KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illness

2014 CONSENSUS POLICY RECOMMENDATIONS

The Kansas Mental Health Coalition is dedicated to improving the lives of Kansans living with Mental Illnesses and Severe Emotional Disorders. We are consumer and family advocates, provider associations, direct services providers, pharmaceutical companies and others who share a common mission. At monthly roundtable meetings, participants develop and track a consensus agenda that provides the basis for legislative advocacy efforts each year. This format enables many groups, that would otherwise be unable to participate in the policy making process, to have a voice in public policy matters that directly affect the lives of their constituencies. The opportunity for dialogue and the development of consensus makes all of us stronger and more effective in achieving our mission. Following are the Coalition's Policy Recommendations for 2014.

KanCare

The Kansas Mental Health Coalition supports those changes in Kansas Medicaid that improve access to the right treatment, at the right time, in the right place, in the right amount and for as long as necessary to ensure a timely and durable recovery for people with mental illnesses.

The Coalition encourages legislative oversight of the operation of the KanCare program in order to determine whether timely, adequate, and cost effective services are being provided to all areas of the state and all types of consumers. Legislative oversight of the implementation of KanCare should include a review of prior authorization and utilization data, analysis of costs and benefits, and application of quality benchmarks.

KMHC believes:

KanCare should actively engage consumers in the implementation and evaluation of KanCare funded services.

The growth of Medicaid is a complex problem and there is no single answer to management of this problem. Therefore, KMHC views changes in the state's Medicaid system as experimental and recognizes that they may have unintended results. Dollars spent on specific treatments today may not reflect future costs. Some programs may need to grow in order to provide more effective and successful treatment for Kansans with serious mental illness and co-occurring disorders.

While the KanCare proposal anticipates that all Medicaid recipient populations will be included in the new programs to be operated by three managed care companies, there are those who would prefer to be carved out. The Coalition believes that current systems know best how to most effectively manage their own service delivery system. Cost containment challenges could be presented within their current systems and recommendations implemented from within.

Certain assumptions have been made about the projected savings and state general fund expenditures for KanCare. If there are changes to the program as it was outlined initially, there must be in depth legislative review of the effects of those changes on the projected savings, state general fund expenditures, services to consumers and impacts on providers in the program. Stakeholders should be involved in any changes to the KanCare proposal. It is imperative that, in addition to the 24 specific objectives outlined in the reform proposal, contracts for Medicaid services for mental health care provide:

- **Statewide access to public and private mental health providers;**
- **Medical homes that are accessible to people of limited means;**

- **Access to an array of services that address the critical needs of individuals with serious mental illnesses;**
- **Treatment by professionals with the appropriate level of expertise and education;**
- **Access to mental health medications that complies with current Kansas law prohibiting preferred drug lists for behavioral health medications;**
- **Transparent utilization review and effective implementation of a medical necessity definition that recognizes the ongoing needs of persons with mental illness for services and supports;**
- **Sufficient preparation to prevent delays in turnaround time and backlogs in determinations of Medicaid /SCHIP eligibility;**
- **Provision of reliable information and assistance about eligibility, services and treatment available, complaint processes, and dispute resolution provided to participants and families by advocacy organizations; and**
- **Kansas should expand and support the availability of evidence based practices where feasible.**

Public Mental Health Funding

Community Mental Health Centers (CMHCs) are the backbone of the Kansas public mental health system, serving an average of 123,000 people every year. The majority of people served by CMHCs are low income and uninsured or underinsured. About 85,000 have neither Medicaid nor any other health insurance coverage. Essential treatment, care, and services provided by CMHCs are supported by a combination of state general funds, Medicaid, and local county tax levies. Mental Health Reform, implemented two decades ago, provided significant state funding for treatment of people who are not eligible for Medicaid and do not have other resources. From FY2008 through FY2011 Mental Health Reform grant funding that made it possible for CMHCs to serve those individuals was reduced by 65%. As a result CMHCs have been forced to reduce staff and programs, placing at risk even the most basic services necessary to maintain people in their communities.

As a result of this funding reduction the Kansas mental health system is rapidly losing the ability to maintain Mental Health Reform. There is no cost saving in this process. There is only cost shifting to pay for the increased need for hospitalization and the increasing incarceration of people with mental illnesses. The cost in lives to suicide or other avoidable violence, the cost of broken families to our communities, and the cost of a lost opportunity for recovery for people struggling to survive must not be discounted. The system has lost $20 million in MH grant funding since 2008.

