AN ACT relating to treatment of substance abuse.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) The Department for Medicaid Services shall provide a substance abuse benefit consistent with federal laws and regulations.

(2) The department shall promulgate administrative regulations to implement this section and to expand the behavioral health network to allow providers to provide services within their licensure category.

(3) Beginning January 1, 2016, the Department for Medicaid Services shall provide an annual report to the Legislative Research Commission detailing the number of providers of substance abuse treatment, the type of services offered by each provider, the geographic distribution of providers, and a summary of expenditures on substance abuse treatment services provided by Medicaid.

➔Section 2. KRS 217.186 is amended to read as follows:

(1) A licensed health-care provider who, acting in good faith, directly or by standing order, prescribes or dispenses the drug naloxone to a ***person or agency***~~[patient]~~ who, in the judgment of the health-care provider, is capable of administering the drug for an emergency opioid overdose, shall not, as a result of his or her acts or omissions, be subject to disciplinary or other adverse action under KRS Chapter 311, 311A, 314, or 315 or any other professional licensing statute.

(2) A prescription for naloxone may include authorization for administration of the drug to the person for whom it is prescribed by a third party if the prescribing instructions indicate the need for the third party upon administering the drug to immediately notify a local public safety answering point of the situation necessitating the administration.

(3) A person or agency, including a peace officer or a first responder, may:

(a) Receive a prescription for the drug naloxone;

(b) Possess naloxone pursuant to this subsection, and any equipment needed for its administration; and

(c) Administer naloxone to an individual suffering from an apparent opiate-related overdose.

(4) A person acting in good faith who administers naloxone as the third party under this section shall be immune from criminal and civil liability for the administration, unless personal injury results from the gross negligence or willful or wanton misconduct of the person administering the drug.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) A person shall have a defense for a violation of a criminal offense prohibiting the possession of a controlled substance or the possession of drug paraphernalia if:

(a) The person in good faith seeks medical assistance from a public safety answering point, emergency medical services, a law enforcement officer, or a health practitioner for a person experiencing a drug overdose;

(b) The person remains with the overdose victim until the requested assistance arrives or is provided; and

(c) The conduct for which the defense is asserted arises from the same course of events from which the drug overdose arose.

(2) The defense provided in subsection (1) of this section:

(a) Shall extend to the person who suffered the drug overdose if, subsequent to the person being charged with a violation of KRS Chapter 218A and prior to trial, the person participates in and demonstrates suitable compliance with the terms of a secular or faith-based substance abuse treatment or recovery program if space is available in a program appropriate to that person; but

(b) Shall not extend to the investigation and prosecution of any other crimes committed by a person who otherwise qualifies for the defense under this section, including a trafficking prosecution based upon possession with the intent to traffic in the controlled substance.

➔SECTION 4. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

Substance abuse treatment or recovery service providers that receive state funding shall give pregnant women priority in accessing services and shall not refuse access to services solely due to pregnancy as long as the provider's services are appropriate for pregnant women.

➔Section 5. KRS 218A.500 is amended to read as follows:

As used in this section and KRS 218A.510:

(1) "Drug paraphernalia" means all equipment, products and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter. It includes but is not limited to:

(a) Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing, or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

(b) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances;

(c) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance;

(d) Testing equipment used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness or purity of controlled substances;

(e) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances;

(f) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, intended for use, or designed for use in cutting controlled substances;

(g) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining marijuana;

(h) Blenders, bowls, containers, spoons, and mixing devices used, intended for use, or designed for use in compounding controlled substances;

(i) Capsules, balloons, envelopes, and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances;

(j) Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances;

(k) Hypodermic syringes, needles, and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body; and

(l) Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing marijuana, cocaine, hashish, or hashish oil into the human body, such as: metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls; water pipes; carburetion tubes and devices; smoking and carburetion masks; roach clips which mean objects used to hold burning material, such as marijuana cigarettes, that have become too small or too short to be held in the hand; miniature cocaine spoons, and cocaine vials; chamber

pipes; carburetor pipes; electric pipes; air-driven pipes; chillums; bongs; ice pipes or chillers.

(2) It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia for the purpose of planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packing, repacking, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter.

(3) It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this chapter.

(4) It is unlawful for any person to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement, in whole or in part, is to promote the sale of objects designed or intended for use as drug paraphernalia.

