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TO: Robert Stivers, President of the Senate
David Osborne, Speaker of the House
Members of the Legislative Research Commission

FROM: Senator Alice Forgy Kerr, Co-chair
Representative Danny Bentley, Co-chair
Severe Mental Illness Task Force

Subject: Findings and Recommendations of the Severe Mental Illness Task Force

DATE: November 16, 2021

In a memorandum dated May 26, 2021, the Legislative Research Commission established the Severe Mental Illness Task Force. The task force was established to study the provision of mental health services to adults diagnosed with a severe mental illness. The duties of the task force included 1) assessing the availability of adequate treatment options, medications, case management, and affordable housing for individuals with a severe mental illness; 2) evaluating the efficacy of psychiatric medications and identifying strategies to maximize the use of best practices in medication therapy, management, and adherence; 3) examining the relationship between being diagnosed with a severe mental illness and experiencing homelessness and making recommendations to reduce the occurrence rate of homelessness among individuals with a severe mental illness; 4) evaluating the effectiveness of mental health courts, crisis intervention teams, and forensic assertive community treatment in diverting individuals with a severe mental illness away from the criminal justice system, and making recommendations for expanding these programs; and 5) exploring the efficacy and utilization of Tim's Law, KRS 202A.0811 to 202A.0831, assistive outpatient treatment, and assertive community treatment in ensuring access to adequate treatment options and reducing reliance on emergency medical services as the primary source of mental health treatment by individuals with a severe mental illness.

The eight-member task force began meeting in June 2021 and convened six times during the 2021 Interim. The task force heard testimony from more than two dozen individuals, consisting of mental health professionals, individuals with severe mental illness, mental health court judges, board certified PharmDs, agency providers, law enforcement, and family members; state

agencies; and advocacy groups on various topics, including treatment options for individuals with severe mental illness, affordable supported housing, Tim's Law and mental health courts, and barriers to resources and care for individuals with severe mental illness.

In accordance with the May 26, 2021, memorandum, the task force submits the following findings and recommendations to the Legislative Research Commission for consideration. These findings and recommendations are based on the testimony provided to the task force during the 2021 Interim. This memorandum serves as the final work product for the task force.

Findings

1) Individuals with severe mental illness (SMI) comprise the only population in Kentucky with a disability that does not have a Medicaid waiver. Two important services—supported housing and supported employment—are not currently reimbursable by Medicaid. An SMI waiver would target services much needed to provide comprehensive care to individuals with SMI.

2) Housing is central to recovery for individuals with SMI, but individuals with SMI experience higher rates of housing insecurity and homelessness than the general population. Social Security Income (SSI) is the primary income for many individuals with SMI; individuals receive less than $10,000 annually of SSI. Average SSI monthly income is $794, and the United States Department of Housing and Urban Development (HUD) fair market rent for 2021 is approximately $760 monthly for a single bedroom apartment. HUD affordability guidelines recommend housing expenses be no more than 30 percent of adjusted income, but individuals on SSI are paying 60 percent to 90 percent of their income on housing.

3) Tim's Law is outlined in KRS Chapter 202A and is the practice of delivering assisted outpatient treatment (AOT) pursuant to a court order to adults with SMI who meet specific criteria. AOT is a team approach that consists of a judge, community health providers, and the patient. Individuals who need AOT are individuals with a history of repeated hospitalizations, a history of noncompliance with outpatient treatment, and a history of noncompliance with medication. It has taken a while to obtain funding for Tim's Law. As of July 2020, Substance Abuse and Mental Health Services Administration awarded to the Department of Behavioral Health, Developmental and Intellectual Disabilities a total of 4 million ($1 million per year for 4 years). AOT is only funded until 2025 and is limited to four specific regions of Kentucky. Services were initiated in December 2020, which is the reason for the limited data on the success of AOT. As of July 31, 2021, the data shows that out of the 18 patients who have been admitted to AOT, 4 have reached the 6-month reassessment period. None of those individuals were hospitalized prior to AOT reassessment. Each patient indicated improved crisis and recovery support and was always or usually medication compliant. In Jefferson County, a mental health court judge testified that there have been about 17 patients in AOT. The first patient was hospitalized over 50 times prior to being admitted in AOT. The patient had multiple hospitalizations and incarcerations, was not cooperative with providers, and was not compliant with medication. At present, that patient has not experienced any hospitalizations and arrests. The other patients have been hospitalized 4-34 times each, had multiple incarcerations, were not cooperative with

