

MENTAL HEALTH SCREENING AND DISCHARGE PLANNING HANDBOOK

A Guide for Community Mental Health Center Screeners and Kansas State Mental Health Hospitals Staff

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FOREWORD

This handbook is published by the Community Services and Programs Commission within the Kansas Department for Aging and Disability Services (KDADS). It is to be used both as a training tool, and also as a reference resource for those who perform mental health inpatient hospitalization screens as a part of their employment responsibilities. It includes both general information about hospital screenings, as well as step by step guidelines for completing the Mental Health Screening Form, particularly for Medicaid Inpatient Psychiatric, State Hospital, and KVC Star/Wheatland screens.

Questions related to this handbook may be directed to Community Services and Programs Commission within KDADS.

SECTION I: GENERAL INFORMATION

A. HISTORY AND BACKGROUND:

Prior to Mental Health Reform, little connection between local mental health services and state mental health hospitals existed. There was both little state funding for local mental health programs as well as little oversight of these programs. In the late 1980s, a movement toward integrating the state and local mental health systems emerged. The concept was to have one unified system which could provide services to people in their homes and communities, follow them if hospitalization became necessary, and work to help them to return home as soon as possible with coordinated, continuing care planned to assist them in the community. This system changed the focus from institution-based care to community-based services.

Mental health Consumers and advocates also had an impact on mental health services during this period of time. There was an increased focus on the strengths, abilities, needs, and desires of persons with mental illness and a growing realization that persons with mental illness could remain in their communities and receive mental health services as opposed to sending persons to a hospital, away from their home community, for treatment. Stakeholder movements, combined with the state's need to integrate the fragmented mental health system, resulted in the passage of the 1990 Kansas Mental Health Reform Act. One outcome of this act was that Community Mental Health Centers (CMHCs) would begin to function as gatekeepers to the state mental health hospitals. This responsibility is met by CMHC employees performing mental health screens to determine the level of care needed to assist a person in meeting their mental health and safety needs. Most of the milestones set out in the Act were accomplished within a six year period, beginning in the eastern part of the state of Kansas and moving westward.

Since Mental Health Reform was enacted, the primary responsibility for providing mental health services in Kansas rests with CMHCs, and CMHCs have progressively increased their capacities to provide an ever wider range of services within Consumers' natural environments. Most Consumer needs are met without admission to a state hospital. The CMHC Screeners are responsible for determining what alternative services can be accessed to maintain community living.

For those Consumers who do go to a state hospital, CMHCs have the responsibility to determine when they will be admitted. When a person is determined appropriate for state hospital care, continuing contact is provided by a liaison from the CMHC to that state hospital. The liaison participates in treatment planning and preparing for discharge back to the community, as well as coordinating the Consumer's care with other providers of services that may be necessary or helpful.

Although the basic measures outlined as "Mental Health Reform" have been completed, the concepts and processes put in place by Mental Health Reform continue as the state mental health system and those employed within it strive to ensure that the citizens of Kansas receive needed mental health services within their communities and integrated care regardless of what part of the system they utilize.

B. HOSPITAL AND HOME INITIATIVE

During the last several legislative sessions concern was raised regarding increased state mental health hospital admissions resulting, in some cases, chronic over-census. The expressed concerns centered on whether or not Kansas has enough inpatient mental health treatment beds. The 2006 Legislative Budget Committee recommended the following:

SRS (KDADS as of 7/01/2012) and mental health stakeholders shall work together to define what the future role of the State Mental Health Hospitals (SMHH) is going to be; to determine what the appropriate number of inpatient beds that is necessary to meet the needs of the citizens of Kansas based on the State's current population and respective population growth projections (either SMHH beds or a combination of SMHH beds and local acute care inpatient resources); and to propose a plan as part of the agency's budget hearings in 2007 to the Ways and Means and Appropriations Committees that would support the needs identified in the plan.

SRS, under the leadership of the Deputy Secretary of Social and Rehabilitation Services Disability and Behavioral Health Services, formed a Hospital and Home Initiative Core Team. This Team included representatives from mental health, substance abuse treatment, developmental disabilities, Consumers, and advocates. The Core Team's Vision, Mission, and Outcomes were established as follows:

Vision: The Mental Health service delivery system in Kansas encourages recovery and services to be provided in the most appropriate and integrated setting.

Mission: To research and design a plan to implement an effective array of hospital and community services that support mental health wellness and recovery through partnerships and data driven strategies.

Outcomes: Persons receive person-centered services in the most appropriate setting

C. WORK OF THE CORE TEAM

The initial Core Team meetings were spent reviewing most recent studies regarding the Kansas mental health service system and key information regarding how services are delivered. One key activity was the analysis of demographic data regarding persons who were served by state mental health hospitals and the type, amount, and scope of services provided to those persons before and after admission. Some key findings amongst those admitted to the state hospitals were:

1. A high number of persons with addictions
2. A significant number of persons admitted who were not previously associated with a community mental health center
3. A wide variance in the amount of services provided before admission and after discharge
4. A small number of persons experiencing significantly longer stays that utilized a large number of bed days
5. A small number of persons experiencing repeated admissions that utilized a large number of bed days
6. Delays in discharge due to lack of safe and affordable housing and adequate transportation
7. The need to develop capacity to serve persons with multiple complex needs such as offenders and persons with addictions, developmental disabilities, severe behavior challenges, traumatic brain injury, intensive medical needs, etc

Based on this work, the Core Team formed work teams/subcommittees that were given specific charges to complete. The Assessment, Screening, and Discharge team was responsible for developing a protocol to assess treatment needs and recommend level of care based on those needs, taking into consideration Consumers with multiple complex needs. This document reflects the work of the Assessment, Screening, and Discharge team.

D. CORE VALUES OF THE SCREENING, ASSESSMENT, AND DISCHARGE SUBCOMMITTEE

A number of important values were identified to guide the assessment and/or screening process to ensure the Consumer may receive care in the least restrictive environment, and that care is coordinated efficiently to improve outcomes (crisis prevention, diversion from state psychiatric hospitalization). Whenever possible, proactive planning should be done with Consumers to prevent situations from becoming crisis in nature and/or requiring a screen. Recommendations were developed to promote consistency during the screening process, but with enough flexibility so the unique needs of each Consumer (active or new to CMHC) are considered. In all interactions, Screeners should promote a Consumer-driven, collaborative process, where the Consumer's best interests are supported. A safe, supportive, non-judgmental environment is essential so the Consumer feels respected and validated. Statements of concerns are documented, and the Consumer's definition of a crisis is considered. It is important to note a crisis contact with a Consumer may not require a screen, but attempts are made to actively engage them, identifying their needs and problems they wish to address, while respecting their individual choices and rights.

It is essential to work with the Consumer to identify and even collaborate with his/her sources of support, people whom he/she finds helpful (family, friends, religious/spiritual leaders, teachers, case managers, peer support specialists, and Consumer Run Organizations). If a guardian of the Consumer is identified, reasonable attempts must be made to consult with the guardian in making an informed decision about the Consumer's care. The clinician must be mindful of confidentiality statutes as it applies to each individual case and obtain releases of information as necessary. The team encourages sensitivity to available resources in the community, as well as differences in frontier, rural, and urban areas in coordinating a Consumer's care.

The work team also acknowledges that during a screen, there may be different strategies for working with Consumers with special needs such as substance abuse, medical fragility, elderly, MR/DD, etc. Furthermore, potential trauma issues should be addressed with sensitivity and with an effort to avoid re-traumatizing the Consumer (i.e. in-depth details of trauma should not be probed during a crisis assessment).

E. STAKEHOLDERS

There are many people that have a stake in the outcome of the screening process, including but not limited to the following:

1. the **Consumer** who is the subject of the screen.
2. the Consumer's **family and support network**. The distance from one's supports makes a vital difference in both the ability of a Consumer to deal with his or her situation as well as the abilities of those who care for him or her to deal with the situation. The long term success of anyone experiencing mental health difficulties is greatly affected by the natural and professional supports available to him or her. The less disruption to any of these supports, the better the outcome for the Consumer.
3. the **Community**. This may include any concerned individuals or agency representative who may have initiated the process of ensuring that the Consumer's safety needs are met.
4. the **Community Mental Health Center (CMHC)**. The employer of the professional conducting the screen relies on him or her to accurately assess the Consumer's needs and determine if hospitalization is necessary, and if it is not, to work with the Consumer to develop an appropriate alternative plan. The appropriateness of the treatment the Consumer will receive is impacted by the decision of the Screener.
5. the **Screener**. Screenings may only be completed by a Qualified Mental Health Professional (QMHP) as designated by the State of Kansas, who has successfully completed an approved Screener's training and post-test examination (note: there is a 90-day window for newly hired QMHP staff to meet this requirement, within which time the QMHP can perform screenings). The Screener acts as a representative of the CMHC, as well as the larger community, and must be familiar with the rules and requirements by which their CMHC's services are provided. They should also be able to access information about the rules, requirements and resources of other CMHC's and communities when working with a Consumer from a different location. Finally, every Screener should be an advocate for the Consumer, working with others as needed to improve Consumer access to necessary services and to lessen barriers for those whom we serve.
6. **Local/Regional Inpatient Psychiatric Facilities**. These facilities may be an invaluable resource to a person experiencing a mental health crisis in lieu of state psychiatric hospitalization. Ties to supports may be better sustained and continued service from familiar providers may be maintained when the Consumer is closer to home.
7. **Local/Regional Medical Facilities**. These facilities are often where a Consumer's mental health concerns are observed and may be a first point of contact for obtaining treatment. Providers within these facilities may contact CMHC's to request assessment, screening, or other intervention including care coordination.
8. **Local law enforcement agencies and courts**. These agencies have the responsibility of providing members of the community with protection from others as well as from themselves when necessary. A mutually responsive relationship with appropriate communication between the parties can make the difficult process of court involvement in the private aspects of another person's life much less

complicated.

9. **State Hospitals.** The state hospitals depend on the screening party to provide them with accurate information about the immediate needs of the Consumer. Following admission, hospital staff assess and treat presenting problems.
10. **Child Welfare Contractors.** These contracted agencies have the responsibility of overseeing the child's mental health needs while the child is in their custody, and may contact CMHC's for crisis intervention services. In any case, the Screener will need to facilitate communication with the child welfare contractors to coordinate the disposition of the screen.
11. **Kansas Health Solutions (KHS).** This agency has oversight and provides care coordination for Medicaid and Medicaid eligible Consumers with Special Health Care Needs. They are also the point of contact for organizing Medicaid Inpatient Psychiatric screens, State Hospital screens, KVC Star/KVC Wheatland screens, and PRTF screens. KHS is also responsible for reimbursement of non-Medicaid screens for Consumers being screened for PRTF, State Hospital, and KVC facilities.
12. **Kansas Department for Aging and Disability Services (KDADS).** The Kansas Department for Aging and Disability Services mission is to foster an environment which; promotes security, dignity and independence, while providing the right care at the right time in a place called home. The Kansas Department for Aging and Disability Services envisions a community that empowers Kansas older adults and persons with disabilities to make choices about their lives.
13. **Department for Children and Families (DCF).** DCF is a new agency focused on protecting children, promoting healthy families and encouraging personal responsibility.

SECTION II: SCREEN CONSIDERATIONS

A. IDENTIFICATION OF THE CRISIS

During the Hospital to Home initiative, there was a need identified to define what constitutes a crisis as well as distinguishing between a crisis assessment and a screen. A crisis can be identified by a Consumer or another referral source (i.e. family, school, law enforcement, CMHC, etc.). Generally, a crisis occurs when the demands of a serious, acute, emotionally hazardous situations exceeds the abilities and resources of those involved to effectively resolve it.

There may, at times, be differences in how people define crises, and not all crisis situations require screening for hospitalization. A crisis assessment is a face-to-face appraisal by a QMHP (the Screener) to define the nature of the problem, determine the appropriate intervention (which may or may not include a screen for hospitalization), and develop treatment recommendations and activities for follow up.

Screening is the process performed by a QMHP using the Mental Health Screening Form to determine whether a person can be treated in the community or should be referred to the appropriate state psychiatric hospital or private acute care facility. Screenings may occur at various community locations (i.e. CMHC, community hospital, law enforcement center, etc.). There is no requirement regarding the location of the evaluation, but issues of safety and confidentiality should be considered. Note that mobile screening policies may vary by CMHC and internal CMHC policies should be referenced and followed. Screenings by televideo conferencing are conducted by some CMHC's.

It is the role of the Screener to help determine which crises situations require screening for inpatient hospitalization and which can be attended to through alternative outpatient means. This determination may depend upon factors such as how well the Consumer is known to the Screener, Consumer's psychiatric history, etc. When in doubt about which is more appropriate, it is recommended that a formal screening assessment should be completed.

In general, a screening is to be performed when requested by a Consumer or by any other community agency or person, or when it appears to CMHC staff or others that a person's psychiatric condition may warrant more than outpatient evaluation and/or treatment. Risk factors identified during a screen will help determine whether a person does meet criteria for inpatient care. Refer to the Appendix for a description of Mild, Moderate, and High Risk which may help a Screener rule whether a screen should be completed.

B. CHILD WELFARE CONTRACTORS/JUVENILE JUSTICE AUTHORITY(JJA)

Child welfare contractors or JJA may facilitate and be directly involved with a screen. However, when a request for a screen comes directly from a foster parent, or the need is identified by the CMHC, or source other than the child welfare contractor or JJA, it will be important for the Screener to contact the child welfare contractor or JJA worker responsible for the child. The child welfare contractor or JJA worker responsible for the child will need to give approval for the screen and, if the disposition is hospitalization, they will likely have input into which hospital is preferred. Typically the child welfare contractor or JJA is responsible for arranging appropriate transportation and for completing admission paperwork at the hospital. If these Consumers are diverted from inpatient care, the Screener should develop a plan for outpatient mental health services. Basically, the plan should not ONLY be for the Consumer to be diverted back to the contractor for care.

C. TYPES OF SCREENS

- 1. State Hospital Screens:** Mental Health Reform provides the gate-keeping activities for Consumers 18 and older seeking state psychiatric hospitalization. The purpose is to determine whether a Consumer can adequately be treated in the community or if a higher level of care is needed in a state psychiatric facility (Mental Health Reform Act, K.S.A. 39-1602 (h)).
- 2. Inpatient Psychiatric Hospitalization (Medicaid Pre-Admission Screening):** The purpose of the Medicaid Pre-Admission Screening Program is to identify whether a Medicaid Consumer or potentially eligible Medicaid Consumer seeking private inpatient psychiatric care meets

medically necessary admission criteria for Medicaid reimbursement. The purpose includes determination of the most appropriate, least restrictive level of care for the individual, taking into consideration available alternative community resources.

3. **Third Party Payer Screens:** Some CMHC's may have contracts or other uses for the Mental Health Screening Form. Reference internal policies for completing these types of screens.
4. **State Hospital Alternative Screens:** Children and adolescents who need hospitalization for serious mental health conditions are now being referred to KVC State Hospital Alternatives with locations in Kansas City and Hays. This is part of an effort by the state of Kansas to make more hospital beds available for mentally ill children. These children were previously treated at the state's Rainbow Mental Health facility and Larned State Hospital. This endeavor, known as STAR, and now Wheatland, serves adolescents up to age 18 who have both acute and sub-acute conditions.
5. **PRTF Screens:** The Mental Health Screening Form is also used for PRTF screens for children and adolescents. Please refer to the PRTF manual for more information regarding these types of screens.

D. COUNTY OF RESIDENCE

County of Residence is defined by the state of Kansas as physical presence with intent to remain in a county. For most people, the county of residence is where their home is located. Therefore, the County of Residence may change depending upon a person's choice to move from one county to another. An exception to this is a person who is residing in a facility in a particular county to receive mental health services because appropriate services are not available in his or her home county. Such individual's residence would be that of his or her primary place of residence prior to entering the facility.

A child's county of residence follows that of the custodial person. In cases of joint custody, the child's residence is determined by the residence of the parent with whom the child lives at the time of the screening. If parental rights have been terminated, the child's residence is determined by the court of jurisdiction.

If the county of residence is disputed, the disagreement resolution process is described in Section G.

E. COUNTY OF RESPONSIBILITY

The concept of County of Responsibility has been assigned by KDADS to address the issue of Consumers who live outside of the county where they were found to be in need of a state hospital or PRTF screen. County of Responsibility, refers to the county within the service area of a CMHC to which a Consumer is assigned. In most cases, the County of Responsibility and County of Residence are the same. However, there are noted exceptions to this policy.

The county of "residence" and the county of "responsibility" may be different when a Consumer moves from his or her home to a facility for the purpose of receiving some special service. This move may be to a nursing care facility because of that facility's ability to provide the Consumer with special services he or she could not get in his or her home county. Subsequently, if that Consumer needs to be admitted to a state hospital, a determination must be made regarding which CMHC will be responsible for working toward discharge with that Consumer and thus, contractually responsible for the Consumer's bed days. The County of Responsibility is the county from which the Consumer originally came or the county where the Consumer lived independently or with family (in other than a group home, boarding home, NF/MH, or other supervised living facility) for at least six continuous months prior to the latest admission to a state hospital or other institution. In the case of children in foster care, the county of responsibility would be where they last resided with their custodial parents for at least six months. The six month qualifier **will not apply** if a person has moved from out of state to Kansas with **intent to stay**. The CMHC's contract may spell out certain of these exceptions, or the hospitals and the involved CMHCs may agree to certain assignments.

At times CMHC Screeners may be called upon to screen individuals who are not residents of Kansas, and have no intent to stay, but may need inpatient psychiatric care. In this case, the County of Responsibility would be "Out of State."

The screening instrument requires the Screener to make an initial determination of the Consumer's "County of Responsibility". The Screener should make this assignment where it seems most reasonable based on the current information. The Screener should begin with the county from which the Consumer enters the system, and work back from there. Consultation between the staff of two or more CMHC's may be required to sort information out. The determination of responsibility at the time of admission on the screening instrument is the assignment the state hospital will initially utilize.

F. COURTESY SCREENS

A courtesy screening is a screening performed by a Screener from one CMHC on a Consumer who is either (1) a current Consumer of another CMHC, or (2) a person for whom another CMHC is responsible based upon that Consumer's "County of Responsibility." When a Screener learns a Consumer is or should be a client of another CMHC, that Center must be contacted and the Screener must request permission to do a Courtesy Screen. If an immediate contact is not possible, then the screening will proceed and the situation will be discussed with staff of that Center as soon as possible. **This is mainly necessary for State Hospital Screens and PRTF Screens.**

During the discussion with staff of the CMHC responsible for the person being screened, the responsible CMHC's staff person should either: (1) arrange to complete the screening by sending their Screener to the location of the person or by utilization of some other method i.e. televideo, or (2) arrange for the screening to be completed by a Screener from the contacting CMHC. It is this second alternative, having the screening done by a Screener from another CMHC that is referred to as a "courtesy screening."

When permission has been obtained, the Screener must document on page one of the screen (1) the CMHC giving approval, and (2) the name of the individual approving the courtesy screen.

A courtesy screening is commonly required when a person is taken into protective custody by a law enforcement officer while that person is in an area other than where the person normally resides, or when a person is experiencing a crisis at a time that they have been "temporarily" placed in an alternative living situation. In either case, the person's "County of Responsibility" falls within the service area of a CMHC other than the one within which the person comes to the attention of the local Screener.

An important aspect of any screening is knowledge of the resources of the person's home community to consider treatment in the least restrictive environment. Since the person performing the courtesy screening may not be familiar with those resources, "matching" the person's assessed needs with the resources of the home area will be difficult. The Screener must make every reasonable effort to contact the responsible CMHC in order to obtain this information, especially if the patient can be diverted from hospitalization. If the person being screened does not intend to return to their "home" community, then the Screener will need to match local resources with the person's assessed needs.

Consultation with staff from the state hospital may assist the Screener in learning about local resources, or staff at the state hospital can be alerted to notify the other CMHC liaison quickly that a person from their service area is or has been admitted to the hospital and may be more appropriately served elsewhere.

A copy of the screening instrument and any admission authorization documents must be faxed to or sent to the CMHC which has responsibility for that Consumer. Normally, the responsible CMHC should become involved in any involuntary legal proceedings that follow from the screening, but since the local Screener in all likelihood signed the Certificate and "ticket letter," that local Screener may be called upon to provide evidence at the probable cause hearing.

In the event that agreement cannot be reached as to which CMHC has responsibility for an individual, the CMHC originally requested to perform the screening must complete that screening and accept temporary responsibility for that Consumer. Thereafter, the dispute resolution process outlined later in this Handbook can be utilized.

The Screener has the option of admitting to a state hospital outside of the Consumer's catchment area in **limited cases** due to proximity, transportation, legal considerations. It is recommended the Screener consult the CMHC of responsibility in these matters.

G. APPEALS AND MODIFICATIONS

State Hospital staff regularly provide each “participating” CMHC with information about Consumers in the hospital including the CMHCs which have been assigned “responsibility” for each of these persons. If a CMHC disagrees with an assignment, that CMHC can make an appeal to the chief social worker of the hospital. The chief social worker will investigate further and attempt to find agreement between the two or more CMHCs involved in the dispute.

If agreement can be reached, the assignment and count of bed-days can be modified, retroactively, to reflect the correct “county of responsibility”. If no agreement can be reached, the appeal is referred to the KDAD Director of Medicaid and Management Operations, within the Community Services and Programs Commission.

H. THE STATE PSYCHIATRIC HOSPITALS

The State of Kansas operates three inpatient psychiatric hospitals; Larned State Hospital (LSH), Osawatomie State Hospital (OSH) and Rainbow Mental Health Facility (RMHF) to serve adult Consumers. Prairie Ridge Star and Wheatland psychiatric hospitals (KVC) have replaced child and adolescent Consumer beds at Larned and Rainbow State Hospitals. The two large state psychiatric hospitals, Larned and Osawatomie, serve persons from specified catchment areas which divide the state in two. The Rainbow facility serves adults principally from the Kansas City metropolitan area. The state psychiatric hospitals provide care and treatment to both voluntary and involuntary (court committed) Consumers. These are the only state psychiatric facilities or units for which CMHC Screeners can facilitate an admission for a Consumer. See Appendices E and F for CMHC and state hospital information. A map of the Kansas counties and corresponding hospital catchment areas can be found at:

<http://csp.kdads.ks.gov/agency/mh/Pages/Services/SMHHs.aspx>

<http://csp.kdads.ks.gov/agency/mh/Documents/MHDirectory.pdf>

I. GUIDELINES FOR DETERMINING IF A PERSON CAN BE ADMITTED TO A STATE PSYCHIATRIC HOSPITAL

General Admission Criteria – This would include symptoms that interfere with the Consumer’s ability to care for themselves and/or dependents outside the structure of a psychiatric hospital, **criteria which, in and of themselves, MAY constitute justification for admission.** The Criteria listed below are related to a documented diagnosis using the current DSM. The Consumer should not have a primary diagnosis of alcohol or chemical abuse, antisocial personality disorder, mental retardation, or an organic mental disorder:

1. **Abnormal thinking** that interferes with the ability to care for themselves and/or their dependents outside the structure of a psychiatric hospital. Abnormal thinking may include:
 - a. Paranoid thinking.
 - b. Ideas of reference.
 - c. Loss of reality testing.
 - d. Loss of time concept.
 - e. Confusion or incoherence.
2. **Abnormal perceptions** that interfere with the ability to care for themselves and/or dependents outside the structure of a psychiatric hospital. Abnormal perceptions may include:
 - a. Auditory hallucinations
 - b. Visual hallucinations
 - c. Unable to recognize familiar people
 - d. Other sensory hallucinations
3. **Abnormal feelings** that interfere with the ability to care for themselves and/or dependents outside the structure of a psychiatric hospital severe enough to threaten self, others, and/or property (where likely property damage is considered substantial). Abnormal feelings may include:
 - a. Severe depression likely to cause a suicide attempt.
 - b. Anger and/or Rage that provoke feelings of wanting to harm other people.
 - c. Unusual fear, anxiety and/or panic that are likely to cause self-injury.

4. Abnormal behavior that interferes with the ability to care for themselves and/or dependents outside the structure of a psychiatric hospital severe enough to threaten self, others, and/or property (where likely property damage is considered substantial). Abnormal behaviors may include:

- a. Suicide threats or attempts of a serious nature.
- b. Homicidal threats or attempts of a serious nature.
- c. Self-care failure due to interference with judgment that may cause self-injury or aggravate illness.
- d. Mutism or catatonia that makes it impossible to assess the patient without hospital admission.
- e. Mania
- f. Failure of self care

J. DIVERSIONS FROM STATE PSYCHIATRIC HOSPITALIZATION

Screeners are the “gatekeepers” for the state psychiatric hospitals and will make efforts to help the Consumer receive care in the least restrictive environment. The Screener should consult the Consumer and collaterals (if available and appropriate) to make an informed decision on the appropriate level of care needed to help the Consumer stabilize.

Diversion options will vary by county and CMHC, but all available resources in the area should be considered before considering an admission to a state psychiatric facility. **Intermediate Care** options may include **Outpatient Services** (intake for services, referrals to natural and community resources) and/or **Crisis Prevention/Intervention Services** (Crisis Case Management, Mobile Crisis Response, In Home Crisis Stabilization, and Out of Home Crisis Stabilization). **Local/Acute Inpatient Psychiatric Hospitalization** is also considered a diversion from state psychiatric hospitalization. If the Consumer has a pre-established crisis plan in place such as a **WRAP plan**, the Screener and Consumer should review this plan and incorporate the elements into the screening outcome, when appropriate.

The Screener should adequately document the proposed crisis plan on the **Alternative Community Services Plan**. In Developing an Alternative Community services Plan, a crucial element is the determination that the services to which the Consumer is being referred are sufficient to protect the Consumer, and others, from harm. Also important is that the Consumer has the capacity (with assistance and support if necessary) to use those services.

An adequate Alternative Community Services Plan should include the following components:

1. Clear documentation of the diversion plan with a record of community services to which the Consumer is being referred
2. The diversion plan is congruent to the Consumer’s service needs as reflected in the screening document
3. Utilization of a safety plan as appropriate - The Screener should take reasonable steps to inform Consumer and family/friends about signs of increased suicide risk and provide emergency/crisis contact numbers if the Consumer later requires a higher level of care.
4. Documentation of the services and supports that will be provided to help the Consumer resolve the crisis in the least restrictive environment
5. Documentation of specific dates and times of services when available
6. Identification of care coordination or follow-up activities that assist the Consumer in remaining in the community
7. Identification of collaborative efforts with the Consumer’s natural supports
8. Documentation of the Consumer’s acceptance of referrals and services as evidenced by signature of the Member, Representative/Guardian.
9. Documentation that the Member and or Representative/Guardian were provided or faxed a copy of the Alternative Community Services Plan

The Screener should take reasonable steps to ensure the Consumer has accessed the necessary services and supports to meet their needs. Continued assessment is recommended to ensure the Consumer's diversion plan is appropriate to resolve the crisis.

If diversion options have been exhausted or are not appropriate, the Screener should document this and the medical necessity for state hospital admission.

K. INDICATORS THAT HOSPITALIZATION MAY BE INAPPROPRIATE

Persons presenting with the following conditions or under the following circumstances should, generally, not be considered for state hospital admission:

1. Persons not screened by a QMHP through a participating CMHC.
2. Children who are in need of placement secondary to their child-in-need-of-care status or adults whose primary need is housing (homelessness).
3. Persons not presenting in an acute psychiatric crisis, even if in need of some psychiatric treatment which could be met on an outpatient or on a less than inpatient basis.
4. Persons whose primary needs would be better met through services for mental retardation or developmental disabilities. (*This does not apply to persons presenting with severe psychiatric symptoms who also happen to have mental retardation or other developmental disabilities.*)
5. Persons presenting with an alcohol or substance abuse crisis, not obviously accompanied by a psychiatric crisis (and not presenting by a law enforcement officer for detention at the social detoxification unit).
6. Persons exhibiting extreme sexual acting out which is harmful to self or others and is not related to psychiatric symptoms.
7. Individuals requiring specialized medical/nursing care services beyond state hospital capabilities to provide. Specialized medical services beyond hospital capabilities include but are not limited to:
 - a. Intravenous catheters, ports, or permanent venous access; foley catheters, intravenous medications, Intravenous fluids.
 - b. Dialysis
 - c. Intensive care services
 - d. Ventilators
 - e. Services associated with total nursing care (i.e., patient confined to bed, cannot feed self requires toileting assistance)
 - f. Wound Care (depends on severity of wound and the care required)
 - g. Other services generally provided in a medical hospital or nursing home should first be discussed with the state hospital physician before referral.

Persons who would not be medically stable outside of a medical or nursing facility (based on a medical examination by a physician or doctor to doctor consult), or who are in need of significant medical care or treatment unrelated to or independent of any psychiatric symptoms. If a person is not in a hospital when screened, the Screener may recommend medical clearance at a general hospital before approving an admission to a state psychiatric hospital. If a Consumer is in hospital, it is important to facilitate doctor to doctor consultation to ensure the client is stable for transfer.

Note: The capability for state mental health hospitals to provide the medical services listed above is very limited – they are a specialty hospital for psychiatric services. If “yes” to any of the above, a consultation with the medical director and a nursing staff by the referring physician is required in order to ensure patient safety.

8. Individuals not presenting in an acute psychiatric crisis who, however, present evidence of dangerousness to self and others, and the sole diagnosis is conduct disorder or anti-social personality traits.

L. ADMISSION TO A STATE PSYCHIATRIC HOSPITAL

It is recommended that CMHC's develop guidelines for internal consultation when state psychiatric hospitalization is indicated. When diversion options have been exhausted or are not appropriate, there are considerations a Screener should attend to prior to facilitating state psychiatric hospitalization for a Consumer:

1. The Screener should make reasonable attempts to discuss hospital admission with the Consumer to determine their willingness to engage in inpatient care.
2. If the Consumer meets inpatient criteria for the state hospital, the Screener should determine whether the admission is voluntary or involuntary.
3. The Screener should coordinate the admission with the state hospital admissions office and consult with medical staff when appropriate, especially if the clinician feels the acceptance of a Consumer for admission might propose a challenge (medically fragile, intoxication).
4. The Screener should document any recommendations for treatment including type of intervention needed, possible length of treatment, and discharge recommendations.

When a CMHC Screener determines a Consumer needs to be admitted to a state mental health hospital and issues the Statement of a Qualified Mental Health Professional (historically referred to as the "ticket letter"), it is the policy of KDADS that the hospital will accept that admission.

Before sending the Consumer to the State Hospital the Screener should:

1. Contact the admissions office of the hospital
2. Forward a copy of the screening instrument and the letter authorizing admission (typically fax and sending paper packet) and assist the admissions office in any other way to arrange the admission
3. Explain the process to the Consumer and help him or her collect any other documents or information that he or she will need in order to be admitted.

Once admitted, the Consumer will be seen by a psychiatrist or psychologist at the hospital. The psychiatrist or psychologist will review the screening instrument and make an independent assessment of the diagnostic impression and the need for hospitalization. If the hospital professional has any concern about the appropriateness of the Screener's determination, a call will be made to the Screener to see if additional information is available or to clarify the Screener's findings. Even if a disagreement persists, the Consumer will remain at the hospital for at least 24 hours for further observation and evaluation.

If, after that 24 hour period, there still exists among hospital staff a disagreement with the Screener's determination, the matter will be referred to the chief social worker of the hospital for review. Should the chief social worker, in coordination with any other staff, concur with the Screener's determination, the disagreement will be dropped. If after review by the chief social worker, disagreement still exists, a joint case review procedure and appeal process as necessary (described below) will be implemented.

M. KVC HOSPITALS PRAIRIE RIDGE STAR AND WHEATLAND – STATE HOSPITAL ALTERNATIVES (SHA)

GENERAL INFORMATION:

Prairie Ridge Star SHA and Wheatland SHA (KVC hospitals) are considered alternatives to state hospitalization for children up to age 18. It is recommended that a Screener consider the range of diversion options available in the community, including local/acute inpatient psychiatric hospitals, prior to requesting a Prairie Ridge STAR or Wheatland SHA screen. It is understood that the range of diversion options will vary across CMHC's.

Alternative to State Psychiatric Hospitalization for Children not in State Custody. Custodial parents, on behalf of their minor child, may give consent for voluntary treatment at the Prairie Ridge Star and Wheatland facilities. If the parents do not consent to voluntary care for their child, but the Screener believes the Consumer is an imminent risk of harm to self, others, property, and the treatment is considered medically necessary, the Screener may pursue involuntary hospitalization at these facilities.

Alternative to State Psychiatric Hospitalization for Children in Custody. If a child in custody of DCF is in need of mental health services (with the exclusion of admission into a state psychiatric hospital), and parental rights have not been terminated, parental permission shall be sought. If, after diligent efforts, it is not possible to obtain parent(s) permission, contracting agency staff shall give consent to mental health treatment. If contract agency staff are not readily available, designated DCF staff shall sign consents. If parental rights are terminated, consent shall be given by contract agency staff. If contract agency staff are not readily available, designated DCF staff shall sign consents. An involuntary hospitalization should not be needed under these circumstances.

N. LEGAL PROCESS AND ISSUES:

Application for Admission for Acute Private Facilities and State Hospitals. Any adult, any parent on behalf of their minor child, and any child who is 14 years of age or older, may apply to any mental health treatment facility for services, including admission to inpatient care, by going to that facility and filling out an application for services or for admission. Legal guardians may do so for their wards only if they have received authorization to do so from the Court having jurisdiction in the guardianship case. In such situations, authorization to consent to inpatient care may be given in a case specific situation, or in cases of repeating need, on a continuing basis. The Letters of Guardianship should describe the guardian's authority.

If the minor's guardian does not concur with the Screener's findings and there is imminent risk of harm to self or others, the Screener has the ability to pursue an involuntary commitment to a psychiatric facility that accepts involuntary patients. The Screener may need to make a report to DCF Child Protective Services (case by case basis) – refer to CMHC policies or recommendations in these types of cases.