(5) ***This section shall not prohibit a local health department from operating a substance abuse treatment outreach program which allows participants to exchange hypodermic needles and syringes. Items exchanged through the program shall not be deemed drug paraphernalia under this section.***

(6) (a) Prior to searching a person, a person's premises, or a person's vehicle, a peace officer may ask the person whether the person is in possession of a hypodermic needle or other sharp object that may cut or puncture the officer or whether a hypodermic needle or other sharp object is on the

premises or in the vehicle to be searched.

(b) If there is a hypodermic needle or other sharp object on the person, on the person's premises, or in the person's vehicle, and the person alerts the officer of that fact prior to the search, the person shall not be charged with or prosecuted for possession of drug paraphernalia for the needle or sharp object or for possession of a controlled substance for residual or trace drug amounts present on the needle or sharp object.

(c) The exemption under this subsection shall not apply to any other drug paraphernalia that may be present and found during the search or to controlled substances present in other than residual or trace amounts.

(7) Any person who violates any provision of this section shall be guilty of a Class A misdemeanor.

➔Section 6. KRS 202A.081 is amended to read as follows:

(1) Following the preliminary hearing but prior to the completion of the final hearing, the court may order the person held in a hospital approved by the cabinet for such purpose for the committing judicial district, or released, upon application and agreement of the parties, for the purpose of community-based outpatient treatment. ***At the time an agreement of the parties for community-based outpatient treatment is reached the attorney for the person to be released shall be present, along with an alternative sentencing social worker, if available as determined by the Department of Public Advocacy. A peer support specialist or other person in a support relationship with the person to be released may also be present.*** No person held under this section shall be held in jail unless criminal charges are also pending.

(2) A hospital shall discharge a patient there held and notify the court and attorneys of record if any authorized staff physician determines that the patient no longer meets the criteria for involuntary hospitalization.

(3) If a patient is discharged by the hospital pursuant to subsection (2) of this section, then the proceedings against the patient shall be dismissed.

(4) The release of the person pursuant to subsection (1) of this section for the purpose of community-based outpatient treatment does not terminate the proceedings against the person, and the court ordering such release may order the immediate holding of the person at any time with or without notice if the court believes from an affidavit filed with the court that it is to the best interest of the person or others that the person be held pending the final hearing, which shall be held within twenty-one (21) days of the person's further holding.

(5) If the person is released pursuant to subsection (1) of this section for the purpose of community-based outpatient treatment, the final hearing may be continued for a period not to exceed sixty (60) days if a provider of outpatient care accepts the respondent for specified outpatient treatment.~~[Community-based outpatient treatment may be ordered for an additional period not to exceed sixty (60) days upon application and agreement of the parties.]~~

(6) Before a person is considered for community-based outpatient treatment, the Department of Public Advocacy may assign an alternative sentencing social worker to the case to conduct evidence-based motivational interviewing with the person in order to initiate a community-based treatment plan in collaboration with a community mental health center. If the Department of Public Advocacy determines that an alternative sentencing social worker will not be assigned, a community mental health center shall initiate a treatment plan. Upon approval by the person, the community-based outpatient treatment plan shall be presented to the court.

(7) If the court orders community-based outpatient treatment, the court shall appoint a case manager or team employed by a community mental health center established pursuant to KRS 210.370 to 210.460 whose responsibilities are to

address the individual and situational factors that may result in violence and teach the person to recognize and respond to high-risk situations by:

(a) Regularly monitoring the person's adherence to the conditions of community-based treatment;

(b) Regularly reporting to the court information descriptive of the person's functioning as requested by the court;

(c) Recommending to the court any community support services the person needs; and

(d) Assisting the person in applying for any social service assistance for which the person may be eligible to meet the person's social needs.

(8) A case manager or team shall be available twenty-four (24) hours a day. The case manager or team members shall be professionals who have training and experience in the human services systems.

(9) A provider of mental health treatment for the purpose of court-ordered community-based outpatient treatment shall use evidence-based practices. As used in this section, "evidence-based practices" means intervention programs, policies, procedures, and practices that have been rigorously tested, are proven by scientific research, have yielded consistent, replicable results, and have proven safe, beneficial, and effective for most people diagnosed with mental illness when implemented competently. Evidence-based practices may include but are not limited to psychotropic medication, psychosocial rehabilitation, recovery-oriented therapies, modified assertive community treatment, supported employment, supported housing, and peer support services.

(10) (a) Failure to abide by the terms of the community-based outpatient treatment plan may result in the initiation of procedures under this chapter that may result in involuntary hospitalization, provided the criteria set forth in KRS 202A.026 are met.

(b) Initiation of these procedures shall begin upon recommendation by the case manager or team and by his or her sworn affidavit attesting that the person did not comply with the terms of the treatment plan.

