COMMONWEALTH OF KENTUCKY STATE FISCAL NOTE STATEMENT
LEGISLATIVE RESEARCH COMMISSION
2017 REGULAR SESSION

MEASURE

2017 BR NUMBER **0088** **SENATE** BILL NUMBER **91**

RESOLUTION NUMBER____ AMENDMENT NUMBER ____

SUBJECT/TITLE An ACT relating to court-ordered outpatient mental health treatment and making an appropriation therefor.

SPONSOR Senator Julie Raque Adams

NOTE SUMMARY

FISCAL ANALYSIS**:** ☒ IMPACT ☐ NO IMPACT ☐ INDETERMINABLE IMPACT

LEVEL(S) OF IMPACT: ☒ STATE ☐ LOCAL ☒ FEDERAL

BUDGET UNIT(S) IMPACT: **Unified Prosecutorial System (County Attorneys); Cabinet for Health and Family Services (CHFS)/Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID); Justice and Public Safety Cabinet/Department of Public Advocacy (DPA); Education and Workforce Development Cabinet/Office of Vocational Rehabilitation (OVR)**

FUND(S) IMPACT: ☒ GENERAL ☐ ROAD ☒ FEDERAL ☐ RESTRICTED AGENCY ____ ☐ OTHER

FISCAL SUMMARY

FISCAL ESTIMATES	2016-2017	2017-2018	ANNUAL IMPACT AT FULL IMPLEMENTATION
REVENUES			
EXPENDITURES	Indeterminable	Indeterminable	Indeterminable
NET EFFECT	(Indeterminable)	(Indeterminable)	(Indeterminable)

( ) indicates a decrease/negative

MEASURE'S PURPOSE: SB 91 clarifies and expands procedures for patient agreed orders (currently termed "community-based outpatient treatment") under KRS 202A.081. At present, patient agreed orders permit the district court to continue the final hearing for an involuntary commitment up to 60 days, which may be extended for up to one additional period of up to 60 days, while the respondent receives outpatient treatment. In addition to formalizing existing practices for patient agreed orders, such as the presence of legal representation for the respondent, and delineating the obligations of the 14 Community Mental Health Centers (CMHCs), SB 91 would allow the patient agreed order to be extended for up to two additional periods of up to 120 days each, rather than the present one additional period of up to 60 days, and adds reporting requirements regarding the respondent's compliance with the patient agreed order, which could result in compliance hearings at the court's discretion.

SB 91 also establishes a process for a district court to order assisted outpatient treatment (AOT) for a person diagnosed with a serious mental illness, who is not currently, or in the process of being, involuntarily committed to a hospital; who was involuntarily hospitalized at least twice in the past year (after the final hearing for involuntary commitment), and for whom AOT is the least restrictive alternative method of appropriate treatment available. Before AOT can be ordered, individuals must be assessed by a qualified mental health professional and found to be unlikely to adhere to voluntary outpatient treatment based upon clinical observation, review of treatment history, and identification of anosognosia (the failure to recognize one's diagnosis of serious mental illness).

Currently, patient agreed orders for outpatient mental health treatment can be only initiated by hospital/outpatient staff as an alternative if a mentally ill individual is, or is in the process of being, involuntarily committed to a hospital. Per statute, a mentally ill person can be involuntarily committed to a hospital if he or she poses a danger, or threat of danger, to him or herself or others as a result of mental illness; can reasonably benefit from treatment; and for whom hospitalization is the least restrictive method of treatment available.

PROVISIONS/MECHANICS:

Section 1 clarifies that the presence of the respondent's attorney is required and the presence of a peer support specialist or other support person is allowed at the time of agreement for a patient agreed order. It also changes terminology from "community-based outpatient treatment" to "patient agreed order" and requires the district court, prior to the hearing, to appoint an outpatient provider agency recognized by Cabinet for Health and Family Services (CHFS) to assemble a multi-disciplinary team for devising a proposed written treatment plan. This would likely be one of the CMHCs, although CHFS could recognize other outpatient provider agencies. Section 1 stipulates that the multi-disciplinary team shall provide reasonable opportunities for the person and others requested by the person to participate in the treatment plan's development, follow any advanced directive for mental health treatment executed by the person, and include evidence-based practices (EBPs) as well as a crisis plan incorporating access to crisis services 24 hours a day in the proposal.