Application for services or admission alone is not enough. In the case of admission to a state psychiatric hospital, a voluntary Consumer must also have been screened by a QMHP from a participating CMHC, and been given authorization for that admission, evidenced by a Statement of a QMHP (ticket letter). In all cases, the facility has the obligation to screen (or re-screen) the applicant for appropriateness for admission, and may refuse admission to anyone whom the facility believes is either:

1. Not in need of such services, or
2. Lacking in understanding of the nature of what he or she is doing, and therefore without the capacity to consent to such treatment.

In the latter cases, involuntary commitment may be appropriate, and a Screener who has authorized a voluntary admission to a hospital may be required to re-screen the individual to determine whether to issue a "ticket letter" for an involuntary admission.

Voluntary Admissions for State Mental Health Hospitals. The requirements for admission to state mental health hospitals for voluntary treatment include:

1. The Consumer (18 and over) must have the capacity to consent to care, and must agree to participate in treatment. Voluntary admissions should not occur just because the patient is willing to be admitted, as there are legal criteria determining voluntary status. The Consumer must be able to understand the nature and effects of hospitalization/treatment, and must demonstrate the ability to engage in rational decision making regarding treatment (weighing the possible risks and benefits of treatment).
2. The Consumer meets **General Admission Criteria** and there is agreement of the treatment facility that the voluntary patient is in need of services which the facility offers and is willing to provide.
3. The Consumer has been diagnosed with a current DSM diagnosis and is not manifesting a primary diagnosis of the following: antisocial personality disorder, chemical abuse/addiction, mental retardation, organic personality syndrome, or an organic mental disorder.

Demand for Discharge. A voluntary Consumer retains the right to consent to or to refuse any treatment. A voluntary Consumer has the right to request discharge even though that may be against the recommendation of treatment staff. The Consumer can be required by hospital policy to do so in writing. Upon receipt of such a written notice, the treatment facility must either discharge the patient within 3 days, or file an involuntary commitment action in Court. A new screening and "ticket letter" is not required in that situation.

Guardianship, Powers of Attorney and Advanced Directives. A guardianship, Power of Attorney, or an Advanced Directive can create special issues concerning “voluntary” consents for care and treatment. The presence of these types of circumstances will require special attention and careful consideration.

A guardian, generally, is an individual appointed by a Court to take charge of and make decisions for their ward. A ward is someone who has been determined to be unable to appropriately make decisions. **If the Consumer has a guardian, consultation is essential to coordinate care.** Screeners should seek to obtain documentation describing the powers of the guardian. A guardian is subject to the Court’s control and has only limited authority to place the ward in certain types of treatment facilities. The guardian must get extra and specific authority to be able to give voluntary consent to inpatient psychiatric treatment. The guardian’s authority should be delineated in a written order or on the guardian’s “Letters”. (“Letters of Guardianship” are issued to a guardian by the Court as evidence of their appointment.) **A Screener should not admit a Consumer to a state psychiatric hospital with the consent of a guardian without reviewing the court documents. Should the court documents not be available or they are not found to support a voluntary admission by guardian, the Screener should consider pursuing an involuntary admission.**

For a voluntary admission to a state mental health hospital, the legal documentation should include reference to Kansas Statute 59-3077. The documentation may not always include this statute, but it may be worded as such that the hospital would accept the admission as voluntary by guardian. The Screener may benefit from consulting the legal departments of the state mental health hospitals to review the guardianship papers.

A power of attorney is a written delegation of decision making authority which a person gives to someone whom they trust to make certain decisions for them should they be unable to do so for themselves at some later time. The authority and the subject matter of this power of attorney, and when this authority begins, should all be carefully and specifically delineated in the actual document. The content of the document must meet certain legal requirements in order to be enforceable. **A power of attorney is not the same as guardianship, and less weight is given in terms of authorizing an admission.**

An advanced directive is a written statement in which a person specifies his or her wishes and desires with regard to certain matters. It is written at a time when the person is able to think clearly about the subject matter, so that later when they are unable to do so or to express their preferences, the advanced directive will be there to speak for them. An advanced directive should be specific and detailed with regard to its subject matters and the directions it gives. An advanced directive will have to comply with certain legal requirements in order to be enforceable.

Note: *A competent person retains the right to revoke a previously given power of attorney or advanced directive. Special care must be taken to ascertain that the power or directive is still in effect at the time it is to be used. Sometimes persons who are no longer competent to do so will attempt to revoke or claim that they have revoked their power or directive at the very time it is intended to go into effect. Consultation with the admissions department of the treatment provider to which the patient is being referred should take place before any decisions are enforced by guardian, power of attorney, or upon an advanced directive are made.*

Involuntary Admissions. This is a critical Screener competency. If it appears that the admission to the state hospital would need to be involuntary, the Screener should carefully review the criteria for an involuntary commitment to a state psychiatric hospital:

1. The Consumer:
 - a. Is suffering from a mental disorder which is manifested by a clinically significant behavioral or psychological syndrome or pattern and associated with either a painful symptom, or impairment in one or more areas of functioning.
 - b. Is experiencing substantial behavioral, psychological or biological dysfunction to the extent that the person is in need of treatment.
2. The Consumer is not manifesting a primary diagnosis of antisocial personality disorder, chemical abuse/addiction, mental retardation, organic personality syndrome, or an organic mental disorder.
3. The Consumer must lack capacity to make an informed decision concerning treatment. A person who lacks capacity is one who by reason of the person’s mental disorder:

- a. Is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment.
- b. Is unable to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by an inability to weigh the possible risks and benefits of treatment.
- 4. The Consumer must be likely to cause harm to self or others. A person who is likely to cause harm to self or others is one who by reason of the person's mental disorder:
 - a. Is likely, in the reasonable foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to property, as evidenced by behavior threatening, attempting or causing such injury, abuse or damage.
 - b. Is threatening, attempting, or causing harm to property to the extent that the harm would be of such value and extent that the state's interest in protecting the property outweighs the person's interest in personal liberty.
 - c. Is substantially unable, except for reason of indigence, to provide for any of the person's basic needs, such as food, clothing, shelter, health or safety, causing a substantial deterioration of the person's ability to function on the person's own.

Law Enforcement Detention. Any time a law enforcement officer can form a reasonable belief, either based upon personal observations, or based upon information learned from an investigation, that a person/Consumer is mentally ill and would likely cause harm to self or to someone else if left on their own, that law enforcement officer is authorized to take that person into protective custody. The officer must then take the person to an appropriate treatment facility to be seen by a Screener/QMHP. If the Screener, after evaluating the Consumer, tells the officer that they are not likely to be a mentally ill person subject to involuntary commitment, the officer is obligated to release the person (or to transport them back to where they were taken into custody). If the professional, however, certifies that the Consumer is likely to be a mentally ill person subject to involuntary commitment, the officer signs an application for emergency admission (for observation and treatment) and has the Consumer admitted to the treatment facility. If that facility is a state psychiatric hospital, the officer must also have the Consumer screened by a QMHP at a participating CMHC who must issue a Statement of a Qualified Mental Health Professional authorizing admission. The law enforcement officer, or someone else with firsthand knowledge of the circumstances necessitating the involuntary admission, must then file the necessary petition in Court by the end of business on the next day that the Court is open.

Emergency Detention and Treatment. If a Consumer is brought to a treatment facility by a family member, friend, by a law enforcement officer, or by anyone else, the treatment facility may detain, under certain circumstances, and hold the person for observation and emergency treatment until the end of business of the next day the Court is open for business. Those circumstances include any in which the Consumer appears to the treatment staff to be a mentally ill person subject to involuntary commitment and in which the person bringing the patient to the facility signs an application for emergency admission. If the facility is a state psychiatric hospital, the Consumer must have been screened by a QMHP at a participating CMHC and the QMHP must have issued a Statement of a Qualified Mental Health Professional authorizing that admission. Refer to statute KSA 59-2954 (b) or (c) for further information.

Filing a Petition in Court. The Screener should manage timely contact and cooperation with county officials when they have facilitated an involuntary admission. The Screener bears the primary responsibility of ensuring that the appropriate paperwork has been submitted to county officials. If the Screener is not the petitioner for the court, they should clearly communicate with the petitioner about expectations for court proceedings, and provide accurate information to county officials to coordinate court proceedings. The Screener should be aware of the respective county's policies and procedures for a Care and Treatment process as there may be variations in each county.

A petition for involuntary commitment can be filed in either the home county (where the patient resides) or the county where the patient was found. Someone with actual knowledge of the Consumer's circumstances is often the petitioner, but the county or district attorney, a law enforcement officer, or the CMHC Screener may also fill that role.

A Certificate of a Physician, Psychologist or QMHP stating that the Consumer has been seen and the professional believes the Consumer meets the legal criteria to be a “mentally ill person subject to involuntary commitment” must be attached to the petition. The Screener may be the professional who signs this Certificate.

If commitment to a state psychiatric hospital is being sought, the petition must also have attached to it a Statement of a Qualified Mental Health Professional.

Probable Cause Hearing. If a Consumer is detained as an inpatient through an ex-parte emergency custody order (issued by the Court after the filing of the petition), the Consumer is entitled to a probable cause hearing, which must be held within two days of the petition being filed. The purpose of the hearing is to see if sufficient evidence exists to establish that the patient is a mentally ill person subject to involuntary commitment. If the QMHP Screener also signed the Certificate of a Physician, Psychologist or QMHP, which was attached to the petition, it is likely that the Screener will be called as a witness at this hearing. If the Screener signed only a “ticket letter,” then often the Screener is not called as a witness. At the end of the hearing, the most likely outcomes include *either* that the petition is dismissed and the patient is released, or that the patient is detained on a temporary custody order and the case is set for a trial.

Order for a Mental Evaluation. Between the time a petition is filed and the occurrence of the commitment hearing, the Court will issue an order for a mental evaluation. This evaluation will be conducted by a psychiatrist, psychologist, or certain QMHPs. It involves a detailed procedure and results in a report which forms the basis for the key testimony at the trial.

Trial of the Case and Criteria for Commitment. Between 7 and 14 days after the filing of the petition (unless the patient agrees to an earlier trial, or the trial is continued from an earlier setting), a trial must be held to determine whether the petitioner can meet their burden to show by the evidence, clearly and convincingly, that the patient meets the legal criteria to be committed for involuntary treatment. Briefly, that consists of three elements:

1. The Consumer has a serious mental illness,
2. The Consumer lacks the capacity to understand the nature of their illness and their need for treatment for that illness, and
3. That because of those reasons, the Consumer, if not committed for treatment, is likely to cause harm to self or to someone else, or to the property of another.

These conditions of the Consumer must not be solely caused by certain disorders that are not considered to be mental illnesses or treatable by mental illness treatments. Conditions such as mental retardation, alcoholism, and organic mental or personality disorders caused by physical illness or injury, are excluded. At the end of the trial, the two most likely outcomes are that the petition is dismissed and the patient released, or that the court issues an order for treatment.

Continuance and Referral. An option available to Consumers between the time a petition is filed and the trial of the case is for the Consumer to agree to a continuance (postponement) of the trial, and to agree to be referred for treatment to a treatment provider. Sometimes this option is utilized by a Consumer to keep an official declaration of mental illness from being legally made. In any case, the Consumer retains the right to later have their trial re-scheduled and heard.

Outpatient Treatment Orders. In lieu of an inpatient treatment order, the law allows the Court to enter an outpatient treatment order. An outpatient treatment order can also be obtained while a Consumer is in a psychiatric facility on an involuntary basis. The Court must determine that the patient is likely to comply with any outpatient treatment requirements and that both the Consumer’s and public’s safety will not likely be threatened by outpatient status. Very often, outpatient orders are entered into after a brief period of inpatient treatment. This allows staff from the CMHC to monitor the Consumer’s continued compliance with medication treatment or outpatient therapy. If a Consumer on an outpatient treatment order fails or refuses to follow their outpatient regime, the Court can be asked to revoke the outpatient order and send the Consumer to an inpatient treatment facility.

Note: Anytime an outpatient treatment order is being revoked and an inpatient order at a state psychiatric hospital is sought, a new "ticket letter" is required.

Court Reviews. Periodically during any time that a Consumer is subject to involuntary commitment orders (whether inpatient or outpatient), the patient is entitled to have the Court conduct a review hearing to determine whether such commitment orders remain appropriate. These reviews are generally scheduled at either 3 or 6 month intervals, but can be set at any interval the Court finds appropriate, except that they cannot be set at any interval longer than 6 months.

Other Legal Proceedings. Other than involuntary commitment, persons might be Court ordered to a treatment facility, including to a state psychiatric hospital, for evaluations or for treatment under certain specific circumstances. This might be pursuant to the criminal laws or the Juvenile Offenders Code. Examples would include commitment for a competency to stand trial evaluation, or for treatment if found not guilty by reason of insanity. Another law which authorizes independent commitments is the child-in-need-of-care code. An example of an order under this code would be one issued for an evaluation to determine whether mental health treatment would be advisable.

O. TRANSPORTATION FOR CONSUMER TO THE STATE PSYCHIATRIC HOSPITALS

The Screener should make reasonable efforts to coordinate secure transportation for the Consumer to the state psychiatric hospitals depending on local or regional resources. The Screener should give consideration both to the Consumer's safety during transport, but also the use/disuse of restraints, making the process as humane as possible. The Screener should make every effort to make the transportation as least restrictive as possible, utilizing family, case managers, attendant care, etc. Law enforcement should be considered the last option for transportation.

P. FINANCIAL RESPONSIBILITY FOR HOSPITALIZATION

The state psychiatric hospitals are supported by the State and are maintained by revenue generated from payment of Consumer charges, receipts from insurance benefits and public funds. All Consumers will be charged according to the actual costs of their care. Matters concerning Consumer charges, adjustments and payment plans are handled through the Patient Account Services office within each hospital's business office. *No Person, however, will be denied any treatment because of an inability to pay their patient charges.*

Financial information is often not available at the time of screening and it should not preclude a Screener from facilitating a state psychiatric hospital admission if it is necessary.

Q. THE CMHC HOSPITAL LIAISON

Screeners should know their CMHC's liaison. This liaison will follow-up specifically on persons for whom the Screener has authorized admission to the hospital.

The liaison is the staff member designated by the CMHC to serve as the link between the person in the hospital and the CMHC. The liaison participates in the hospital's discharge planning meetings and can commit the CMHC to particular programs and services for a Consumer for whom the CMHC has "responsibility", and assist the Consumer and hospital staff to coordinate and secure community resources necessary for the Consumer to return to the community.

The Screener should alert the respective CMHC state hospital liaison as soon as possible following the Consumer's admission to the hospital to facilitate appropriate treatment planning. If the screen was done as a courtesy to another CMHC, the Screener should contact the respective CMHC, and provide a copy of the completed screen so that the appropriate liaison can facilitate the discharge planning process upon admission to the state psychiatric hospital.

R. EMTALA ISSUES

EMTALA stands for the Emergency Medical Treatment and Active Labor Act. It is a Federal law. EMTALA is enforced by the U.S. Department of Health and Human Services (HHS), specifically under the Centers for Medicare and Medicaid Services (CMS). EMTALA, and the regulations which CMS has adopted to spell out the responsibilities and liabilities of hospitals, are aimed at preventing hospitals that participate in CMS funded services (Medicaid and Medicare, virtually all hospitals) from “dumping” persons without adequate payment resources and otherwise difficult to serve persons out of the hospital’s emergency room. In some cases, hospitals were sending those patients to other hospitals to avoid treating them, and in some cases, they were either refusing to see those patients at all, or were simply “discharging” them without providing any care or attempting to transfer them to appropriate levels of care.

EMTALA requires any hospital that has a dedicated Emergency Department to accept any person who comes to, or is brought to, the hospital seeking assistance, for, at least, the purposes of assessing their needs and providing stabilizing care or other appropriate emergency care. There are limitations on when that hospital can transfer or discharge that Consumer. Included in the requirement to provide emergency care is a requirement to see and evaluate that Consumer to determine what care the person needs. **The limitations placed on transferring such Consumers include the requirement that the Consumer be medically stable prior to transport (so that transfer does not risk further harm to the Consumer) and that the hospital to which the Consumer is to be transferred agrees to accept that patient.** The accepting hospital need only accept a Consumer when the accepting hospital has determined through a “doctor-to-doctor” discussion that it has the capability of providing for the medical needs of the Consumer. This is after disclosure of the condition(s) and needs of that Consumer have been made to a physician on behalf of the receiving hospital. **The sending hospital must make available, a physician knowledgeable about that Consumer so that the receiving hospital’s physician can confer with the sending hospital’s physician and have any questions answered prior to giving consent to the transfer.** These requirements are very strict, and large fines (of up to \$50,000.00 per violation and/or discontinuation of a hospital’s CMS certification) can be imposed for failure to comply.

This becomes relevant to a Screener when he or she comes into a community hospital to perform a screen and recommends transfer of that Consumer to any other community service or any hospitalization of that Consumer that involves transporting the Consumer from a hospital with an emergency room to any other hospital. This includes transfers to both the state psychiatric hospitals and to other community or regional hospitals, and is true even if the Consumer will be driven to that other hospital by his or her family or friends. The fact that the Consumer came to or was brought to that community hospital and is now being “discharged” or “transferred” could create EMTALA issues.

Screeners must educate themselves about the hospital’s policies and their scope of practice in that hospital before providing screening services in that location. For example, while a Screener has the authority to authorize an admission to a state hospital, the transfer will not occur from a hospital’s emergency department (ED) unless the attending physician in the ED has arranged for an EMTALA compliant transfer. At the same time, if a Screener does not authorize the admission to a state hospital, that decision must be communicated to the hospital’s ED physician and that physician must approve the diversion plan before the patient can be discharged from the ED.

If there is ever a question involving EMTALA, the Screener should always find staff in the ED to answer questions so that the Screener does not put the hospital at risk for costly violations.

S. MENTAL RETARDATION/DEVELOPMENTAL DISABILITY AND SUBSTANCE ABUSE SYSTEMS

Two of the most complex problems a Screener is likely to encounter are when that Screener is presented with a request to screen a Consumer who is exhibiting symptoms that include or may be related to either mental retardation or a developmental disability, or alcohol or substance abuse. Many times, the underlying problem causing a crisis may not be discernable in these cases. In other cases, the cause of the crisis may be fairly clear, but the nature of the treatment, and provided by whom, first, is the more perplexing question. In either case, the Screener should keep two things in mind. First, the mental health services system is there to assist and

treat everyone. Just because an individual is developmentally disabled does not mean that he or she may not also have a mental illness. Likewise, it is not uncommon to see someone who has a mental illness attempting to “self medicate” with alcohol or drugs. Accordingly, the mental health services system has an obligation to provide mental health services in a coordinated manner with DD and SA service providers.

Secondly, the Screener should understand an individual with mental retardation or a developmental disability, or with an alcohol or substance abuse problem, may have whole other systems of support and assistance. The Screener should have knowledge of how these systems work so the Consumer may be assisted in obtaining these services in coordination and conjunction with mental health services.

Mental retardation and developmental disability. The existence of such a disability often may require a person who is extremely familiar with the Consumer to assist in the assessment of the Consumer’s need. MR/DD services are coordinated and arranged through a local Community Developmental Disabilities Organization (CDDO). The local CDDO’s service area will not necessarily be the same as the area served by a CMHC. The MR/DD system is built on individualized “slots” through which services are provided. An individual must be found eligible for services by their local CDDO, and will then be provided services as the CDDO has funding sufficient to move that person into a “slot” from the CDDO’s waiting list. A person in services cannot be denied re-access to services if they have had to be temporarily hospitalized because of mental illness.

Each CMHC should enter into a local agreement with each CDDO providing services within the CMHC’s service area. This agreement should provide for communication, cross-training and Consumer access procedures. Each CMHC Screener should be familiar with MR/DD eligibility criteria and the application process. No civil commitment laws exist in Kansas that compel a person to receive MR/DD treatment, absent criminal charges having been filed against that person, and the person having been found to be incompetent to stand trial.

It is important to note that admission to a state psychiatric hospital may not be appropriate or helpful to some MR/DD Consumers. For example, if they have a low level of functioning, they may not be able to participate in the treatment milieu and may be at risk of exploitation by peers. Screeners should take time to consider the individual’s capabilities and symptoms to determine if the person requires or can benefit from state psychiatric hospitalization, or if their needs can be better met in the community. Admission to a state psychiatric hospital is not a pathway for admission to a state MR/DD facility such as Parsons State Hospital.

Alcohol and Substance Abuse. Screeners will often be called upon by the local community to perform screenings on persons who are under the influence of substances. In these situations, the Screener will need to attempt to assess the individual to determine if the Consumer is experiencing a psychiatric crisis.

In some situations, the Screener may be unable to assess the need of the Consumer, other than the need for medical or social detox. In these instances, the Screener will not be able to complete a state hospital screen and other resources should be sought, such as admission to the local hospital for medical detox, a local detox unit (if available), or transportation by law enforcement to the state hospital social detox unit. Detox Care and Treatment (which is emergent, involuntary treatment) can only be on signature of law enforcement.

Note: Social detox is an “on demand” service. Prior approval through RADAC **does not** need to be obtained to refer someone to social detox services.

In other situations, the Consumer who has been using substances may not be so intoxicated so as to prevent the completion of a screening. Psychiatric crisis may be evident and the need for hospitalization should be assessed. Because of the variation among individuals in alcohol tolerance levels, the size of the individual, frequency of use of alcohol, etc., a B.A.C. (Blood Alcohol Content) is not an appropriate way for the Screener to determine whether an individual’s intoxication level is too high for the screening to be performed. In many, if not most circumstances, the Screener will have to observe the Consumer and their coherency before knowing if the screening can be completed. The main concern of the state psychiatric hospitals is that the Consumer will not require medical care when they are transferred to their facilities. Though they can be screened, transfer to the hospitals may not be appropriate due to detox issues and withdrawal symptoms. The Consumer may need to remain at ER or other location for further observation, or the BAC may need to be lower before they are considered medically stable for admission. The state psychiatric hospitals do not have a medical unit.

T. DISAGREEMENTS WITHIN THE SYSTEM

Between the Screener and the State Hospital:

- 1. Admission, Hospital Review and Informal Review:** When a CMHC Screener determines that a Consumer needs to be admitted to a state mental health hospital and issues a “ticket letter” to that effect, it is the policy of KDADS that the hospital will accept that admission. The Screener should contact the admissions office of the hospital, forward a copy of the screening instrument and the Letter Authorizing Admission, and assist the admissions office in any other way to arrange the admission.

The Screener should explain the process to the Consumer and help him or her collect any other documents or information that he or she will need in order to be admitted.

Once admitted, the Consumer will be seen by a psychiatrist or psychologist at the hospital. The psychiatrist or psychologist will review the screening instrument and make an independent assessment of the diagnostic impression and the need for hospitalization. If the hospital professional has any concern about the appropriateness of the Screener’s determination, a call may be made to the Screener to see if additional information is available or to clarify the Screener’s findings. Even if a disagreement persists, the Consumer will remain at the hospital for at least 24 hours for further observation and evaluation.

If after the 24 hour period, there still exists among hospital staff a disagreement with the Screener’s determination, the matter may be referred to the chief social worker of the hospital for review. Should the chief social worker, in coordination with any other staff, concur with the Screener’s determination, the disagreement will be dropped. Otherwise, the chief social worker may informally request a review of the Screener’s determination by the appropriate supervisory staff at the CMHC.

- 2. Formal Complaint:** If after the above informal reviews, an agreement still cannot be reached, or disagreement exists about similar issues which may arise relative to future screens, the chief social worker of the hospital may file a formal, written complaint with the CMHC pursuant to the CMHC’s policy and procedure concerning complaints.

No review, complaint, or decision concerning such a complaint shall affect the legitimacy of the admission. The Consumer shall at all times be provided appropriate care and treatment by the hospital, but may be discharged from the hospital as may be appropriate according to the hospital’s criteria for discharge.

SECTION III: PRTF SCREEN REQUIREMENTS

A. REQUIREMENTS.

All screens for PRTF Psychiatric Residential Treatment Facility's must be requested through Kansas Health Solutions (KHS) by contacting the toll-free number 1-800-466-2222. The caller must provide basic information including presenting problem, location of the youth and intended facility if approved.

B. AGENCIES THAT CAN REQUEST A PRTF SCREEN.

- KDADS
- JJA
- CWC
- KHS
- CMHC

C. URGENCY STANDARDS.

- PRTF Initial and Extension screens including the CBST must be completed within **(7) seven calendar days of TMHC's receipt of request.**
- PRTF Emergency Exception Screens must be completed ASAP and no later than **48 hours of KHS's receipt of the request.** The CBS Plan must be completed within seven days of the PRTF screen request.
- The Initial PRTF preadmission screen completed by the CMHC will authorize **up to 90 days** in PRTF treatment
- At around day 60, the designated person at the CWC'S Provider or KDADS Regional Office, CMHC, OR JJA office will receive notification to contact KHS **within 7 calendar days** if they would like to request a screen for continued PRTF treatment.
- The Extension PRTF preadmission screen completed by the CMHC will authorize **up to 60 additional days** in PRTF treatment
- At around day 30, the designated person at the CWC'S Provider or KDADS Regional Office, CMHC, OR JJA office will receive notification to contact KHS **within 7 calendar days** if they would like to request a screen for continued PRTF treatment.

D. PROCESS.

- A PRTF screen request is called into KHS
- A CBST meeting must take place and a Community Based Services Plan (CBSP) developed. A CBST (Community-Based Service Team) is an individualized team established to access and integrate community resources to meet mental health needs in the least restrictive environment. The CBST is comprised of the resident (as appropriate), a responsible family member/guardian, a knowledgeable representative from the Community Mental Health Center (CMHC), the PRTF Screener (either in person or via phone or TVC), other clinicians, the custodial case manager, and any other individuals considered to be helpful in determining how to best help the youth.
- The CBST process is required as a part of all PRTF screens. The CMHC of responsibility is responsible for screening for PRTF treatment and shall be the lead agency in the CBST process. This CMHC may request a courtesy screen from the CMHC where the Consumer is located.
- A face-to-face screening of the youth is completed on all PRTF requests. The same screening form for inpatient hospitalization will be used, but the PRTF section will be marked on page one and the PRTF recommendation page will be completed if the youth meets admission criteria. The same form will be used for all PRTF Extension screens.

- KHS will notify the CMHC of responsibility **(from MMIS – or based on information provided by the agency requesting the screen)** to perform the face-to-face screen and to act as the lead agency in the CBST process. The CMHC considered the county of origin can work with other CMHC's to request a courtesy screen.
- The CBST meeting may be completed prior to the screen **or** during the screen. If completed prior to the screen, the CBST will forward a copy of the plan to the Screener.
- Upon completion of a **PRTF** screen, the Screener will 1) Provide a copy of the PRTF screen and Community Based Services Plan (CBSP) to the youth's guardian and KHS as an admission ticket for the PRTF facility AND, 2) Call in the results to KHS and 3) Notify all other parties
- If PRTF screen and CBSP recommend admission to PRTF facility, the person or agency that requested the CBST/pre-admission screening is responsible for contacting facilities to inquire about bed availability and arranging admission for treatment. The CBSP may serve as a contingency plan until a bed has been secured for treatment.
- Admission to a PRTF facility must occur within 30 days of the completed screening, or the CBST/pre-admission screening process must be completed again to determine the continued need for PRTF treatment.

SECTION IV: TECHNICAL MANUAL

STEP BY STEP GUIDELINES FOR COMPLETING THE MENTAL HEALTH SCREENING FORM

This section includes detailed instructions on how to complete a thorough screen of an identified Consumer. “Reasonable steps” will appear throughout the manual which implies these are **steps any Screener would be expected to complete to ensure the Consumer receives the level of care needed**. The screen is a tool to gather data to determine the outcome of a screen as well as provide any receiving providers/hospitals with details to triage and coordinate treatment. A Screener may refer back to earlier sections of the manual for further elaboration of screen considerations such as courtesy screens, county of responsibility, hospital criteria and admission considerations.

INITIATING A SCREEN

A screen is typically initiated by the CMHC where the Consumer is located at the time of the crisis. When the need for a screen has been identified (Medicaid, State Hospital, KVC Prairie Ridge Star/Wheatland), the first step is to contact KHS Call Center and request a “**tracking number**” for the screen. A tracking number should be requested when inpatient psychiatric hospitalization is being considered and the presenting problem is sufficient to warrant a screen (examples: risk of harm to self, others, property; self care failure; psychosis; mania).

Tracking numbers are required for any screen of a Consumer who has Medicaid or is Medicaid-eligible seeking local/private inpatient psychiatric care. It is also required for screening any Consumer who might be hospitalized voluntarily or involuntarily within a state psychiatric hospital. If a Consumer has third-party insurance, KHS may issue an “X tracking number,” which would subsequently convert to a true tracking number should that Consumer require state psychiatric hospitalization. X tracking numbers are also generated in situations when a screen is requested, but not authorized.

Typically a Screener may be given an X tracking number when the person is NOT ABLE TO PARTICIPATE IN THE SCREENING PROCESS (I.E. THE PERSON IS ASLEEP, THE PERSON IS INTOXICATED, OR THE PERSON IS NOT CONSIDERED TO BE MEDICALLY STABLE). A Screener may call the KHS Call Center to request authorization for a screen when the Consumer is considered capable of being assessed and/or can participate in the evaluation; and is considered medically stable for transfer by a physician. Please refer to **Appendix E** for additional information when a screen would not be authorized.

All hospitals, physicians, or other providers who intend to hospitalize a Medicaid or potentially Medicaid-eligible Consumer to a community hospital with a **primary psychiatric diagnosis** or to transfer from a medical or substance abuse unit to a psychiatric unit, must request a pre-admission screening before admission or they will be admitting at their own financial risk. **It is understood that Consumers with private insurance or who are self pay may be screened with the Mental Health Screening Form without setting up a tracking number, especially if the intent is to gather information for a diversion. It is recommended the Screener defer to their CMHC policies in this case.**

To acquire a KHS tracking number, contact 1-800-466-2222 (available 24 hours per day, 7 days per week). The caller must provide the following information on the Consumer to be screened: Name, Medicaid ID number OR Social Security Number (SSN) OR Date of Birth (DOB), presenting problem, location of the individual, County of Responsibility, contact person/phone number, and potential hospital being considered should inpatient care be deemed necessary. **Once a tracking number has been obtained, the screen is “good” for five days, which means the screen can be updated/amended, and the disposition can be changed.**

Urgency Standards (time frame when screen must be started after KHS is contacted): These are the urgency standards that will most often be utilized when a screen has been initiated.

Post-Stabilization (1hour) – The screen must be initiated within 1 hour of referral time from KHS when the Consumer is located in an emergency room or hospital without a psychiatric unit.

Emergent (3 hours) – The screen must be initiated within 3 hours of the referral time through KHS. This would apply if the Consumer is in a hospital ER with a psychiatric unit or if the Consumer is at any other location (CMHC, nursing home, client’s home, jail, group home, etc.).

Urgent (24 Hours) – The screen must be initiated within 24 hours of the referral time through KHS. This screen will be completed with a Consumer who is admitted to a hospital with a psychiatric unit.

Discharge planning: Discharge planning begins at, and even before, admission to a state psychiatric hospital. Discharge criteria are based on stabilization of the admitting condition to the point that the condition should not interfere with the patient’s ability to safely live outside of the hospital setting. A plan of continuing care in the community will be developed. This plan will be developed with the participation of the patient, and the family, and/or other support systems that the patient chooses to include. It should specify CMHC and/or other community services as well as naturally occurring supports, and necessary support persons, hospital treaters, and CMHC staff identified by the patient.

The screening instrument provides for the entry of data that clarifies the admitting condition and the specification of preliminary discharge criteria. The Screener should use great care in completing these portions of the instrument as they will impact the course of hospitalization and serve as the foundation for the discharge planning done at the hospital.

I. Identifying Data

MENTAL HEALTH SCREENING FORM				
I. IDENTIFYING DATA		Screen Urgency _____	Tracking # _____	
QMHP/LMHP		Location of Interview		
Screen Date	Screen Start Time	AM/PM	Screen Decision Time	AM/PM
Screening CMHC/LMHP				
Courtesy Screen <input type="checkbox"/> No <input type="checkbox"/> Yes		CMHC	Staff	Date/Time
<input type="checkbox"/> Inpatient Rescreen	Date	QMHP		

Screen Urgency – Document the urgency of the screen as issued by Kansas Health Solutions (Post-Stabilization, Emergent, Urgent)

Tracking # - List the tracking number provided by Kansas Health Solutions

QMHP/LMHP – Enter the name of the QMHP responsible for the screening document – basically the QMHP completing the screen

Location of Interview – Enter the location of the face-to-face interview with the individual being screened (Hospital emergency department, nursing facility, CMHC, Consumer’s home, etc.)

Screen Date – Enter the date the screen is started by the QMHP

Screen Start Time – Enter the clock time the screening was started. Indicate AM/PM by circling (if paper screen). If possible, it may be best to document time in military time as this is how KHS records results of the screen.

Screen Decision Time – Document the time at which the treatment decision was first made (i.e. hospitalization, diversions)

Screening CMHC/LMHP – Enter the name of the CMHC where the designated QMHP/LMHP is employed or affiliated with

Courtesy Screen – When the Consumer is not the responsibility of the county where the screen will be conducted and they “belong” to another CMHC (where they last lived 6 months independently), that CMHC must give prior authorization to do a courtesy screen. Check “**No**” if the Consumer being screened is from the CMHC’s catchment area and “**Yes**” if the screen is being completed for another CMHC as the person is their “responsibility.” The Screener should document the **CMHC, Staff** giving permission, and **Date/Time** permission was given for the screen to be completed. Please refer to **page 11** to review when a courtesy screen is completed.

Inpatient Rescreen – The tracking number issued by KHS is considered good for 5 days. If there is a re-screen during that time, check this box. Then enter the **Date** and **QMHP** completing the re-screen.

Identifying Data - Left Box Information:

Name: Last			First			MI		
Pre-Marital Name			Also Known As (AKA)					
Street Address _____								
City, State, Zip _____								
Phone _____								
County of Residence _____								
County of Responsibility _____								
SSN _____								
DOB _____			Age _____			Gender _____		
Current outpatient treatment order: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UK								

Name - Enter the **Last** and **First** Name and Middle Initial **MI** (if known) of the Consumer who is the subject of the screening. Enter **Pre-Marital Name** (if known) for females. Enter any names that the person is **Also Known As (AKA)**.

