirements of the Head of the Center*

When a person is involuntarily admitted to or detained at a center under the Act, the head of the center would be required to immediately advise the person that the person is entitled to immediately contact the person's legal counsel, legal guardian, personal physician or psychologist, minister of religion, or immediate family. If the person desires to make

such contact, the head of the center would be required to make available reasonable means for such communication.

The head of the center would also be required to provide notice of the person's involuntary admission, including a copy of the documentation authorizing the admission, to the person's attorney or legal guardian (once known), unless the attorney or guardian was the person who signed the application. If authorized by the patient under the act governing confidential communications and information of treatment facility patients, the head of the center would also be required to provide notice to the patient's immediate family (once known), unless the family member to be notified was the person who signed the application.

Finally, the head of the center would be required to immediately advise the person in custody of the person's rights as detailed in the Act.

#### *Medications and Treatment*

The Act would require medications and other treatments be prescribed, ordered, and administered only in conformity with accepted clinical practice. Medications could be administered only by written order of a physician or by verbal order noted in the patient's records and subsequently signed by the physician, and the attending physician would be required to regularly review the drug regimen and monitor any symptoms or side effects. Prescriptions for psychotropic medications could be written for no longer than 30 days but could be renewed.

During treatment, the responsible physician or psychologist (or designee) would be required to reasonably consult with the patient or patient's legal guardian and give consideration to the views expressed by such persons regarding treatment and any alternatives, including views in a wellness recovery action plan or psychiatric advance directive. No medication or other treatment could be

administered to any voluntary patient without the consent of such patient or the patient's legal guardian.

The Act would require consent for medical or surgical treatments not intended primarily to treat a patient's mental disorder be obtained in accordance with applicable law.

If a patient objects to taking any medication prescribed for psychiatric treatment, and after full explanation of the benefits and risks of such medication such objection continues, the medication could be administered over the patient's objection, with the objection recorded in the patient's medical record.

The administration of experimental medication would be prohibited without the patient's written consent.

#### *Restraints or Seclusion*

Restraints or seclusion would be prohibited unless the head of the center or a physician or psychologist determines such measures are necessary to prevent immediate substantial bodily injury to the patient or others and alternative methods are not sufficient to accomplish this purpose. Restraints or seclusion could not be used as punishment or for the convenience of staff. When restraint or seclusion is used, the Act would require use of the least restrictive measure necessary to prevent injury, and the use could not exceed three hours without medical reevaluation, except between the hours of midnight and 8:00 a.m. The Act would require monitoring of the use of restraint or seclusion no less than once per each 15 minutes. The head of the center or a physician or psychologist would be required to sign a statement explaining the treatment necessity for the use of seclusion or restraint, which would be added to the patient's permanent treatment record.

The above provisions would not prevent, for a period of up to two hours without review and approval by the head of

the center or a physician or psychologist, the use of restraints as necessary for a patient likely to cause physical injury to self or others without such restraint, the use of restraints primarily for examination or treatment or to ensure the healing process, or the use of seclusion as part of a treatment methodology that calls for time out due to the patient's refusal to participate or disruption.

*Rights of Patients; Penalty for Deprivation of Rights*

The bill would include in the Act a list of rights of patients (in addition to the rights provided elsewhere in the Act), including rights related to clothing\*, possessions\*, and money\*; communication\* and correspondence\*; conjugal visits\*; visitors\*; refusal of involuntary labor; prohibition of certain treatment methods without written consent of the patient; explanation of medication and treatment; communication with the Secretary, the head of the center, and any court, attorney, physician, psychologist, qualified mental health professional, licensed addiction counselor, or minister of religion; contact of, consultation with, and visitation by the patient's physician, psychologist, qualified mental health professional, licensed addiction counselor, minister of religion, legal guardian, or attorney at any time; information regarding these rights upon admission; and humane treatment, consistent with generally accepted ethics and practices.

The head of a center could, for good cause only, restrict those rights marked above with "\*." The remaining rights could not be restricted by the head of a center under any circumstances. Each center would be required to adopt policies governing patient conduct that are consistent with the above provisions. The Act would require a statement explaining the reasons for any restriction of a patient's rights be immediately entered on the patient's medical record, with copies of the statement made available to the patient and to the patient's attorney, and the bill would require notice of any

restriction to be communicated to the patient in a timely manner.

Any person willfully depriving any patient of the rights listed above, except for the restriction of rights as permitted by the Act or in accordance with a properly obtained court order, would be guilty of a class C misdemeanor.

### *Records*

Any district court, treatment, or medical records of a person admitted to a center under the Act that are in the possession of a district court or center would be privileged and not subject to disclosure, except as provided under the Care and Treatment Act for Mentally Ill Persons.

### *Immunity and Criminal Making of a Report*

The Act would provide immunity from civil and criminal liability for acting or declining to act pursuant to the Act for any person, law enforcement agency, governing body, center, or community mental health center or personnel.

It would be a class A misdemeanor to, for corrupt consideration, advantage, or malice, make, join in making, or advise the making of a false petition, report, or order provided for in the Act.

### ***Amendments to Law***

#### *Act Establishing Standards for Facilities Providing Residential Care and Support, Psychiatric and Mental Health Care and Treatment, and Other Disability Services*

The definitions section of this act would be amended to define "crisis intervention center" and include this term within

the definition of “center.” The sections of this act setting forth the purpose of the act and the authority, powers, and duties of the Secretary (for purposes of the act) would be amended to incorporate crisis intervention centers.