providers, and were not compliant with medication. After entering AOT, none of the patients have been hospitalized or incarcerated. Testimony presented research findings from other states that showed that 77 percent of individuals in AOT programs experienced fewer psychiatric hospitalizations; 74 percent fewer experienced homelessness; 84 percent fewer experienced arrest; and 87 percent fewer experienced incarcerations. Judges across Kentucky have expressed interest in operating a similar style court in their jurisdictions, but more funding is needed. The scope of Tim's Law is also narrow and limits the eligibility of individuals. The AOT statute needs to expand the population of individuals who would qualify for it and there needs to be due process and clarity improvements.

4) Community Mental Health Centers (CMHCs) are nonprofit organizations established by KRS Chapter 210 to provide community services for Kentuckians who experience issues with mental health, developmental and intellectual disabilities, and substance use disorders. The 14 CMHCs provide a variety of services including assertive community treatment designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to individuals with SMI; targeted case management defined as services that are furnished to assist adults with SMI in gaining access to needed medical, social, educational, or other services; peer support services provided by trained, self-identified consumers of mental health services; and comprehensive community support services that are necessary to allow clients to live with maximum independence in the community. CMHCs are the safety net providers for individuals with SMI. CMHCs have not received an increase in funding in 22 years but in that same time period, the population of Kentucky increased by over 500,000. In addition to a lack of funding, CMHCs face issues with prior authorizations with managed care organizations (MCOs) that can lead to a delay in service delivery. This is particularly true of targeted case management, which allows a caseworker to guide the individual with SMI. CMHCs also have low reimbursement rates, which can lead to staff limitations. A lack of regional service providers has created additional issues with continuity of care for CMHCs because any provider can enter a CMHC's region and provide services. These providers can choose which services to offer, which typically are ones that have higher reimbursement rates. CMHCs usually rely on services that have higher reimbursement rates to sustain programs that function at a loss.

5) Medication non-adherence rates among individuals with SMI range from 30 percent to 65 percent. Consequences of medication non-adherence include relapse, re-hospitalization, impairment in functioning, and suicide. The 1-year relapse rate for individuals with major depressive disorder who do not take antidepressants is 80 percent, whereas the rate for those who do take antidepressants is 30 percent. The 1-year relapse rate for individuals with schizophrenia who do not take antipsychotic medications is 55 percent, but for those who do take antipsychotic medication, it is 14 percent. One way to improve medication adherence is through the use of long-acting injectable antipsychotics that reduce the need to maintain medication schedules, provide for stable drug levels, improve adherence, and decrease hospitalizations. Oral antipsychotics are cheaper, more likely to be covered under Medicaid, and are easier to administer. Some long-acting injectable antipsychotics are only required to be administered twice a year, which greatly reduces the need to continue to take medication daily or even weekly. The most common causes of relapse in those who have schizophrenia and bipolar disorder are non-adherence to oral medications, substance use, and stress.

6) Mental health courts are designed to help stop the criminalization of individuals with SMI and intervene to reduce victimization, repeat criminal activity, homelessness, and drug and alcohol abuse. Mental health courts receive referrals from law enforcement, prosecutors, defense attorneys, and judges to assist criminal defendants who suffer from SMI. Kentucky incarcerates individuals with SMI at high numbers. Incarcerated persons with SMI require an average of 60 percent more resources than other individuals. Each program graduate of mental health courts saves law enforcement an average of $22,865 annually. Upon entry into Fayette County Mental Health Court, 33 percent of participants had experienced homelessness, but after 12 months, 96 percent of participants were housed. Upon entry, 75 percent of participants were unemployed, but after 12 months, about 71 percent of graduates were employed. Upon entry, 84 percent of participants had experienced previous arrests, after 12 months, 74 percent were arrest free. Additional mental health courts can be established but more funding is needed.

7) Some individuals with SMI spend months in jail with no alternative recourse. If an individual with SMI is arrested and attends court, and the individual's attorney believes he or she is not competent and may have SMI, the attorney may file a motion of competency that stays the proceedings. The court cannot make a determination of whether the individual is competent and the individual may spend months in jail waiting for a psychiatric evaluation to be completed.