Street Address – Enter the known address for the Consumer who is the subject of the screening. If living in a shelter, PRTF, corrections setting, etc., enter the name of that facility. If homeless, enter “Homeless” on the Street Address line.

City, State, Zip – Enter the City, State, and Zip Code to complete the address of the Consumer being screened. If in a shelter, PRTF, corrections setting, etc., enter the City, State, and Zip of that facility.

Phone – Enter the phone number for the Consumer who is the subject of the screening, where they can best be reached. If no phone number, leave blank. It may otherwise be helpful to list the phone number of any legally responsible individual or contact person.

County of Residence - Enter the County that includes the primary place of residence for the given for the Consumer who is the subject of the screening. If homeless, enter the county where the Consumer is currently located. See **page 10** for more details regarding the definition of County of Residence.

County/Responsibility – Enter the County where the Consumer last lived INDEPENDENTLY for 6 consecutive months. For children, enter the County of Responsibility where the parents last resided for 6 consecutive months. County of Responsibility for children in custody would be determined by the DCF or Juvenile Justice Authority (JJA) office responsible for the care of the child. See **page 10** for more details regarding the definition of County of Responsibility.

SSN – Enter the Social Security Number of the Consumer who is the subject of the screening

DOB – Enter the Date of Birth of the Consumer who is the subject of the screening

Age – Enter the age of the Consumer

Gender – Enter the gender of the Consumer who is the subject of the screening. [Please note that AIMS data identifies four gender types: Male (M), Female (F), Transgender Male to Female (TMF) and Transgender Female to Male (TFM). When utilizing transgender options, please note that gender needs to be established & documented. When conducting a courtesy screen, establish gender definition on transgender individuals with the County of Responsibility if possible.]

Current Outpatient Treatment Order – Mark the box Yes, No or Unknown for the existence of a court order addressing involuntary outpatient treatment for the subject of the screening. Note that this may affect your inpatient care options and the manner in which you may admit someone to the state hospital if needed. Please review **page 19** for further information.

Identifying Data - Right Box Information:

<p>Referred by _____</p> <p>Consumer Status</p> <p><input type="checkbox"/> Current CMHC Consumer <input type="checkbox"/> Former CMHC Consumer</p> <p><input type="checkbox"/> Other CMHC Consumer <input type="checkbox"/> Never a CMHC Consumer</p> <p><input type="checkbox"/> Private Provider _____</p> <p>Screening Informants</p> <p><input type="checkbox"/> Family _____</p> <p><input type="checkbox"/> CMHC/Private Provider _____</p> <p><input type="checkbox"/> Hospital Staff _____</p> <p><input type="checkbox"/> JJA/Contractor _____</p> <p><input type="checkbox"/> LEO/Other Agency _____</p> <p><input type="checkbox"/> Other _____</p> <p>Child Custody Status</p> <p><input type="checkbox"/> Parental <input type="checkbox"/> DCF _____</p> <p><input type="checkbox"/> JJA <input type="checkbox"/> Contractor _____</p> <p>Type of Screening Completed</p> <p><input type="checkbox"/> State Hospital</p> <p><input type="checkbox"/> Medicaid Inpatient Psychiatric</p> <table border="1"> <tr> <td><input type="checkbox"/> State Hospital Alternative</td> <td><input type="checkbox"/> Prairie Ridge STAR</td> <td><input type="checkbox"/> Wheatland</td> </tr> <tr> <td><input type="checkbox"/> PRTF</td> <td><input type="checkbox"/> Emergency Exception</td> <td><input type="checkbox"/> Initial <input type="checkbox"/> Extension</td> </tr> </table>	<input type="checkbox"/> State Hospital Alternative	<input type="checkbox"/> Prairie Ridge STAR	<input type="checkbox"/> Wheatland	<input type="checkbox"/> PRTF	<input type="checkbox"/> Emergency Exception	<input type="checkbox"/> Initial <input type="checkbox"/> Extension
<input type="checkbox"/> State Hospital Alternative	<input type="checkbox"/> Prairie Ridge STAR	<input type="checkbox"/> Wheatland				
<input type="checkbox"/> PRTF	<input type="checkbox"/> Emergency Exception	<input type="checkbox"/> Initial <input type="checkbox"/> Extension				

Referred by – Enter the Referral Source that initiated the screen request which may include the following: Family, CMHC/Private Provider, Hospital, Law Enforcement, other agencies (KDADS, JJA, contract providers, etc.).

Consumer Status – Check the box or boxes to denote the Consumer Status of the person who is the subject of the screening.

- **Current CMHC Consumer** – The Consumer has an open/active chart with the screening CMHC
- **Former CMHC Consumer** – The Consumer is not considered to have an open/active chart with the screening CMHC
- **Other CMHC Consumer** – The Consumer has an open/active chart with another CMHC
- **Never a CMHC Consumer** – The Consumer is not known to have ever been involved with the screening CMHC or another CMHC
- **Private Provider** – The Consumer participates in treatment with a private practitioner – If known, provide the name of the Member’s private provider in the space indicated.

Screening Informants – Check the box(es) to denote informants or collaterals that provided information for the screen. Lines are provided to note names.

Child Custody Status – Check the box to denote the child Consumer’s custody status: Residing with parents (Parental); DCF custody (list name of social worker if possible); JJA custody; or Contractor (foster care agencies - KVC, TFI, St Francis, etc.)

Type of Screening Completed – **CHECK ONLY ONE BOX** to denote type of screen being completed:

- **State Hospital**
- **Medicaid Inpatient Psychiatric** - for potential admission to ANY acute inpatient psychiatric unit that accepts Kansas Medicaid.
- **State Hospital Alternative (SHA)** – Also, check the box to denote whether the screen is being completed for potential admission to KVC Prairie Ridge STAR or KVC Wheatland **STATE HOSPITAL ALTERNATIVES**.
- **PRTF** – Also check the box to denote whether the screen type is **Emergency Exception, Initial, or Extension** screen.

***When completing a STATE HOSPITAL ALTERNATIVE (SHA) screen, use PAGE 6A for the disposition.

II. PSYCHOSOCIAL ASSESSMENT

<p>II. PSYCHOSOCIAL ASSESSMENT: Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Address/Phone #: _____</p> <p>This individual has others involved in helpful way (circle): Parent, Family, Friends, Case Worker, Neighbor, Landlord, Other Name/Address/Phone #: _____ Name/Address/Phone #: _____</p> <p>This Individual: <input type="checkbox"/> Has adequate support systems <input type="checkbox"/> Has limited support systems <input type="checkbox"/> Has no support systems <input type="checkbox"/> Stable living environment <input type="checkbox"/> Unstable Living Environment <input type="checkbox"/> Homeless <input type="checkbox"/> Currently Incarcerated</p> <p><input type="checkbox"/> Receiving MR/DD services – Agency/Case Worker Name/Phone #: _____</p>
--

In this section it is important to identify collaterals that are involved with the Consumer as identified in the core values, ascertaining from the Consumer who is helpful in their environment.

Guardian – Check **Yes** or **No** to note whether the Consumer has a guardian and document contact information on the line provided. If they do have a guardian, contact is recommended if possible. Refer to **page 16** to review guardianship considerations when a Consumer may be admitted to a state psychiatric hospital.

Significant Supports – Identify supports that the Consumer may find helpful or that have a stake in their care or the screening process. Circle (or check) those involved and provide names, addresses, and phone numbers if possible. Some Consumers are sensitive to the possibility their information will be released to these individuals. Obtain releases of information when possible or necessary.

Stability of Living Environment – Check the box or boxes that would best define the Consumer’s current level of support and stability in their environment. If the Consumer is receiving **MR/DD Services**, document the agency, case worker, and phone number if available.

<p>Armed Forces: <input type="checkbox"/> Veteran <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> None Period(s) of Service: _____</p> <p>Additional Information/Clarification regarding psychosocial supports, conflicts, stressors concerns, housing etc. _____</p> <p>_____</p> <p>_____</p>
--

Armed Forces – Check **Veteran, Active, Inactive, or None** to indicate whether the Consumer or collateral identifies him/her as having current or history of military duty and identify periods of service if possible.

Additional Information/Clarification regarding Psychosocial Supports – This area should be utilized to make additional comments regarding a Consumer’s home environment, support systems, involvement with community resources, other collaterals not already identified, employment related concerns, treatment involvement.

<p>FINANCIAL RESOURCES: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Student Other: _____</p> <p>Third Party Payer(s) Medicaid ID# _____ <input type="checkbox"/> Pending Medicaid Medicare ID # _____</p> <p>Other ID#/Group #/Responsible Party _____ VA Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p>

Financial Resources – Check the box that best captures the Consumer’s current employment status, utilizing “Other” if status is not listed.

Third Party Payer(s) – If known, check the box or boxes indicating the Consumer’s insurance coverage if available. **Medicaid Pending** is used if the person has applied/is planning to apply/is unemployed, but has not yet been approved for benefits. This may often be the case when obtaining tracking numbers for inpatient psychiatric screens. If known, identify a Consumer’s eligibility for **VA Benefits**.

.....

III. PRESENTING PROBLEM(S)

III. PRESENTING PROBLEM(S)			
<input type="checkbox"/> Current Danger	<input type="checkbox"/> Potential Danger to SELF	<input type="checkbox"/> Self Care Failure	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Current Danger	<input type="checkbox"/> Potential Danger to OTHERS	<input type="checkbox"/> Psychotic Symptoms	<input type="checkbox"/> Conduct/Behavior
<input type="checkbox"/> Current Danger	<input type="checkbox"/> Potential Danger to PROPERTY	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> Other

Document information about the reason the Consumer has presented in crisis. Take reasonable steps to identify current stressors and triggers. Document losses, potential losses that may influence the current crisis (i.e. interpersonal, occupational, physical, chronic medical illness, financial problems, legal problems, family discord). It would be helpful, when available, to provide specific dates, information regarding referring agencies as applicable, and create a timeline for the crisis. Check the boxes that are applicable to the current crisis - **Current/Potential Danger to Self; Current/Potential Danger to Others; and Current/Potential Danger to Property**. Also check behaviors or symptoms that may be evident: **Self Care Failure, Psychotic Symptoms, Mood Disorder, Substance Abuse, Conduct/Behavior Problems, or Other**.

EXAMPLE: "Ct was brought in by law enforcement for threatening behavior and appears psychotic," is certainly a statement of the problem, **but hospitals are looking for information that really communicates what is happening in the Consumer's life**. Consider adding more details following above sentence, "Ct has missed several recent medication and case management appointments and has shown decompensation in the past week. This day he was observed by his family to be talking to unseen others, more emotionally labile. Family members report he broke a coffee table and punched holes in walls, as well as threatened to beat them up. Ct does not believe he needs to take medications as he believes they are poison."

Consumer Statement of Concern(s) (In his/her own words): _____

Consumer Statement of Concern(s) (In his/her own words) – This is a new and important part of the screening instrument. This section was designed so the Consumer can give their perception of the problem, as they are often concerned their views are not taken into consideration during the screen process. Therefore, the Screener should actively seek and document the Consumer's perception of the current crisis in **his/her own words** if possible. Even if the Consumer's statement is not logical or contradicts collateral statements, it's still ok to document what they report:

EXAMPLE: "People won't leave me alone and I don't need help or to take my meds."

IV. RISK FACTORS

Current Danger to Self: <input type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Threat <input type="checkbox"/> Intent with Means <input type="checkbox"/> Intent w/o Means
<input type="checkbox"/> Self Care Failure <input type="checkbox"/> Gesture/Attempt <input type="checkbox"/> Risk aggravated by substance use <input type="checkbox"/> At Risk
Explain (Include dates, means, rescue) _____

Current Danger to Self – Use the boxes to check all applicable risk factors for danger to self, and if risk is exacerbated by substance use. The **At Risk** box may be used to identify the client has significant symptoms or has decompensated to the point where they are at risk for hospitalization. The clinician should take reasonable steps to clearly document/explain the Consumer's current risk of harm to self: **Ideation, Plan, Threat, Intent, Self Care Failure, etc.** (in the past 48 hours). Provide specific dates of incidents if known. Consider other risk factors such as gender, age, marital status, etc. The clinician should assess the need for any medical intervention, especially for self injurious acts.

History of Danger to Self: None Ideation Plan Threat Intent with Means Intent w/o Means
 Self Care Failure Gesture/Attempt Risk aggravated by substance use

Explain (Include dates, means, rescue) _____

History of Danger to Self - Check all applicable boxes to denote the Consumer’s history of suicidal ideation, plans, threats, intent, gestures, as well as history of self care failure. This may include self injurious behavior that was not necessarily a suicide attempt. Identify whether history of danger to self was exacerbated by substance use. Clearly document/explain the history of acts that constituted danger to self in the lines provided. Include documentation of specific dates of incidents if known.

History of family members or significant acquaintances that attempted or completed suicide Yes No Unknown

Explain _____

Family History/Acquaintances that Attempted or Completed Suicide – This is known to be a significant risk factor for danger to self and this should be queried and documented in evaluating the Consumer.

Current Danger to Others: None Ideation Plan Threat Intent with Means Intent w/o Means
 Gesture/Attempt Risk aggravated by substance use At Risk

Explain (Include dates, means) _____

Current Danger to Others – Check all applicable boxes that denote issues related to danger to others. This may include threats of harm, actual physical aggression, or thoughts of harming others. Indicate whether the danger to others is exacerbated by substance use. The **At Risk** box may be checked when the Consumer may be displaying physical intimidation, aggressive posturing, etc. Take reasonable steps to document/explain in the given lines the acts that constitute current danger to others in the past 48 hours. Provide specific dates of incidents if known. If the Consumer has reported information to suggest intent to harm another person (and name is given), the Screener should refer to their CMHC policies regarding warning potential victims (i.e. Duty to Warn). **It would be helpful for hospital staff to know the extent of actions taken by the CMHC.**

History of Danger to Others: None Ideation Plan Threat Intent with Means Intent w/o Means
 Gesture/Attempt Risk aggravated by substance use Physical Aggression

Explain (Include dates, means) _____

History of Danger to Others – Check all applicable boxes that denote issues related to history of danger to others. Indicate whether the danger was influenced by substance use. The **Physical Aggression** box would indicate history of physical aggression not necessarily tied to homicidal thinking or behavior. Take reasonable steps to document/explain the history of aggressive behavior and danger to others. Provide specific dates of incidents if known.

Current Destruction of Property: YES NO UNK History of Destruction of Property: YES NO UNK

Explain _____

Current and History of Destruction of Property – Check all applicable boxes that indicate the presence of property destruction currently and in the past. Take reasonable steps to document/explain the history of destruction of property, and include specific dates of incidents if known.

Current Abuse: YES NO UNK TYPES: Physical Sexual Emotional Neglect History Reported
 If yes, individual is: Victim Perpetrator Both Neither, but abuse reported in environment
 Explain _____

Trauma Screening – The clinician should acknowledge history of trauma, but during the assessment, **demonstrate sensitivity to avoid re-traumatizing the client** – it can be traumatic to ask the Consumer to describe traumatic events in detail. Limit questioning to very brief and general questions. If the Consumer reports recent trauma such as rape or assault, the clinician should take reasonable steps to recommend medical and/or law enforcement intervention. Also document any current PFA orders either against the Consumer or for the protection of the Consumer.

Check all applicable boxes that indicate current and/or history of abuse; indicate type of abuse the Consumer is **currently** experiencing as well as if they are the victim, perpetrator, or both. Use the additional lines to summarize the Consumer’s abuse experiences. This is another area where information reported may indicate warning a potential victim. The Screener should consider laws for reporting abuse or neglect in the State of Kansas. The Screener should also refer to their CMHC policies for reporting abuse and neglect.

SUBSTANCE USE/ADDICTIONS: Indication of Current/History of Substance Use Yes No Unknown

Drug/Type	Amount	Frequency	Last Use/Dose
Drug of choice:			
Secondary:			
Tertiary:			

Substance Use – The clinician should take reasonable steps to assess current and past substance use, history of dependence, treatment, legal problems as a result of use. Though a Consumer may report the substance use is no longer a problem, it is recommended the Screener attempt to document the Consumer’s history of use. This section should be used to document other kinds of addictions such as **GAMBLING** or **INTERNET** addictions.

Check the box that indicates the **Consumer’s Current/History of Substance Use** (Yes, No, Unknown). If there is Current or History of substance use, document the **Drug of Choice, Amount, Frequency, and Last Use/Dose** if applicable. If the Consumer currently or has historically used more than one substance, attempt to document **Secondary, Tertiary** drugs of choice, etc.

**WHEN APPROPRIATE- Recommend medical consultation/evaluation to determine medical stability for transfer.*

Positive Lab Screen for the following: _____ BAC/BAL _____ Not Available

History of Withdrawal Symptoms/Complications with Detox? Seizures DT’s (Delirium Tremens)

Explain (Identify withdrawal symptoms, medical intervention etc): _____

*****Acute Intoxication** – This is a critical area of assessment, and the Screener should take steps to assess for last substance use (not just alcohol-cocaine, opioids, benzos) and the need for medical intervention. If anything about the Consumer’s presentation or behavior would suggest recent substance use, it is recommended they be evaluated medically if possible or available (hospital emergency room). If the Consumer has used substances within the past 24 hours, consider the following:

When Appropriate – Recommend Medical Consultation/Evaluation to Determine Medical Stability for Transfer – There are times when, if possible, the Screener should take reasonable steps to arrange for a blood alcohol level or urinalysis before determining the disposition of the Consumer. The Screener should consider consultation with the state hospital prior to arranging an admission when the person is under the influence of substances. The Screener must recognize when a person is under the influence, or when their substance use has created instability in the Consumer’s ability to manage mental health symptoms. Their risk of harm may be heightened if there is noncompliance with medication, missed appointments, impaired judgment and impulse control in addition to substance use. However, the Screener must bear in mind that the primary focus of the state hospital is to treat mental health symptoms.

If lab screen/results have been obtained, document the substances for which the Consumer tested positive, and document the **BAC/BAL** if available. Next, query the Consumer for any **History of Withdrawal Symptoms or Complications with Detox** such as **Seizures** or **Delirium Tremens**. Provide documentation regarding the withdrawal symptoms and any history of medical intervention if known.

* **GAMBLING ADDICTION:** Past Current Unk N/A **INTERNET ADDICTION:** Past Current Unk N/A

Gambling Addiction/Internet Addiction – It is important to **query for any potential gambling issues**. If the Consumer admits to gambling when asked, a Screener may ask the following, **“Have you ever felt the need to bet more and more money?”** and **“Have you ever had to lie to people important to you about how much you gambled?”** Take steps to document any steps the Consumer may have taken to obtain treatment for gambling or other addictions.

Substance Treatment History:		
Type of Treatment	Agency	Month/Year

Substance Treatment History – Often it is helpful to know where a Consumer has had substance treatment. Take reasonable steps to document the **Type of Treatment** the Consumer has had in the past (**Detox, Inpatient, Outpatient, or Halfway House**), the **Agency** that provided the treatment, and the approximate **Month/Year** in which it occurred, if available.

Additional information/clarification of Substance/Addiction Concerns (Including collateral concerns, interaction of substances with mental health symptoms, etc):

Additional Information/Clarification of Substance/Addiction Concerns – Please utilize this space to provide any additional information that will be helpful in determining the Consumer’s acute care needs – whether the substances may be the main concern, supports the Consumer has available in managing their recovery, Collateral concerns, legal problems as a result of use. The Screener may also document any considerations for substance treatment such as a RADAC screen, social detox, etc.

MEDICAL: <input type="checkbox"/> None by Client Report <input type="checkbox"/> Self/Family Report <input type="checkbox"/> Physician/Nurse Report <input type="checkbox"/> Medical Records			
Current Medical Conditions/Concerns (Check those that apply):			
<input type="checkbox"/> Unknown	<input type="checkbox"/> Diabetes-Insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Kidney Disease/UTI
<input type="checkbox"/> Pregnant Wks: _____	<input type="checkbox"/> History of Dementia Diagnosis	<input type="checkbox"/> History of Traumatic Brain Injury	
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> NKDA <input type="checkbox"/> Drug/Food Allergies: _____			
List Current Medications: Specify Name & Dosage (Include Psychiatric & Non-Psychiatric Medications)			
Taking as Directed: (Y) Yes (N) No (U) Unknown	Y	N	U
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Provider/Location: _____			
Primary Care Physician/Location: _____			
Comments regarding reported medical issues (i.e. Medication Compliance, Current Medical Treatment, etc): _____			

Medical –It is understood that the Screener is not a medical professional. However, the Screener should take reasonable steps to identify/document any presenting or ongoing medical issues, especially if there is intent to place the individual in a level of care other than outpatient mental health or substance treatment services. This information can be obtained by asking the **Consumer** or **Family**, consulting the **Physician/Nurse** and reviewing **Medical Records** (if available). Please check the box that indicates the source of the medical information. If the Consumer reports no medical concerns, check the box for **None by Client Report**.

Current Medical Concerns – Please check all that may apply. The conditions listed were those considered to be of increased concern in developing a treatment plan for the Consumer’s acute care needs. The Screener should recognize that certain medical diagnoses/conditions are associated with higher risk of suicide: HIV/AIDS; kidney failure requiring dialysis; pain syndromes; organic brain injuries; diseases of the nervous system. Urinary Tract Infections (UTI’s) may increase psychotic features in Consumers. The clinician should take reasonable steps to assess for and identify Consumers with special needs (ie, traumatic brain injury, elderly, dementia). Though a medical condition may not be listed, the Screener should still document any identified medical conditions in the **Other**.

Check the boxes to indicate whether the Consumer has NO KNOWN DRUG ALLERGIES (**NKDA**) or if the Consumer does have **Drug/Food Allergies** and identify the substance and effects if possible.

List Current Medications – Take reasonable steps to document all of the Consumer’s current medications, both **Psychiatric** and **Non-Psychiatric Medications** and list the dosage for each medication if known. In the boxes next to each listed medication, check whether the client is taking the medications as directed [**Yes (Y)**, **No (N)**, or **Unknown (U)**] if known.

Psychiatric Provider/Location – Document the Consumer’s current/most recent **Psychiatric Provider** (the one that last prescribed the listed medications) if known and their **location/facility**, etc.

Primary Care Physician/Location – Document the Consumer’s current/most recent **Primary Care Physician** (the one that may have last prescribed listed medications) if known, and their **location/facility**, etc.

Comments regarding Medical Information - The clinician should carefully evaluate the Consumer’s current level of care and whether their needs can be provided for if hospitalized at the state psychiatric hospital. Explain any current issues with medical compliance, current medical treatment.

*Special Medical Considerations: N/A Self/Family Report Physician/Nurse Report Medical Records Unknown
 "Do you need or use any of the following medical equipment or treatment?"
 Oxygen Equipment Ventilator Wound care
 Foley or Catheters, Dialysis Insulin pump Surgery/Post-operative care
 Intravenous ports or permanent venous access Current cancer treatment
 IV medications, care or services
 "Do you require assistance with any of the following?"
 Getting out of bed Toileting Feeding Moving Using wheelchair
 Comments/other: _____

Medical Fragility/Special Medical Considerations - Check the box or boxes that identify the source of the information about the special medical conditions (**N/A, Self/Family Report, Physician/Nurse Report, Medical Records, Unknown**).

It is recommended that the Screener ask the following if possible: **"Do you need or use any of the following medical equipment or treatment?"** Check the boxes that indicate the medical conditions and do not hesitate to consult medical staff regarding the Consumer's medical needs. If applicable, it is also recommended the Screener ask, **"Do you require assistance with any of the following?"** in reference to **Getting out of Bed, Toileting, Feeding, Moving, or Using Wheelchair**. Use the **Comments** section for explanation if any boxes were checked.

If any of the boxes in this section are checked, this may indicate medical fragility, and consultation with the state hospital medical staff is then recommended to ensure they have the resources to appropriately care for the Consumer if admitted. Doctor to doctor consultation would also be indicated, especially if the Consumer is in a hospital. At this time, the state hospitals do not have a medical unit and have only limited abilities to manage medical conditions. **If they are not able to provide for the Consumer, it may require a transfer to a medical hospital.** The Screener should review guidelines for a state hospital admission, especially those considered inappropriate admissions.

If the Consumer is approved for admission and special medical needs are identified, they may need to take any of their necessary equipment with them to the hospital (oxygen, CPAP, etc.).

.....
V. TREATMENT/PLACEMENT INFORMATION

Currently in treatment: Yes No Unknown Therapist/Case Manager: _____
 Agency/Provider/Service(s): _____

 Service Progress/Failure: _____

Currently in Treatment – Check the box (**Yes, No, Unknown**) to indicate whether the Consumer is currently involved in mental health treatment. Next Identify the **Therapist and/or Case Manager** if known. Document the **Agency/Provider** and **Services** (therapy, case management, attendant care, medication services, etc.) if known, and then explain any **Service Progress/Failure** if known.

In this section, it would also be helpful, if known, to provide documentation explaining the range and frequency of services the Consumer is receiving.

Previously Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Multiple Hospitalizations: <input type="checkbox"/> Yes x ____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Last Psychiatric Hospitalization: _____	Date Admitted _____ Date Dismissed _____ <input type="checkbox"/> AMA
Other Psychiatric Hospitalizations: _____	
PRTF Treatment History (Include Dates if Known): _____	

Psychiatric Hospitalization History – Check the boxes that would indicate if the Consumer has been **Previously Hospitalized** (Yes, No, Unknown). Check the boxes that would indicate if the Consumer has had **Multiple Hospitalizations** (Yes, No, Unknown). If there has been more than one hospitalization, enter the number of hospitalizations (if known) in the line given.

Last Psychiatric Hospitalization – For Consumers with a previous psychiatric hospital admission, document the location of that hospitalization, the **Date Admitted**, the **Date Dismissed**. If known, check the box that would indicate the Consumer left Against Medical Advice (**AMA**).

Other Psychiatric Hospitalizations – It is often helpful to know other places that the Consumer has been hospitalized to either consider diversions from state hospitalizations, or to provide evidence that diversion options have been exhausted. If known, document **Other Psychiatric Hospitalizations**, and include specific dates if known. KHS may have information regarding prior admissions if the Screener feels it helpful to communicate to a receiving hospital.

PRTF Treatment History – Provide documentation of any previous PRTF treatment for youth Consumers and identify dates of service if known.

Legal History:
Current/History of Legal Contacts/Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Charges Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Probation x ____ <input type="checkbox"/> Parole x ____ <input type="checkbox"/> Incarcerations/Detention x ____
<input type="checkbox"/> CINC x ____ <input type="checkbox"/> JO x ____ <input type="checkbox"/> Foster Care x ____ <input type="checkbox"/> YRC x ____ <input type="checkbox"/> Other ____ <input type="checkbox"/> Not Applicable
Explain: _____

Legal History – Check the boxes to indicate **Current/History of Legal Contacts/Problems** (Yes, No, Unknown) and whether there are Charges Pending (Yes, No, Unknown). Identify if known the number of times the Member has been experienced **Probation, Parole or Incarcerations/Detention**.

Check the boxes that would indicate if the youth Consumer was ever a **Child in Need of Care (CINC)** or **Juvenile Offender (JO)**, or choose **Not Applicable**. Check the boxes that would indicate whether the Consumer was in **Foster Care**, a **Youth Residential Center (YRC)**, or **Other** youth treatment facilities (explain) and indicate if applicable the number of times the child was in those facilities.

Explain the Consumer’s history of legal involvement if known such as past arrests, types of charges for which the Consumer may have been convicted, history of incarcerations, parole, or probation. Document the status of the legal involvement and include the name of the probation/JJA worker or parole officer if known or applicable.

Education Status: Name of School _____ Highest Grade Completed _____ <input type="checkbox"/> Regular Education <input type="checkbox"/> Special Education - Category (if known): _____
--

School Information – This section is applicable to youth Consumers. Document the Name of School the youth currently attends and the Highest Grade Completed. Check the boxes that would indicate if the child is in **Regular Education** or **Special Education** and identify the type of designation or category of the disability. Examples may include the following:

- Autism
- Deaf-blindness
- Deafness
- Developmental delay
- Emotional disturbance
- Hearing impairment
- Intellectual disability
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment, including blindness

It would also be helpful to note whether the Consumer has an Individualized Education Plan (IEP), or if they are attending an Alternative School.

VI. CLINICAL IMPRESSIONS

This section is used to capture behavioral observations, mental status of the Consumer being screened. When possible, it is recommended that most sections are reviewed with the Consumer: querying their mood, observing affect, thought content; assessing memory, orientation X 4, cognition; behavior and motor activity, patterns of appetite, sleep; identifying patterns of anxiety symptoms; conduct disturbance, impairment in occupational/academic functioning; and considerations of any interpersonal patterns that contribute to the Consumer’s current difficulties. **When there are two options (Hypersomnia/Insomnia or Decreased/Increased Appetite) the Screener should CIRCLE the appropriate designation.** Lines are provided to include any notes regarding the clinical impressions, and to summarize the observations of the Screener.

VII. CLINICAL SUMMARY AND DIAGNOSTIC IMPRESSIONS

<p>VII. CLINICAL SUMMARY AND DIAGNOSTIC IMPRESSIONS (Include medical necessity, exhaustion of resources, treatment alternatives, etc)</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

Clinical Summary & Diagnostic Impressions – This section is used to summarize the presenting problems, current mental health symptoms, substance disorder symptoms, personality disorder symptoms, etc., the Consumer is reporting as described in the current Diagnostic and Statistical Manual (DSM). The clinician should take reasonable steps to understand the Consumer’s mental health history, if available, to arrive at the appropriate diagnosis. The Consumer may have more than one DSM diagnosis, and the Screener will need to indicate the “Primary” diagnosis.

When a Consumer is known to a CMHC, their documented diagnosis may not “match” the clinical presentation at the time of the screen. The Screener should use the information from the screen to develop a diagnosis that would capture the current clinical presentation. The Screener may designate it as a provisional diagnosis if necessary. If the plan is for the Consumer to be hospitalized, the receiving hospital needs to understand the symptoms in order to triage their care.

This section is also used to summarize the Consumer’s current level of risk and to justify the level of care needed. It is in this area that the Screener can document any concerns regarding placement, medical fragility, exclusionary criteria for placements. It is in this section the Screener may identify any strengths, supports or protective factors that may aid in diverting the Consumer from a higher level of care. It is recommended that the Screener document any plans of care that were considered or utilized/exhausted in arriving at a preliminary plan for acute care.

DIAGNOSTIC CODE	DIAGNOSES	✓ PRIMARY
AXIS I: _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
AXIS II: _____	_____	_____
_____	_____	_____
AXIS III: _____	_____	_____
AXIS IV: _____	_____	_____
AXIS V: CURRENT GAF: _____	HIGHEST PAST YEAR: _____	

Diagnostic Impressions – If a Consumer’s history of mental illness is not readily available, the clinician should make reasonable efforts to develop a preliminary/working diagnosis to facilitate placement in the appropriate treatment track at an inpatient facility. The Screener should use knowledge of the current DSM diagnoses to document their impressions on Axes I-V, and check (✓) the primary diagnosis.

KHS SPECIAL HEALTH CARE NEEDS:				
<input type="checkbox"/> SED	<input type="checkbox"/> SPMI	<input type="checkbox"/> SMI	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
<input type="checkbox"/> MR/DD	<input type="checkbox"/> Pregnant & Using Substances	<input type="checkbox"/> Substance Use & Mental Illness	<input type="checkbox"/> IV Drug User & Mental Illness	

KHS Special Health Care Needs – For every screen that is set up through Kansas Health Solutions (KHS), when results are called in, the Screener will be expected to identify whether the Consumer’s chronicity status is Severely Emotionally Disturbed (**SED**), Severe and Persistently Mentally Ill (**SPMI**), Unknown, or Not Applicable (**N/A**).

In addition, KHS also tracks other Special Health Care Needs in coordinating a Consumer’s care: Severe Mental Illness (**SMI**), **MR/DD**, **Pregnant and Using Substances**, **Substance Use and Mental Illness**, and **IV Drug User and Mental Illness**. Please check the boxes that may indicate these additional Consumer treatment needs.

*Clinical impression, diagnoses, and recommendations have been shared with consumer, parents and/or guardian (unless contraindicated).
--

Sharing screen information with the Consumer, parents, and/or Guardian – Consumers should be included as much as possible in the development of a treatment plan for their acute care needs. It is recommended that the **Clinical Impression, Diagnoses, and Recommendations** be shared with the Consumer, parents, and/or guardian unless contraindicated.

VIII. TIME DOCUMENTATION SUMMARY (Include Travel Time):		
Contact/Activity	Amount of Time	Rescreen in 5 days
<input type="checkbox"/> Chart Review:	_____	_____
<input type="checkbox"/> Paperwork:	_____	_____
<input type="checkbox"/> Face-to-Face Interview:	_____	_____
<input type="checkbox"/> Coordination of Admission:	_____	_____
<input type="checkbox"/> Collateral Contacts:	_____	_____
<input type="checkbox"/> Consultation/Team Meetings:	_____	_____
Total Screen Time:	_____ Hrs _____ Min	_____ Hrs _____ Min
Travel Time To/From:	_____ Hrs _____ Min	_____ Hrs _____ Min
Total Time:	_____ Hrs _____ Min	_____ Hrs _____ Min

Time Documentation – A Screener may have to go back to this section after the screen is completed to record time spent on screen activities. There are now two columns to account for time to complete the initial screen, and the rescreen in 5 days if needed. Account for all time spent for **Chart Review, Paperwork, Face-to-Face Interview, Coordination of Admission, Collateral Contacts, and Consultation/Team Meetings**. Don't forget Travel documentation which KHS will also ask for when screen results are called in.

DISPOSITION FOR MEDICAID, STATE HOSPITAL, AND PRTF SCREENS – A Screener will only fill out **ONE** of pages 6A through 6C depending on the type of screen completed. Alternatives to State Hospital (**Prairie Ridge Star** and **Wheatland**) screens would be documented on **PAGE 6A** (Medicaid Inpatient Psychiatric).