KMHC urges the restoration of all categories of Community Mental Health Center state funding to their previous levels and opposes any further reductions in state grants or other state funding to community mental health services.

Consumer & Family Support

Through strong advocacy, consumer and family organizations have gained a voice in mental health research, legislation, and service delivery. While the organizations representing consumer and family members differ in their origins and philosophy, all share the goals of overcoming stigma and preventing discrimination, promoting peer support groups, and fostering recovery from mental illness. Consumer peer support is an important part of efficient and effective healthcare delivery. When consumers are provided with the information and support necessary to promote wellness, the road to recovery is shorter and less expensive.

Recognizing the importance of involving consumers and their family members in policy decisions that affect their lives, the 2012 Legislature restored funding to consumer and family organizations.

KMHC believes:

In light of agency reorganizations and the implementation of KanCare, consumers and families must have access to information and assistance from organizations unaffiliated with MCOs or providers.

KMHC supports maintaining dedicated funding for the consumer advisory council and annual recovery conference. KMHC also supports maintaining dedicated funding for the operation of consumer run organizations and statewide advocacy organizations.

Peer support programs come in many forms. These may serve as an alternative to, or complementary to, traditional mental health treatment options. In many cases, these programs are less expensive to operate or can reduce the costs of accompanying traditional treatment, such as hospitalization, medication or therapy.

Peer support works. Unfortunately, it is not available to many of the people who need it. As Kansas develops initiatives to improve behavioral health, peer support must be a part of those plans.

State Psychiatric Hospitals and the Hospital to Home Project

Osawatomie State Hospital (OSH), Larned State Hospital (LSH), and the Rainbow Mental Health Facility (RMHF)serve Kansans who present the most acute, challenging, and difficult to treat symptoms of mental illnesses. Their budgets have not kept pace with the need to address deteriorating physical plants, recruitment and retention of competent professional and direct care staff, the bed capacity to serve the mounting number and acuity of admissions, and the growing number of forensic patients. As a result, the hospitals frequently exceed their licensed capacity and the emphasis has shifted from management of clinical outcomes to management of admissions and discharges. This is neither the most appropriate nor the most effective way to deliver inpatient treatment to the most acutely ill and difficult to treat people in the mental health system.

Five years ago the Kansas legislature recognized that, while operating the state psychiatric hospitals based upon operational crises and emergent budget issues may have temporarily fixed immediate problems, it also seriously eroded the physical and programmatic capacity of the hospitals to address the state's changing inpatient treatment needs. In 2007, SRS established a ***Hospital to Home Project*** tasked with determining what services are needed by persons with mental illnesses in order to prevent hospitalization and to insure effective and timely transition to community services post hospitalization. Although the Hospital to Home project provided many useful tactical recommendations for managing the mental health hospital and community interfaces, it did not deal with the strategic issues that should be the framework for planning the future of the state's psychiatric hospitals. A critical part of the project, assigned by the Legislature, was the development of a strategic plan for the future of the state's psychiatric hospitals. While the agency is currently moving forward with plans to develop needed community resources and reform current hospital programming, the Hospital to Home group could be better utilized to enhance and support comprehensive strategic planning.

KMHC believes:

The licensed and budgeted bed capacity of our state mental health hospitals is currently inadequate and must not be reduced any further until hospital reforms and community based strategies are able to modify or reverse hospital admissions and such trends can be verified over a period of years.

The recently announced transformation of the Rainbow Mental Health Facility to a crisis stabilization center is a promising and encouraging development. This new initiative must be monitored closely to assure it is adequately supported, and to measure its impact on hospital admissions.

Staffing for the 30 bed unit at Osawatomie State Hospital currently serving the Rainbow catchment area must continue beyond FY 14.

Changes to Rainbow Mental Health Facility should follow the recommendations of the Mercer Study Review and Recommendations for the Alternative Use of Rainbow MHF submitted by the Hospital and Home Team May 3, 2013. These recommendations are specific to RMHF but have implications for future work and the development of similar resources across the state.

Further changes to the future mission, capacity, and operation of these facilities must be based upon a strategic plan that incorporates meaningful participation by stakeholders.

The Kansas Mental Health Coalition believes that it is imperative the Department for Aging and Disability Services further this strategic planning process and support it with timely research data made accessible to the Hospital and Home Team, as well as other interested stakeholders.

