KANSAS MENTAL HEALTH COALITION

Speaking with one voice to meet critical needs of people with mental illness.

Minutes

October 26, 2016 Monthly Meeting Valeo Behavioral Health Center - 330 SW Oakley, Topeka, KS - Basement Conference Room

Introductions and sign-in sheet Susan Lewis, President

Stephanie West, DRC
Kevin McGuire, JoCo MHC
Sky Westerlund, KNASW
Rob Mealy, KS Psych Society
Susanna Honaker, KAAP/ACMHCK
Susan Zalenski, J&J
Carol Manning, MHA of SCK
Mike Burgess, DRC
Heather Elliott, ACMHCK
Lynn Lemke, Marillac
Dana Schoffelman, Florence Critenton
Jane Adams, Keys for Networking
Lori Gonzales, Emberhope
Amy Henson, MHA
Sandra Dixon, DCCCA
Kyle Kessler, ACMHCK
Nick Reinecker
Amy Campbell
On the phone:
Patrick Yancey, KHS
Eric Harkness
Marcia Epstein
Christine Thompson
Joe Jekel, GAN
Steve Feinstein, ELC
Tisha Darling, ComCare
Guests:
Meg Wingerter, KHI News Service
Angela DeRocha, KDADS
Charlie Bartlett, KDADS

Financial Report Andy Brown, Treasurer

Please renew your membership at KMHC website. First, log in, select your membership renewal and the site will generate an invoice to pay by check. Contact Amy if you have questions.

Minutes of the previous meeting. Adopted.

9:15 a.m. Reports

Board of Directors - Quarterly meeting was held in September.

Advocacy Committee –Grassroots Advocacy Network - NAMI is applying for Kansas Health Foundation health disparities grant with support from KMHC.

Governor's Behavioral Health Services Planning Council – Wes Cole

Advance Psychiatric Directives – Mike Burgess

Psychiatric Advance Directives are legal documents created by individuals to communicate their preferred plan of care in the case of a crisis. The document may select the least restrictive environment preferred, members of the family or other supportive people to be notified or not notified. Individuals wear a medical bracelet or other item to indicate that there is a psychiatric advance directive on file. It is a voluntary opportunity for people who deal with mental illness in their lives to make their wishes known.

(Note: add information about other states who have these statutes to the paper and details of the contents)

Draft Position Document:

Position: The Coalition supports creating a new and visible statute concerning Psychiatric Advance Directives (PADs), a plan that would make the state's mental health care system more functional when responding to the individual needs of Kansans. This action would increase the quality of our system and decrease the cost of operation overall by reducing the number of involuntary commitments by mitigating and potentially preventing numerous crisis situations from occurring or escalating. The Kansas Legislature must adopt a policy that reflects the state's commitment to the free will and autonomy of all citizens, which is done explicitly through the use of PADs as a tool for an individual's free will and self-determination in dealing with mental health conditions. This policy would affirm that PADs are simple to create and effective in usage. A visible statute concerning the availability and use of PADs would indubitably increase their use.

The Problem: Kansas's mental health infrastructure is in dire need of support. One such measure that can play a small, but important role should be the widespread use of PADs. While technically available under the current laws, these directives are not visible to the public at large. Additionally, PADs are doubly hard to attain due to the numerous hoops one has to jump through to legally secure a PAD. Further compounding the problem, Kansas's PAD template is outdated,

confusing and limited at best. A new policy update to fix even one of these problems would be momentous for mental health care in Kansas. PADs are a newly developed idea, but are proven to help people get the right care when they are in crisis.

Why this matters: Repeated hospitalizations that could otherwise be totally avoided result in increased costs to counties, Medicaid, and the public mental health system. Persons with mental illness involved in altercations that result in institutionalization, especially in situations that could easily have been averted, end up reducing the number of beds available to those who need the access to constant attention and mental health resources available in a state psychiatric hospital. This issue is particularly grievous considering the waiting period for these spots can last for weeks, months, or even years, with the future growing ever bleaker. This continued waiting period is of significant concern to mental health advocates. PADs can reduce this problem. Other states have proven PADs can work and their laws should serve as a model for a newe PAD law in Kansas.

The bottom line: Psychiatric advance directives are underutilized and can be an excellent tool for empowering individuals while offering the significant potential for preventing or mitigating crises. While Kansas has enacted legislation authorizing a form of advance directive for health care, this general advance directive law does not adequately provide for unique problems relating to the individual treatment of mental illnesses. Specifically, Kansas's guardianship clause precludes an individual from making autonomous decisions when competent to do so and can lead to the revocation of a PAD even against the will of the patient. Barriers to the implementation of psychiatric advance directives, such as state laws that add unnecessary procedural or legal burdens, should be eliminated.

General discussion – not ready to endorse. Seeking additional information about how the program works in other states. Some concern that this furthers the difference / separation between behavioral health and primary health care.