IX. MEDICAID INPATIENT PSYCHIATRIC, KVC PRAIRIE RIDGE STAR, AND KVC WHEATLAND SCREENS

(PAGE 6A)

Level 1, Independent: Criteria which, in and of themselves, MAY constitute justification for admission.

- 1. Suicide attempt, threats, gestures indicating potential danger to self.
- 2. Homicidal threats or other assaultive behavior indicating potential danger to others.
- 3. Extreme acting out behavior indicating danger or potential danger to property.
- 4. Self-care failure indicating an inability to manage daily basic needs that may cause self-injury.

Level 2, Dependent: Clinical characteristics of psychiatric disorders, any of which in combination with at least ONE Level 3 criterion, MAY constitute justification for admission.

- 5. Clinical Depression.
- 6. Intense anxiety or panic that may cause injury to self or others.
- 7. Loss of reality testing with bizarre thought processes such as paranoia, ideas of reference, etc.
- 8. Impaired memory, orientation, judgment, incoherence, or confusion.
- 9. Impaired thinking, and/or affect accompanied by auditory or visual hallucinations.
- 10. Mania or Hypomania.
- 11. Mutism or catatonia.
- 12. Somatoform disorders.
- 13. Severe eating disorders such as bulimia or anorexia.
- 14. Severely impaired social, familial, academic, or occupational functioning, which may include excessive use of substances.
- 15. Severe maladaptive or destructive behaviors in school, home, or placement, which may include excessive use of substances.
- 16. Extremely impulsive and demonstrates limited ability to delay gratification.

Level 3, Contingent: Acute-care program needs which MAY justify psychiatric hospital admission.

- 17. Need for medication evaluation or adjustment under close medical observation.
- 18. Need for 24-hour structured environment due to inability to maintain treatment goals or stabilize in less intensive levels of care.
- 19. Need for continuous secure setting with skilled observation and supervision.
- 20. Need for 24-hour structured therapeutic milieu to implement treatment plan.

Criteria for Medicaid Inpatient Psychiatric Admissions – Check the boxes to indicate symptoms or impaired functioning that MAY Constitute Justification for Admission to inpatient psychiatric treatment. The Screener should note that **Level 1** criteria are **Independent**, and can “stand alone” in justifying the admission. **Level 2** criteria are **Dependent**, and must be accompanied by at least one **Level 3** criterion to authorize reimbursement for an inpatient psychiatric admission. Level 3 criteria alone will not constitute justification for admission. Endorse all applicable criteria to reflect the documentation in the screening instrument.

DISPOSITION/REIMBURSEMENT AUTHORIZATION

(A.) Meets inpatient criteria; Hospitalization recommended. Voluntary Involuntary

Admitted/transferred/referred to hospital _____ Admission Date _____

Treatment Expectations/Preliminary Discharge Plan _____

(B.) Alternative community services plan recommended in lieu of hospitalization, copy given to legally responsible individual.

(C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual.

Comments: _____

Disposition/Reimbursement Authorization – At this point the Screener should check the box that indicates the disposition of the screen.

(A.) Meets Inpatient Criteria; Hospitalization is Recommended – If the plan is for the Consumer to enter a local/private inpatient psychiatric facility, check the box to indicate whether the admission is **Voluntary** or **Involuntary**. Then enter the name of the hospital (**Admitted/Transferred/Referred to Hospital**) in the space provided as well as the **Admission Date**. KHS will ask for this information when results are phoned in. In some occasions, the date of admission may not match the date of the screen and this is acceptable as long as it is within 5 days of the initial screen request.

Treatment Expectations/Preliminary Discharge Plan – The Screener should utilize this space to identify the client’s treatment needs, potential goals for treatment, and any recommendations for discharge planning.

(B.) Alternative Community Services Plan Recommended in Lieu of Hospitalization, Copy Given to Legally Responsible Individual – This box would be checked if the Consumer met the criteria for hospital admission, but a diversion to the hospitalization was developed (Crisis Services, Outpatient Services, etc.). It is expected that the Screener will then take reasonable steps to complete the **Alternative Community Services Plan** that clearly outlines the diversion plan. See **page 48** for instructions.

(C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual – This box would be checked if the Consumer did NOT meet the criteria for hospital admission. It is still expected that the Screener will take reasonable steps to complete the **Alternative Community Services Plan**. See **page 48** for instructions.

Comments: _____ _____ _____ _____
--

Comments – The Screener should use this section to document any other concerns regarding the disposition, treatment/discharge planning, or other recommendations.

I certify that local community resources have been investigated and or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and evaluated him/her and his/her situation. I have also considered alternative modes of treatment. Available community resources have been investigated, and are not appropriate if hospitalization is recommended.

Signature of QMHP designated as a member of MHC Screening Team

Date

The Screener should acknowledge this certification that they have considered community resources and alternate modes of treatment if hospitalization is recommended. The Screener must then sign off on the screen in the space indicated.

*****If the plan is for the Consumer to be admitted to a local/acute psychiatric unit, the Screener should now contact the potential hospital to facilitate the admission before sending the Consumer to the facility. Each hospital will have their own protocol on approving admissions. Links to contact numbers can be found in Appendix E, and addresses/phone numbers can be found in Appendix G.**

***** If the client is to be admitted to a private psychiatric facility on an involuntary basis, the current understanding is that the Screener must complete the Commitment/State Hospital paperwork as if the person were being sent to a State Psychiatric Hospital: Statement from a QMHP Certificate of a Physician, Licensed Psychologist, or a Designated QMHP, and the Application for Emergency Admission. Instructions can be found starting on page 51.**

*****Once the screen has been completed, the Screener should contact KHS to provide the screen results. For diversions, KHS will ask for the diversion plan as well as contact information for the Consumer.**

*****There will be times when a State Hospital screen may need to be changed to a Medicaid screen if the person is diverted from state hospital admission but has Medicaid only or is Self pay/Medicaid Eligible. It is recommended the Screener review this with the KHS clinician.**

X. STATE HOSPITAL ADMISSION CRITERIA (PAGE 6B)

ADMISSION CRITERIA – Symptoms that interfere with the consumer’s ability to care for themselves and/or dependents outside of the structure of a psychiatric hospital. Criteria which, in and of themselves, MAY constitute justification for admission.		
Cognitive	<input type="checkbox"/> Paranoid Ideations	<input type="checkbox"/> Ideas of Reference
	<input type="checkbox"/> Disorientation to Time, Place, Person, or Situation	<input type="checkbox"/> Loss of Reality Testing
	<input type="checkbox"/> Disorganization, Confusion or Incoherence	
	<input type="checkbox"/> Other/Explain: _____	
Perceptual	<input type="checkbox"/> Auditory Hallucinations	<input type="checkbox"/> Visual Hallucinations
	<input type="checkbox"/> Inability to recognize familiar people	
	<input type="checkbox"/> Other/Explain: _____	
Emotional	<input type="checkbox"/> Severe anger likely to cause a suicide attempt	<input type="checkbox"/> Anger/rage - provokes thoughts of harming others
	<input type="checkbox"/> Unusual fear, anxiety and/or panic that is likely to cause self injury	
	<input type="checkbox"/> Other/Explain: _____	
Behavioral	<input type="checkbox"/> Suicidal threats/serious attempts to harm self	<input type="checkbox"/> Homicidal threats/serious attempts to harm others
	<input type="checkbox"/> Self Care Failure	<input type="checkbox"/> Mutism or Catatonia
	<input type="checkbox"/> Conduct Disturbance: _____	<input type="checkbox"/> Mania or hypomania
	<input type="checkbox"/> Other/Explain: _____	

Admission Criteria – Check the boxes that indicate the symptoms the Consumer is experiencing that interfere with their ability to care for themselves and dependents outside the structure of a psychiatric hospital. **At least one** would need to be checked to constitute justification for the hospital admission and may be: **Cognitive, Perceptual, Emotional, or Behavioral.** Endorse all applicable criteria to reflect the documentation in the screening instrument.

Screening Disposition:

<p>SCREENING DISPOSITION</p> <p><input type="checkbox"/> (A.) Admission Recommended</p> <p><input type="checkbox"/> Recommended VOLUNTARY admission to _____ State Hospital.</p> <p><input type="checkbox"/> Recommended INVOLUNTARY admission to _____ State Hospital in accordance with KSA Statutes.</p> <p>(Must meet criteria 1, 2, and 3, plus 4 and/or 5 below)</p> <p><input type="checkbox"/> 1. Is suffering from a severe mental disorder to the extent that he/she needs involuntary care in a State Hospital.</p> <p><input type="checkbox"/> 2. Lacks the capacity to make an informed decision concerning his/her need for treatment.</p> <p><input type="checkbox"/> 3. Is not manifesting a primary diagnosis of antisocial personality disorder, chemical abuse/addiction, mental retardation, organic personality syndrome, or an organic mental disorder.</p> <p><input type="checkbox"/> 4. Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another’s property, as evidenced by behavior causing, attempting, or threatening such injury, abuse or damage; OR</p> <p><input type="checkbox"/> 5. Is substantially unable, except for a reason of indigence, to provide for any of his/her basic needs, such as food, clothing, shelter, health, or safety, causing a substantial deterioration of the person’s ability to function with current level of support, care or structure.</p> <p><input type="checkbox"/> (B.) Alternative community services plan recommended in lieu of state hospitalization, copy given to legally responsible individual.</p> <p><input type="checkbox"/> Recommended involuntary outpatient commitment to _____.</p> <p><input type="checkbox"/> (C.) Does not meet state hospital criteria. Alternative community services plan recommended, copy given to legally responsible individual.</p>
--

(A.) Admission Recommended

Recommended voluntary admission to _____ State Hospital – This box would be checked if the disposition is for the Consumer to enter voluntary inpatient psychiatric treatment at one of the state hospitals. The Screener should enter the name of the hospital on the line given.

Recommended involuntary admission to _____ State Hospital in accordance with KSA Statutes – This box would be checked if the disposition is for the Consumer to be admitted to a state psychiatric hospital on an involuntary basis. The Screener then needs to check the boxes that indicate the criteria the Consumer meets that would justify the involuntary hospitalization, which must be sections 1, 2, 3, and/or 4 and 5.

(B.) Alternative plan to State Hospital Admission and copy given to legally responsible individual – This box would be checked if the Consumer met the criteria for state hospital admission, but a diversion to the hospitalization was developed (Crisis Services, Outpatient Services, etc.). It is expected that the Screener will

then take reasonable steps to complete the **Alternative Community Services Plan** that clearly outlines the diversion plan. See **page 48** for instructions.

Involuntary outpatient commitment is considered a potential diversion from state psychiatric hospitalization. **Recommended involuntary outpatient commitment to _____** - This box would be checked if the recommendation is for the Consumer to be placed on an outpatient commitment. The Screener should enter the name of the facility in the space provided.

(C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual – This box would be checked if the Consumer did NOT meet the criteria for hospital admission. It is still expected that the Screener will take reasonable steps to complete the **Alternative Community Services Plan**. See **page 48** for instructions.

Treatment Expectations: _____ _____
Preliminary Discharge Plan (Housing, Legal, Finances, Supports, Services): _____ _____
Consumer Response to Proposed Intervention: _____ _____

Treatment Expectations - The Screener should utilize this space to identify the client’s treatment needs, potential goals for treatment.

Preliminary Discharge Plan – The Screener should utilize this space to document any preliminary considerations of the client’s discharge plan as “discharge begins at admission.”

Consumer Response to Proposed Intervention – It is recommended that the Screener attempt to engage the Consumer as much as possible and to document their response to the proposed disposition if possible. The Screener should use the lines given to document whether the Consumer is in agreement with the plan or if their preferences are in conflict with the Screener recommendations.

I certify that local community resources have been investigated and or consulted to determine whether or not any of them can furnish appropriate and necessary care. I have seen this individual and evaluated him/her and his/her situation. I have also considered alternative modes of treatment. Available community resources have been investigated, and are not appropriate if hospitalization is recommended.

Signature of QMHP designated as a member of MHC Screening Team

Date

The Screener should acknowledge this certification that they have considered community resources and alternate modes of treatment if hospitalization is recommended. The Screener must then sign off on the screen in the space indicated.

*****Any time a state hospital admission is planned, additional paperwork is required. A Statement from a QMHP is required for voluntary and involuntary admissions. The Application for Voluntary Admission is signed by the client, prior to transport or upon arrival to the state hospital. The Certificate of a Physician, Licensed Psychologist, or a Designated QMHP is required for involuntary admissions. The Application for Emergency Admission is required for involuntary admissions that take place prior to court hearing. Instructions can be found starting on page 51.**

*****If the plan is for the Consumer to be admitted to a state psychiatric hospital, the Screener should then contact the appropriate state hospital to facilitate the admission, before sending the Consumer to the facility. The Screener should forward copy of screen to the hospitals. Links and contact numbers can be found in Appendix E.**

*****Don’t forget to call KHS with Screen Results (1-800-466-2222)!**

XI. PRTF SCREENS (PAGE 6C)

This manual pertains mainly to Medicaid Inpatient Psychiatric Screens and State Hospital Screens. It is recommended that the Screener refer to the PRTF Requirements on page 24 and the PRTF Training Website <http://prtfttraining.org/prtfTraining1.0/>

In endorsing PRTF Admission Criteria, it is important to consider the pattern of symptoms and behaviors (**CHRONICITY**) rather than just focusing on acute symptoms or what is going on at the time of the screening. Review of clinical the Community Based Services Plan and consultation with family and providers is essential in rendering a disposition of this type of screening. Endorse all applicable criteria to reflect the documentation in the screening instrument.

ADMISSION CRITERIA
Level 1 Diagnostic Criteria (both required) <input type="checkbox"/> 1. Axis I diagnosis that is psychiatric in nature and not solely due to MR/DD and/or substance abuse. <i>If sole diagnosis of Substance abuse, refer youth to Prepaid Inpatient Health Plan (PIHP)</i> <input type="checkbox"/> 2. Less restrictive treatment is not considered to be adequate. Psychiatric Residential Treatment services can reasonably be expected to improve the youth's condition or prevent further regression so that those services will no longer be needed.
Level 2, Chronic Safety Concerns (at least one required) (if acute safety concerns, complete page 6A) <input type="checkbox"/> 3. Suicide attempt, threats, gestures indicating potential danger to self. <input type="checkbox"/> 4. Homicidal threats or other assaultive behavior indicating potential danger to others. <input type="checkbox"/> 5. Self-care failure indicating an inability to care for own physical health and safety which creates a danger to own life.
Level 3, Functional Impairment (at least one required) <input type="checkbox"/> 6. Severely impaired social, familial, academic, or occupational functioning, which may include excessive use of substances. <input type="checkbox"/> 7. Severe maladaptive or destructive behaviors in school, home, or placement, which may include excessive use of substances. <input type="checkbox"/> 8. Extremely impulsive and demonstrates limited ability to delay gratification. <input type="checkbox"/> 9. Sexual acting-out that is harmful to self or others, and/or age inappropriate. <input type="checkbox"/> 10. History of running away which renders youth/others at risk.
Level 4, Contingent: need for continual support (at least one required) <input type="checkbox"/> 11. Need for medication evaluation or adjustment under close medical observation. <input type="checkbox"/> 12. Need for 24-hour structured environment due to inability to maintain treatment goals or stabilize in less intensive levels of care. <input type="checkbox"/> 13. Need for continuous secure setting with skilled observation and supervision.

Admission Criteria for PRTF Screens - Check the boxes to indicate symptoms or impaired functioning that MAY Constitute Justification for Admission to inpatient psychiatric treatment. The Screener should note that for **Level 1 Diagnostic Criteria**, **BOTH** criteria must apply to constitute justification for PRTF admission. Then, for **Levels 2, 3** and **4**, there must be at least one box checked in each section to constitute justification for PRTF admission. Also note that if the Consumer has **Acute Safety Concerns**, the Screener must complete page 6A to determine need for acute psychiatric care.

<input type="checkbox"/> (A.) Meets psychiatric residential treatment criteria; admission recommended. Admitted/transferred/referred to hospital _____ Admission Date _____ Risk factors associated with admission to PRTF: _____ Recommended Treatment Goals/Preliminary Discharge Plan: _____
<input type="checkbox"/> (B.) Alternative community services plan recommended in lieu of hospitalization, copy given to legally responsible individual.
<input type="checkbox"/> (C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual.

Disposition/Reimbursement Authorization – At this point the Screener should check the box that indicates the disposition of the screen.

(A.) Meets Psychiatric Residential Treatment Criteria; Admission is Recommended – If the plan is for the Consumer to enter a PRTF, enter the name of the hospital (**Admitted/Transferred/Referred to Hospital**) in the space provided as well as the **Admission Date**. KHS will ask for this information when results are phoned in. In some occasions, the date of admission may not match the date of the screen and this is acceptable as long as it is within 5 days of the initial screen request.

Risk Factors Associated with Admission to PRTF – Provide documentation of the behaviors/symptoms the admitting facility will need to be aware of that substantiate the need for placement, and so an appropriate treatment plan may be developed for the Consumer.

(B.) Alternative Community Services Plan Recommended in Lieu of Hospitalization, Copy Given to Legally Responsible Individual – This box would be checked if the Consumer met the criteria for PRTF admission, but a diversion plan was developed (Crisis Services, Outpatient Services, Wraparound Services, etc.). It is expected that the Screener will then take reasonable steps to complete the **Alternative Community Services Plan** that clearly outlines the diversion plan.

(C.) Does not meet inpatient criteria. Alternative community services plan recommended, copy given to legally responsible individual – This box would be checked if the Consumer did NOT meet the criteria for PRTF admission. It is still expected that the Screener will take reasonable steps to complete the **Alternative Community Services Plan**. See **page 48** for instructions.

Comments: _____ _____ _____
CMHC Contact Person (name/center/phone #) _____ _____

Comments – The Screener should use this section to document any other concerns regarding the disposition, treatment/discharge planning, or other recommendations.

CMHC Contact Person (Name/Center/Phone #) – Provide the contact information for the CMHC provider that is “heading up” the PRTF screening process.

I certify that: <input type="checkbox"/> I have seen this individual and evaluated him/her and his/her situation including consulting with the legal guardian of the youth. I have reviewed the CBSP which indicates that local community resources have been identified and determined inadequate to meet the immediate treatment needs of the youth at this time. <input type="checkbox"/> This is an Exception Screen; therefore the CBSP has not yet been completed. I have seen this individual and have evaluated him/her and his/her situation including consulting with the legal guardian of the youth. A short length of stay is authorized pending complete certification of need indicated by the CBSP.

Signature of QMHP designated as a member of MHC Screening Team

Date

The Screener should review this certification and check the boxes: 1.) Indicating they have considered community resources and alternate modes of treatment if hospitalization is recommended; and 2.) Check in the event that the CBSP has not been completed, but a short stay is authorized pending complete certification of the need as indicated by the CBSP. The Screener must then sign off on the screen in the space indicated.

XII. ALTERNATIVE COMMUNITY SERVICES PLAN

When a tracking number has been issued and the Consumer is diverted from inpatient care, the Screener must complete an Alternative Community Services Plan (ACSP) with the Consumer – parents, guardians, collaterals should be involved if available. While the Alternative Community Services Plan is part of the screening process, it is a stand-alone document.

Components of an adequate Alternative Community Services Plan (ACSP):

- Clear documentation of the diversion plan with a record of community services to which the Consumer is being referred
- The diversion plan is congruent to the Consumer's service needs as reflected in the screening document
- Utilization of a safety plan as appropriate
- Documentation of the services and supports that will be provided to help the Consumer resolve the crisis in the least restrictive environment
- Documentation of specific dates and times of services
- Identification of care coordination or follow-up activities that assist the Consumer in remaining in the community
- Identification of collaborative efforts with the Consumer's natural supports
- Documentation of the Consumer's acceptance of referrals and services as evidenced by signature of the Member, Representative/Guardian.
- Documentation that the Member and or Representative/Guardian received a copy of the Alternative Community Services Plan

KHS will do **Care Coordination** with the individuals who have **KHS Special Health Care Needs** (identified on page 5 of screen) to ensure an appropriate plan has been developed to prevent psychiatric hospitalization. The Screener will need to provide each identified Consumer with a Care Coordination pamphlet, along with a copy of the Plan. **An ACSP must be developed regardless of a Consumer's legal status (JJA Custody, Jail, DOC involvement).**

<p>Consumer Strengths, Natural Supports, and Resources (friends, family, Peer Support, Consumer Run Organization):</p> <p>1.) _____</p> <p>2.) _____</p> <p>3.) _____</p> <p>4.) _____</p> <p>Consumer Action Steps (Including Safety Plan):</p> <p>1.) _____</p> <p>2.) _____</p> <p>3.) _____</p> <p>4.) _____</p>
--

Consumer Strengths, Natural Supports, and Resources – In developing the diversion plan, it is helpful for the Screener, Consumer, and/or Collaterals to identify Strengths, Supports, and Resources that will provide a buffer against requiring a higher level of care. This may include Family, CRO's, church, 12 step programs, sobriety, employed, etc.

Consumer Action Steps – In this section, the Screener, Consumer, and/or Collaterals would **identify specific steps the Consumer will take to keep themselves and others safe, and steps they may take to improve their recovery.** This could include things like connecting with family/friends, self soothing activities, self care activities, attending groups or other recovery meetings, and utilizing CMHC crisis services. Basically it is identifying any kind of plan that will help the Consumer minimize risk for a higher level of care.

Crisis Services (*include provider address & phone number for appointments):

24 Hour Crisis services available at #: _____ or address: _____

Phone Welfare Check within 24 Hours at consumer number #: _____

Crisis Appointment (Specify type and provider appt within 24 hours of screen): _____

In Home Stabilization: Crisis Attendant Care Peer Support In Home Family Therapy

Out of Home Crisis Stabilization: _____

Other: _____

Appointment: _____

Appointment: _____

DETAILS: _____

Outpatient Services (*include provider address & phone number for appointments):

Intake Assessment Psychotherapy Medication Services Private Practitioner

Case Management Attendant Care Psychosocial Rehab Family Therapy

Substance Evaluation MR/DD Services SED Waiver Services PRTF CBA Grant

Other (Community Resources): _____

Appointment: _____

Appointment: _____

Appointment: _____

DETAILS: _____

Acute Care Services (Diversion from State Hospital): Facility _____ Date of Admission _____

Crisis Services, Outpatient Services, Acute Care Services – In these sections the Screener should check the boxes that would indicate the Crisis Services and Outpatient Services the Consumer is being diverted to and document any pending appointments. It is understood that the availability or range of services will vary across CMHC’s. There are also “other” boxes to indicate any other services not listed that the Consumer is being referred to. If the Consumer is being diverted to an Acute Care facility, list the name of the facility in the space provided and document the admission date. **Provide documentation in the DETAILS sections that may adequately describe the diversion plan.**

Comments/Other (may include safety plan, consultations, other referrals etc.) _____

Comments/Other – The Screener should use this section to document any additional information to outline the diversion plan, other referrals, recommendations.

Signature below indicates I have reviewed and received a copy of this plan

_____ Date _____

Consumer and/or Legally Responsible Individual

_____ Date _____ Collateral _____ Date _____

QMHP/LMHP

The Consumer or Legally Responsible Individual must sign off on this plan as well as the Screener, evidencing they have reviewed and received a copy of the plan. The Consumer/Legally Responsible Individual is to receive a copy of the plan. If a collateral or other individual will be integral to implementation of the plan, that individual should also sign the ACSP, if available. Examples may include: case managers, family members, or child welfare contractor.

If the Legally Responsible Individual is not present, a copy of the ACSP must be /sent faxed to this person. The Screener should document the fax process by entering the name, date, and time of fax on the “Consumer and/or Legally Responsible Signature” line.

If a Consumer or Legally Responsible Individual refuses to sign the plan, this response should be documented by the Screener on the “Consumer and/or Legally Responsible Signature” line.

*****Don’t forget to call KHS with the screen results (1-800-466-2222) – you will need to provide specific information regarding the Alternative Community Services Plan such as appointment dates/times, provider information, and the phone number for the Consumer or their legal guardian.**

SECTION V: COMMITMENT/STATE HOSPITAL PAPERWORK

A copy of the **screening instrument** along with the **Statement of a QMHP** is **required** for **ANY state psychiatric hospital admission** and must accompany the client or be faxed to the hospital prior to the transfer. The hospitals will vary on admission procedures so Screeners will be advised to consult the admission offices regarding protocol.

Voluntary admissions – There is an **Application for Voluntary Admission** for each state psychiatric hospital. Some CMHC's make it a standard practice for the Consumer to sign this application prior to transfer. It is recommended the Screener consult the admissions clerks to obtain this form if the Consumer is expected to sign it prior to transfer. Defer to your CMHC, state hospital protocols.

Involuntary admissions - The Screener must ensure that the **Certificate of a Physician, Licensed Psychologist, or a Designated QMHP** is signed. Most times the QMHP/Screener will be the professional completing this form.

Application for Emergency Admission - This is for **involuntary Consumers** who basically need emergent treatment at the state psychiatric hospitals, and the admission cannot be delayed until the care and treatment hearing.

***Other materials which may be useful or necessary include: records from the CMHC showing recent care and treatment provided; other medical records, including immunizations and recent care or treatment; and copy of a birth certificate or social security identification.

Statement of a Qualified Mental Health Professional:

RE:	_____	_____	_____	_____
	(name of patient)	(DOB)	(age)	(sex)
	_____	_____	_____	_____
	(patient's address)	(city, state, zip)	(county)	

Identifying Information – This should essentially be carried over from page 1 of the screen

Based upon my screening of the above named person, done by me in person and/or by review of this person's records and of reports concerning this person, and being familiar with the resources and services which are available within this community, I find that the needs of this person for the services indicated below cannot be adequately met in this community, and I therefore authorize that the following service(s) be provided at a state psychiatric hospital.

Statement – It would be good practice for a Screener to review this statement that essentially states the Screener has exhausted the community resources and that the Consumer is in need of state psychiatric hospitalization.

<u>CHECK ONLY EACH TYPE OF SERVICE AUTHORIZED:</u>	
A.	<input type="checkbox"/> VOLUNTARY care and treatment (which this person has indicated to me that he/she wishes to be admitted for and which I believe he/she has the capacity to consent to (See KSA 59-2949(a)).
B.	INVOLUNTARY care and treatment as specified below:
	<input type="checkbox"/> EMERGENCY or TEMPORARY DETENTION AND TREATMENT pursuant to KSA 59-2954, or under the Court's EX PARTE EMERGENCY CUSTODY ORDER (see KSA 59-2958), or under the Court's TEMPORARY CUSTODY ORDER (see KSA 59-2959) if either are issued.
	<input type="checkbox"/> MENTAL EVALUATION , including the examination(s) necessary to prepare the report to be submitted to the Court to assist in the trial of the issue of whether or not this person is a mentally ill person subject to involuntary commitment (see KSA 59-2961).
	<input type="checkbox"/> INPATIENT CARE AND TREATMENT as may be ordered by the Court in any ORDER of CONTINUANCE AND REFERRAL (see KSA 59-2964) or ORDER FOR TREATMENT (see KSA 59-2966), or ORDER FOR CONTINUED TREATMENT (see KSA 59-2969(f)).
_____	_____
(Date)	(Signature of QMHP)
_____	_____
(Telephone No.)	(CMHC address)
<input type="checkbox"/>	Original to be filed with the Court (if involuntary proceedings)
<input type="checkbox"/>	Copy to _____ State Hospital
<input type="checkbox"/>	Copy to _____ CMHC (if courtesy screen)

Voluntary Care and Treatment – Check **box A** if the Consumer agrees to Voluntary Care and Treatment at a state psychiatric hospital and demonstrates the capacity to consent to this care.

Involuntary Care and Treatment – Check **box B** if the Consumer meets the criteria for Involuntary Care and Treatment.

Emergency Admission – The Screener should check this box if the **Application for Emergency Treatment** has been completed and the plan is for the Consumer to be sent to the state psychiatric hospital prior to the Care and Treatment hearing.

Mental Evaluation – The Screener should check this box to give authorization for the Consumer to undergo a mental evaluation as part of their treatment at the state psychiatric hospital to assist in the trial of whether they are a mentally ill person subject to involuntary commitment.

Inpatient Care and Treatment – The Screener should check this box for authorization of Inpatient Care and Treatment as may be ordered by the Court.

Clinician Signature – The Screener should then sign off on the Statement and provide their best contact information.

Original to be filed with the Court (for involuntary proceedings) – This is basically an acknowledgement by the Screener that they will follow up with Court proceedings.

Copy to – Document the name of the state hospital the Consumer will be transferred to, along with the name of the CMHC responsible for the client if the Screener completed a Courtesy Screen.

EMERGENCY ROOM/HOSPITAL TRANSFERS: If the patient has been taken to any emergency room of any community hospital, or is currently admitted to any inpatient department at any community hospital, medical consultations must have been completed prior to any transfer of the patient to any state psychiatric hospital and the treating physician at the community hospital and the physician on duty at the state hospital must concur that the patient is medically stable and that the state hospital is capable of managing the patient's physical condition (See 42U.S.C. Sec. 1395dd). List below (1) the name of the local treating/emergency room physician and (2) the name of the physician on duty at the state hospital who has agreed to accept the transfer:

(1) _____ (2) _____

“Doctor to Doctor” Consult – This statement is an acknowledgment by the Screener that if the Consumer is in an emergency room or inpatient department in a community hospital, or an acute psychiatric hospital, a “doctor to doctor” consult is required to approve the transfer of the patient to a state psychiatric hospital. The Screener should document on the lines below: 1.) the name of the doctor transferring the Consumer, and 2.) the name of the doctor agreeing to receive the Consumer for admission.

Certificate of a Physician, Licensed Psychologist, or a Designated Qualified Mental Health Professional:

RE: _____
(name of patient)

_____ (city, state, zip)
(patient's address)

Identifying Information – This should essentially be carried over from page 1 of the screen

I Certify That:

I am a licensed physician; licensed psychologist; qualified mental health professional designated by the head of a mental health center to make this certificate;

I have on _____ (date) personally examined the above named patient and reviewed any available records, and on the basis thereof:

The Professional designated to sign this form should check applicable boxes and enter date that they personally examined the Consumer

It is my professional opinion that the patient is likely to be a mentally ill person subject to involuntary commitment for care and treatment as that term is defined in KSA 59-2946 (f), including that this patient:

- () is suffering from a mental disorder to the extent the person is in need of treatment;
- () lacks the capacity to make an informed decision concerning treatment, despite conscientious efforts at explanation or efforts to elicit a response from the patient showing an ability to engage in a rational decision-making process;
- () is likely to cause harm to self or others or substantial damage to property of another;
- () is not solely diagnosed with one of the following mental disorders: alcohol or chemical substance abuse; anti-social personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

NOTE: all four of the above described conditions must be applicable to this person in order for the patient to meet the legal definition of a mentally ill person subject to involuntary commitment.

(OPTIONAL) For this reason, I recommend that the patient be detained and admitted to an appropriate inpatient treatment facility for further observation and treatment pending Court proceedings.

The Professional must check the box indicating their opinion that the Consumer is a mentally ill person subject to involuntary commitment. The Professional must check the ()'s that identify the involuntary criteria the commitment is based from. All four conditions must be applicable to meet the legal definition for commitment. The Professional may check the OPTIONAL box recommending inpatient treatment for further observation pending Court proceedings.

_____ X _____
(date) (Signature of physician, psychologist, QMHP)

_____ (bus. Telephone no.) _____ (name of facility, mental health center or clinic associated with)

_____ (business address) _____ (city, state, zip)

The Professional must then Date and Sign the certificate and provide contact information.

mental health center screening form attached

other medical record or statement attached

copy to _____

copy to _____

Check the box indicating the screening form is attached and if there are any medical records that will be transferred to the state psychiatric hospital.

Application for Emergency Admission (for Observation and Treatment): Either a law enforcement officer or the individual agreeing to file a petition for the care and treatment of the Consumer will be required to complete this form.

_____ STATE HOSPITAL		
APPLICATION FOR EMERGENCY ADMISSION (FOR OBSERVATION AND TREATMENT)		
Pursuant to KSA 59-2954 (b) or (c)		
Patient:	_____	_____
(name)	(DOB)	(sex)
_____	_____	_____
(home address)	(SSN)	
_____	_____	_____
(city, state, zip)	(county of residence)	
_____	_____	_____
(name of spouse or nearest relative)	(telephone no.)	
_____		_____
(address, if different from the patient's)		

Identifying Information – Indicate the state hospital where the Consumer will be transferred. The Consumer information should essentially be carried over from page 1 of the screen. The only addition is the identification of the Consumer’s spouse or nearest relative and their contact information.

I request admission of the above named person for emergency observation and treatment upon the following circumstances:

<p>(1) <input type="checkbox"/> I am a law enforcement officer having custody of this person pursuant to the provisions of KSA 59-2953, and:</p> <p><input type="checkbox"/> I will file a petition seeking the involuntary commitment of this person with the District Court of _____ County, not later than the close of business on _____ (date), or;</p> <p><input type="checkbox"/> I have been informed by _____ that s/he will file such a petition. This individual may be contacted at: _____.</p>
--

Section 1 is to be completed by the law enforcement officer, if they are involved and willing to fill out this form. The Law Enforcement officer could be the petitioner as well. If the officer is not the petitioner they will need to identify the name and contact information of the petitioner.

<p>(2) <input type="checkbox"/> I am not a law enforcement officer, but I am familiar with the circumstances of this patient immediately preceding this application, and I will file a petition seeking the involuntary commitment of the patient with the District Court of _____ County, not later than the close of business on _____ (date).</p>

Section 2 is to be completed if the petitioner is not a law enforcement officer. They must agree to file a petition with the District Court (indicate county), not later than the close of business on the next work day (insert date).

<p>(3) <input type="checkbox"/> I believe this patient to be a mentally ill person subject to involuntary commitment for care and treatment (as defined in KSA 59-2946(f) and is likely to cause harm to self or others if not immediately detained. In support thereof I state that:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Section 3 is to be completed by either the individual completing this form, explaining their reasons and evidence that would support the need for emergency admission.