Section 1 also specifies that the treatment plan included in the patient agreed order shall be limited in scope to the recommendations in the proposed treatment plan. The outpatient provider agency is required to monitor the respondent's adherence to the patient agreed order and regularly report to the court that ordered the respondent's release. This report can be either in written format, in person, or via electronic means, at the court's discretion. Substantial failure to comply with the patient agreed order may result in involuntary hospitalization, initiated via recommendation by the multi-disciplinary team and sworn affidavit, if current criteria for involuntary hospitalization is met. Examinations to determine whether the conditions for involuntary hospitalization are met may be performed at a CMHC.

Section 1 permits the patient agreed order to be extended for up to two additional periods of up to 120 days each, if it is determined during another hearing that the person has failed to adhere to one or more of the conditions of the prior patient agreed order, that continued outpatient treatment is appropriate and necessary, and that the parties continue to be in agreement with the patient agreed order. The presence of the respondent's attorney is required and the presence of a

peer support specialist or other support person is allowed during the hearing and "appropriate and necessary" is based upon the recommendations of the multi-disciplinary team.

Further provisions in Section 1 direct coverage of patient agreed order services by Medicaid in the same manner as all other covered behavioral health services and that patient agreed orders are reported to the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (House Bill 343 Commission).

Section 2 amends KRS 202A.261 to exempt non-state operated or contracted mental hospitals or institutions from the requirement of providing court-ordered AOT services.

Section 3 amends KRS 202A.271 to stipulate that non-state operated or contracted mental hospitals or institutions providing court-ordered AOT services be paid at the rates negotiated with the Department for Behavioral Health, Developmental and Intellectual Disabilities or local CMHC.

Section 4 identifies the included elements in a petition for district court-ordered AOT. It specifies that the following may file the petition: qualified mental health professional, peace officer, County Attorney, Commonwealth's Attorney, a spouse, relative, friend, or guardian of the person concerning whom the petition if filed; or any other person. By statute, the County Attorney (KRS 202A.016) prepares petitions and participates in the presentation of evidence for involuntary hospitalizations.

Section 4 requires the district court to examine the petitioner under oath to determine if there is probable cause to believe the respondent should be court-ordered to AOT. If so, then the court can order the respondent to be examined by a qualified mental health professional whose findings shall be certified within 72 hours of the hearing, unless the court has already received the certified findings of such an examination conducted within five days prior to the filing of the petition. The court must set a date for a hearing within six days from the date of the examination to determine if the respondent should be court-ordered to AOT. If the court finds there is no probable cause to believe the respondent should be court-ordered to AOT, then the proceedings shall be dismissed.

Section 5 outlines the manner in which the respondent is transported to the hospital or site designated by CHFS for the examination by the qualified mental health professional. The district court may order the sheriff, peace officer, or designee to transport the respondent to the examination site. When the court is authorized to issue such an order, the court may issue a summons directed to the respondent to appear at a specified time and place for the examination. If the respondent fails to appear for the examination, then the court may order the sheriff or peace officer to transport the respondent to the examination site.

Section 6 establishes criteria for determining who may be district court-ordered to AOT. Individuals must have been involuntarily hospitalized at least twice in the past year (after the final hearing for involuntary commitment), diagnosed with a serious mental illness, and unlikely to adhere to voluntary outpatient treatment as assessed by the qualified mental health

professional, based upon clinical observation, review of treatment history, and identification of anosognosia. AOT also must be the least restrictive alternative method of appropriate treatment available.

Section 7 requires the qualified mental health individual who examined the respondent to present a proposed written treatment plan to the district court no later than the date of the hearing to determine if the respondent should be district court-ordered to AOT. The proposed treatment plan shall be developed in the same manner as that for patient agreed orders denoted in Section 1.