Alliance for a Healthy Kansas - Amy Campbell

Expand KanCare Event in Topeka on November 2nd 6:30-8pm - Topeka Public Library, Marvin Auditorium 101B, 1515 SW 10th Avenue, Topeka KS. Encourage members to attend and support expanding KanCare because it:

- Creates jobs and economic impact by bringing hundreds of millions of dollars into the state.
- Protects hospitals and rural communities.
- Improves health and financial security for 150,000 Kansans and increases access to preventive care.

Members can show their support by signing petition, http://action.expandkancare.com/, in support of expanding KanCare. If you need any assistance, email david@expandKancare.com.

9:45 a.m. **KMHC Consensus Recommendations**- 2016 process for updates and amendment. Please draft an issue paper for the topic that you would like to see included in the Coalition's October or November agenda. Linked here: sample issue paper format.doc Consideration of potential issues for 2017:

Mental Health 2020: The Association of Community Mental Health Centers of Kansas Funding Initiative
- Funding – Crisis Stabilization
- RSI and ComCare Crisis Program with SAC
- Restoration of State MH Grants
- Expansion of Psychiatric Training / Residency Program at KU
- Amend statute to include Psychiatry as one of the medical loan repayment programs.
- Funding for data analytics and performance measurement as part of care coordination initiatives

Emergency Observation and Treatment Initiative – currently under review by a subcommittee of the Judicial Council. KMHC was neutral last session due to lack of consensus among members.

Possibly support the Recommendations of the Subcommittee on Housing and Homelessness

Addictions treatment issues - Insurance Statutes exempt insurance from paying for damages/medical costs when alcohol is deemed a cause of the accident

Medicaid suspension v. termination for people who are in custody or hospitalized (involuntary)

May endorse recommendations of the Adult Continuum of Care Committee

There may be issues relating to the new RFP for KanCare

10:00 a.m. Guest Speaker Ed Klumpp - the Law Enforcement Perspective

Sheriffs Association, Chiefs of Police, Law Enforcement Officers Association – Mr. Klumpp has worked in law enforcement for 30 years. Nothing said here is meant to take away from the work being done by KDADS and the State, especially the hard work they are doing to address the problems we face today

Danger to themselves or others, those who have mental illness that causes problems that require encounters with law enforcement, and people who we are called in to assist by families or who are victims of crime themselves.

Contact with people with substance abuse is sky high compared to those with traditional mental illness. Also not talking about those with other disabilities.

Law enforcement is a problem solving job. We are often called as a last resort to solve problems or address crimes.

We often are adept at short term solutions, but long term solutions are often out of our depth.

We've come a long way in the last few years in dealing with mental health in learning better techniques to deal with problems. If the mental health system

Handed out a sheet with a graph showing number of people being held in state custody in mental health hospitals and those held in jails. During the 60's to the 90's we actually decreased the number of people being held in these environments. Now, the numbers are back up, but more are being held in the jails and fewer in the hospitals.

There is a very thin line between an act that is done due to mental illness or an act that is done by a person with mental illness but not due to the illness. Law enforcement is asked to be able to make these determinations on location with only the information at hand.

Training used to be four weeks long when I started and now it is fourteen weeks.

Crisis Intervention Teams are growing across the United States. In Topeka, the agency trains all of its officers. In other areas, designated individuals go through the course. We are also seeing expanded use of Mental Health Fist Aid training. It is better than nothing, but is really like the difference between learning first aid and being trained as an EMT. Additionally, in many areas, law enforcement officers are engaged with mental health centers to cooperate to divert individuals from arrest where possible.

There is more of an awareness today of how law enforcement can play a role in pre-arrest diversion to refer to mental health services.

There are serious crimes that must be treated as crimes and courts must determine how to intervene in those cases, because law enforcement can only divert for minor violations.

The biggest barrier that we encounter today is the moratorium for state hospital beds. We are on day 490 of the moratorium. When Osawatomie dropped from 206 beds to 146 beds, the impact was felt on the street.

I can tell you without a doubt that law enforcement is more hesitant to take someone in for the assessments. I can tell you without a doubt that the screeners are aware of the pressure to not screen for commitment.

You have people put on a waiting list for admission and it is as frustrating to individuals as it is to the hospital or law enforcement.

I don't hear enough about what it does to the person with the mental illness. Every hour that person sits in a waiting room is an hour they are sitting there with no treatment, it is not a good setting that is helpful to them or to us – and can lead to more violations.

I have been sitting in on a lot of these meetings lately, and I can tell you that I don't see any urgency on the part of the State to fix this yet. I know that there are staffing issues and I know there are funding issues, but we are talking about people who are in need.

I have never heard anyone speak with any idea at all when the moratorium is going to end.