Local Public/Private Partnerships to Create Psychiatric Inpatient Beds

Admissions to the state mental health hospitals have increased dramatically over the past decade, while the total number of beds in these facilities has declined. During this decade most of the community based psychiatric inpatient beds have also closed. With only two state mental health hospitals, Kansans must often travel great distances under very difficult conditions to receive inpatient treatment. Because of the distance, it is often impossible for rural families to maintain close contact while a loved one is being treated and this makes recovery more difficult. Additionally, at times of high bed utilization, all CMHCs, including those in urban areas, are periodically asked to defer admissions to the state hospitals, or send patients to a hospital other than the one assigned to their area.

KMHC believes:

People who can be treated safely and effectively in a community general hospital or a private psychiatric hospital should have that option. **Financially viable contracts with regional inpatient facilities should be funded to provide the inpatient psychiatric treatment necessary to eliminate the onerous distances rural people must travel for treatment, reduce isolation from family and community, and alleviate the shortage of psychiatric inpatient beds for people with serious mental illness. Such contracts should also accommodate the overflow situations which arise when state psychiatric hospitals are over capacity and cannot accept additional patients.**

Mental Health Medications

There is strong research and clinical evidence that supports exempting mental health drugs from restricted access, while other research identifies potential problems with preferred formularies. In particular, many studies have reported that PDLs, which prevent access to specific medications, are a danger to Medicaid subscribers with mental illness. Policies, that include a PDL with prior authorization requirements, restrictive formularies, fail first requirements, monthly prescription limits, or tiered co-payment structures, have been demonstrated to:

- Fail to reduce overall healthcare costs;
- Prolong suffering; and
- Reduce the potential for an individual with mental illness to achieve full Recovery.

The Kansas Legislature has repeatedly reviewed this evidence and has concluded that a Preferred Drug List (PDL) for mental health medications is unwise. In 2002, the Kansas Legislature exempted “Medications including atypical anti-psychotic medications, conventional anti-psychotic medications and other medications used for the treatment of severe mental illness,” from a Medicaid preferred formulary and prior authorization.

Restrictive policies simply shift costs to hospitals and the public mental health system. Preferred Drug Lists and other drug management policies usurp the right of consumers, with the advice of their physician, to make treatment decisions. These policies have the potential to ignore the unique and non-interchangeable nature of psychotropic medications and may not take into account both the individual as well as the fiscal consequences of arbitrary third person medication decisions.

The Kansas Health Policy Authority established a Mental Health Prescription Drug Advisory Committee in 2009. The committee was neglected, and then dropped during the KHPA reorganization. KMHC supports the reinstatement of this committee or similar task force and recommends that it continue to advise the accountable agency with regard to the Medicaid pharmacy program.

The KMHC opposes policies that restrict access to psychiatric medications and opposes removing the mental health exemption for PDL management from Kansas statute. KMHC will work with KDHE and Managed Care Organizations (MCO) to identify, study, and promote policies that enhance patient safety and promote program efficiency without jeopardizing patient access to mental health medications.

Access to Health Care for the Uninsured

Budget cuts in FY2009 reduced access to medical treatment and general assistance by limiting these services to 18 months. November allotments further reduced the benefits to 12 months. At least 2000 Kansans have lost MediKan coverage since July 1, 2009. This represents a loss of $3.1M in reimbursement to mental health centers each year and significantly more to hospitals and other providers who have an obligation to serve. Current resources are already inadequate to meet the existing need. Nevertheless, without MediKan as a payer source or without additional funding provided to meet the needs of those previously served on MediKan, who will not become eligible for SSI or Medicaid, the burden continues to fall on existing resources within the public mental health system.

Homeless shelters have increased censuses because of prior funding reductions as well as the current recession. The uninsured population must be served by Community Mental Health Centers, health care providers and local hospitals. This is a serious issue in Kansas, because we have one of the lowest income thresholds for adult Medicaid eligibility in the country.