Section 8 states that the presence of the respondent's attorney is required and the presence of a peer support specialist or other support person is allowed during a hearing and at all stages of a proceeding for district court-ordered AOT. The respondent shall be afforded an opportunity to present evidence, call witnesses on his or her behalf, and cross-examine adverse witnesses. If the respondent does not appear at the hearing and appropriate attempts to elicit his or her appearance have failed, then the court may conduct the hearing in the respondent's absence. The qualified mental health individual recommending court-ordered AOT shall testify at the hearing, in person or via electronic means, as to how the respondent meets the criteria for court-ordered AOT as specified in Section 6 and how each category of proposed evidence-based treatment in the plan is essential to the maintenance of the respondent's health or safety.

If the district court does not find by clear and convincing evidence that the respondent meets the criteria for court-ordered AOT as specified in Section 6, then the court shall deny the petition and dismiss the proceedings against the respondent.

If the district court does find by clear and convincing evidence that the respondent meets the criteria for court-ordered AOT as specified in Section 6, then the court may order the respondent to receive AOT for up to 360 days. The order shall include a treatment plan, limited in scope to the recommendations in the proposed treatment plan and shall be reported to the (House Bill 343 Commission).

If the district court orders AOT, Section 9 mandates the court to appoint an outpatient provider agency recognized by CHFS. This would likely be one of the CMHCs, although CHFS could recognize other outpatient provider agencies, to assemble a multi-disciplinary team for monitoring the respondent's adherence to the order and regularly reporting to the court that ordered the respondent's release. This report can be either in written format, in person, or via electronic means, at the court's discretion.

Section 10 stipulates that the respondent's substantial failure to comply with district court-ordered AOT may constitute presumptive grounds for an authorized staff physician to order a 72 hour emergency admission pursuant to KRS 202A.031. Failure to comply with court-ordered AOT shall not be grounds to find the respondent in contempt of court.

Section 11 allows the respondent to request the court-ordered AOT to be stayed, vacated, or modified by the district court at any time. Section 11 also permits the treating qualified mental health professional to propose a material change to the court-ordered treatment plan, meaning an

addition or deletion of a category of services, to the court. If the respondent agrees to the material change, then the court may approve the change without a hearing. If the respondent does not agree to the material change, then the court shall hold a hearing within five days of receiving the proposed change.

Within 30 days of the expiration of the court-ordered AOT, the original petitioner may petition the district court for an additional period of court-ordered AOT. Procedures for consideration of the petition shall be identical to the procedures for implementing the initial period of court-ordered AOT, except that the parties may mutually agree to waive the requirement for a new hearing. The respondent shall be represented by an attorney in responding to the petition for an additional period of court-ordered AOT.

Section 12 directs coverage of district court-ordered AOT services by Medicaid in the same manner as all other covered behavioral health services.

Section 13 states that implementation of Sections 4 to 14 of this Act is contingent upon adequate funding by a unit of state or local government, special purpose governmental entity, or any other entity able to utilize funds. Funds may be provided from federal, state, or local resources or from private resources.

Section 14 names Sections 4 to 14 of this Act "Tim's Law."

FISCAL EXPLANATION:

Estimates of Potential Patient Agreed Orders and District Court-Ordered AOT Cases
The Department of Public Advocacy (DPA), via the Protection and Advocacy Division (an independent entity within DPA), stated that state hospitals reported an average of about 150 community-based outpatient treatment agreed orders annually in the last three years.

The following, while not a rolling count, provides an estimate for volume and geographic distribution of potential district court-ordered AOT cases.