<p>(4) <input type="checkbox"/> The following criminal charges are known by me to be pending against this patient: _____</p> <p>_____</p> <p><input type="checkbox"/> None <input type="checkbox"/> It is unknown by me whether any charges are pending against this person.</p>
--

Section 4 is to be used to identify any pending criminal charges. Select None or Unknown if applicable.

(5) Because this application is for admission to a state psychiatric hospital, the required statement from a qualified mental health professional is attached, having been obtained at the _____ Community Mental Health Center.

Section 5 – The Screener should insert the name of the CMHC where the screen was obtained.

(6) Other documentation, medical records or reports concerning this patient are attached.

(7) Other documentation, medical records or reports concerning this patient may be found and consulted at: _____

Sections 6 and 7 are to be checked if there is accompanying documentation regarding the Consumer’s medical treatment and where records may be obtained.

_____	X	_____
(date)	(signature)	
_____	(printed name)	(L.E.O. badge #)
(time)	(address)	
_____	(city, state, zip)	
(telephone no.)		

The individual that completed this Application for Emergency Admission should sign off on this form.

SECTION VI: DISCHARGE PLANNING PROTOCOL

ADAPTED FROM: U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES. (1997). Exemplary practices in discharge planning.

A. Core Values in Discharge Planning

1. Discharge planning is “the process to prepare a person, who has been admitted to a psychiatric hospital, treatment facility, or other institution for community integration.”
2. Discharge planning begins immediately upon a Consumer’s admission to a facility and creates linkages for the individual to essential community services and supports.
3. Discharge planning is a TEAM APPROACH, a partnership among agencies and institutions which are responsible for the care, support, housing, and treatment of the Consumer, and designated CMHC’s have the primary responsibility for reintegration.
4. Discharge planning should be driven by Consumer needs rather than the availability of resources.

B. Team Care Coordination as a Function of Discharge Planning

1. Team Composition (Can be flexible and may consist of the following):
 - a. **Core members of discharge planning team** – Consumer, Hospital Social Worker, CHMC Liaison
 - b. **Non-Core members of discharge planning team** (to be included when the services they provide are included in the discharge plan)
 - Family
 - Community Case Manager (may be provided when Consumer is SMI, SPMI, SED)
 - Other Mental Health and Substance Abuse Specialists
 - Housing Specialist
 - Income Specialist
 - Payee and/or Guardian
 - Peer Support (from Consumer Run Organization (CRO’s), hospital, CMHC)
 - Representatives from the Criminal Justice system (parole, probation, community corrections)
 - Child Welfare Contractor (Foster Care, Family Preservation or others)
 - Other Consumer Advocates
2. **Designated Care Coordinator** – This element is important due to the need for collaterals to know who to go to for information regarding the Consumer they are involved with.
 - a. The designated care coordinator for the individual during the psychiatric hospitalization is the hospital social worker; the designated care coordinator for the Consumer upon hospital discharge is the CMHC liaison.
 - b. Develops goals and objectives with the Consumer to be implemented immediately prior and/or immediately upon discharge to ensure continuity of care
 - c. Identifies and assists in accessing community and natural resources needed to meet goals/objectives upon discharge
 - d. Provides short term follow up to ensure access to and effectiveness of resources implemented after discharge
 - e. Communicates follow up services to community treatment team and any custodial agency

C. Components of Exemplary Discharge Planning

1. Exemplary discharge plans are **developed with Consumers** and feature the most extensive input from Consumers.
2. Exemplary discharge plans are **written in the form of a contract** between the Consumer, service providers, psychiatric hospital and CMHC representatives.
3. Exemplary discharge plans are **culturally competent** and consider important issues in race, ethnicity, religion, gender, sexual orientation, and the culture’s view of mental illness and stigma.
4. **CMHC Liaison Participation**
 - a. It is strongly recommended that discharge planners maintain consistent participation in the

treatment process. Successful discharge planning relies on the full participation of all stakeholders.

- b. All CMHC liaisons are expected to attend quarterly meetings with the state mental health hospitals. If they are not able to attend, the liaison is expected to send a substitute.

5. Housing, Health Care, & Treatment

- a. For a discharge plan to be successful, it needs to facilitate the Consumer finding and maintaining housing, health care, and treatment.
- b. Exemplary discharge plans identify and secure a variety of housing options, recognizing that the needs and preferences of Consumers vary and change over time as conditions and interests change.
- c. Exemplary plans stem from an assessment of a community's housing stock and partnerships between housing and service providers, to help the Consumer secure affordable housing if that is their choice.
- d. Ongoing, comprehensive assessment, undertaken in collaboration with the Consumer and emphasizing the Consumer's strengths and preferences, is essential to the discharge and community re-entry process.
- e. Exemplary discharge plans provide for the mental and physical health needs of the Consumer.
- f. Exemplary discharge plans identify needs for substance abuse treatment, occupational and physical therapy if indicated.

6. Income, Employment, & Entitlements

- a. Exemplary discharge plans encourage Consumers to be as independent and self-sufficient as possible.
- b. Exemplary discharge plans ensure that Consumers are connected to the entitlements they are eligible or potentially eligible for.
- c. Exemplary discharge plans examine the possibility of employment, education, and training.
- d. Exemplary discharge plans ensure appropriate management of money and other resources.

7. Personal Support and Life Skills Training

- a. Individuals have better opportunities for a successful and permanent community re-entry if they can develop adequate support systems. Exemplary discharge planning facilitates the development of this support.
- b. Exemplary discharge plans features case managers (for those Consumers who are SMI, SPMI, SED) with small caseloads who work with Consumers and agencies to ensure the discharge plan is followed or revised as necessary.
- c. Exemplary discharge plans ensure the development of support networks.
- d. Exemplary discharge plans involve family members, friends, and other supporters as appropriate or requested, provided the Consumer has given consent, release of information for their involvement.
- e. Peer support groups can be very helpful to community re-entry, and discharge plans should make use of these resources whenever appropriate.
- f. Exemplary discharge plans identify training needs for community-based life skills.

8. Difficult Cases:

- a. For some individuals, non-compliance or relapse may be a part of their community re-entry experience. Exemplary discharge planning recognizes and anticipates these possibilities.
- b. Exemplary discharge planning recognizes that, for a variety of reasons, difficult cases can happen. Some Consumers will choose to become disconnected from the system
 - Exemplary discharge planning anticipates these difficulties and attempts to develop alternative resources to meet potential and likely needs such as outreach programs, safe havens, jail diversion programs, and other innovative programs
 - Exemplary discharge planning ensures that if Consumers leave a program or facility against medical advice, they will be able to return to the system and resources will be available.

- c. In some cases, dispute resolution may be needed which may involve other agencies such as Department of Corrections, Community Corrections, District Attorney's, courts, etc. Resources for dispute resolution may include the Regional Disability and Behavioral Health Services (DBHS) field Staff, and/or DBHS central office staff.
- d. It is generally understood and accepted that the agency with current primary responsibility for the identified Consumer, has the most information to make an informed decision about the Consumer's readiness for discharge. Of course, other collaterals, who know the Consumer, should provide input in order for the responsible agency (in this case, the hospital) to make the best decision and that feedback should be strongly considered. Ultimately, the hospital where the patient is admitted bears responsibility for the final decision on when to discharge.

D. Collaboration, Partnerships, and Information Sharing

1. Levels of Collaboration:

- a. A variety of forms of partnerships and collaboration can achieve an effective discharge planning system. It is the responsibility of each local community to determine which level works best in its own situation.
- b. Exemplary discharge planning recognizes a continuum of collaboration. It ranges from shared information and memorandums of understanding to interactions with blended staff on the care coordination team.

2. Developing Partnerships:

- a. The benefit of partnerships is that successful ones expand the amount of resources available to Consumers engaged in community re-entry.
- b. Exemplary partnerships involve agencies in the areas in which they have demonstrated expertise.
- c. Exemplary partnerships require all agencies at the table to contribute actively in the discharge process.

3. Information Sharing:

- a. When a Consumer is admitted to the SMHH, the standard practice is for the designated CMHC to send to the state mental health hospital the hospitalization screening. If the individual is a current Consumer of the CMHC, a current medication list, intake assessment, and recent progress notes should also be submitted to the hospital to enhance treatment coordination efforts.
- b. For each Consumer being discharged to a CMHC, the standard practice is for the state mental health hospital to send the BioPsychoSocial Assessment with the working diagnoses, the discharge summary identifying the discharge diagnoses, recommendations for treatment, pertinent progress notes, and the current medication list to facilitate the appropriate treatment. It is understood that in some instances the discharge summaries are not yet dictated, but the CMHC provider should at receive records containing the intake assessment, discharge diagnoses, and the current medication regimen prior to the next scheduled appointment.

E. Roles of Key Stakeholders

1. Role of the Hospital Social Worker

a. Collaboration/Coordination – The Hospital Social Worker will:

- Before the initial treatment planning meeting for the Consumer, take reasonable steps to notify the CMHC liaison via fax, email, or phone. The CMHC liaison will request written discharge recommendations from the Social Worker.
- On admission, interview the newly admitted patient to identify what the patient believes will be needed on discharge. In the event family members or other person's-of-support are involved, obtain release of information and ascertain what they believe the patient will need upon discharge.

- For non-state psychiatric inpatient providers, ascertain with patient, willingness to sign a release of information for communication with CMHC or other mental health providers. Obtain the releases if patient agrees.
 - Collaborate with the hospital treatment team and CMHC or other mental health providers to develop recommendations for Outpatient Treatment Order if needed/indicated.
 - Collaborate with the Consumer, treatment team, CMHC and other collaterals to develop a continuum of care plan, taking into account discharge any discharge recommendations of the CMHC providers.
 - Develop and maintain family/collateral contact as indicated. This includes obtaining releases of information for identified collaterals and advocates. If the Consumer refuses to sign releases at the time of admission, the social worker will work proactively with the Consumer to obtain key releases at a later time to improve communication, coordination of discharge. Discharge planners still recognize that some Consumers do not want family involvement and they do have that right.
 - Initiate/maintain weekly contact with CMHC liaison.
 - Collaboration on transportation with CMHC, family, others and notify nursing department if hospital is providing the transportation.
 - Take reasonable steps to ensure that when a Consumer is transferring services to another CMHC or agency, both the Consumer and referred agency receive notice of discharge recommendations.
- b. Therapeutic Contact - The Hospital Social Worker will:**
- Provide supportive counseling throughout the course of hospitalization.
 - Engage in active discussion of discharge planning with the Consumer.
 - Provide assistance with phone calls as necessary.
- c. Treatment Plan Development - The Hospital Social worker will:**
- Interview the Consumer prior to the development of the Treatment Plan.
 - Participate in the development of the treatment plan, with the primary responsibility of developing the discharge planning portion of the plan.
- d. Assessment and Referral - The Hospital Social Worker will:**
- Complete the BioPsychoSocial Assessment.
 - Request information from outside agencies and document efforts accordingly
 - Identify Consumer needs and progress toward discharge throughout the course of the hospitalization
 - Explore Consumer resources and treatment needs (financial, housing, MH services, social, medical, substance abuse issues).
 - Request RADAC screen as indicated. If the Consumer is not able to be seen prior to hospital discharge, the social worker will coordinate a first available RADAC assessment appointment on an outpatient basis.
 - Coordinate PASRR I & II as indicated, which may include obtaining and organizing medical records.
 - Assist Consumers with completion of financial applications (GA, disability, SSI, Medicaid, VA, food stamps) and discuss referral to Vocational Rehabilitation Services.
 - Document progress toward discharge in hospital notes
 - Assist with assembly of the discharge packet including patient education about illness, re-admission prevention plan (which may be the SMART Strategy Summary Action Worksheet or other type of wrap-around plan), and other appropriate information that summarizes the care and treatment provided and expected on discharge.

2. Role of the CMHC Liaison

a. Collaboration/Coordination - The CMHC Liaison will:

- Before the initial treatment planning meeting for the Consumer, provide recommendations (either in written, or by phone, or by e-mail, or face-to-face verbal) for discharge, which will include recommendations for services following discharge.
- Obtain CMHC medical records and provide to psychiatric hospital (including medication records, intake evaluations, case management, therapy notes, current treatment plan, and crisis plans/WRAP plans, or other re-admission prevention plan which **may** include the SMART Strategy Summary Action Worksheet) within 48 hours of admission whenever possible
- Participate in the development of the treatment plan whenever possible
- Maintain contact with the Consumer (can use tele-video, unit phone, and/or face-to-face)
- Maintain weekly contact with the hospital social worker
- Consult with the hospital treatment team/social worker in the event that an outpatient treatment order is requested and if required; submit a letter to the court. In the event of a change of venue to a different state hospital catchment area, the liaison will submit a letter to the state hospital social worker who will then in turn file it with the resident county.
- Take reasonable steps to ensure that when a Consumer is transferring services to another CMHC or agency, both the Consumer and referred agency receive notice of discharge recommendations.
- Notify hospital social worker about the CMHC services available to the Consumer in the community including housing, funding, case management, therapy, medication, etc. using the following format:

(Name of State Hospital) Discharge planning for (Name of Patient) on (Date of Discharge): _____
(Name of State Hospital) unit name: _____
(Name of State Hospital) Social worker: _____
(Name of Patient) Discharge address: _____
(Name of CMHC) CSS case management is: _____
(Name of CMHC) Therapist is: _____
(Name of CMHC) Supported Education is with: _____
(Name of CMHC) Community Integration Services plan: _____
(Name of CMHC) medication evaluation appointment is scheduled for (date,place and time: _____
Information regarding Outpatient Treatment Order-(insert order number)
CMHC Instructions to (State Hospital Name) unit nurse: example:** Please have the patient ready for discharge by 12:30 pm at Sedricks. Please include discharge instructions, medications and labwork. Discharge/Lab instructions should be faxed to 999-888-7777 by 1:00 pm.

- Communicate with the Consumer, family and guardian about the services available to the patient and family in the community, provided the Consumer has signed the appropriate releases of information.
- Collaborate with the state mental health hospital to develop continuum of care plan and provide updated recommendations to the social worker/treatment team
- Collaborate with hospital social worker on the discharge transportation plans.
- Provide accurate fax numbers for each CMHC office where discharge instruction forms (intake, medication information, etc) are to be faxed

b. Coordinating Successful Re-Entry - The CMHC Liaison will:

- Facilitate acquisition of appropriate housing (e.g. Foster Home, independent living resource, nursing facility, etc.)
- Arrange for PASRR II as indicated
- Coordinate access to funds as necessary (e.g. supported housing funds, tenant based

rental assistance, Section 8, etc.)

- Take reasonable steps to coordinate a Consumer's aftercare for discharge to a different CMHC or other agency, including medication, intake, case management appointments

3. Role of Peer Support.

a. The Peer Support Liaison's (PSL) role is based on peer support principles and provides a "human experience context" within a clinical environment. It is structured in such a way as to add peer support to the current continuum of care. The PSL challenges negative beliefs about the disabling power of the psychiatric diagnosis in the life of the individual by offering a number of supports and life skills for successful community living based on personal experience. The PSL makes contact with the individual at the hospital and focuses on building a relationship that supports positive change by:

- Role modeling the reality of recovery
- Identifying strategies for successful living and working in the community based on life experience
- Providing information to the individual about opportunities for support and meaningful contribution and involvement in Consumer run/Consumer led initiatives in Kansas - including the Kansas Mental Health Consumer Advisory Council (CAC), Leadership Academy, and Consumer Run Organizations (CROs) and their programs and communities.
- Teaching self-directed recovery tools for wellness management, including WRAP, Common Ground and the development of areas of personal interest, including journal writing, creative writing, photography, music, etc.
- Anticipating dates of discharge for the individual in order to coordinate resources needs, including transportation, and first-day back at home supports (grocery store, pharmacy, other).
- Linking with available peer support services, both formal and informal, in anticipation of individual's support needs on discharge.
- Linking peer support service providers and the individual, including the CPS at the CMHC, the Community Transition Coordinator (CTC) within the CRO, and the Peer Support Program staff within the hospital.
- Assisting the individual to build purposeful and meaningful relationships with self, others and his/her environment; to foster hope; provide meaningful networks of support; and transmit new skills. Activities to achieve the above will be described in a later draft but are based on the CPS Basic Training curriculum.
- Assisting with goal achievement by the individual beginning at the hospital and continues in the community through peer support relationships.
- Ensuring that the individual's voice and choice are part of successful discharge planning. The PSL strives to develop strategies and/or resources for multiple types of support to meet the unique needs, wants and preferences of the individual. (Example: In rural communities, PSL might assist individual with accessing Internet in order to join the many online peer support communities now available around the world.)

b. Current and available trained peer support providers who may act as Peer Support Liaison:

- Consumer Transition Coordinator – SIDE, Bridge to Freedom, and Bright Horizons
- Certified Peer Specialists employed by the hospital
- Certified Peer Specialists employed by the CMHC

F. Access Standard for Discharge to Outpatient Services

1. When a Consumer is discharged from a psychiatric hospital, an outpatient intake and/or medication appointment shall be scheduled so that the patient is seen within 3 working days. The medication appointment should be scheduled so that the Consumer is seen no more than 1 week following hospital discharge. Efforts should be made to ensure that Consumers have a prescription or a continuous supply of their prescribed medication regardless of the date of the follow-up appointment.
2. If the Consumer is a current CMHC Consumer, the CMHC will take steps to make contact with the Consumer prior to discharge from the state hospital to promote the therapeutic alliance and continuity of care.

SECTION VII: REFERENCES

STATUTES PERTAINING TO GUARDIANSHIP AND CARE AND TREATMENT

59-3077

Chapter 59.--PROBATE CODE

Article 30.--GUARDIANS OR CONSERVATORS

59-3077. Authority of guardian to admit ward to treatment facility; petition; contents; notice; hearing; procedure. (a) At any time after the filing of the petition provided for in K.S.A. 59-3058, 59-3059, 59-3060 or 59-3061, and amendments thereto, any person may file in addition to that original petition, or as a part thereof, or at any time after the appointment of a temporary guardian as provided for in K.S.A. 59-3073, and amendments thereto, or a guardian as provided for in K.S.A. 59-3067, and amendments thereto, the temporary guardian or guardian may file, a verified petition requesting that the court grant authority to the temporary guardian or guardian to admit the proposed ward or ward to a treatment facility, as defined in subsection (h), and to consent to the care and treatment of the proposed ward or ward therein. The petition shall include:

- (1) The petitioner's name and address, and if the petitioner is the proposed ward's or ward's court appointed temporary guardian or guardian, that fact;
- (2) the proposed ward's or ward's name, age, date of birth, address of permanent residence, and present address or whereabouts, if different from the proposed ward's or ward's permanent residence;
- (3) the name and address of the proposed ward's or ward's court appointed temporary guardian or guardian, if different from the petitioner;
- (4) the factual basis upon which the petitioner alleges the need for the proposed ward or ward to be admitted to and treated at a treatment facility, or for the proposed ward or ward to continue to be treated at the treatment facility to which the proposed ward or ward has already been admitted, or for the guardian to have continuing authority to admit the ward for care and treatment at a treatment facility pursuant to subsection (b)(3) of K.S.A. 59-2949, or subsection (b)(3) of K.S.A. 59-29b49, and amendments thereto;
- (5) the names and addresses of witnesses by whom the truth of this petition may be proved; and
- (6) a request that the court find that the proposed ward or ward is in need of being admitted to and treated at a treatment facility, and that the court grant to the temporary guardian or guardian the authority to admit the proposed ward or ward to a treatment facility and to consent to the care and treatment of the proposed ward or ward therein.

(b) The petition may be accompanied by a report of an examination and evaluation of the proposed ward or ward conducted by an appropriately qualified professional, which shows that the criteria set out in K.S.A. 39-1803, subsection (e) of K.S.A. 59-2946, subsection (f) of K.S.A. 59-29b46 or K.S.A. 76-12b03, and amendments thereto, are met.

(c) Upon the filing of such a petition, the court shall issue the following:

(1) An order fixing the date, time and place of a hearing on the petition. Such hearing, in the court's discretion, may be conducted in a courtroom, a treatment facility or at some other suitable place. The time fixed in the order shall in no event be earlier than seven days or later than 21 days after the date of the filing of the petition. The court may consolidate this hearing with the trial upon the original petition filed pursuant to K.S.A. 59-3058, 59-3059, 59-3060 or 59-3061, and amendments thereto, or with the trial provided for in the care and treatment act for mentally ill persons or the care and treatment act for persons with an alcohol or substance abuse problem, if the petition also incorporates the allegations required by, and is filed in compliance with, the provisions of either of those acts.

(2) An order requiring that the proposed ward or ward appear at the time and place of the hearing on the petition unless the court makes a finding prior to the hearing that the presence of the proposed ward or ward will be injurious to the person's health or welfare, or that the proposed ward's or ward's impairment is such that the person could not meaningfully participate in the proceedings, or that the proposed ward or ward has filed with the court a written waiver of such ward's right to appear in person. In any such case, the court shall enter in the record of the proceedings the facts upon which the court has found that the presence of the proposed ward or ward at the hearing should be excused. Notwithstanding the foregoing provisions of this subsection, if the proposed ward or ward files with the court at least one day prior to the date of the hearing a written notice stating the person's desire to be present at the hearing, the court shall order that the person must be present at the hearing.

(3) An order appointing an attorney to represent the proposed ward or ward. The court shall give preference, in the appointment of this attorney, to any attorney who has represented the proposed ward or ward in other matters, if the court has knowledge of that prior representation. The proposed ward, or the ward with the consent of the ward's conservator, if one has been appointed, shall have the right to engage an attorney of the proposed ward's or ward's choice and, in such case, the attorney appointed by the court shall be relieved of all duties by the court. Any appointment made by the court shall terminate upon a final determination of the petition and any appeal therefrom, unless the court continues the appointment by further order.

(4) An order fixing the date, time and a place that is in the best interest of the proposed ward or ward, at which the proposed ward or ward shall have the opportunity to consult with such ward's attorney. This consultation shall be scheduled to occur prior to the time at which the examination and evaluation ordered pursuant to subsection (d)(1), if ordered, is scheduled to occur.

(5) A notice similar to that provided for in K.S.A. 59-3066, and amendments thereto.

(d) Upon the filing of such a petition, the court may issue the following:

(1) An order for a psychological or other examination and evaluation of the proposed ward or ward, as may be specified by the court. The court may order the proposed ward or ward to submit to such an examination and evaluation to be conducted through a general hospital, psychiatric hospital, community mental health center, community developmental disability organization, or by a

private physician, psychiatrist, psychologist or other person appointed by the court who is qualified to examine and evaluate the proposed ward or ward. The costs of this examination and evaluation shall be assessed as provided for in K.S.A. 59-3094, and amendments thereto.

(2) If the petition is accompanied by a report of an examination and evaluation of the proposed ward or ward as provided for in subsection (b), an order granting temporary authority to the temporary guardian or guardian to admit the proposed ward or ward to a treatment facility and to consent to the care and treatment of the proposed ward or ward therein. Any such order shall expire immediately after the hearing upon the petition, or as the court may otherwise specify, or upon the discharge of the proposed ward or ward by the head of the treatment facility, if the proposed ward or ward is discharged prior to the time at which the order would otherwise expire.

(3) For good cause shown, an order of continuance of the hearing.

(4) For good cause shown, an order of advancement of the hearing.

(5) For good cause shown, an order changing the place of the hearing.

(e) The hearing on the petition shall be held at the time and place specified in the court's order issued pursuant to subsection (c), unless an order of advancement, continuance, or a change of place of the hearing has been issued pursuant to subsection (d). The petitioner and the proposed ward or ward shall each be afforded an opportunity to appear at the hearing, to testify and to present and cross-examine witnesses. If the hearing has been consolidated with a trial being held pursuant to either the care and treatment act for mentally ill persons or the care and treatment act for persons with an alcohol or substance abuse problem, persons not necessary for the conduct of the proceedings may be excluded as provided for in those acts. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure. The court shall have the authority to receive all relevant and material evidence which may be offered, including the testimony or written report, findings or recommendations of any professional or other person who has examined or evaluated the proposed ward or ward pursuant to any order issued by the court pursuant to subsection (d). Such evidence shall not be privileged for the purpose of this hearing.

(f) Upon completion of the hearing, if the court finds by clear and convincing evidence that the criteria set out in K.S.A. 39-1803, subsection (e) of K.S.A. 59-2946, subsection (f) of K.S.A. 59-29b46 or K.S.A. 76-12b03, and amendments thereto, are met, and after a careful consideration of reasonable alternatives to admission of the proposed ward or ward to a treatment facility, the court may enter an order granting such authority to the temporary guardian or guardian as is appropriate, including continuing authority to the guardian to readmit the ward to an appropriate treatment facility as may later become necessary. Any such grant of continuing authority shall expire two years after the date of final discharge of the ward from such a treatment facility if the ward has not had to be readmitted to a treatment facility during that two-year period of time. Thereafter, any such grant of continuing authority may be renewed only after the filing of another petition seeking authority in compliance with the provision of this section.

(g) Nothing herein shall be construed so as to prohibit the head of a treatment facility from admitting a proposed ward or ward to that facility as a voluntary patient if the head of the treatment facility is satisfied that the proposed ward or ward at that time has the capacity to understand such ward's illness and need for treatment, and to consent to such ward's admission and treatment. Upon any such admission, the head of the treatment facility shall give notice to the temporary guardian or guardian as soon as possible of the ward's admission, and shall provide to the temporary guardian or guardian copies of any consents the proposed ward or ward has given. Thereafter, the temporary guardian or guardian shall timely either seek to obtain proper authority pursuant to this section to admit the proposed ward or ward to a treatment facility and to consent to further care and treatment, or shall otherwise assume responsibility for the care of the proposed ward or ward, consistent with the authority of the temporary guardian or guardian, and may arrange for the discharge from the facility of the proposed ward or ward, unless the head of the treatment facility shall file a petition requesting the involuntary commitment of the proposed ward or ward to that or some other facility.

(h) As used herein, "treatment facility" means the Kansas neurological institute, Larned state hospital, Osawatomie state hospital, Parsons state hospital and training center, the rainbow mental health facility, any intermediate care facility for the mentally retarded, any psychiatric hospital licensed pursuant to K.S.A. 75-3307b, and amendments thereto, and any other facility for mentally ill persons or mentally retarded or developmentally disabled persons licensed pursuant to K.S.A. 75-3307b, and amendments thereto, if the proposed ward or ward is to be admitted as an inpatient or resident of that facility.

History: L. 2002, ch. 114, § 28; July 1.

59-2945

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2945. Name and citation of act. The provisions of K.S.A. 59-2945 through 59-2986 and amendments thereto shall be known and may be cited as the care and treatment act for mentally ill persons.

History: L. 1996, ch. 167, § 1; Apr. 18.

59-2946

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2946. Definitions. When used in the care and treatment act for mentally ill persons:

(a) "Discharge" means the final and complete release from treatment, by either the head of a treatment facility acting pursuant to K.S.A. 59-2950 and amendments thereto or by an order of a court issued pursuant to K.S.A. 59-2973 and amendments thereto.

(b) "Head of a treatment facility" means the administrative director of a treatment facility or such person's designee.

(c) "Law enforcement officer" shall have the meaning ascribed to it in K.S.A. 22-2202, and amendments thereto.

(d) (1) "Mental health center" means any community mental health center organized pursuant to the provisions of K.S.A. 19-4001 through 19-4015 and amendments thereto, or mental health clinic organized pursuant to the provisions of K.S.A. 65-211 through 65-215 and amendments thereto, or a mental health clinic organized as a not-for-profit or a for-profit corporation pursuant to K.S.A. 17-1701 through 17-1775 and amendments thereto or K.S.A. 17-6001 through 17-6010 and amendments thereto, and licensed in accordance with the provisions of K.S.A. 75-3307b and amendments thereto.

(2) "Participating mental health center" means a mental health center which has entered into a contract with the secretary of social and rehabilitation services pursuant to the provisions of K.S.A. 39-1601 through 39-1612 and amendments thereto.

(e) "Mentally ill person" means any person who is suffering from a mental disorder which is manifested by a clinically significant behavioral or psychological syndrome or pattern and associated with either a painful symptom or an impairment in one or more important areas of functioning, and involving substantial behavioral, psychological or biological dysfunction, to the extent that the person is in need of treatment.

(f) (1) "Mentally ill person subject to involuntary commitment for care and treatment" means a mentally ill person, as defined in subsection (e), who also lacks capacity to make an informed decision concerning treatment, is likely to cause harm to self or others, and whose diagnosis is not solely one of the following mental disorders: Alcohol or chemical substance abuse; antisocial personality disorder; mental retardation; organic personality syndrome; or an organic mental disorder.

(2) "Lacks capacity to make an informed decision concerning treatment" means that the person, by reason of the person's mental disorder, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by an inability to weigh the possible risks and benefits.

(3) "Likely to cause harm to self or others" means that the person, by reason of the person's mental disorder: (a) Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior threatening, attempting or causing such injury, abuse or damage; except that if the harm threatened, attempted or caused is only harm to the property of another, the harm must be of such a value and extent that the state's interest in protecting the property from such harm outweighs the person's interest in personal liberty; or (b) is substantially unable, except for reason of indigency, to provide for any of the person's basic needs, such as food, clothing, shelter, health or safety, causing a substantial deterioration of the person's ability to function on the person's own.

No person who is being treated by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone through prayer for healing shall be determined to be a mentally ill person subject to involuntary commitment for care and treatment under this act unless substantial evidence is produced upon which the district court finds that the proposed patient is likely in the reasonably foreseeable future to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior threatening, attempting or causing such injury, abuse or damage; except that if the harm threatened, attempted or caused is only harm to the property of another, the harm must be of such a value and extent that the state's interest in protecting the property from such harm outweighs the person's interest in personal liberty.

(g) "Patient" means a person who is a voluntary patient, a proposed patient or an involuntary patient.

(1) "Voluntary patient" means a person who is receiving treatment at a treatment facility pursuant to K.S.A. 59-2949 and amendments thereto.

(2) "Proposed patient" means a person for whom a petition pursuant to K.S.A. 59-2952 or 59-2957 and amendments thereto has been filed.

(3) "Involuntary patient" means a person who is receiving treatment under order of a court or a person admitted and detained by a treatment facility pursuant to an application filed pursuant to subsection (b) or (c) of K.S.A. 59-2954 and amendments thereto.

(h) "Physician" means a person licensed to practice medicine and surgery as provided for in the Kansas healing arts act or a person who is employed by a state psychiatric hospital or by an agency of the United States and who is authorized by law to practice medicine and surgery within that hospital or agency.

(i) "Psychologist" means a licensed psychologist, as defined by K.S.A. 74-5302 and amendments thereto.

(j) "Qualified mental health professional" means a physician or psychologist under a contract with a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health center, a licensed masters level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

(1) "Direction" means monitoring and oversight including regular, periodic evaluation of services.

(2) "Licensed master social worker" means a person licensed as a master social worker by the behavioral sciences regulatory board under K.S.A. 65-6301 through 65-6318 and amendments thereto.

(3) "Licensed specialist social worker" means a person licensed in a social work practice specialty by the behavioral sciences regulatory board under K.S.A. 65-6301 through 65-6318 and amendments thereto.

(4) "Licensed masters level psychologist" means a person licensed as a licensed masters level psychologist by the behavioral sciences regulatory board under K.S.A. 74-5361 through 74-5373 and amendments thereto.

(5) "Registered nurse" means a person licensed as a registered professional nurse by the board of nursing under K.S.A. 65-

1113 through 65-1164 and amendments thereto.

(k) "Secretary" means the secretary of social and rehabilitation services.

(l) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility or Topeka state hospital.

(m) "Treatment" means any service intended to promote the mental health of the patient and rendered by a qualified professional, licensed or certified by the state to provide such service as an independent practitioner or under the supervision of such practitioner.

(n) "Treatment facility" means any mental health center or clinic, psychiatric unit of a medical care facility, state psychiatric hospital, psychologist, physician or other institution or person authorized or licensed by law to provide either inpatient or outpatient treatment to any patient.

(o) The terms defined in K.S.A. 59-3051 and amendments thereto shall have the meanings provided by that section.

History: L. 1996, ch. 167, § 2; L. 1997, ch. 142, § 5; L. 1998, ch. 163, § 1; L. 2001, ch. 154, § 5; L. 2002, ch. 114, § 62; July 1.

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2947. Computation of time. In computing the date upon or by which any act must be done or hearing held by under provisions of this article, the day on which an act or event occurred and from which a designated period of time is to be calculated shall not be included, but the last day in a designated period of time shall be included unless that day falls on a Saturday, Sunday or legal holiday, in which case the next day which is not a Saturday, Sunday or legal holiday shall be considered to be the last day.

History: L. 1996, ch. 167, § 3; Apr. 18.

59-2948

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2948. Civil rights of persons subject to the provisions of this act. (a) The fact that a person may have voluntarily accepted any form of psychiatric treatment, or become subject to a court order entered under authority of this act, shall not be construed to mean that such person shall have lost any civil right they otherwise would have as a resident or citizen, any property right or their legal capacity, except as may be specified within any court order or as otherwise limited by the provisions of this act or the reasonable rules and regulations which the head of a treatment facility may for good cause find necessary to make for the orderly operations of that facility. No person held in custody under the provisions of this act shall be denied the right to apply for a writ of habeas corpus.

(b) There shall be no implication or presumption that a patient within the terms of this act is for that reason alone a person in need of a guardian or a conservator as provided for in K.S.A. 59-3050 through 59-3095, and amendments thereto.

(c) A person who is a mentally ill person subject to involuntary commitment for care and treatment as defined in K.S.A. 59-2946, and amendments thereto, or a person with an alcohol or substance abuse problem subject to involuntary commitment for care and treatment as defined in K.S.A. 59-29b46, and amendments thereto, shall be subject to K.S.A. 21-4204, and amendments thereto.

History: L. 1996, ch. 167, § 4; L. 2002, ch. 114, § 63; L. 2006, ch. 210, § 15; July 1, 2007.