KMHC believes:

> **A comprehensive person-centered benefit and service delivery model for income support that promotes long-term self-sufficiency for low-income adults with disabilities who do not meet the SSA standard and do not qualify for other federal programs, must be developed.**
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> **A health care model that meets the needs of this population must be developed and implemented. It should be designed and implemented within the context of ongoing health care reform discussions, recognizing that it is a population that is not served by current programs. It must address both physical and mental health care. Until this new model is funded and implemented, MediKan program funding and general assistance should be restored and the program itself should be retained to continue to provide coverage for basic health care needs of our most vulnerable citizens.**

KanCare Expansion

The federal Affordable Care Act provides states the option of expanding Medicaid programs to include adults with incomes at or below 133 percent of federal poverty guidelines or about $30,700 a year for a parent in a four-person household or about $14,900 a year for a childless adult. Currently, the state's Medicaid program is mostly restricted to poor children, pregnant women, the disabled and the elderly. A non-disabled adult rearing children is currently eligible for Medicaid, if his or her income is below 32 percent of the poverty level – about $5,200 a year for a young mother with two children. Kansas' eligibility threshold is among the lowest in the nation.

Kansas has reduced mental health grant funding by $20 million since 2007. This funding is supposed to support treatment for the uninsured. The majority of the people treated by community mental health centers are uninsured, which has resulted in a triage system when an individual seeks care.

Further, the Affordable Care Act drastically reduces funding for Disproportionate Share for Hospitals payments – the supplemental funding stream meant to offset the loss of uncompensated care from the treatment of uninsured

patients. This funding also supports the State Mental Health Hospitals. The methodology has not been established, but the reduction could mean a loss of $10 million used to fund our state hospitals.

Kansas must reduce the number of people who have no insurance coverage, or our community mental health centers, community hospitals, safety net clinics and state mental health hospitals will need a new source of public funding.

KMHC believes:

> **Kansas should expand KanCare eligibility to include adults with incomes at or below 133 percent of federal poverty guidelines. The federal government will pay 100 percent of the costs for the first three years, and 90 percent thereafter. States that choose to take advantage of this opportunity to expand the number of people who have coverage in their state will receive a greater share of federal funding for providing health care – expanding access to quality health care as well as jobs in the health professions.**

Substance Abuse Treatment

State funding of substance abuse treatment was reduced between 2009 and 2012. All available funds should now be used to ensure consumers receive necessary treatment. The Kansas Expanded Lottery Act (KELA) was passed in 2007 and allowed for state controlled casinos in Kansas. This Act also established the Problem Gambling and Addiction Fund. Because state-owned and operated casinos are now operating in Kansas, the funding is available to follow legislative intent and use the funds support addiction treatment and prevention programs. 2 percent of state gaming revenues are supposed to go to the "addictions fund" for use in a broader range of addictions, address long-standing funding deficiencies and co-occurring diagnoses, and broad-based treatment and prevention services.

While approximately $740,000 has consistently been appropriated for the problem gambling initiative, the 2011 Legislature swept $900,000 to prop up the State General Fund for fiscal year 2012 and $1,450,000 was shifted to cover lost funding for the Medicaid substance abuse program. Instead of adding needed treatment capacity, the funds have been used to replace state general funds.

KMHC believes:

1. **Reductions in alcohol and drug prevention and treatment funding must be restored.**
2. **The problem gambling and addictions fund should be used as required by Kansas Statute.**
3. **The liquor tax fund should be increased to fund substance abuse and mental health treatment.**
4. **The state's thirteen regional prevention centers are underfunded because they have not received a funding increase in over nine years. This situation must be corrected.**

Mental Illness and the Criminal Justice System

An unintended result of the massive reduction in state hospital beds during the last decades of the 20th century was the parallel growth in the proportion of people with mental illnesses incarcerated in local jails as well as state and federal prisons. One recent review of the scientific literature revealed that, nationally, 6 to 15 percent of people in city and county jails and 10 to 15 percent of people in state prisons have severe mental illness and a large proportion of them were homeless prior to arrest. U.S. Department of Justice data indicate that 24 percent of state prisoners and 21 percent of local jail prisoners have a recent history of a mental health disorder. KDOC data shows that from July 2008 to June 2009, 18% of inmates (1,558) were on psychotropic medications. In that same timeframe, 1,037 inmates were newly diagnosed with an Axis I disorder or dual diagnosis. In 2007, of the 5,008 inmates released, 10% had a serious mental illness and another 10% had a severe and persistent mental illness. Other investigators estimated that the percentage of inmates who are seriously mentally ill with schizophrenia, bipolar disorder, or severe recurrent depression range from 6% to15%, depending on the study and on the institution. The majority of these incarcerations are

unnecessary, counterproductive to recovery, and permanently stigmatizing. They strain the capacity of both the criminal justice system and the mental health system to adequately serve Kansans. We criminalize mental illness by having five times as many beds for persons with mental illness in the criminal justice system than we have in our state hospitals.