Think of what this is doing to people. Think of the liability that this creates for the law enforcement or health providers involved. Sometimes, after someone is put on the waiting list, we turn them loose – and it could be a matter of time before something happens – in the holding space or elsewhere – and people will say that

We are beyond our capacity to serve the people who need it today. Last session, legislation passed to close youth centers and they are supposed to be served by programs in the community. It is frustrating to think that we may be setting ourselves up for failure here by not recognizing the lack of capacity in the community.

There are 105 counties in Kansas. Counties have jails. They do not all have a Valeo or a Johnson County Mental Health Center to work with – so, they are left with whatever they get through their jail's health contractor.

Policy concerns:

- End the moratorium – we don't care where they get the treatment, at Osawatomie or at Valeo/CMHCs, but it must be done
- Funding for CIT and Mental Health First Aid training. ½ of the law enforcement agencies in the state have less than 5 officers. They do not have the resources to send an officer away for a week of training. I think Wisconsin recently passed legislation to require training and provided funding. We need to be looking at those types of issues. Need to give resources to law enforcement to develop these skills. Our associations regularly oppose unfunded mandates, we always ask for funding and none comes.
- Hopeful to see Emergency Observation and Treatment statutes move forward in the right way with adequate due process and individual rights protected.
- Want to see more post-arrest diversion opportunities / Mental Health Courts put in place
- Need more detox services – when the State removed the law regarding public intoxication, they promised there would be detox services available, but that didn't happen. We are seeing a few new resources open, but they are being funded locally.

- Need programs to be able to provide medication continuity for people who are in jail and then move into the community.
- Medicaid suspension v. revocation during incarceration
- Currently found a resource through Dept. of Labor to track people who are in jail and can notify victims. Could use this system to notify Medicaid when people are released which could trigger re-activation of Medicaid instead of them having to go through entire application process again.
- Working with KDADS for transition from state hospital to community.

Q&A

Jane Adams – would that tracking system apply to kids?

No. Kids don't go to jail and this system was set up for jails.

Jane Adams – school resource officers need training to work with kids with mental illness. Schools have unfortunately abdicated their responsibilities in dealing with kids in crisis and handed that over to school resource officers who do not seem to have any information about the kids.

I know that school resource officers have to have a long list of training specific to schools, and I believe mental health is a part of that. The data shows that, in districts with school resource officers, more kids go to juvenile justice system. So, there are statutes that specify that schools with resource officers must have policies for school interventions in order to divert activities prior to entering justice system. They are required to have memorandums of understanding in place by July 2017.

In Topeka, all USD 501 / Topeka Police Department resource officers must be trained in CIT Juvenile program. Kansas is actually on the cutting edge of mental health programs and law enforcement.

Ira Stamm – Menninger used to collaborate with the Topeka Police Department and Kansas has a long history of collaboration.

Will the law enforcement organizations support Medicaid Expansion in light of the Wichita Police Chief's statements?

Medicaid Expansion is a volatile political issue. We will support whatever we can to help the local providers to get the funding they need to provide the needed services. We don't care where the funding comes from.

10:30 a.m. Legislative Update - Amy Campbell

Legislative Interim Committees - Public Health Boards, Foster Care and Step Therapy topics meet after the November elections.
Mental Health Medications Advisory Committee - DUR Committee schedules: DUR met in October, MHMAC meets November 8, 2-4 pm.
Adult Continuum of Care Committee - meeting every two weeks to develop recommendations
2016 Elections Information – Reach out to your local candidates and talk about mental health. It is important to bring mental health to the attention of candidates. They are hearing a lot about taxes, education, and Medicaid. We need to be sure that mental health is on their radar.

11:00 a.m. KDADS Update - Charles Bartlett, Behavioral Health Services, KDADS

Kelli Ludlum left KDADS, Cody Gwaltney will fill the position of Policy Director - Cody.Gwaltney1@ks.gov 785-291-0652.

KDADS job posting: CIT and Veterans outreach position is now being advertised. Substance Use Disorders Coordinators position posted to manage block grant and programs/training.

Field staff for mental health and substance use have been moved to the Commission of Survey Certification and Credentialing. Rhonda Gabel has been hired to oversee that commission. Will be working to achieve goals of consistent guidelines for survey visits and uniform interpretations of regulations and statutes.

Sandra Dixon – standards for Substance Use Treatment Facilities have been under revision for many years and would like to have a timeline for implementation.

Encouraged her to work through the Council to push for completion – coordinated effort between policy side and survey side of the agency.

There is not a plan yet for certified peer specialist training and the other trainings that had been conducted under university contracts.

11:25 a.m. Announcements

11:30 a.m. Adjourn

2016 KMHC Meetings: 9 a.m.–11:30 a.m. Jan 27, Feb. 24, Mar. 23, April 27, May 25, June 22, July 27, Aug 24, Sept. 28, Oct. 26, Nov 16, Dec. 14

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