59-2949

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2949. Voluntary admission to treatment facility; application; written information to be given voluntary patient. (a) A mentally ill person may be admitted to a treatment facility as a voluntary patient when there are available accommodations and the head of the treatment facility determines such person is in need of treatment therein, and that the person has the capacity to consent to treatment, except that no such person shall be admitted to a state psychiatric hospital without a written statement from a qualified mental health professional authorizing such admission.

(b) Admission shall be made upon written application:

(1) If such person is 18 years of age or older the person may make such application for themselves; or

(2) (A) If such person is less than 18 years of age, a parent may make such application for their child; or

(B) if such person is less than 18 years of age, but 14 years of age or older the person may make such written application on their own behalf without the consent or written application of their parent, legal guardian or any other person. Whenever a person who is 14 years of age or older makes written application on their own behalf and is admitted as a voluntary patient, the head of the treatment facility shall promptly notify the child's parent, legal guardian or other person known to the head of the treatment facility to be interested in the care and welfare of the minor of the admittance of that child; or

(3) if such person has a legal guardian, the legal guardian may make such application provided that if the legal guardian is required to obtain authority to do so pursuant to K.S.A. 59-3077, and amendments thereto. If the legal guardian is seeking admission of their ward upon an order giving the guardian continuing authority to admit the ward to a treatment facility, as defined in K.S.A. 59-3077, and amendments thereto, the head of the treatment facility may require a statement from the patient's attending physician or from the local health officer of the area in which the patient resides confirming that the patient is in need of psychiatric treatment in a treatment facility before accepting the ward for admission, and shall divert any such person to a less restrictive treatment alternative, as may be appropriate.

(c) No person shall be admitted as a voluntary patient under the provisions of this act to any treatment facility unless the head of the treatment facility has informed such person or such person's parent, legal guardian, or other person known to the head of the

treatment facility to be interested in the care and welfare of a minor, in writing, of the following:

- (1) The rules and procedures of the treatment facility relating to the discharge of voluntary patients;
- (2) the legal rights of a voluntary patient receiving treatment from a treatment facility as provided for in K.S.A. 59-2978 and amendments thereto; and
- (3) in general terms, the types of treatment which are available or would not be available to a voluntary patient from that treatment facility.

(d) Nothing in this act shall be construed as to prohibit a proposed or involuntary patient with capacity to do so from making an application for admission as a voluntary patient to a treatment facility. Any proposed or involuntary patient desiring to do so shall be afforded an opportunity to consult with their attorney prior to making any such application. If the head of the treatment facility accepts the application and admits the patient as a voluntary patient, then the head of the treatment facility shall notify, in writing, the patient's attorney, the patient's legal guardian, if the patient has a legal guardian, and the district court which has jurisdiction over the patient of the patient's voluntary status. When a notice of voluntary admission is received, the court shall file the same which shall terminate the proceedings.

History: L. 1996, ch. 167, § 5; L. 2002, ch. 114, § 64; July 1.

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2950. Discharge of a voluntary patient. The head of a treatment facility shall discharge any voluntary patient whose treatment in the facility is determined by the head of the treatment facility to have reached maximum benefit. Prior to the discharge, the head of the treatment facility shall give written notice of the date and time of the discharge to the patient and, if appropriate, to the patient's parent, legal guardian or other person known to the head of the treatment facility to be interested in the care and welfare of a minor patient.

History: L. 1996, ch. 167, § 6; Apr. 18.

59-2951

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2951. Right to discharge of voluntary patient; procedure. (a) A voluntary patient shall be entitled to be discharged from a treatment facility, by the head of the treatment facility, by no later than the third day, excluding Saturdays, Sundays and holidays, after receipt of the patient's written request for discharge. If the voluntary patient is a patient in a state psychiatric hospital, that hospital shall immediately give either oral or facsimile notice to the participating mental health center serving the area where the patient intends to reside and shall consider any recommendations from that mental health center which may be received prior to the time set for discharge as specified in the notice.

(b) (1) If the voluntary patient is an adult admitted upon the application of a legal guardian or pursuant to an order of the court issued pursuant to K.S.A. 59-3077, and amendments thereto, any request for discharge must be made, in writing, by the legal guardian.

(2) If the voluntary patient is a minor, the written request for discharge shall be made by the child's parent or legal guardian except if the minor was admitted upon their own written application to become a voluntary patient made pursuant to K.S.A. 59-2949 and amendments thereto, then the minor may make the request. In the case of a minor 14 or more years of age who had made written application to become a voluntary patient on their own behalf and who has requested to be discharged, the head of the treatment facility shall promptly inform the child's parent, legal guardian, or other person known to the head of the treatment facility to be interested in the care and welfare of the minor of the minor's request for discharge.

History: L. 1996, ch. 167, § 7; L. 2002, ch. 114, § 65; July 1.

59-2952

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2952. Petition for involuntary commitment of a voluntary patient. The head of a treatment facility or other person may file a petition pursuant to K.S.A. 59-2957 and amendments thereto seeking involuntary commitment of a voluntary patient who now lacks capacity to make an informed decision concerning treatment and who is refusing reasonable treatment efforts or has requested discharge from the treatment facility. A petition filed by the head of a state psychiatric hospital, or such person's designee, accompanied by a statement from a physician or psychologist employed at the hospital that the physician or psychologist believes the person to be a mentally ill person subject to involuntary commitment does not need to be accompanied by a written statement from a qualified mental health professional authorizing admission to a state psychiatric hospital.

History: L. 1996, ch. 167, § 8; L. 1998, ch. 134, § 39; July 1.

59-2953

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2953. Investigation; emergency detention; authority and duty of law enforcement officers. (a) Any law enforcement officer who has a reasonable belief formed upon investigation that a person is a mentally ill person and because of such person's mental illness is likely to cause harm to self or others if allowed to remain at liberty may take the person into custody without a warrant. The officer shall transport the person to a treatment facility where the person shall be examined by a physician or psychologist on duty at the treatment facility, except that no person shall be transported to a state psychiatric hospital for examination, unless a written statement from a qualified mental health professional authorizing such an evaluation at a state psychiatric hospital has been obtained. If no physician or psychologist is on duty at the time the person is transported to the treatment facility, the person shall be examined

within a reasonable time not to exceed 17 hours. If a written statement is made by the physician or psychologist at the treatment facility that after preliminary examination the physician or psychologist believes the person likely to be a mentally ill person subject to involuntary commitment for care and treatment and because of the person's mental illness is likely to cause harm to self or others if allowed to remain at liberty, and if the treatment facility is willing to admit the person, the law enforcement officer shall present to the treatment facility the application provided for in subsection (b) of K.S.A. 59-2954 and amendments thereto. If the physician or psychologist on duty at the treatment facility does not believe the person likely to be a mentally ill person subject to involuntary commitment for care and treatment the law enforcement officer shall return the person to the place where the person was taken into custody and release the person at that place or at another place in the same community as requested by the person or if the law enforcement officer believes that it is not in the best interests of the person or the person's family or the general public for the person to be returned to the place the person was taken into custody, then the person shall be released at another place the law enforcement officer believes to be appropriate under the circumstances. The person may request to be released immediately after the examination, in which case the law enforcement officer shall immediately release the person, unless the law enforcement officer believes it is in the best interests of the person or the person's family or the general public that the person be taken elsewhere for release.

(b) If the physician or psychologist on duty at the treatment facility states that, in the physician's or psychologist's opinion, the person is likely to be a mentally ill person subject to involuntary commitment for care and treatment but the treatment facility is unwilling to admit the person, the treatment facility shall nevertheless provide a suitable place at which the person may be detained by the law enforcement officer. If a law enforcement officer detains a person pursuant to this subsection, the law enforcement officer shall file the petition provided for in subsection (a) of K.S.A. 59-2957 and amendments thereto, by the close of business of the first day that the district court is open for the transaction of business or shall release the person. No person shall be detained by a law enforcement officer pursuant to this subsection in a nonmedical facility used for the detention of persons charged with or convicted of a crime.

History: L. 1996, ch. 167, § 9; L. 1998, ch. 134, § 40; July 1.

59-2954

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2954. Emergency observation and treatment; authority of treatment facility's procedure. (a) A treatment facility may admit and detain any person for emergency observation and treatment upon an ex parte emergency custody order issued by a district court pursuant to K.S.A. 59-2958 and amendments thereto.

(b) A treatment facility may admit and detain any person presented for emergency observation and treatment upon written application of a law enforcement officer having custody of that person pursuant to K.S.A. 59-2953 and amendments thereto, except that a state psychiatric hospital shall not admit and detain any such person unless a written statement from a qualified mental health professional authorizing such admission to a state psychiatric hospital has been obtained. The application shall state:

- (1) The name and address of the person sought to be admitted, if known;
- (2) the name and address of the person's spouse or nearest relative, if known;
- (3) the officer's belief that the person may be a mentally ill person subject to involuntary commitment and because of the person's mental illness is likely to cause harm to self or others if not immediately detained;
- (4) the factual circumstances in support of that belief and the factual circumstances under which the person was taken into custody including any known pending criminal charges; and
- (5) the fact that the law enforcement officer will file the petition provided for in K.S.A. 59-2957 and amendments thereto, by the close of business of the first day thereafter that the district court is open for the transaction of business, or that the officer has been informed by a parent, legal guardian or other person that such parent, legal guardian or other person, whose name shall be stated in the application will file the petition provided for in K.S.A. 59-2957 and amendments thereto within that time.

(c) A treatment facility may admit and detain any person presented for emergency observation and treatment upon the written application of any individual, except that a state psychiatric hospital shall not admit and detain any such person, unless a written statement from a qualified mental health professional authorizing such admission to a state psychiatric hospital has been obtained. The application shall state:

- (1) The name and address of the person sought to be admitted, if known;
- (2) the name and address of the person's spouse or nearest relative, if known;
- (3) the applicant's belief that the person may be a mentally ill person subject to involuntary commitment and because of the person's mental illness is likely to cause harm to self or others if not immediately detained;
- (4) the factual circumstances in support of that belief;
- (5) any pending criminal charges, if known;
- (6) the fact that the applicant will file the petition provided for in K.S.A. 59-2957 and amendments thereto by the close of business of the first day thereafter that the district court is open for the transaction of business; and
- (7) if the application is to a treatment facility other than a state psychiatric hospital it shall also be accompanied by a statement in writing of a physician, psychologist, or qualified mental health professional finding that the person is likely to be a mentally ill person subject to involuntary commitment for care and treatment under this act.

(d) Any treatment facility or personnel thereof who in good faith renders treatment in accordance with law to any person admitted pursuant to subsection (b) or (c), shall not be liable in a civil or criminal action based upon a claim that the treatment was rendered without legal consent.

History: L. 1996, ch. 167, § 10; L. 1998, ch. 134, § 41; July 1.

59-2955

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2955. Notice of right to communicate upon admission; notice of admission; notice of rights. (a) Whenever any person is involuntarily admitted to or detained at a treatment facility pursuant to subsection (b) or (c) of K.S.A. 59-2954 and amendments thereto, or pursuant to an ex parte emergency custody order issued pursuant to K.S.A. 59-2958 and amendments thereto, the head of the treatment facility shall:

(1) Immediately advise the person in custody that such person is entitled to immediately contact the person's legal counsel, legal guardian, personal physician or psychologist, minister of religion, including a Christian Science practitioner or immediate family as defined in subsection (b) or any combination thereof. If the person desires to make such contact, the head of the treatment facility shall make available to the person reasonable means for making such immediate communication;

(2) provide notice of the person's involuntary admission including a copy of the document authorizing the involuntary admission to that person's attorney or legal guardian, immediately upon learning of the existence and whereabouts of such attorney or legal guardian, unless that attorney or legal guardian was the person who signed the application resulting in the patient's admission. If authorized by the patient pursuant to K.S.A. 65-5601 through 65-5605 and amendments thereto, the head of the treatment facility also shall provide notice to the patient's immediate family, as defined in subsection (b), immediately upon learning of the existence and whereabouts of such family, unless the family member to be notified was the person who signed the application resulting in the patient's admission; and

(3) immediately advise the person in custody of such person's rights provided for in K.S.A. 59-2978 and amendments thereto.

(b) "Immediate family" means the spouse, adult child or children, parent or parents, and sibling or siblings, or any combination thereof.

History: L. 1996, ch. 167, § 11; L. 1998, ch. 134, § 42; July 1.

59-2956

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2956. Emergency observation; discharge. The head of the treatment facility shall discharge any person admitted pursuant to subsection (a) of K.S.A. 59-2954 and amendments thereto when the ex parte emergency custody order expires, and shall discharge any person admitted pursuant to subsection (b) or (c) of K.S.A. 59-2954 and amendments thereto not later than the close of business of the first day that the district court is open for the transaction of business after the admission date of the person, unless a district court orders that such person remain in custody under an ex parte emergency custody order issued pursuant to the provisions of K.S.A. 59-2958 and amendments thereto, or a temporary custody order issued pursuant to the provisions of K.S.A. 59-2959 and amendments thereto.

History: L. 1996, ch. 167, § 12; Apr. 18.

59-2957

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2957. Petition for determination of mental illness; request for ex parte emergency custody order; content. (a) A verified petition to determine whether or not a person is a mentally ill person subject to involuntary commitment for care and treatment under this act may be filed in the district court of the county wherein that person resides or wherein such person may be found.

(b) The petition shall state:

(1) The petitioner's belief that the named person is a mentally ill person subject to involuntary commitment and the facts upon which this belief is based;

(2) to the extent known, the name, age, present whereabouts and permanent address of the person named as possibly a mentally ill person subject to involuntary commitment; and if not known, any information the petitioner might have about this person and where the person resides;

(3) to the extent known, the name and address of the person's spouse or nearest relative or relatives, or legal guardian, or if not known, any information the petitioner might have about a spouse, relative or relatives or legal guardian and where they might be found;

(4) to the extent known, the name and address of the person's legal counsel, or if not known, any information the petitioner might have about this person's legal counsel;

(5) to the extent known, whether or not this person is able to pay for medical services, or if not known, any information the petitioner might have about the person's financial circumstances or indigency;

(6) to the extent known, the name and address of any person who has custody of the person, and any known pending criminal charge or charges or of any arrest warrant or warrants outstanding or, if there are none, that fact or if not known, any information the petitioner might have about any current criminal justice system involvement with the person;

(7) the name or names and address or addresses of any witness or witnesses the petitioner believes has knowledge of facts relevant to the issue being brought before the court; and

(8) if the petitioner wishes to recommend to the court that the proposed patient should be sent to a treatment facility other than a state psychiatric hospital, then the name and address of the treatment facility to which the petitioner recommends that the proposed patient be sent for treatment if the proposed patient is found to be a mentally ill person subject to involuntary commitment for care and treatment under this act.

(c) The petition shall be accompanied by:

(1) A signed certificate from a physician, psychologist, or qualified mental health professional designated by the head of a participating mental health center, stating that such professional has personally examined the person and any available records and has found that the person, in such professional's opinion, is likely to be a mentally ill person subject to involuntary commitment for care and treatment under this act, unless the court allows the petition to be accompanied by a verified statement by the petitioner that the petitioner had attempted to have the person seen by a physician, psychologist or such qualified mental health professional, but that the person failed to cooperate to such an extent that the examination was impossible to conduct;

(2) if admission to a treatment facility other than a state psychiatric hospital is sought, if it is then available, a statement of consent to the admission of the proposed patient to the treatment facility named by the petitioner pursuant to subsection (b)(8) signed by the head of that treatment facility or other documentation which shows the willingness of the treatment facility to admitting the proposed patient for care and treatment; and

(3) if applicable, a copy of any notice given pursuant to K.S.A. 59-2951 and amendments thereto in which the named person has sought discharge from a treatment facility into which they had previously entered voluntarily, or a statement from the treating physician or psychologist that the person was admitted as a voluntary patient but now lacks capacity to make an informed decision concerning treatment and is refusing reasonable treatment efforts, and including a description of the treatment efforts being refused.

(d) The petition may include a request that an ex parte emergency custody order be issued pursuant to K.S.A. 59-2958 and amendments thereto. If such request is made the petition shall also include:

(1) A brief statement explaining why the person should be immediately detained or continue to be detained;

(2) the place where the petitioner requests that the person be detained or continue to be detained;

(3) if applicable, because detention is requested in a treatment facility other than a state psychiatric hospital, a statement that the facility is willing to accept and detain such person; and

(4) if applicable, because admission to a state psychiatric hospital is sought, the necessary statement from a qualified mental health professional authorizing admission and emergency care and treatment.

(e) The petition may include a request that a temporary custody order be issued pursuant to K.S.A. 59-2959 and amendments thereto.

History: L. 1996, ch. 167, § 13; L. 1997, ch. 152, § 5; L. 1998, ch. 134, § 43; July 1.

59-2958

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2958. Ex parte emergency custody order. (a) At the time the petition for the determination of whether a person is a mentally ill person subject to involuntary commitment for care and treatment under this act is filed, or any time thereafter prior to the trial upon the petition as provided for in K.S.A. 59-2965 and amendments thereto, the petitioner may request in writing that the district court issue an ex parte emergency order including either or both of the following: (1) An order directing any law enforcement officer to take the person named in the order into custody and transport the person to a designated treatment facility or other suitable place willing to receive and detain the person; (2) an order authorizing any named treatment facility or other place to detain or continue to detain the person until the further order of the court or until the ex parte emergency custody order shall expire.

(b) No ex parte emergency custody order shall provide for the detention of any person at a state psychiatric hospital unless a written statement from a qualified mental health professional authorizing such admission and detention at a state psychiatric hospital has been filed with the court.

(c) No ex parte emergency custody order shall provide for the detention of any person in a nonmedical facility used for the detention of persons charged with or convicted of a crime.

(d) If no other suitable facility at which such person may be detained is willing to accept the person, then the participating mental health center for that area shall provide a suitable place to detain the person until the further order of the court or until the ex parte emergency custody order shall expire.

(e) An ex parte emergency custody order issued under this section shall expire at 5:00 p.m. of the second day the district court is open for the transaction of business after the date of its issuance, which expiration date shall be stated in the order.

(f) The district court shall not issue successive ex parte emergency custody orders.

(g) In lieu of issuing an ex parte emergency custody order, the court may allow the person with respect to whom the request was made to remain at liberty, subject to such conditions as the court may impose.

History: L. 1996, ch. 167, § 14; L. 1997, ch. 152, § 6; L. 1998, ch. 134, § 44; July 1.

59-2959

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2959. Temporary custody order; request for; procedure. (a) At the time that the petition for determination of mental illness is filed, or any time thereafter prior to the trial upon the petition as provided for in K.S.A. 59-2965 and amendments thereto, the petitioner may request in writing that the district court issue a temporary custody order. The request shall state:

(1) The reasons why the person should be detained prior to the hearing on the petition;

(2) whether an ex parte emergency custody order has been requested or was granted; and

(3) the present whereabouts of the person named in the petition.

(b) Upon the filing of a request for a temporary custody order, the court shall set the matter for a hearing which shall be held not later than the close of business of the second day the district court is open for the transaction of business after the filing of the

request. The petitioner and the person with respect to whom the request has been filed shall be notified of the time and place of the hearing and that they shall each be afforded an opportunity to appear at the hearing, to testify and to present and cross-examine witnesses. If the person with respect to whom the request has been filed has not yet retained or been appointed an attorney, the court shall appoint an attorney for the person.

(c) At the hearing scheduled upon the request, the person with respect to whom the request has been filed shall be present unless the attorney for the person requests that the person's presence be waived and the court finds that the person's presence at the hearing would be injurious to the person's welfare. The court shall enter in the record of the proceedings the facts upon which the court has found that the presence of the person at the hearing would be injurious to such person's welfare. However, if the person with respect to whom the request has been filed states in writing to the court or to such person's attorney that such person wishes to be present at the hearing, the person's presence cannot be waived.

The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the person with respect to whom the request has been filed. All persons not necessary for the conduct of the proceedings may be excluded. The court shall receive all relevant and material evidence which may be offered. The rules governing evidentiary and procedural matters shall be applied to hearings under this section in a manner so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties. The facts or data upon which a duly qualified expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing and if of a type reasonably relied upon by experts in their particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence. The expert may testify in terms of opinion or inference and give the expert's reasons therefor without prior disclosure of the underlying facts or data unless the court requires otherwise. If requested on cross-examination, the expert shall disclose the underlying facts or data.

If the petitioner is not represented by counsel, the county or district attorney shall represent the petitioner, prepare all necessary papers, appear at the hearing and present such evidence as the county or district attorney determines to be of aid to the court in determining whether or not there is probable cause to believe that the person with respect to whom the request has been filed is a mentally ill person subject to involuntary commitment for care and treatment under this act, and that it would be in the best interests of the person to be detained until the trial upon the petition.

(d) After the hearing, if the court determines from the evidence that:

(1) There is probable cause to believe that the person with respect to whom the request has been filed is a mentally ill person subject to involuntary commitment for care and treatment under this act, and that it is in the best interests of the person to be detained until the trial upon the petition, the court shall issue a temporary custody order;

(2) there is probable cause to believe that the person with respect to whom the request has been filed is a mentally ill person subject to involuntary commitment for care and treatment under this act, but that it would not be in their best interests to be detained until the trial upon the petition, the court may allow the person to be at liberty, subject to such conditions as the court may impose;

(3) there is not probable cause to believe that the person with respect to whom the request has been filed is a mentally ill person subject to involuntary commitment for care and treatment under this act, the court shall terminate the proceedings and release the person.

(e) (1) A temporary custody order issued pursuant to this section may direct any law enforcement officer or any other person designated by the court to take the person named in the order into custody and transport them to a designated treatment facility, and authorize the designated treatment facility to detain and treat the person until the trial upon the petition.

(2) No temporary custody order shall provide for the detention and treatment of any person at a state psychiatric hospital unless a written statement from a qualified mental health professional authorizing such admission and detention at a state psychiatric hospital has been filed with the court.

(3) No temporary custody order shall provide for the detention of any person in a nonmedical facility used for the detention of persons charged with or convicted of a crime.

(4) If no other suitable facility at which such person may be detained is willing to accept the person, then the participating mental health center for that area shall provide a suitable place to detain the person until the further order of the court or until the trial upon the petition.

History: L. 1996, ch. 167, § 15; Apr. 18.

59-2960

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2960. Preliminary orders; continuances and advancement of trial. (a) Upon the filing of the petition provided for in K.S.A. 59-2957 and amendments thereto, the district court shall issue the following:

(1) An order fixing the time and place of the trial upon the petition. Such hearing, in the court's discretion, may be conducted in a courtroom, a treatment facility or at some other suitable place. The time fixed in the order shall in no event be earlier than seven days or later than 14 days after the date of the filing of the petition. If a demand for a trial by jury is later filed by the proposed patient, the court may continue the trial and fix a new time and place of the trial at a time that may exceed beyond the 14 days but shall be fixed within a reasonable time not exceeding 30 days from the date of the filing of the demand.

(2) An order that the proposed patient appear at the time and place of the hearing and providing that the proposed patient's presence will be required at the hearing unless the attorney for the proposed patient shall make a request that the proposed patient's presence be waived and the court finds that the proposed patient's presence at the hearing would be injurious to the proposed patient's welfare. The order shall further provide that notwithstanding the foregoing provision, if the proposed patient requests in

writing to the court or to such person's attorney that the proposed patient wishes to be present at the hearing, the proposed patient's presence cannot be waived.

(3) An order appointing an attorney to represent the proposed patient at all stages of the proceedings and until all orders resulting from such proceedings are terminated. The court shall give preference, in the appointment of this attorney, to any attorney who has represented the proposed patient in other matters if the court has knowledge of that prior representation. The proposed patient shall have the right to engage an attorney of the proposed patient's own choice and, in such event, the attorney appointed by the court shall be relieved of all duties by the court.

(4) An order that the proposed patient shall appear at a time and place that is in the best interests of the patient where the proposed patient will have the opportunity to consult with the proposed patient's court-appointed attorney, which time shall be at least five days prior to the date set for the trial under K.S.A. 59-2965 and amendments thereto.

(5) An order for a mental evaluation as provided for in K.S.A. 59-2961 and amendments thereto.

(6) A notice as provided for in K.S.A. 59-2963 and amendments thereto.

(7) If the petition also contains allegations as provided for in K.S.A. 59-3058, 59-3059, 59-3060, 59-3061 or 59-3062, and amendments thereto, those orders necessary to make a determination of the need for a legal guardian or conservator, or both, to act on behalf of the proposed patient. For these purposes, the trials required by K.S.A. 59-2965 and 59-3067, and amendments thereto, may be consolidated.

(b) Nothing in this section shall prevent the court from granting an order of continuance, for good cause shown, to any party for no longer than seven days, except that such limitation does not apply to a request for an order of continuance made by the proposed patient or to a request made by any party if the proposed patient absents him or herself such that further proceedings can not be held until the proposed patient has been located. The court also, upon the request of any party, may advance the date of the hearing if necessary and in the best interests of all concerned.

History: L. 1996, ch. 167, § 16; L. 2002, ch. 114, § 66; July 1.

59-2961

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2961. Order for a mental evaluation; procedure. (a) The order for a mental evaluation required by subsection (a)(5) of K.S.A. 59-2960 and amendments thereto, shall be served in the manner provided for in subsections (c) and (d) of K.S.A. 59-2963 and amendments thereto. It shall order the proposed patient to submit to a mental evaluation to be conducted by a physician, psychologist or qualified mental health professional designated by the head of a participating mental health center and to undergo such other physical or other evaluations as may be ordered by the court, except that any proposed patient who is not subject to a temporary custody order issued pursuant to K.S.A. 59-2959 and amendments thereto and who requests a hearing pursuant to K.S.A. 59-2962 and amendments thereto, need not submit to such evaluations until that hearing has been held and the court finds that there is probable cause to believe that the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under this act. The evaluation may be conducted at a treatment facility, the home of the proposed patient or any other suitable place that the court determines is not likely to have a harmful effect on the welfare of the proposed patient. A state psychiatric hospital shall not be ordered to evaluate any proposed patient, unless a written statement from a qualified mental health professional authorizing such an evaluation at a state psychiatric hospital has been filed with the court.

(b) At the time designated by the court in the order, but in no event later than three days prior to the date of the trial provided for in K.S.A. 59-2965 and amendments thereto, the examiner shall submit to the court a report, in writing, of the evaluation which report also shall be made available to counsel for the parties at least three days prior to the trial. The report also shall be made available to the proposed patient and to whomever the patient directs, unless for good cause recited in the order, the court orders otherwise. Such report shall state that the examiner has made an examination of the proposed patient and shall state the opinion of the examiner on the issue of whether or not the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under the act and the examiner's opinion as to the least restrictive treatment alternative which will protect the proposed patient and others and allow for the improvement of the proposed patient if treatment is ordered.

History: L. 1996, ch. 167, § 17; L. 1998, ch. 134, § 45; July 1.

59-2962

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2962. Mental evaluation; hearing in noncustodial circumstances. Whenever a proposed patient who is not subject to a temporary custody order issued pursuant to K.S.A. 59-2959 and amendments thereto requests a hearing pursuant to this section, a hearing shall be held within a reasonable time thereafter. The petitioner and the proposed patient shall be notified of the time and place of the hearing, afforded an opportunity to testify, and to present and cross-examine witnesses. The proposed patient shall be present at the hearing, and the proposed patient's presence cannot be waived. All persons not necessary for the conduct of the proceedings may be excluded. The hearing shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the welfare of the proposed patient. The court shall receive all relevant and material evidence which may be offered. If the petitioner is not represented by counsel, the county or district attorney shall represent the petitioner, prepare all necessary papers, appear at the hearing and present such evidence as the county or district attorney determines to be of aid to the court in determining whether or not there is probable cause to believe that the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under this act. If the court determines from the evidence

that there is probable cause to believe that the proposed patient is a mentally ill person subject to involuntary commitment, the court shall issue the order for a mental evaluation; otherwise, the court shall terminate the proceedings.

History: L. 1996, ch. 167, § 18; Apr. 18.

59-2963

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2963. Notice; contents. (a) Notice as required by subsection (a)(6) of K.S.A. 59-2960 and amendments thereto shall be given to the proposed patient named in the petition, the proposed patient's legal guardian if there is one, the attorney appointed to represent the proposed patient, the proposed patient's spouse or nearest relative and to such other persons as the court directs. The notice shall also be given to the participating mental health center for the county where the proposed patient resides.

(b) The notice shall state:

- (1) That a petition has been filed, alleging that the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under the act and requesting that the court order treatment;
- (2) the date, time and place of the trial;
- (3) the name of the attorney appointed to represent the proposed patient and the time and place where the proposed patient shall have the opportunity to consult with this attorney;
- (4) that the proposed patient has a right to a jury trial if a written demand for such is filed with the court at least four days prior to the time set for trial; and
- (5) that if the proposed patient demands a jury trial, the trial date may have to be continued by the court for a reasonable time in order to empanel a jury, but that this continuance will not exceed 30 days from the date of the filing of the demand.

(c) The court may order any of the following persons to serve the notice upon the proposed patient:

- (1) The physician or psychologist currently administering to the proposed patient, if the physician or psychologist consents to doing so;
- (2) the head of the participating mental health center or the designee thereof;
- (3) the local health officer or such officer's designee;
- (4) the secretary of social and rehabilitation services or the secretary's designee if the proposed patient is being detained at a state psychiatric hospital;
- (5) any law enforcement officer; or
- (6) the attorney of the proposed patient.

(d) The notice shall be served personally on the proposed patient as soon as possible, but not less than six days prior to the date of the trial, and immediate return thereof shall be made to the court by the person serving notice. Unless otherwise ordered by the court, notice shall be served on the proposed patient by a nonuniformed person.

(e) Notice to all other persons may be made by mail or in such other manner as directed by the court.

History: L. 1996, ch. 167, § 19; L. 1998, ch. 134, § 46; July 1.

59-2964

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2964. Continuance of hearings; order of referral for short-term treatment. (a) The patient at any time may request, in writing, that any further proceedings be continued for not more than three months so that the court may make an order of continuance and referral for short-term treatment. The written request must be acknowledged before a notary public or a judge of the district court. The patient may request successive orders of continuance and referral. Upon receipt of such a request, the court may order the patient referred for short-term treatment to a designated treatment facility for a specified period of time not to exceed three months from the date the request is signed by the patient. An order of referral for short-term treatment in a treatment facility other than a state psychiatric hospital shall be conditioned upon the consent of the head of that treatment facility to accept the patient. No order may be issued for referral to a state psychiatric hospital, unless a written statement from a qualified mental health professional authorizing such admission and treatment at a state psychiatric hospital has been filed with the court. The court may not issue an order of referral unless the attorney representing the patient has filed a statement, in writing, that the attorney has explained to the patient the nature of an order of referral and the right of the patient to have the further proceedings conducted as scheduled.

(b) If the patient's request for an order of referral for short-term treatment is made prior to the hearing required to be held pursuant to the provisions of K.S.A. 59-2959 or 59-2962 and amendments thereto, and granted, it shall constitute a waiver of the patient's right to this hearing.

(c) Within any order of continuance and referral, the court shall confirm the new date and time set for the trial and direct that a copy of the court's order shall be given to the patient, to the attorney representing the patient, the petitioner or the county or district attorney as appropriate, the patient's legal guardian if there is one, the patient's spouse or nearest relative as appropriate, the head of the treatment facility to which the patient is being referred, and such other persons as the court directs. Any trial so continued shall then be held on the date set at the end of the referral period, unless again continued by the court upon the patient's request for another order of continuance and referral, or on the date set in any order of continuance necessitated by the patient's demand for a jury trial.

(d) Not later than 14 days prior to the date set for the trial provided for in K.S.A. 59-2965 and amendments thereto by any order of continuance and referral, unless the proposed patient has been accepted as a voluntary patient by the treatment facility or unless the proposed patient has filed a written request for another successive period of continuance and referral, the facility treating the

proposed patient shall submit a written report of its findings and recommendations to the court, which report also shall be made available to counsel for the parties. The report also shall be made available to the proposed patient and to whomever the patient directs, unless for good cause recited in the order, the court orders otherwise.

History: L. 1996, ch. 167, § 20; L. 1998, ch. 134, § 47; July 1.

59-2965

Chapter 59.--PROBATE CODE

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59-2965. Trial upon the petition; procedure. (a) Trial upon the petition shall be held at the time and place specified in the court's order issued pursuant to subsection (a) of K.S.A. 59-2960 and amendments thereto unless a continuance as provided in K.S.A. 59-2960 or 59-2964 and amendments thereto, has been granted. The hearing shall be held to the court only, unless the proposed patient, at least 4 days prior to the time set for the hearing, demands, in writing, a jury trial.

(b) The jury, if one is demanded, shall consist of 6 persons. The jury panel shall be selected as provided by law. Notwithstanding the provision within K.S.A. 43-166 otherwise, a panel of prospective jurors may be assembled by the clerk upon less than 20 days notice in this circumstance. From such panel 12 qualified jurors, who have been passed for cause, shall be empaneled. Prior service as a juror in any court shall not exempt, for that reason alone, any person from jury service hereunder. From the panel so obtained, the proposed patient or the proposed patient's attorney shall strike one name; then the petitioner, or the petitioner's attorney, shall strike one name; and so on alternatively until each has stricken 3 names so as to reach the jury of 6 persons. During this process, if either party neglects or refuses to aid in striking the names, the court shall strike a name on behalf of such party.

(c) The proposed patient shall be present at the hearing unless the attorney for the proposed patient requests that the proposed patient's presence be waived and the court finds the person's presence at the hearing would be injurious to their welfare. The court shall enter in the record of the proceedings the facts upon which the court has found that the presence of the proposed patient at the hearing would be injurious to their welfare. However, if the proposed patient states in writing to the court or such person's attorney that such patient wishes to be present at the hearing, the person's presence cannot be waived. The petitioner and the proposed patient shall be afforded an opportunity to appear at the hearing, to testify, and to present and cross-examine witnesses. All persons not necessary for the conduct of the proceedings may be excluded. The hearings shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the welfare of the proposed patient. The court shall receive all relevant and material evidence which may be offered, including the testimony or written findings and recommendations of the examiner who evaluated the proposed patient pursuant to the court's order issued under K.S.A. 59-2961 and amendments thereto. Such evidence shall not be privileged for the purpose of this hearing.