KMHC commends the 2012 Legislature for the passage of HCR 5032, recognizing Crisis Intervention Teams as a model of best practice for law enforcement personnel who work with persons who have a mental illness. However, when programs like CIT are successful, they result in additional referrals to community based treatment. Therefore, as we improve our law enforcement programs, there must be sufficient mental health funding allocated to support the increased caseload.

Competency evaluations that are performed in the community reduce waiting times in county jails and the cost of transporting persons to state hospitals for these evaluations. In 2009, SRS trained over 100 mental health providers to increase capacity to conduct community based competency evaluations, but was unable to fund additional agency evaluators that had been requested.

The State Security Hospital is a maximum security forensic psychiatric hospital serves patients ordered by courts of criminal jurisdiction, and/or transferred from the Department of Corrections. 30 additional beds were funded by the 2012 Legislature.

The KMHC believes:

1. **Positive programs to move Kansas forward in addressing the mental health of people who are incarcerated in the state's jails and prisons must be developed and funded. They must include therapeutic care for offenders living with mental illness in the state correctional facilities and local jails, and effective discharge planning to ensure that incarcerated individuals with serious mental illnesses are linked to community-based services upon their release.**
2. **Community liaisons and programs serving recently released inmates with community supports should be sufficiently funded to meet the need.**
3. **Medicaid eligibility should be suspended rather than revoked during incarceration in order to facilitate prompt treatment options on release.**
4. **The program providing competency evaluations at Larned State Hospital and within the communities should be monitored and report back to the Legislature regarding the efficiency of this process and its impact on waiting times.**
5. **Mental Health Courts have proven to be an effective agency for early post-booking diversion of people with mental illnesses from the criminal justice system, while assuring access to appropriate treatment and support. In order to shrink the number of people with serious mental illnesses in Kansas' jails and prisons, both of these options should be encouraged, supported, and funded.**

Supported Employment

Employment is a critical ingredient in the recovery process for individuals with a serious mental illness. The Individual Placement and Support services (IPS) model averages a 40% placement rate in competitive employment compared to a 15% placement rate by centers that use other methods. As of January 1, 2012, IPS programs and other evidence based mental health practices have helped more than 200 Kansans with a serious mental illness find employment and retain it for a period of at least 90 days. However, many individuals in the target population are currently being denied equal access to supported employment services due to the limited scope of the program.

Of the total caseload population of 6,937 individuals classified as having a serious and persistent mental illness (SPMI), it is estimated that 60 percent or 4,161 want at least part-time employment as part of their recovery plan. Currently, 868 individuals are receiving IPS services. That's about 20% of the statewide target population. While approximately 90% of the costs of implementing IPS can be covered by Medicaid, many centers lack sufficient revenue to offer the service or to expand the scope to reach a more significant portion of the target population.

KMHC believes:

Kansas should help people with mental illnesses find competitive employment and enable them to move beyond the mental health system of care to become more self-supporting. Kansas should appropriate $250,000 new funding to support costs not reimbursed by Medicaid in order to increase the number of individuals with serious mental illness who are able to benefit from Evidence-Based Supported Employment.

Children's Mental Health

As many as 70,000 Kansas children under the age of 18 have a serious emotional disturbance, but not all of them will seek or receive treatment. These children are at great risk for school dropout, school expulsion, drug or alcohol abuse, unplanned teen pregnancy, and conviction of crimes. Kansas families whose children have multiple health needs (mental health, physical health and/or substance abuse) encounter many barriers to quality health care. Investment in an adequate array of community-based out-patient and residential mental health service options is necessary to assure that children receive the treatment they need to be successful citizens. Children's mental health treatment is associated with a 20% reduction in the use of overall health services.