8) Many individuals with SMI living in rural areas do not have a reliable source of transportation. The lack of transportation is a barrier to housing and employment and hinders individuals from following up after having been discharged from a hospital or in general, from seeking help. Pathways Inc. started a mobile mental health project that has served 220 individuals in rural areas since May 2021.

9) There are four CMHCs in the process of becoming Certified Community Behavioral Health Centers (CCBHCs) by January 2022. CCBHCs are required to offer specific services to any individual in need of care, including individuals with SMI, children with severe emotional disturbance, and individuals with long-term chronic addiction. CCBHCs are funded to provide care regardless of an individual's ability to pay, including individuals who are uninsured, covered by Medicaid, and active-duty military or veterans.

10) There are only 350 actively practicing psychiatrists in Kentucky—about 8 per 100,000 residents. To adequately serve individuals with severe mental illness, there should be at least 50 actively practicing psychiatrists per 100,000 residents. Due to this chronic shortage of psychiatrists, primary care providers are providing up to 74 percent of all psychiatric care in the United States. However, primary care providers may not have the training or experience to accurately diagnose or treat individuals with SMI or other mental health conditions.

Recommendations

1) Direct the Cabinet for Health and Family Services to apply for a Medicaid waiver targeting individuals with SMI to provide for supported housing, including medical respite care and supported employment.

2) Fund and expand the use of Tim's Law and assisted outpatient treatment (AOT) to all Community Mental Health Center (CMHC) regions across the state.

3) Amend KRS 202A.0815 to expand the class of individuals who can have access to assisted outpatient treatment pursuant to Tim's Law.
   a. In order to be eligible for AOT, the individual shall have been involuntarily hospitalized pursuant to KRS 202A.051 for at least two times in the past 24 months. The recommended amendments are to apply it to individuals who have a history of repeated nonadherence with mental health treatment defined as at least twice within the last 48 months and has been a significant factor in necessitating hospitalization or arrest of the person; or within the last 24 months has resulted in an act, threat, or attempt at serious physical harm to self or others.
   b. As the statute is currently written, to qualify for AOT, an individual's condition must be described as anosognosia. This term is not often used in medical health settings, which makes it difficult for an individual to qualify for AOT treatment. It is recommended that the language be amended to identify specific characteristics of the individual's clinical condition that significantly impair the ability to make and maintain a rational and informed decision as to whether to engage in outpatient treatment voluntarily.

4) Direct the Department for Medicaid Services to make suspension of prior authorizations for behavioral health services, particularly targeted case management, permanent and to require managed care organizations to cover the cost of long-acting injectable medications when appropriately prescribed.

5) Establish and fund mental health courts across Kentucky to expand the court's mission and to allow more courts to participate.

6) Amend KRS 202A.0811 for clarity and due process issues.
   a. As the statute is written, the word, "examined," is used inconsistently throughout the statute. It is recommended that the language be changed to state that the respondent shall be "evaluated" and not "examined."
   b. As the statute is written, it is not clear where the mental health professional certifies his or her findings and when the findings must be certified. It is recommended to amend the language to state that the qualified mental health professional shall certify his or her findings to the court within 72 hours from receipt of the order, excluding weekends and holidays.
   c. As it is written, a date for a hearing shall be set within six days from the date of examination. It is recommended that this be changed so that a date for a hearing shall be set within six days from the date of the filing of the petition because this is in line with current court procedures.

7) Fund mobile health clinics to eliminate the barriers of stigma and lack of transportation and to provide both physical and mental health services to disenfranchised individuals and to those in underserved areas of the state.

8) Direct the Cabinet for Health and Family Services to expand Certified Community Behavioral Health Clinic designation to all 14 CMHCs to provide integrated mental health, substance use, and physical health services to any individual in need of care, including individuals with SMI, children with severe emotional disturbance, and individuals with addictions and other chronic health problems.

9) Direct the Cabinet for Health and Family Services to assess if in-state programs currently providing psychiatric primary care physician training are sufficient to meet the need. If not sufficient, direct the CHFS to contract with another university or medical association of its choosing to provide additional psychiatric primary care physician training programs.

10) Require all mental health professional licensure boards to either enter into an interstate compact or to ease or establish reciprocity procedures so as to increase the mental health workforce in Kentucky.