(d) The rules governing evidentiary and procedural matters at hearings under this section shall be applied in a manner so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties.

(e) If the petitioner is not represented by counsel, the county or district attorney shall represent the petitioner, prepare all necessary papers, appear at the hearing and present such evidence as the county or district attorney shall determine to be of aid to the court in determining whether or not the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under this act.

History: L. 1996, ch. 167, § 21; Apr. 18.

59-2966

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2966. Order for treatment; dismissal. (a) Upon the completion of the trial, if the court or jury finds by clear and convincing evidence that the proposed patient is a mentally ill person subject to involuntary commitment for care and treatment under this act, the court shall order treatment for such person for a specified period of time not to exceed three months from the date of the trial at a treatment facility, except that the court shall not order treatment at a state psychiatric hospital, unless a written statement from a qualified mental health professional authorizing such treatment at a state psychiatric hospital has been filed with the court. Whenever an involuntary patient is ordered to receive treatment, the clerk of the district court shall send a copy of the order to the Kansas bureau of investigation within five days after receipt of the order. The Kansas bureau of investigation shall immediately enter the order into the national criminal information center and other appropriate databases. An order for treatment in a treatment facility other than a state psychiatric hospital shall be conditioned upon the consent of the head of that treatment facility to accepting the patient. In the event no other appropriate treatment facility has agreed to provide treatment for the patient, and no qualified mental health professional has authorized treatment at a state psychiatric hospital, the participating mental health center for the county in which the patient resides shall be given responsibility for providing or securing treatment for the patient or if no county of residence can be determined for the patient, then the participating mental health center for the county in which the patient was taken into custody or in which the petition was filed shall be given responsibility for providing or securing treatment for the patient.

(b) A copy of the order for treatment shall be provided to the head of the treatment facility.

(c) When the court orders treatment, it shall retain jurisdiction to modify, change or terminate such order, unless venue has been changed pursuant to K.S.A. 59-2971 and amendments thereto and then the receiving court shall have continuing jurisdiction.

(d) If the court finds from the evidence that the proposed patient has not been shown to be a mentally ill person subject to involuntary commitment for care and treatment under this act the court shall release the person and terminate the proceedings.

History: L. 1996, ch. 167, § 22; L. 1997, ch. 152, § 7; L. 1998, ch. 134, § 48; L. 2006, ch. 210, § 16; July 1, 2007.

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2967. Order for outpatient treatment; revocation; reviews. (a) An order for outpatient treatment may be entered by the court at any time in lieu of any type of order which would have required inpatient care and treatment if the court finds that the patient is likely to comply with an outpatient treatment order and that the patient will not likely be a danger to the community or be likely to cause harm to self or others while subject to an outpatient treatment order.

(b) No order for outpatient treatment shall be entered unless the head of the outpatient treatment facility has consented to treat the patient on an outpatient basis under the terms and conditions set forth by the court, except that no order for outpatient treatment shall be refused by a participating mental health center.

(c) If outpatient treatment is ordered, the order may state specific conditions to be followed by the patient, but shall include the general condition that the patient is required to comply with all directives and treatment as required by the head of the outpatient treatment facility or the head's designee. The court may also make such orders as are appropriate to provide for monitoring the patient's progress and compliance with outpatient treatment. Within any outpatient order for treatment the court shall specify the period of treatment as provided for in subsection (a) of K.S.A. 59-2966 or subsection (f) of K.S.A. 59-2969 and amendments thereto.

(d) The court shall retain jurisdiction to modify or revoke the order for outpatient treatment at any time on its own motion, on the motion of any counsel of record or upon notice from the treatment facility of any need for new conditions in the order for outpatient treatment or of material noncompliance by the patient with the order for outpatient treatment. However, if the venue of the matter has been transferred to another court, then the court having venue of the matter shall have such jurisdiction to modify or revoke the outpatient treatment order. Revocation or modification of an order for outpatient treatment may be made ex parte by order of the court in accordance with the provisions of subsections (e) or (f).

(e) The treatment facility shall immediately report to the court any material noncompliance by the patient with the outpatient treatment order. Such notice may be verbal or by telephone but shall be followed by a verified written or facsimile notice sent to the court, to counsel for all parties and, as appropriate, to the head of the inpatient treatment facility designated to receive the patient, by not later than 5:00 p.m. of the first day the district court is open for the transaction of business after the verbal or telephonic communication was made to the court. Upon receipt of verbal, telephone, or verified written or facsimile notice of material noncompliance, the court may enter an ex parte emergency custody order providing for the immediate detention of the patient in a designated inpatient treatment facility except that the court shall not order the detention of the patient at a state psychiatric hospital, unless a written statement from a qualified mental health professional authorizing such detention at a state psychiatric hospital has been filed with the court. Any ex parte emergency custody order issued by the court under this subsection shall expire at 5:00 p.m. of the second day the district court is open for the transaction of business after the patient is taken into custody. The court shall not enter successive ex parte emergency custody orders.

(f) (1) Upon the taking of a patient into custody pursuant to an ex parte emergency custody order revoking a previously issued order for outpatient treatment and ordering the patient to involuntary inpatient care the court shall set the matter for hearing not later than the close of business on the second day the court is open for business after the patient is taken into custody. Notice of the hearing shall be given to the patient, the patient's attorney, the patient's legal guardian, the petitioner or the county or district attorney as appropriate, the head of the outpatient treatment facility and the head of the inpatient treatment facility, similarly as provided for in K.S.A. 59-2963 and amendments thereto.

(2) Upon the entry of an ex parte order modifying a previously issued order for outpatient treatment, but allowing the patient to remain at liberty, a copy of the order shall be served upon the patient, the patient's attorney, the county or district attorney and the head of the outpatient treatment facility similarly as provided for in K.S.A. 59-2963 and amendments thereto. Thereafter, any party to the matter, including the petitioner, the county or district attorney or the patient, may request a hearing on the matter if the request is filed within five days from the date of service of the ex parte order upon the patient. The court may also order such a hearing on its own motion within five days from the date of service of the notice. If no request or order for hearing is filed within the five-day period, the ex parte order and the terms and conditions set out in the ex parte order shall become the final order of the court substituting for any previously entered order for outpatient treatment. If a hearing is requested, a formal written request for revocation or modification of the outpatient treatment order shall be filed by the county or district attorney or the petitioner and a hearing shall be held thereon within 5 days after the filing of the request.

(g) The hearing held pursuant to subsection (f) shall be conducted in the same manner as hearings provided for in K.S.A. 59-2959 and amendments thereto. Upon the completion of the hearing, if the court finds by clear and convincing evidence that the patient violated any condition of the outpatient treatment order, the court may enter an order for inpatient treatment, except that the court shall not order treatment at a state psychiatric hospital unless a written statement from a qualified mental health professional authorizing such treatment at a state psychiatric hospital has been filed with the court, or may modify the order for outpatient treatment with different terms and conditions in accordance with this section.

(h) The outpatient treatment facility shall comply with the provisions of K.S.A. 59-2969 and amendments thereto concerning the filing of written reports for each period of treatment during the time any outpatient treatment order is in effect and the court shall receive and process such reports in the same manner as reports received from an inpatient treatment facility.

History: L. 1996, ch. 167, § 23; L. 1997, ch. 152, § 8; L. 1998, ch. 134, § 49; July 1.

59-2968

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2968. Admissions to a state psychiatric hospital; moratorium; procedure. (a) All admissions to a state psychiatric hospital upon any order of a court shall be to the state psychiatric hospital designated by the secretary of social and rehabilitation services. The time and manner of the admission shall be arranged by the participating mental health center authorizing such admission and coordinated with the hospital and the official or agent who shall transport the person.

(b) No patient shall be admitted to a state psychiatric hospital pursuant to any of the provisions of this act, including any court-ordered admissions, if the secretary has notified the supreme court of the state of Kansas and each district court which has jurisdiction over all or part of the catchment area served by a state psychiatric hospital, that the census of a particular treatment program of that state psychiatric hospital has reached capacity and that no more patients may be admitted. Following notification that a state psychiatric hospital program has reached its capacity and no more patients may be admitted, any district court which has jurisdiction over all or part of the catchment area served by that state psychiatric hospital, and any participating mental health center which serves all or part of that same catchment area, may request that patients needing that treatment program be placed on a waiting list maintained by that state psychiatric hospital.

(c) In each such case, as a vacancy at that state psychiatric hospital occurs, the district court and participating mental health center shall be notified, in the order of their previous requests for placing a patient on the waiting list, that a patient may be admitted to the state psychiatric hospital. As soon as the state psychiatric hospital is able to admit patients on a regular basis to a treatment program for which notice has been previously given under this section, the superintendent of the state psychiatric hospital shall inform the supreme court and each affected district court that the moratorium on admissions is no longer in effect.

History: L. 1996, ch. 167, § 24; Apr. 18.

59-2969

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2969. Hearing to review status of patient; procedure. (a) At least 14 days prior to the end of each period of treatment, as set out in the court order for such treatment, the head of the treatment facility furnishing treatment to the patient shall cause to be filed with the court a written report summarizing the treatment provided and the findings and recommendations of the treatment facility concerning the need for further treatment for the patient. Upon the filing of this written report, the court shall notify the patient's attorney of record that this written report has been filed. If there is no attorney of record for the patient, the court shall appoint an attorney and notify such attorney that the written report has been filed.

(b) When the attorney for the patient has received notice that the treatment facility has filed with the district court its written report, the attorney shall consult with the patient to determine whether the patient desires a hearing. If the patient desires a hearing, the attorney shall file a written request for a hearing with the district court, which request shall be filed not later than the last day ending any period of treatment as specified in the court's order for treatment issued pursuant to K.S.A. 59-2966 or 59-2967 and amendments thereto, or the court's last entered order for continued treatment issued pursuant to subsection (f). If the patient does not desire a hearing, the patient's attorney shall file with the court a written statement that the attorney has consulted with the patient; the manner in which the attorney has consulted with the patient; that the attorney has fully explained to the patient the patient's right to a hearing as set out in this section and that if the patient does not request such a hearing that further treatment will likely be ordered, but that having been so advised the patient does not desire a hearing. Thereupon, the court may renew its order for treatment and may specify the next period of treatment as provided for in subsection (f). A copy of the court's order shall be given to the patient, the attorney for the patient, the patient's legal guardian, the petitioner or the county or district attorney, as appropriate, and to the head of the treatment facility treating the patient as the court directs.

(c) Upon receiving a written request for a hearing, the district court shall set the matter for hearing and notice of such hearing shall be given similarly as provided for in K.S.A. 59-2963 and amendments thereto. Notice shall also be given promptly to the head of the treatment facility treating the patient. The hearing shall be held as soon as reasonably practical, but in no event more than 10 days following the filing of the written request for a hearing. The patient shall remain in treatment during the pendency of any such hearing, unless discharged by the head of the treatment facility pursuant to K.S.A. 59-2973 and amendments thereto.

(d) The district court having jurisdiction of any case may, on its own motion or upon written request of any interested party, including the head of the treatment facility where a patient is being treated, hold a hearing to review the patient's status earlier than at the times set out in subsection (b) above, if the court determines that a material change of circumstances has occurred necessitating an earlier hearing, however, the patient shall not be entitled to have more than one review hearing within each period of treatment as specified in any order for treatment, order for out-patient treatment or order for continued treatment.

(e) The hearing shall be conducted in the same manner as hearings provided for in K.S.A. 59-2965 and amendments thereto, except that the hearing shall be to the court and the patient shall not have the right to demand a jury. At the hearing it shall be the petitioner's or county or district attorney's or treatment facility's burden to show that the patient remains a mentally ill person subject to involuntary commitment for care and treatment under this act.

(f) Upon completion of the hearing, if the court finds by clear and convincing evidence that the patient continues to be a mentally ill person subject to involuntary commitment for care and treatment under this act, the court shall order continued treatment for a specified period of time not to exceed three months for any initial order for continued treatment, nor more than six months in any subsequent order for continued treatment, at an inpatient treatment facility as provided for in K.S.A. 59-2966 and amendments thereto, or at an outpatient treatment facility if the court determines that outpatient treatment is appropriate under K.S.A. 59-2967 and amendments thereto, and a copy of the court's order shall be provided to the head of the treatment facility. If the court finds

that it has not been shown by clear and convincing evidence that the patient continues to be a mentally ill person subject to involuntary commitment for care and treatment under this act, it shall release the patient. A copy of the court's order of release shall be provided to the patient, the patient's attorney, the patient's legal guardian or other person known to be interested in the care and welfare of a minor patient, and to the head of the treatment facility at which the patient had been receiving treatment.

History: L. 1996, ch. 167, § 25; L. 1997, ch. 152, § 9; L. 1998, ch. 134, § 50; July 1.

59-2970

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2970. Transportation. The court may issue orders providing for the transportation of patients as necessary to effectuate the provisions of this act. All orders of ex parte emergency custody, temporary custody, referral or treatment may authorize a relative or other suitable person to transport the individual named in the order to the place of detention or treatment specified in the order. All orders for transportation shall be served by the person transporting the individual named in the order upon the person in charge of the place of detention or treatment or such person's designee and due return of execution thereof shall be made to the court. A female being transported shall be accompanied by a female attendant, unless she is accompanied by an adult relative. An individual shall not be transported in a marked police car or sheriff's car if other means of transportation are available. The least amount of restraint necessary shall be used in transporting the patient.

History: L. 1996, ch. 167, § 26; Apr. 18.

59-2971

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2971. Change of venue. (a) At any time after the petition provided for in K.S.A. 59-2957 and amendments thereto has been filed venue may be transferred in accordance with this section.

(1) Prior to trial required by K.S.A. 59-2965 and amendments thereto. Before the expiration of two full working days following the probable cause hearing held pursuant to K.S.A. 59-2959 or 59-2962 and amendments thereto, the district court then with jurisdiction, on its own motion or upon the written request of any person, may transfer the venue of the case to the district court of the county where the patient is being detained, evaluated or treated in a treatment facility under the authority of an order issued pursuant to K.S.A. 59-2958, 59-2959 or 59-2964 and amendments thereto. Thereafter the district court may on its own motion or upon the written request of any person transfer venue to another district court only for good cause shown.

When an order changing venue is issued, the district court issuing the order shall immediately send to the district court to which venue is changed a facsimile or electronic copy of the entire file of the case. The district court shall also immediately send a facsimile or electronic copy of the order transferring venue to the treatment facility where the patient is being detained, evaluated or treated.

(2) After trial required by K.S.A. 59-2965 and amendments thereto, the district court may on its own motion or upon the written request of any person transfer venue to another district court for good cause shown. When an order changing venue is issued, the district court issuing the order shall immediately send to the district court to which venue is changed a facsimile or electronic copy of the entire file of the case. The transferring district court shall also immediately send a facsimile or electronic copy of the order transferring venue to the treatment facility where the patient is being detained, evaluated or treated.

(b) The district court issuing an order transferring venue, if not in the county of residence of the proposed patient, shall transmit to the district court in the county of residence of the proposed patient a statement of any court costs incurred by the county of the district court issuing the order and, if the county of residence is not the receiving county, a facsimile or electronic copy of the entire file of the case.

(c) Any district court to which venue is transferred shall proceed in the case as if the petition had been originally filed therein and shall cause notice of the change of venue to be given to the persons named in and in the same manner as provided for in K.S.A. 59-2963 and amendments thereto. In the event that notice of a change of location of a hearing due to a change of venue cannot be served at least 48 hours prior to any hearing previously scheduled by the transferring court or because of scheduling conflicts the hearing can not be held by the receiving court on the previously scheduled date, then the receiving court shall continue the hearing for up to seven full working days to allow adequate time for notice to be given and the hearing held.

(d) Any district court to which venue is transferred, if not in the county of residence of the patient, shall transmit to the district court in the county of residence of the patient a statement of any court costs incurred and a facsimile or electronic copy of all pleadings and orders entered in the case after transfer.

History: L. 1996, ch. 167, § 27; L. 1997, ch. 152, § 10; L. 2009, ch. 116, § 20; July 1.

59-2972

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2972. Transfer by secretary of social and rehabilitation services. (a) The secretary of social and rehabilitation services or the secretary's designee may transfer any patient from any state psychiatric hospital under the secretary's control to any other state psychiatric hospital whenever the secretary or the secretary's designee considers it to be in the best interests of the patient. Except in the case of an emergency, the patient's spouse or nearest relative or legal guardian, if one has been appointed, shall be notified of the transfer, and notice shall be sent to the committing court not less than 14 days before the proposed transfer. The notice shall name the hospital to which the patient is proposed to be transferred to and state that, upon request of the spouse or nearest relative or legal

guardian, an opportunity for a hearing on the proposed transfer will be provided by the secretary of social and rehabilitation services prior to such transfer.

(b) The secretary of social and rehabilitation services or the designee of the secretary may transfer any involuntary patient from any state psychiatric hospital to any state institution for the mentally retarded whenever the secretary of social and rehabilitation services or the designee of the secretary considers it to be in the best interests of the patient. Any patient transferred as provided for in this subsection shall remain subject to the same statutory provisions as were applicable at the psychiatric hospital from which the patient was transferred and in addition thereto shall abide by and be subject to all the rules and regulations of the retardation institution to which the patient has been transferred. Except in the case of an emergency, the patient's spouse or nearest relative or legal guardian, if one has been appointed, shall be notified of the transfer, and notice shall be sent to the committing court not less than 14 days before the proposed transfer. The notice shall name the institution to which the patient is proposed to be transferred to and state that, upon request of the spouse or nearest relative or legal guardian, an opportunity for a hearing on the proposed transfer will be provided by the secretary of social and rehabilitation services prior to such transfer. No patient shall be transferred from a state psychiatric hospital to a state institution for the mentally retarded unless the superintendent of the receiving institution has found, pursuant to K.S.A. 76-12b01 through 76-12b11 and amendments thereto, that the patient is mentally retarded and in need of care and training and that placement in the institution is the least restrictive alternative available. Nothing in this subsection shall prevent the secretary of social and rehabilitation services or the designee of the secretary from allowing a patient at a state psychiatric hospital to be admitted as a voluntary resident to a state institution for the mentally retarded, or from then discharging such person from the state psychiatric hospital pursuant to K.S.A. 59-2973 and amendments thereto, as may be appropriate.

History: L. 1996, ch. 167, § 28; L. 1997, ch. 152, § 11; L. 1998, ch. 134, § 51; July 1.

59-2973

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2973. Discharge. (a) When any proposed patient or involuntary patient has been admitted to any treatment facility pursuant to K.S.A. 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967 and amendments thereto, the head of the treatment facility shall discharge and release the patient when the patient is no longer in need of treatment, except that no patient shall be discharged from a state psychiatric hospital without the hospital receiving and considering recommendations from the participating mental health center serving the area where the patient intends to reside.

(b) Nothing in this section shall be construed to amend or modify or repeal any law relating to the confinement of persons charged with or convicted of a criminal offense.

History: L. 1996, ch. 167, § 29; Apr. 18.

59-2974

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2974. Notice of discharge; restoration of certain rights. The head of the treatment facility shall notify, in writing, the patient, the patient's attorney, the petitioner or the petitioner's attorney, the county or district attorney as appropriate, and the district court which has jurisdiction over the patient of the patient's discharge pursuant to K.S.A. 59-2973 and amendments thereto. When a notice of discharge is received, the court shall file the same which shall terminate the proceedings, unless there has been issued a superseding inpatient or outpatient treatment order not being discharged by the notice. Whenever a person who is involuntarily committed to a state psychiatric hospital is released by order of the court or termination of the case, the court shall review the case upon request of the patient, and may order the issuance of the certificate of restoration pursuant to K.S.A. 2009 Supp. 75-7c26, and amendments thereto. If the court issues such release or termination and certificate, the court shall order the clerk of the district court to report the release or termination of the case and the certificate of restoration to the Kansas bureau of investigation within five days after the order.

History: L. 1996, ch. 167, § 30; L. 2006, ch. 210, § 17; July 1, 2007.

59-2975

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2975. Unauthorized absence; procedure. If any involuntary patient leaves the place of the patient's detention or treatment without the authority of the head of the treatment facility, the head of the treatment facility shall notify the sheriff of the county in which the treatment facility is located of the involuntary patient's unauthorized absence and request that the patient be taken into custody and returned to the treatment facility. If oral notification is given, it shall be confirmed in writing as soon thereafter as reasonably possible.

History: L. 1996, ch. 167, § 31; Apr. 18.

59-2976

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2976. Administration of medications and other treatments. (a) Medications and other treatments shall be prescribed, ordered and administered only in conformity with accepted clinical practice. Medication shall be administered only upon the written order of a physician or upon a verbal order noted in the patient's medical records and subsequently signed by the physician. The attending

physician shall review regularly the drug regimen of each patient under the physician's care and shall monitor any symptoms of harmful side effects. Prescriptions for psychotropic medications shall be written with a termination date not exceeding 30 days thereafter but may be renewed.

(b) During the course of treatment the responsible physician or psychologist or such person's designee shall reasonably consult with the patient, the patient's legal guardian, or a minor patient's parent and give consideration to the views the patient, legal guardian or parent expresses concerning treatment and any alternatives. No medication or other treatment may be administered to any voluntary patient without the patient's consent, or the consent of such patient's legal guardian or of such patient's parent if the patient is a minor.

(c) Consent for medical or surgical treatments not intended primarily to treat a patient's mental disorder shall be obtained in accordance with applicable law.

(d) Whenever any patient is receiving treatment pursuant to K.S.A. 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967 and amendments thereto, and the treatment facility is administering to the patient any medication or other treatment which alters the patient's mental state in such a way as to adversely affect the patient's judgment or hamper the patient in preparing for or participating in any hearing provided for by this act, then two days prior to and during any such hearing, the treatment facility may not administer such medication or other treatment unless such medication or other treatment is necessary to sustain the patient's life or to protect the patient or others. Prior to the hearing, a report of all such medications or other treatment which have been administered to the patient, along with a copy of any written consent(s) which the patient may have signed, shall be submitted to the court. Counsel for the patient may preliminarily examine the attending physician regarding the administration of any medication to the patient within two days of the hearing with regard to the affect that medication may have had upon the patient's judgment or ability to prepare for or participate in the hearing. On the basis thereof, if the court determines that medication or other treatment has been administered which adversely affects the patient's judgment or ability to prepare for or participate in the hearing, the court may grant to the patient a reasonable continuance in order to allow for the patient to be better able to prepare for or participate in the hearing and the court shall order that such medication or other treatment be discontinued until the conclusion of the hearing, unless the court finds that such medication or other treatment is necessary to sustain the patient's life or to protect the patient or others, in which case the court shall order that the hearing proceed.

(e) Whenever a patient receiving treatment pursuant to K.S.A. 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967 and amendments thereto, objects to taking any medication prescribed for psychiatric treatment, and after full explanation of the benefits and risks of such medication continues their objection, the medication may be administered over the patient's objection; except that the objection shall be recorded in the patient's medical record and at the same time written notice thereof shall be forwarded to the medical director of the treatment facility or the director's designee. Within five days after receiving such notice, excluding Saturdays, Sundays and legal holidays, the medical director or designee shall deliver to the patient and the patient's physician the medical director's or designee's written decision concerning the administration of that medication, and a copy of that decision shall be placed in the patient's medical record.

(f) In no case shall experimental medication be administered without the patient's consent, which consent shall be obtained in accordance with subsection (a)(6) of K.S.A. 59-2978 and amendments thereto.

History: L. 1996, ch. 167, § 32; Apr. 18.

59-2977

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2977. Restraints; seclusion. (a) Restraints or seclusion shall not be applied to a patient unless it is determined by the head of the treatment facility or a physician or psychologist to be necessary to prevent immediate substantial bodily injury to the patient or others and that other alternative methods to prevent such injury are not sufficient to accomplish this purpose. Restraint or seclusion shall never be used as a punishment or for the convenience of staff. The extent of the restraint or seclusion applied to the patient shall be the least restrictive measure necessary to prevent such injury to the patient or others, and the use of restraint or seclusion in a treatment facility shall not exceed 3 hours without medical reevaluation, except that such medical reevaluation shall not be required, unless necessary, between the hours of 12:00 midnight and 8:00 a.m. When restraints or seclusion are applied, there shall be monitoring of the patient's condition at a frequency determined by the treating physician or psychologist, which shall be no less than once per each 15 minutes. The head of the treatment facility or a physician or psychologist shall sign a statement explaining the treatment necessity for the use of any restraint or seclusion and shall make such statement a part of the permanent treatment record of the patient.

(b) The provisions of subsection (a) shall not prevent, for a period not exceeding 2 hours without review and approval thereof by the head of the treatment facility or a physician or psychologist:

(1) Staff at the state security hospital from confining patients in their rooms when it is considered necessary for security or proper institutional management;

(2) the use of such restraints as necessary for a patient who is likely to cause physical injury to self or others without the use of such restraints;

(3) the use of restraints when needed primarily for examination or treatment or to insure the healing process; or

(4) the use of seclusion as part of a treatment methodology that calls for time out when the patient is refusing to participate in a treatment or has become disruptive of a treatment process.

(c) "Restraints" means the application of any devices, other than human force alone, to any part of the body of the patient for the purpose of preventing the patient from causing injury to self or others.

(d) "Seclusion" means the placement of a patient, alone, in a room, where the patient's freedom to leave is restricted and where the patient is not under continuous observation.

History: L. 1996, ch. 167, § 33; Apr. 18.

59-2978

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2978. Rights of patients. (a) Every patient being treated in any treatment facility, in addition to all other rights preserved by the provisions of this act, shall have the following rights:

- (1) To wear the patient's own clothes, keep and use the patient's own personal possessions including toilet articles and keep and be allowed to spend the patient's own money;
- (2) to communicate by all reasonable means with a reasonable number of persons at reasonable hours of the day and night, including both to make and receive confidential telephone calls, and by letter, both to mail and receive unopened correspondence, except that if the head of the treatment facility should deny a patient's right to mail or to receive unopened correspondence under the provisions of subsection (b), such correspondence shall be opened and examined in the presence of the patient;
- (3) to conjugal visits if facilities are available for such visits;
- (4) to receive visitors in reasonable numbers and at reasonable times each day;
- (5) to refuse involuntary labor other than the housekeeping of the patient's own bedroom and bathroom, provided that nothing herein shall be construed so as to prohibit a patient from performing labor as a part of a therapeutic program to which the patient has given their written consent and for which the patient receives reasonable compensation;
- (6) not to be subject to such procedures as psychosurgery, electroshock therapy, experimental medication, aversion therapy or hazardous treatment procedures without the written consent of the patient or the written consent of a parent or legal guardian, if such patient is a minor or has a legal guardian provided that the guardian has obtained authority to consent to such from the court which has venue over the guardianship following a hearing held for that purpose;
- (7) to have explained, the nature of all medications prescribed, the reason for the prescription and the most common side effects and, if requested, the nature of any other treatments ordered;
- (8) to communicate by letter with the secretary of social and rehabilitation services, the head of the treatment facility and any court, attorney, physician, psychologist, or minister of religion, including a Christian Science practitioner. All such communications shall be forwarded at once to the addressee without examination and communications from such persons shall be delivered to the patient without examination;
- (9) to contact or consult privately with the patient's physician or psychologist, minister of religion, including a Christian Science practitioner, legal guardian or attorney at any time and if the patient is a minor, their parent;
- (10) to be visited by the patient's physician, psychologist, minister of religion, including a Christian Science practitioner, legal guardian or attorney at any time and if the patient is a minor, their parent;
- (11) to be informed orally and in writing of their rights under this section upon admission to a treatment facility; and
- (12) to be treated humanely consistent with generally accepted ethics and practices.

(b) The head of the treatment facility may, for good cause only, restrict a patient's rights under this section, except that the rights enumerated in subsections (a)(5) through (a)(12), and the right to mail any correspondence which does not violate postal regulations, shall not be restricted by the head of the treatment facility under any circumstances. Each treatment facility shall adopt regulations governing the conduct of all patients being treated in such treatment facility, which regulations shall be consistent with the provisions of this section. A statement explaining the reasons for any restriction of a patient's rights shall be immediately entered on such patient's medical record and copies of such statement shall be made available to the patient or to the parent, or legal guardian if such patient is a minor or has a legal guardian, and to the patient's attorney. In addition, notice of any restriction of a patient's rights shall be communicated to the patient in a timely fashion.

(c) Any person willfully depriving any patient of the rights protected by this section, except for the restriction of such rights in accordance with the provisions of subsection (b) or in accordance with a properly obtained court order, shall be guilty of a class C misdemeanor.

(d) The provisions of this section do not apply to persons civilly committed to a treatment facility as a sexually violent predator pursuant to K.S.A. 59-29a01 et seq., and amendments thereto.

History: L. 1996, ch. 167, § 34; L. 2007, ch. 170, § 3; July 1.

59-2979

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2979. Disclosure of records. (a) The district court records, and any treatment records or medical records of any patient or former patient that are in the possession of any district court or treatment facility shall be privileged and shall not be disclosed except:

- (1) Upon the written consent of (A) the patient or former patient, if an adult who has no legal guardian; (B) the patient's or former patient's legal guardian, if one has been appointed; or (C) a parent, if the patient or former patient is under 18 years of age, except that a patient or former patient who is 14 or more years of age and who was voluntarily admitted upon their own application made pursuant to subsection (b)(2)(B) of K.S.A. 59-2949 and amendments thereto shall have capacity to consent to release of their records without parental consent. The head of any treatment facility who has the records may refuse to disclose portions of such records if the head of the treatment facility states in writing that such disclosure will be injurious to the welfare of the patient or former patient.

(2) Upon the sole consent of the head of the treatment facility who has the records if the head of the treatment facility makes a written determination that such disclosure is necessary for the treatment of the patient or former patient.

(3) To any state or national accreditation agency or for a scholarly study, but the head of the treatment facility shall require, before such disclosure is made, a pledge from any state or national accreditation agency or scholarly investigator that such agency or investigator will not disclose the name of any patient or former patient to any person not otherwise authorized by law to receive such information.

(4) Upon the order of any court of record after a determination has been made by the court issuing the order that such records are necessary for the conduct of proceedings before the court and are otherwise admissible as evidence.

(5) In proceedings under this act, upon the oral or written request of any attorney representing the patient, or former patient.

(6) To appropriate administrative or professional staff of the department of corrections whenever patients have been administratively transferred to the state security hospital or other state psychiatric hospitals pursuant to the provisions of K.S.A. 75-5209 and amendments thereto. The patient's or former patient's consent shall not be necessary to release information to the department of corrections.

(7) To the state central repository at the Kansas bureau of investigation for use only in determining eligibility to purchase and possess firearms or qualifications for licensure pursuant to the personal and family protection act.

(8) To the commission on judicial performance in the discharge of the commission's duties pursuant to article 32 of chapter 20 of the Kansas Statutes Annotated, and amendments thereto.

(9) As otherwise provided for in this act.

(b) To the extent the provisions of K.S.A. 65-5601 through 65-5605, inclusive, and amendments thereto are applicable to treatment records or medical records of any patient or former patient, the provisions of K.S.A. 65-5601 through 65-5605, inclusive, and amendments thereto shall control the disposition of information contained in such records.

(c) Willful violation of this section is a class C misdemeanor.

History: L. 1996, ch. 167, § 35; L. 2007, ch. 166, § 2; L. 2008, ch. 145, § 10; May 22.

59-2980

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2980. Civil and criminal liability. Any person acting in good faith and without negligence shall be free from all liability, civil or criminal, which might arise out of acting pursuant to this act. Any person who for a corrupt consideration or advantage, or through malice, shall make or join in making or advise the making of any false petition, report or order provided for in this act shall be guilty of a class A misdemeanor.

History: L. 1996, ch. 167, § 36; Apr. 18.

59-2981

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2981. Costs; payment by residence county, when. In each proceeding the court shall allow and order paid to any individual or treatment facility as part of the costs thereof a reasonable fee and expenses for any professional services ordered performed by the court pursuant to this act other than those performed by any individual or hospital under the jurisdiction of the secretary of social and rehabilitation services, and including the fee of counsel for the patient when counsel is appointed by the court and the costs of the county or district attorney incurred in cases involving change of venue. Other costs and fees shall be allowed and paid as are allowed by law for similar services in other cases. The costs shall be taxed to the estate of the patient, to those bound by law to support such patient or to the county of the residence of the patient as the court having jurisdiction shall direct, except that if a proposed patient is found not to be a mentally ill person subject to involuntary commitment under this act, the costs shall not be assessed against such patient's estate but may at the discretion of the court be assessed against the petitioner or may be paid from the general fund of the county of the residence of the proposed patient. Any district court receiving a statement of costs from another district court shall forthwith approve the same for payment out of the general fund of its county except that it may refuse to approve the same for payment only on the ground that the patient is not a resident of that county. In such case it shall transmit the statement of costs to the secretary of social and rehabilitation services who shall determine the question of residence and certify the secretary's findings to each district court. Whenever a district court has sent a statement of costs to the district court of another county and such costs have not been paid within 90 days after the statement was sent, the district court that sent the statement may transmit such statement of costs to the secretary for determination and certification as provided above. If the claim for costs is not paid within 30 days after such certification, an action may be maintained thereon by the claimant county in the district court of the claimant county against the debtor county. The findings made by the secretary of social and rehabilitation services as to the residence of the patient shall be applicable only to the assessment of costs. Any county of residence which pays from its general fund court costs to the district court of another county may recover the same in any court of competent jurisdiction from the estate of the patient or from those bound by law to support such patient, unless the court shall find that the proceedings in which such costs were incurred were instituted without probable cause and not in good faith.

History: L. 1996, ch. 167, § 37; Apr. 18.

59-2982

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2982. Notice of death of patients in treatment facilities. In the event of the death of a patient in a treatment facility, the head of the treatment facility shall immediately give notice of the date, time, place and cause of such death, to the extent known, to the nearest known relative of the patient, and, as appropriate, to the court having jurisdiction over the patient, the attorney for the patient, and to the county or district attorney and as otherwise provide for by law, to the coroner for the county in which the patient died.

History: L. 1996, ch. 167, § 38; Apr. 18.