We ask the Legislature to do the following:

1. **Maintain at minimum the current array of services and eligibility for the HCBS waiver in KanCare.**
2. **Preserve CIF funding for Children's Mental Health Initiative at $3.8 million.**
3. **Maintain funding for adequate numbers of regional children's psychiatric hospital beds--in locations close to home so families can participate in their recovery.**
4. **Ensure the current cost reimbursement methodology for PRTF's is maintained and that the screening process and authorization time frames meet the needs of youth, ensuring the safety and well-being of the youth and their communities.**
5. **Continue to track the number of youth not screened into a PRTF, the destination of youth when discharged from a PRTF, and other data related to the care these youth receive post discharge.**
6. **Provide flexible funding streams that assure effective and timely wraparound planning and services close to home, and that provide continued care following discharge from any PRTF or hospital.**
7. **Fund coordination of care among providers and emphasize services and supports that maintain children with their family or other caregivers in their community.**
8. **Fund statewide parent education and services, including applications for Medicaid, SCHIP, and prescription assistance programs that help families care for children with severe emotional disturbances (SED.**

Children's Initiative Fund (CIF)

The Children's Initiative Fund (CIF) receives funding from the tobacco master settlement. Some of those programs are:

- The HCBS/SED Waiver ($3.8 million) is a statewide Medicaid program for youth with serious emotional disturbance (SED), providing in-home and community based services and supports as an alternative to psychiatric hospitalization or other levels of institutional care. It allows over 5,500 youth to live with their family and remain in their own communities. Not funding this program means these youth are at greater risk of entering inpatient care.
- For FY 2013, the CIF funded Family Preservation contracts in the amount of $2,154,357, and represents approximately 20% of state funding for this critical early intervention program for strengthening families and

protecting children via behavioral health services and other supportive interventions. Continued funding at the current level needs to be provided through the CIF or other revenue stream and made available to the Department for Children and Families.

- Three mental health programs have been eliminated that were also funded with CIF including Family Centered Systems of Care ($4.75 million: deleted in 2013); Therapeutic Services to Preschool Children ($1 million; deleted in 2008); and School Violence Prevention ($500,000; eliminated in 2008).

KMHC believes:

KMHC supports the use of CIF funding for important programs serving children in Kansas.

Seclusion and Restraint of Children

The Coalition believes that seclusion and restraint must be emergency interventions that may only be used in cases of imminent risk of physical harm to self or others. The growing national consensus is that these interventions must be governed by statutory standards and regulated by administrative rules. Thirty six states have enacted statutes and/or administrative rules that are designed to protect students from misuse of seclusion and restraint in schools. In 2013, Kansas did enact minimal rules for the use of seclusion or restraint in schools.

KMHC believes that it is time for Kansas to protect from the needlessly traumatizing and sometimes deadly misuse of seclusion and restraint through strict enforcement and monitoring.

Housing: Creating Homes for Kansans Initiative

Access to decent, safe, affordable housing is a major challenge for persons with mental illness and substance use disorders. Lack of housing is frequently identified as one of the significant barriers to living successfully in the community. When a person with a chronic and severe illness is homeless, they strain the resources of the community hospital emergency rooms and frequently spend prolonged periods in jails, often for minor misdemeanors. Homeless Kansans must spend all their waking hours struggling to survive, and so are prevented from making any progress toward a recovery that would make them self-sufficient and a contributing member of the community.

The Kansas Statewide Homeless Coalition, Kansas Housing Resource Corporation, the University of Kansas Office of Mental Health Research and Training, the Association of Community Mental Health Centers of Kansas, and numerous other agencies and individuals are in agreement. Each is committed to supporting the creation of centralized data-driven pilot programs dedicated to Creating Homes for Kansans. Additionally, these groups have done extensive research on the successes that other states have had with similar initiatives. The State of Tennessee housing program is highly effective and the groups mentioned above, along with the Kansas Department of Aging and Disability Services (KDADS) have met with Tennessee officials about their program and how it could be replicated in Kansas.

With the information gained from well-designed, data-driven pilot studies evaluating the feasibility of the Creating Homes for Kansans Initiative, this program can be implemented in every area of the state. This will enhance the lives of thousands of Kansans, permitting them to improve their health, participate in meaningful ways with their communities, and significantly reduce the demand on hospital emergency rooms, law enforcement personnel and jails, and state hospital services. The taxpayers of Kansas will pay for the care of these individuals one way or another. It is far better to invest in stable housing to help people toward recovery rather than spending additional dollars on expensive and intrusive services.

KMHC believes:

The Kansas Legislature should appropriate $300,000 to KDADS for the creation of pilot programs to expand housing options for people with mental illness and/or substance use disorders in transition from hospitalization.

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