*Care and Treatment Act for Mentally Ill Persons*

This act would be amended to allow an LEO within a crisis intervention center service area to transport a person covered by this act to a center. The statute setting forth the rights of patients under this act would be amended to add “qualified mental health professional” to the list of persons with whom a patient has the right to communicate by letter, to contact or consult privately, or to be visited by at any time. The statute providing immunity under this act would be amended to add law enforcement agencies, governing bodies, and community mental health centers or personnel to those receiving immunity, and immunity for declining to act would be added.

*Care and Treatment Act for Persons with an Alcohol or Substance Abuse Problem*

This act would be amended to allow an LEO within a crisis intervention center service area to transport a person covered by this act to a center. The statute setting forth the rights of patients under this act would be amended to add “licensed addiction counselor” to the list of persons with whom a patient has the right to communicate by letter, to contact or consult privately, or to be visited by at any time. The statute providing immunity under this act would be amended to add law enforcement agencies, governing bodies, and community mental health centers or personnel to those receiving immunity, and immunity for declining to act would be added.

## **Conference Committee Action**

The Conference Committee agreed to remove the original contents of Senate Sub. for HB 2053, which would have enacted the Asbestos Bankruptcy Trust Claims Transparency Act, and to insert the contents of HB 2240, as amended by the House Committee of the Whole, enacting the Crisis Intervention Act. [Note: This agreement removed the Senate amendments to HB 2240 regarding social workers and data collection.]

## **Background**

### ***Senate Sub. for HB 2053 - Asbestos Bankruptcy Trust Claims Transparency Act***

As it entered conference, Senate Sub. for HB 2053 would have enacted the Asbestos Bankruptcy Trust Claims Transparency Act. The Conference Committee agreed to remove those contents and insert the contents of HB 2240, as amended by the House Committee of the Whole, enacting the Crisis Intervention Act.

### ***HB 2240— Crisis Intervention Act***

The Chairperson of the 2016 House Committee on Corrections and Juvenile Justice, Representative Gonzalez, requested the Kansas Judicial Council study 2016 HB 2639, enacting the Emergency Observation and Treatment Act. The Judicial Council created an advisory committee to undertake the study and subsequently submitted a report on January 5, 2017, that included proposed legislation as an alternative to 2016 HB 2639. This language was incorporated in HB 2240, as introduced by the 2017 House Committee on Judiciary.

In the House Committee on Judiciary hearing, conferees testifying in support of the bill included a representative of the

Kansas Association of Chiefs of Police, Kansas Peace Officers Association, and Kansas Sheriffs' Association; the superintendent of Larned State Hospital; and representatives of the Association of Community Mental Health Centers of Kansas, the Disability Rights Center of Kansas, the Kansas Academy of Physician Assistants, Mental Health America of the Heartland, the National Alliance on Mental Illness—Kansas, and Wyandot, Inc. Written-only proponent testimony was submitted by the Kansas Bureau of Investigation, the Kansas Judicial Council, a disability advocate, and a citizen. A representative of the National Association of Social Workers—Kansas Chapter testified in opposition to the bill. Written-only opponent testimony was submitted by the Kansas Association of Criminal Defense Lawyers.

The House Committee adopted amendments adding “physician assistant” to the definition of “behavioral health professional” and establishing that no judicial action taken as part of the 48-hour review shall constitute a finding by the court.

The House Committee of the Whole adopted a technical amendment adding a reference to the Care and Treatment Act for Mentally Ill Persons.

In the Senate Committee on Judiciary hearing, conferees testifying in support of the bill included the superintendent of Larned State Hospital and representatives of the Association of Community Mental Health Centers of Kansas, the Disability Rights Center of Kansas, and the Kansas Psychiatric Society. Written-only proponent testimony was submitted by the Kansas Association of Chiefs of Police, Kansas Peace Officers Association, and Kansas Sheriffs' Association; Kansas Hospital Association; Kansas Judicial Council; Mental Health America of the Heartland; and National Alliance on Mental Illness—Kansas. A representative of the National Association of Social Workers—Kansas testified in opposition to the bill, requested an amendment adding licensed social workers to the definition of “behavioral

health professional,” and indicated the association would support the bill with the amendment.

The Senate Committee adopted the amendment requested by the National Association of Social Workers–Kansas and an amendment regarding data collection requested by the Disability Rights Center of Kansas. [Note: The Conference Committee did not agree to include this amendment in the report.]

According to the fiscal note prepared by the Division of the Budget on the bill as introduced, enactment of the bill would require KDADS to add a minimum of 3.0 FTE positions to handle the increased caseload due to licensure of the facilities at an estimated cost of \$198,982 for salaries, wages, and benefits. Equipment, office space, and other operating expenditures of \$83,307 would be required from federal funds for a total cost of \$282,289, of which \$191,957 would be from the State General Fund.

Additionally, enactment of the bill could cause hardships for centers required to accept any individual brought to the center by law enforcement, but an estimate of this fiscal effect cannot be provided. KDADS currently provides contract funding to at least three centers.

Enactment of the bill could have a fiscal effect for cities that provide support for centers and would require additional education and staff training for law enforcement personnel, but the League of Kansas Municipalities indicates it is not possible to estimate the fiscal effect.

The Office of Judicial Administration (Office) indicates enactment of the bill could have a significant effect on Judicial Branch expenditures due to affidavit and petition review requirements, but the Office is unable to estimate the fiscal effect.

Enactment of the bill could result in additional reports or complaints regarding physicians alleged to have violated the

requirements in the bill, which could require additional investigations by the Board of Healing Arts (Board), thereby increasing operational expenses, but the Board cannot estimate the additional costs.

Any fiscal effect is not reflected in *The FY 2018 Governor's Budget Report*.

crisis intervention act; mental health; judiciary; behavioral health; law enforcement; emergency observation and treatment; crisis intervention center; Care and Treatment Act for Mentally Ill Persons; Care and Treatment Act for Persons with an Alcohol or Substance Abuse Problem

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