59-2983

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2983. Applicability to persons in custody on criminal charges. Nothing in this act shall be construed to apply to any person alleged or thought to be a mentally ill person subject to involuntary commitment for care and treatment under this act who is in custody on a criminal charge, except with the consent of either the prosecuting attorney or trial court.

History: L. 1996, ch. 167, § 39; Apr. 18.

59-2984

Chapter 59.--PROBATE CODE

Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS

59-2984. Severability. If any provision of this act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

History: L. 1996, ch. 167, § 40; Apr. 18.

APPENDIX A: DEFINITIONS OF TERMS USED

The following terms and phrases have the following meanings:

CDDO:	Community Developmental Disability Organization
CMHC:	Community Mental Health Center
DCF	Kansas Department for Children and Families
EMTALA:	The Federal Emergency Medical Treatment and Active Labor Act
ICF/MR:	Intermediate care facility for the mentally retarded or otherwise developmentally disabled
KDADS:	Kansas Department for Aging and Disability Services
LSH:	Larned State Hospital
MI:	Mental Illness
ID/DD:	Intellectual Disability or Otherwise Developmentally Disabled
NF/MH:	Nursing Facility for Mental Health
OSH:	Osawatomie State Hospital
QMHP:	Qualified Mental Health Professional
RADAC:	Regional Alcohol and Drug Assessment Center
RMHF:	Rainbow Mental Health Facility
SA:	Substance Abuse
SED:	Serious Emotional Disturbance
SRS:	Kansas Department of Social and Rehabilitation Services (As of July 1, 2012 – Kansas Department for Children and Families. The former Disability and Behavioral Health Services division of SRS is now merged with the former Kansas Department on Aging and is now called the Kansas Department for Aging and Disability Services).
SHCN:	Special Health Care Needs
SPMI:	Severe and Persistent Mental Illness

APPENDIX B: U.S. SUPREME COURT OLMSTEAD DECISION

The Olmstead Decision represents the U.S. Supreme Court's first consideration of whether the institutionalization of disabled persons who could appropriately receive treatment in the community is permissible under Title II of the Americans with Disabilities Act (ADA). The court recognized that the ADA required the placement of persons with mental disabilities be in the community rather than in institutions upon the satisfaction of three conditions:

- 1). Such action is in order when the State's treatment professionals have determined that the community placement is appropriate,
- 2). The transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and
- 3). The placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities

It is the responsibility of CMHC Screeners to ensure that all options have been considered and discussed with the Consumer and/or legal representative when assessing the needs of the individual. The least restrictive setting available should always be utilized if it meets the needs of the Consumer.

APPENDIX C: RISK CRITERIA

Following are guidelines to consider in determining the need for a formal screening. It is recommended that a screen be completed when a Consumer falls into the High or Moderate Risk categories as defined below. Screening at the Low Risk level may also be indicated at times (i.e. when the Consumer is unknown to the Screener):

1. A request for a screening for either state hospitalization authorization, medicaid coverage **authorization**, or third-party payer coverage authorization, is made by a private hospital, physician, other mental health services provider, or by some other community agency, such as the KDADS Regional Office, a DCF foster care contractor, or a third-party payer intermediary;
2. A request for a screening is made pursuant to a proposal to transfer a patient from a private or community hospital, an NF/MH, an ICF/MR, or another residential setting, to a state hospital;
3. A request is made for assistance by either the Consumer himself or herself or by family, or friends of the Consumer.
4. When someone is a moderate to high risk for hospitalization, the clinician should complete a formal screening with the Mental Health Screening Form

High Risk:

The Consumer lacks the capacity to make an informed decision, when, by reason of their mental condition, is unable, despite conscientious efforts at explanation, to understand the nature and effects of hospitalization or treatment

- Is likely to cause harm to self or others when, by reason of their mental disorder:
 - Is likely, in the **reasonably foreseeable future**, to cause substantial physical injury or physical abuse to self or others, or substantial damage to property of others, as evidenced by behavior threatening, attempting, or causing such injury, abuse, or damage.
 - Is substantially unable, except for reason of indigence, to provide for any of their basic needs (food, clothing, health, shelter, safety), causing a substantial deterioration of his or her ability to function independently.
- Actual suicide attempt and without available services in place, person is likely to attempt again.
- Suicidal ideation with a plan, and a means to carry out the plan.
- Vegetative Symptoms of depression, or catatonia (detached from reality, oblivious to environmental stimuli)
- Is without substantial professional interventions required to alleviate the crisis and the person is most likely to be hospitalized.

Moderate Risk:

- A request for hospitalization assessment made by a community agency, including the following: A request from a community hospital, NFMH, or other residential facility to assist in, or approve of, the transfer of an inpatient or resident to a state psychiatric hospital.
- Suicidal ideation with a plan, but no intent, or suicidal ideation with intent and no plan, is able/willing to contract to call therapist or Crisis Services before acting on self-destructive feelings.
- A person with a diagnosable mental illness not committable at present.
- Situations involving a request by law enforcement, the court or community corrections to evaluate a person for hospital risk
- Any suicidal gesture.

Minimum Risk:

- Presents with suicidal ideation at times, but has no plan or intent.
- Is in crisis, but has an available support system.

No Risk (At least 1):

- No evidence of any suicidal ideation or history.
- No one perceives a need for hospitalization.
- The person is in an inpatient setting and is calling from the unit.

APPENDIX D: COGNITIVE CAPACITY SCREENING EXAM

Examiner: _____ Date: _____

Instructions: Check items answered correctly. Write incorrect or unusual answers in space provided. If necessary, urge patient once to complete task.

Introduction to patient: "I would like to ask you a few questions. Some you will find very easy and others may be very hard. Just do your best."

For every correct answer, score that question as a "1".

-
- | | | | |
|--|-------|---|-------|
| 1. What day of the week is this? | _____ | 16. The opposite of large is | _____ |
| 2. What month? | _____ | 17. The opposite of hard is | _____ |
| 3. What day of month? | _____ | 18. An orange and a banana are both fruits. Red and blue are both | _____ |
| 4. What year? | _____ | 19. A penny and a dime are both | _____ |
| 5. What place is this? | _____ | 20. What were those words that I asked you to remember? (HAT) | _____ |
| 6. Repeat the numbers: 8 7 2 | _____ | 21. (CAR) | _____ |
| 7. Say them backwards. | _____ | 22. (TREE) | _____ |
| 8. Repeat these numbers: 6 3 7 1 | _____ | 23. (TWENTY-SIX) | _____ |
| 9. Listen to these numbers: 6 9 4. Count 1 through 10 out loud, then repeat 6 9 4. (Help if needed.) Then use the numbers 5 7 2. | _____ | 24. Take away 7 from 100 and then take away 7 from what is left and keep on going: 100-7 is | _____ |
| 10. Listen to these numbers 8 1 4 3. Count 1 through 10 out loud, then repeat 8 1 4 3. | _____ | 25. Minus 7 | _____ |
| 11. Beginning with Sunday, say the days of the week backwards. | _____ | 26. Minus 7 (write down answers; check correct subtraction of 7) | _____ |
| 12. 9 + 3 is | _____ | 27. Minus 7 | _____ |
| 13. Add 6 (to previous answer or "to 12.") | _____ | 28. Minus 7 | _____ |
| 14. Take away 5 ("from 18.") Repeat these words after me and remember them. I will ask for them later: HAT, CAR, TREE, TWENTY-SIX. | _____ | 29. Minus 7 | _____ |
| 15. The opposite of fast is slow. The opposite of up is | _____ | 30. Minus 7 | _____ |

Total Correct (maximum score=30) _____

Patient's occupation (previous if not employed): _____

Education: _____ Age: _____

Estimated Intelligence (based on education, occupation, and history, not on test score):

Below Average Average Above Average _____

Patient was: Cooperative___ Uncooperative___ Depressed___ Lethargic___ Other_____

Medical Diagnosis: _____

IF PATIENT'S SCORE IS LESS THAN 20, THE EXISTENCE OF DIMINISHED COGNITIVE CAPACITY IS PRESENT. THEREFORE, AN ORGANIC MENTAL SYNDROME SHOULD BE SUSPECTED. IF AN ORGANIC MENTAL SYNDROME IS PRESENT, **THE PATIENT IS MOST LIKELY NOT APPROPRIATE** FOR TRANSFER TO A PSYCHIATRIC HOSPITAL.

IF AN ORGANIC MENTAL SYNDROME IS SUSPECTED, IT WILL BE HELPFUL IF THE FOLLOWING INFORMATION COULD BE OBTAINED EITHER AS A NEW LAB ORDER OR IF POSSIBLE, FOUND IN EXISTING MEDICAL RECORDS. IF THIS INFORMATION IS AVAILABLE, IT **SHOULD BE COMMUNICATED TO THE PHYSICIAN AT THE RECEIVING HOSPITAL** TO ENSURE THE ADMISSION IS APPROPRIATE.

Temp _____	BUN _____	Endocrine dysfunction? _____
B.P. _____	Glu _____	T, T, Ca, P, etc.
Hct _____	PO ₂ _____	History of previous psychiatric difficulty? _____
Na _____	PCO ₂ _____	Drugs: _____
K _____		Steroids? L-Dopa? Amphetamines? Tranquilizers? Digitalis?
Cl _____		Focal neurological signs: _____
CO ₂ _____		Diagnosis: _____
EEG _____		
ECG _____		

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APPENDIX E: X TRACKING NUMBERS

X-TRACKING NUMBERS ARE GENERATED IN SITUATIONS WHERE A SCREEN IS REQUESTED, BUT NOT AUTHORIZED.

Reasons a screen would not be authorized for ALL screen types include:

- There is no intent to hospitalize the Consumer.
- A Non-psychiatric diagnosis is identified as the primary presenting problem.
- The Consumer is unable to participate in a screen (examples: Consumer is asleep, intoxicated, or not medically stable)
 - If the caller has been using drugs and/or alcohol, ask the caller if the Consumer is able to be screened at this time. If not, have someone call back to request the screen once the Consumer is coherent enough to be able to take part in the screen.
 - An exception to this would be when the Consumer may be unable to participate as a result of their increased mental health symptoms such as psychosis, defiant behaviors, etc.
- The Consumer has been screened, and diverted from admission within the past 5 days to an inpatient psychiatric unit (30 days for PRTF screens).
- The tracking number was not requested within two days of admission to an inpatient psychiatric unit.
- The tracking number was not requested within two days of the screen being completed by a CMHC Screener.
- The Consumer is not a US citizen (does not apply to State Hospital screen type)
- The Consumer is NOT medically stable
 - The Consumer must be considered medically stable **AND** ready for transfer.
 - The Screener may call KHS to request a tracking number once the Consumer is medically stable and ready for transfer.
- The Consumer is in route to the location of the screen.
 - The Screener may contact KHS Call Center to request a tracking number once the Consumer arrives at the new location.
- The Consumer is in the process of being transferred.
 - If the Consumer is currently being transferred, the Screener should call KHS Call Center to request a tracking number once the Consumer arrives at the new location.
 - If it will be a while before the Consumer is transferred (i.e., 2-3 hours or longer), a caller may request the tracking number for the screen and KHS will inform the CMHC of the impending transfer. The Screener will be advised to call the Consumer's reported current location prior to traveling to determine the exact location of the Consumer.
- The presenting problem is considered inadequate.
 - If the presenting problem is questionable and not solely due to substance abuse or medical issues, KHS may issue a screen, and the Screener will decide whether or not the Consumer meets admission criteria.

Reasons a screen would not be authorized for Medicaid Inpatient Psychiatric screens ONLY:

- Consumer is gainfully employed
- Consumer has no intent to apply for Medicaid
- Consumer has other insurance with hospitalization coverage
- Consumer has Medicaid from a state other than Kansas
- Consumer is transient and does not intend to stay in Kansas
- Consumer is not a U.S. citizen

In these situations, the KHS Call Center will issue an X tracking number. The Screener will be advised that a screen is **NOT AUTHORIZED**.

Reasons a screen would not be authorized for State Hospital screens ONLY:

- A Kansas resident presents in Missouri and a State Hospital screen is requested.
 - In these cases, KHS Call Center would issue an X Tracking number.

APPENDIX F: HELPFUL LINKS, WEBSITES

Association of Community Mental Health Centers - <http://www.acmhck.org/>

Child Welfare Contractors

<http://www.dcf.ks.gov/services/Pages/MapFosterCare.aspx>

Developmental Disability Organizations

Map of CDDO's and Counties/Catchment areas

<http://csp.kdads.ks.gov/services/Pages/MapCDDO.aspx>

Directory of Mental Health Resources in Kansas - This would include contact information for CMHC's, State Hospitals, Community Partners, Inpatient Psychiatric Facilities/Private Psychiatric Facilities, Advocacy Groups, Consumer Run Organizations, Nursing Facilities for Mental Health, Psychiatric Rehabilitation Treatment Facilities, Residential Care Facilities.

<http://csp.kdads.ks.gov/agency/mh/Documents/MHDirectory.pdf>

Map of Community Mental Health Centers

<http://csp.kdads.ks.gov/agency/mh/Documents/Services/CMHC%20Locations.pdf>

Kansas Health Solutions - <https://www.kansashealthsolutions.org/>

Provider Manual

https://www.kansashealthsolutions.org/providers/index/resources_manual

Provider Directory

https://www.kansashealthsolutions.org/providers/index/provider_directory

Clinical Forms

https://www.kansashealthsolutions.org/providers/index/clinical_forms

Kansas Department for Children and Families - <http://www.dcf.ks.gov/Pages/default.aspx>

Kansas Department for Aging and Disability Services - <http://www.kdads.ks.gov/>

Medicaid Training - <http://www.medicaidtraining.org>

State Psychiatric Facilities

Larned State Hospital - <http://csp.kdads.ks.gov/agency/LSH/Pages/default.aspx>

1301 KS Hwy 264

Larned, KS 67550

620-285-2131

Osawatomie State Hospital- <http://csp.kdads.ks.gov/agency/OSHandRMHF/Pages/default.aspx>

500 State Hospital Dr.

Osawatomie, KS 66064-0500 Admissions: 913-755-7276

Rainbow Mental Health - <http://csp.kdads.ks.gov/agency/OSHandRMHF/Pages/default.aspx>

2205 W 36th Ave.

Kansas City, KS 66103-2198 913-789-5800

Substance Treatment Resources (KDADS Website) –

Addiction and Prevention Services Home Page

http://www.kdads.ks.gov/CSP/Addict_Prevent_Index.html

Substance Treatment Provider Directory and Map

<http://csp.kdads.ks.gov/services/Pages/MapAAPS.aspx>

Value Options

1-866-645-8216

<http://www.valueoptions.com/kansas/>

APPENDIX G: COMMUNITY MENTAL HEALTH CENTERS, STATE HOSPITAL

CATCHMENT AREAS

AREA MENTAL HEALTH CENTER (LSH)

1111 East Spruce Garden City, KS 67846
Phone/Emergency: 620-276-7689

BERT NASH CMHC (OSH)

200 Maine St Ste A Lawrence, KS 66044
Phone/Emergency: 785-843-9192

CENTER FOR COUNSELING/CONSULTATION (LSH)

5815 Broadway Great Bend, KS 67530
Phone: 620-792-2544 Toll Free: 800-875-2544

CENTRAL KANSAS MENTAL HEALTH CENTER (LSH)

809 Elmhurst Salina, KS 67401
Phone: 785-823-6322
Emergency: 785-823-6324 or 800-823-6380

COMCARE OF SEDGWICK COUNTY (OSH)

635 N Main Wichita, KS 67203
Phone: 316-660-7600 Emergency: 316-660-7500

COMMUNITY MHC OF CRAWFORD COUNTY (OSH)

911 E Centennial Pittsburg, KS 66762
Phone: 620-231-5130 Emergency: 620-232-7283

COWLEY COUNTY MENTAL HEALTH CENTER (LSH)

22214 D St Winfield, KS 67156
Phone: 620-442-4540 or 620-221-9664
Emergency: 620-4424554 or 620-221-9686

ELIZABETH LAYTON CENTER – FRANKLIN Co (OSH)

2537 Eisenhower Rd PO Box 677 Ottawa, KS 66067
Phone: 785-242-3780 Emergency: 800-241-1266

ELIZABETH LAYTON CENTER – MIAMI Co (OSH)

505 S. Hospital Dr. Paola, KS 66071
Phone: 913-557-9096 Emergency: 800-241-1266

FAMILY SERVICE & GUIDANCE CENTER (OSH)

325 SW Frazier Topeka, KS 66606
Phone/Emergency 785-232-5005

FOUR COUNTY MENTAL HEALTH CENTER (OSH)

3751 W Main Box 688 Independence, KS 67301
Phone: 620-331-1748 Emergency: 800-499-1748

THE GUIDANCE CENTER (RMHF)

500 Limit St Leavenworth, KS 66048
Phone: 913-682-5118

HIGH PLAINS MENTAL HEALTH CENTER (LSH)

208 E 7th St Hays, KS 67601
Phone: 785-628-2871
Emergency: 785-6282871 or 800-432-0333

HORIZONS MENTAL HEALTH CENTER (LSH)

1600 N Lorraine Ste 202 Hutchinson, KS 67501
Phone: 620-663-7595
Crisis Management: 620-694-1099 or 800-794-0163

IROQUOIS CENTER FOR HUMAN DEVELOPMENT (LSH)

610 E Grant Ave Greensburg, KS 67054
Phone: 620-723-2272
Emergency: 620-723-2656 or 888-877-0375

JOHNSON COUNTY MENTAL HEALTH CENTER (OSH)

6000 Lamar Ste 130 Mission, KS 66202
Phone: 913-831-2550 Emergency: 913-268-0156

KANZA MENTAL HEALTH & GUIDANCE CENTER (RMHF)

909 S 2nd St Box 319 Hiawatha, KS 66434
Phone: 785-742-7113 Emergency: 785-742-3666

LABETTE CENTER FOR MENTAL HEALTH SERVICES (OSH)

1730 Belmont Parson, KS 67357
Phone Daytime: 620-421-3770 24 Hr: 800-303-3770
Emergency (Office closed): 620-421-4880

MHC OF EAST CENTRAL KANSAS (OSH)

1000 Lincoln St Emporia, KS 66801
Phone Daytime: 620-343-2211 or 800-279-3645
Emergency (Office closed): 620-343-2626/

PAWNEE MENTAL HEALTH SERVICES (OSH)

2001 Claflin Rd Manhattan, KS 66502
Phone: 785-587-4346 Emergency: 800-609-2002

PRAIRIE VIEW INC. (LSH)

1901 E 1st St Box 467 Newton, KS 67114
Phone: 316-284-6400 Emergency: 800-992-6292

SOUTH CENTRAL MH COUNSELING CENTER (LSH)

2365 W Central El Dorado, KS 67042
Phone: 316-321-6036 Emergency: 866-660-3300

SOUTHEAST KANSAS MHC (OSH)

304 N Jefferson Box 807 Iola, KS 66749
Phone: 620-365-8641 / 800-973-2241
After Hours Emergency: 1-888-588-6774

SOUTHWEST GUIDANCE CENTER (LSH)

333 W 15th PO Box 2945 Liberal, KS 67905
Phone/Emergency: 620-624-8171

SPRING RIVER MENTAL HEALTH & WELLNESS, Inc. (OSH)

6610 SE Quakerville Box 550 Riverton, KS 66770
Phone: 620-848-2300 Emergency: 866-634-2301

SUMNER COUNTY MENTAL HEALTH CENTER (LSH)

1601 W 16th St Wellington, KS 67152
Ph: 620-326-7448 / 24 Hr: 800-369-8222

VALEO BEHAVIORAL HEALTH CARE (OSH)

330 SW Oakley Topeka, KS 66606
Phone: 785-233-1730 Emergency: 785-234-3300

WYANDOT CTR FOR BEHAVIORAL HEALTHCARE (RMHF)

757 Armstrong Ave Box 171578 KC, KS 66117
Phone: 913-233-3300 Call Ctr: 913-328-4623
Emergency: 913-788-4200

APPENDIX H: INPATIENT PSYCHIATRIC FACILITIES

CUSHING MEMORIAL HOSPITAL (Consumers ages 18+)

711 Marshall Street
Leavenworth, KS 66048
Phone: 913-684-1101 <http://www.saintlukeshalthsystem.org>

CRITTENTON (Consumers ages 5-18)

10918 Elm Avenue
Kansas City, Missouri 64134
Phone: 816-765-6600 <http://www.saintlukeshalthsystem.org>

DENVER CHILDRENS' HOSPITAL (Consumers ages 4-18)

13123 East 16th Avenue,
Aurora, CO 80045
Phone: 720-777-1234
<http://www.thechildrenshospital.org/about/index.aspx>

FREEMAN HOSPITAL (Consumers ages 18+)

3006 McClelland Boulevard
Joplin, Missouri 64804
Phone: 417-347-7600 <http://www.freemanhealth.com/?id=24&sid=1>

HEARTLAND REGIONAL MEDICAL CENTER (Consumers ages 18+)

5325 Faraon St.
St. Joseph, MO 64506
Phone: 816-271-7273 <http://www.heartland-health.com/default.cfm>

HEARTLAND BEHAVIORAL HEALTH (Consumers ages 3-19)

1500 West Ashland St
Nevada, MO 64722
Phone: 800-654-9605 <http://www.heartlandbehavioral.com/>

MARILLAC CENTER, INC. (Consumers ages 5-17)

8000 West 127th Street
Overland Park, KS 66213
Phone: 913-663-KIDS <http://www.marillac.org/>

NEVADA REGIONAL MEDICAL CENTER (Consumers ages 18+)

800 South Ash Street
Nevada, MO 64772
Phone: 417-667-3355 <http://www.nrmchealth.com/>

PRAIRIE RIDGE PSYCHIATRIC HOSPITAL - ACUTE (Consumers ages 6-18)

4300 Brenner Drive
Kansas City, KS 66104-1163
Phone: 913-334-0294 <http://www.kvc.org/kansas>

PRAIRIE VIEW, INC. (Consumers ages 18+)

1901 E. 1st P.O. Box 467
Newton, KS 67114
Phone: 316-284-6400 <http://www.prairieview.org/index.html>

PROMISE REGIONAL MEDICAL CENTER (Consumers ages 18+)

1701 East 23rd Ave
Hutchinson, KS 67502
Phone: 620-665-2001 <http://www.promiseregional.com/>

RESEARCH PSYCHIATRIC CENTER (Consumers ages 4-61)

2323 E 63rd St
Kansas City, MO
Phone: 816-444-8161 <http://www.researchpsychiatriccenter.com/>

RICHARD H. YOUNG HOSPITAL (Consumers ages 15+)

1755 Prairie View Place
Kearney, NE 68845
Phone: 308-865-2249 <http://www.gshs.org/>

ST. CATHERINE HOSPITAL (Consumers 12+)

401 East Spruce Street
Garden City, KS 67846
Phone: 620-272-2222 <http://www.stcath-hosp.org/>

ST. JOHN'S REGIONAL MEDICAL CENTER (Adolescents/Adults)

2727 McClelland Blvd
Joplin, Missouri 64804
Phone: 417-625-2354 <http://www.stj.com/>

ST. LUKES NORTHLAND (Consumers ages 12-18)

601 US 169
Smithville, MO 64089
Phone: 816-532-7160 <http://www.saintlukeshalthsystem.org>

SALINA REGIONAL HEALTH CENTER (Consumers ages 18+)

400 South Santa Fe Avenue
Salina, KS 67401
Phone: 785-452-7000 <http://www.srhc.com/>

SHAWNEE MISSION MEDICAL CENTER (Consumers ages 18+)

9100 West 74th Street
Shawnee Mission, KS 66204
Phone: 913-789-3218 <http://www.shawneemission.org/>

SOUTHWEST MEDICAL CENTER (Consumers ages 18+)

315 West 15th Street P.O. Box 1340
Liberal, KS 67901
Phone: 620-626-4333 <http://www.swmedcenter.com/>

STORMONT VAIL WEST (Consumers ages 5+)

3707 SW 6th St Topeka, KS 66606
Phone: 785-270-4600
After Hours 785-270-4680
<http://www.stormontvail.org/Facilities/SVWest.html>

TRUMAN MEDICAL CENTER – Hospital Hill (Consumers ages 18+)

2301 Holmes Street
Kansas City, MO 64108
Phone: 816-404-5700 <http://www.trumed.org/truweb/bh/BH.aspx>

TRUMAN MEDICAL CENTER – Lakewood (Consumers ages 18+)

7900 Lee's Summit Road
Kansas City, MO 64139
Phone: 816-404-5700 <http://www.trumed.org/truweb/bh/BH.aspx>

TWO RIVERS

5121 Raytown Road
Kansas City, MO 64133-2141
Phone: 816 382-6300 <http://www.tworivershospital.com/>

UNIVERSITY OF KANSAS HOSPITAL Children/Adolescents/Adults)

3901 Rainbow Blvd.
Kansas City, KS 66160-7200
Phone: (913) 588-1227 <http://www.kumed.com/>

VIA CHRISTI BEHAVIORAL HEALTH CENTER (Consumers ages 12+)

8901 E Orme St
Wichita, KS 67214-3882
Phone: (316) 858-0333 <http://www.via-christi.org/>

STATE HOSPITAL ALTERNATIVES

KVC PRAIRIE RIDGE PSYCHIATRIC HOSPITAL - STAR

4300 Brenner Drive Kansas City, KS 66104
Phone: 913-334-0294 Fax: 913-312-9025
Unit Desk ext.6460/ext.6461; Nurse ext. 6462

KVC WHEATLAND PSYCHIATRIC HOSPITAL

205 East 7th Street Hays, KS 67601
Phone: 785-624-6000
Fax: 785-650-0620

APPENDIX I: GERIATRIC PSYCHIATRIC UNITS

EDWARDS COUNTY HOSPITAL

620 W. 8th Street P.O. Box 99
Kinsley, KS 67547
Phone: 620-659-3623

FREDONIA REGIONAL HOSPITAL

1527 Madison P.O. Box 579
Fredonia, KS 66736
Phone: 620-378-2121

FREEMAN HOSPITAL

3006 McClelland Boulevard
Joplin, Missouri 64804
Phone: 417-347-7600
<http://www.freemanhealth.com/>

GEARY COMMUNITY HOSPITAL

1102 S. Marys Road Box 490
Junction City, KS 66441
Phone: 785-238-4131 <http://www.gchks.org/>

GIRARD MEDICAL CENTER

302 North Hospital Drive
Girard, KS 66743
Phone: 620-724-8291
<http://www.girardmedicalcenter.com/>

HAYS MEDICAL CENTER – SENIOR FOCUSED CARE

205 E 7th, Suite 308
Hays, KS 67601
Tel: (785) 623-5137 / Fax: (785) 623-5138
<http://www.haysmed.com/seniorfocusedcare>

HEARTLAND REGIONAL MEDICAL CENTER

5325 Faraon St.
St. Joseph, MO 64506
Phone: 816-271-7273
<http://www.heartland-health.com/default.cfm>

INTEGRIS BAPTIST REGIONAL HEALTH

200 2nd Ave SW
Miami, OK 74355
Phone: 918-542-3391
<http://www.integrish-health.com/>

MEMORIAL HOSPITAL

511 NE 10th Street
Abilene, KS 67410
Phone: 785-263-6610 <http://www.mhsk.org/>

MITCHELL CO HOSPITAL HEALTH SYSTEMS

400 W. 8TH STREET P.O. Box 399
Beloit, KS 67420
Phone: 785-738-2266 <http://www.mchks.com/>

MORTON COUNTY HOSPITAL

445 N. Hilltop P.O. Box 937
Elkhart, KS 67950
Phone: 620-697-2141
<http://www.mchswecare.com/>

NEWTON MEDICAL CENTER

600 Medical Center Drive P.O. Box 308
Newton, KS 67114
Phone: 316-804-6001
<http://www.newtonmedicalcenter.com/>

SAINT JOHN HOSPITAL

3500 South 4th Street
Leavenworth, KS 66048
Phone: 913-596-5031
<http://www.providence-health.org/sjh/default.cfm>

ST. CATHERINE HOSPITAL

401 East Spruce Street
Garden City, KS 67846
Phone: 620-272-2561 <http://www.stcath-hosp.org/>

SHAWNEE MISSION MEDICAL CENTER

9100 West 74th Street
Shawnee Mission, KS 66204
Phone: 913-789-3218
<http://www.shawneemission.org/>

STORMONT VAIL SENIOR DIAGNOSTIC UNIT

100 SW 10th
Topeka, KS 66604
Phone: 785-354-6695
<http://www.stormontvail.org/>

SUMNER REGIONAL MEDICAL CENTER

1323 North A. Street
Wellington, KS 67152
Phone: 620-326-7453 <http://www.srmcks.org/>

SUSAN B. ALLEN MEMORIAL HOSPITAL

720 W. Central Avenue
El Dorado, KS 67042
Phone: 316-322-4557 <http://www.sbamh.com/>

APPENDIX J: NURSING FACILITIES FOR MENTAL HEALTH

APPLEWOOD REHABILITATION, INC.

1720 W. 2nd Street
Chanute, KS 66720-1939
Phone: (620) 431-7300
Fax: (620) 431-2127

BRIGHTON PLACE NORTH

1301 NE Jefferson
Topeka, KS 66608-1118
Phone: (785) 233-5127
Fax: (785) 232-2727

BRIGHTON PLACE WEST

331 SW Oakley Ave.
Topeka, KS 66606-1914
Phone: (785) 232-1212
Fax: (785) 232-3907

COUNTRYSIDE HEALTH CENTER

440 Woodland
Topeka, KS 66607-2172
Phone: (785) 234-6147
Fax: (785) 232-8781

GOLDEN LIVING CENTER OF EDWARDSVILLE

751 Blake Street
Edwardsville, KS 66111-1338
Phone: (913) 441-1900
Fax: (913) 441-0410

GOLDEN LIVING CENTER OF ESKRIDGE

505 N. Main Street
Eskridge, KS 66423
Phone: (785) 449-2294
Fax: (785) 449-2285

LAKESWOOD REHABILITATION CENTER OF HAVILAND

200 Main Street
Haviland, KS 67059-9525
Phone: (620) 862-5291
Fax: (620) 862-5233

MEDICALODGE OF PAOLA

501 Assembly Lane
Paola, KS 66071-1854
Phone: (913) 294-3345
Fax: (913) 294-3115

PROVIDENCE LIVING CENTER

1112 SE Republican Ave.
Topeka, KS 66607-5517
Phone: (785) 233-0588
Fax: (785) 233-5603

VALLEY HEALTH CARE CENTER

400 12th Street
P.O. Box 189
Valley Falls, KS 66088-0189
Phone: (785) 945-3832
Fax: (785) 945-3708

WESTVIEW MANOR OF PEABODY

500 Peabody
P.O. Box 142
Peabody, KS 66866-0142
Phone: (620) 983-2165
Fax: (620) 983-2364

APPENDIX K: PSYCHIATRIC REHABILITATION TREATMENT FACILITIES

CAMELOT OF KANSAS, RIVERSIDE ACADEMY

2050 W. 11th St.
Wichita, KS 67203
Phone: (316) 267-5710
Fax: (316) 267-7510 <http://www.camelotforkids.org/>

CRITTENTON CHILDREN'S CENTER

10918 Elm Avenue
Kansas City, Missouri 64134
Phone: (816) 765-6600 <http://www.saintlukeshalthsystem.org/>

FLORENCE CRITTENTON SERVICES, INC.

2649 Arrowhead Rd.
Topeka, KS 66614
Phone: (785) 233-0516
Fax: (785) 233-3806 <http://www.flocritkansas.org/index.php>

LAKEMARY CENTER, INC.

100 Lakemary Drive
Paola, KS 66071
Phone: (913) 557-4000
Fax: (913) 557-4910 <http://www.lakemaryctr.org/>

MARILLAC CENTER FOR CHILDREN

(a member of Cornerstones of Care, Inc.)
8000 W 127th St.
Overland Park, KS 66213
Phone: (816) 508-3300
Fax: (816) 508-3321 <http://www.marillac.org/>

NILES GROUP HOME FOR CHILDREN

1911 SE 23rd ST.
Kansas City, MO 64127
Phone: (816) 241-3448
Fax: (816) 241-2797 <http://www.nhc-kc.org/>

OZANAM HOME FOR BOYS (Cornerstones of Care, Inc.)

421 East 137th St.
Kansas City, MO 64145
Phone: (816) 508-3600
Fax: (816) 508-3797 <http://www.ozanam.org/>

PATHWAYS FAMILY SERVICES, INC.

4101-B SW Martin Dr
Topeka, KS 66609
Phone: (785) 783-8438
Fax: (785) 861-7147
<http://www.pathwayfs.org/programs/prtf.aspx>

PRAIRIE RIDGE

4300 Brenner Road
Kansas City, KS 66104
Phone: (913) 334-0294
Fax: (913) 334-0284 <http://www.kvc.org/kansas>

PRAIRIE VIEW, INC.

1901 E. 1st St.
Newton, KS 67114
Phone: (316) 284-6400
Fax: (316) 284-6492 <http://www.prairieview.org/>

THE SPOFFORD HOME (Cornerstones of Care, Inc.)

P.O. Box 9888
9700 Grandview Road
Kansas City, MO 64134
Phone: (816) 508-3414
Fax: (816) 508-3400 <http://www.spooffordhome.org/>

ST. FRANCIS ACADEMY – SALINA

5097 W. Cloud St., Salina, KS 67401
Phone: (785) 825-0563
Fax: (785) 825-2549
http://www.st-francis.org/residential_care.html

TLC FOR CHILDREN AND FAMILIES, INC.

480 S. Rogers Road
Olathe, KS 66062
Phone: (913) 764-2887
Fax: (913) 764-5437 <http://kidstlc.org/>

UNITED METHODIST YOUTHVILLE – DODGE CITY

1200 Lariat Way
Dodge City, KS 67801
Phone: (620) 225-0276
Fax: (620) 225-0279 <http://www.youthville.org/>

CORNERSTONES OF CARE, INC.

VP of Programs: Bill MacCarty
Phone: (816) 508-3401
Facilities: Ozanam - Spofford - Marillac
<http://www.cornerstonesofcare.org/>