(c) Any mental health examination required for these procedures may be performed at a community mental health center, established pursuant to KRS 210.370 to 210.460.

(11) (a) Community-based outpatient treatment may be ordered for up to three (3) additional periods, each of which shall not exceed sixty (60) days.

(b) Prior to the issuance of an order for an additional period of community-based outpatient treatment, the court shall hold a hearing at which the attorney for the person along with, if available as determined by the Department of Public Advocacy, an alternative sentencing social worker is present. A peer support specialist or other person in a support relationship with the person may also be present. At the hearing, the court must find that:

1. The person has failed to adhere to one or more of the conditions of the prior community-based outpatient treatment order;

2. Continued outpatient treatment is appropriate and necessary, based on recommendations of the case manager or team appointed under subsection (7) of this section; and

3. The parties continue to be in agreement with the order for community-based outpatient treatment.

(12) Community-based outpatient treatment services identified under this section shall be authorized by the Department for Medicaid Services and its contractors as Medicaid-eligible services and shall be subject to the same medical necessity criteria and reimbursement methodology as for all other covered behavioral health services.

(13) A court shall report every order for community-based outpatient treatment to the cabinet.

➔Section 7. KRS 100.982 is amended to read as follows:

As used in KRS 100.982 to 100.984, unless the context otherwise requires:

(1) "Person with a disability" means a person with a physical, emotional, or mental disability, including, but not limited to, an intellectual disability, cerebral palsy, epilepsy, autism, deafness or hard of hearing, sight impairments, and orthopedic impairments, but not including convicted felons or misdemeanants on probation or parole or receiving supervision or rehabilitation services as a result of their prior conviction, or mentally ill persons who have pled guilty but mentally ill to a crime or not guilty by reason of insanity to a crime. "Person with a disability" does not include persons with current, illegal use of ~~[or addiction to]~~alcohol or any controlled substance as regulated under KRS Chapter 218A.

(2) "Residential care facility" means a residence operated and maintained by a sponsoring private or governmental agency to provide services in a homelike setting for persons with disabilities.

(3) "Services" means, but is not limited to, supervision, shelter, protection, rehabilitation, personal development, and attendant care.

➔Section 8. The Cabinet for Health and Family Services is encouraged to study the advantages and disadvantages of:

(1) Requiring the Medicaid program and private insurers to pay for one year postpartum medication-assisted treatment for women with heroin and other opioid addiction;

(2) Continuing medication-assisted treatment indefinitely and only discontinuing at the discretion of the patient, physician, and treatment team; and

(3) Establishing a mechanism to direct heroin and other opioid-addicted postpartum women into treatment facilities instead of the judicial system unless the

patient is already incarcerated.

➔Section 9. The Cabinet for Health and Family Services is encouraged to study the feasibility of and, if warranted, establish a physician-led committee composed of diverse regional, state, and national experts to assist in the development of evidence-based medical management standards to treat the disease of addiction in the Commonwealth and assist in developing overdose prevention and reaction protocols.

➔Section 10. The Cabinet for Health and Family Services is encouraged to study and develop guidelines for the development and implementation of county and regional level wraparound teams for heroin and other opioid addiction that utilize physicians, social workers, and treatment and recovery professionals. The cabinet is encouraged to include the use of state qualified mental health facilities; treatment plans that utilize nonaddictive and nondivertible medication-assisted treatment to be continued indefinitely, and only discontinued at the discretion of the patient, physician, and treatment team; peer support services as necessary to overcome barriers to treatment; and cognitive and behavioral therapy.

➔Section 11. The Cabinet for Health and Family Services is encouraged to collaborate with all medical schools and medical-related post-graduate training programs in Kentucky, including nursing schools, to include a minimum of ten (10) hours of coursework on the disease of addiction for all medical professionals providing direct patient care, including but not limited to physicians, registered nurse practitioners, registered nurses, and physical therapists.

➔Section 12. The Cabinet for Health and Family Services is encouraged to work with the licensing boards for medical and allied health professionals in Kentucky to increase continuing education units, at least to two (2) units every two (2) years, that focus on the disease of addiction.

➔Section 13. The Cabinet for Health and Family Services is encouraged to make any recommendations for legislation to the Interim Joint Committee on Health and

Welfare by November 30, 2015.

➔Section 14. By December 31, 2016, the Department of Criminal Justice Training shall offer voluntary regionalized in-service training on the topic of heroin for law enforcement officers employed by agencies that utilize Department of Criminal Justice Training basic training for their recruits, including instructional material on the detection and interdiction of heroin trafficking, the dynamics of heroin abuse, and available treatment options for addicts.