INDIVIDUALS WITH MULTIPLE ORDERS INVOLVING INVOLUNTARY COMMITMENT IN SAME COUNTY DURING FISCAL YEAR 2016					
COUNTY	**INDIVIDUALS**	**COUNTY**	**INDIVIDUALS**	**COUNTY**	**INDIVIDUALS**
ADAIR	12	DAVIESS	30	MARTIN	1
ALLEN	8	FAYETTE	35	MASON	2
BALLARD	1	FLOYD	6	MCCRACKEN	13
BARREN	6	FRANKLIN	5	MCCREARY	1
BATH	1	GRAVES	8	MONROE	1
BELL	4	GRAYSON	1	MONTGOMERY	6
BOONE	2	GREEN	2	OHIO	3
BOYD	11	GREENUP	1	PERRY	8
BOYLE	4	HARDIN	9	PIKE	32
BREATHITT	1	HARLAN	5	POWELL	1
BUTLER	1	HART	2	PULASKI	48
CALDWELL	13	HENDERSON	30	ROCKCASTLE	14
CALLOWAY	3	HOPKINS	30	ROWAN	9
CAMPBELL	13	JACKSON	7	RUSSELL	4
CARLISLE	1	JEFFERSON	59	TAYLOR	18
CARTER	1	JOHNSON	7	TRIGG	1
CASEY	3	KNOX	3	UNION	2
CHRISTIAN	129	LAWRENCE	1	WARREN	28
CLAY	13	LESLIE	2	WAYNE	12
CLINTON	3	LETCHER	2	WEBSTER	1
CRITTENDEN	4	LOGAN	2	WHITLEY	10
CUMBERLAND	2	MARSHALL	4	WOLFE	3
TOTAL 705					

Source: Administrative Office of the Courts (AOC) (orders applying to same individual cannot be tracked across counties which may result in underreporting of data as it isn't uncommon for individuals to be checked into hospitals in different counties)

The degree of increased expenditures cannot be determined with the extension of patient agreed orders and the creation of district-court ordered AOT. Areas of impact are specified below.

Cabinet for Health and Family Services

Section 1

With respect to the multi-disciplinary team services required by the legislation, Assertive Community Treatment (ACT) teams are the recognized standard according to CHFS. CHFS states that "EBPs strongly favor 10 person teams; however, modified 4 person teams provide an acceptable option where resources are limited, and there is an appropriate understanding of their related reduction in scope/capacity. Due to Kentucky's rural nature, large geographic service regions, and available workforce limitations, many CMHCs have implemented (or are in the process of implementing) the modified ACT team concept. Experience has found that there are not sufficient numbers of qualified providers to staff full teams in each region. A modified 4

person ACT team could serve up to 40 individuals at a time in optimal circumstances, but this capacity declines as geographic challenges and external demands (such as court appearances) increase."

Given that many modified ACT teams exist already and that the provisions specify a "multi-disciplinary team", the CMHCs could be considered to be in fulfillment of the requirements in Section 1 of the legislation already, although ability to provide full ACT team services in each of the 120 counties (at least one 10 person team per CMHC, possibly more in high-population areas or large service regions) is constrained due to the above factors as well as limited funding. The funding necessary to support one full 10-member ACT team is in excess of $1 million per year, which would be reduced with the modified 4-member ACT teams. Even with four-member ACT teams, there are establishment and maintenance (recruitment/turnover in rural areas, travel, support services, office space, court testimony) costs that are not eligible for Medicaid or other reimbursement.

While CHFS does not anticipate a significant change in the volume of community-based outpatient treatment agreed orders, CHFS does expect greater overall utilization of services and reporting requirements and, as a result of substantial failure to comply with patient agreed orders, possibly increased involuntary hospitalizations. CHFS states that there will be additional costs with Section 1, particularly when transferring supervision responsibility from the hospitals to CMHCs, some of which will not be reimbursed by Medicaid. At present, prior to the final hearing for an inpatient commitment, 60-day commitments are transferred from the hospitals to CMHCs with community-based outpatient treatment agreed orders and failure to comply with community-based outpatient treatment agreed orders will result in hospitalization pending the final hearing.

Sections 4 to 14
With increased outpatient treatment orders, there would be an increased cost for the CMHCs to provide the additional services and reporting required by this bill. Without adequate funding necessary to support the various components of the bill, it would, in effect, bind CMHCs to provide services, including additional multi-disciplinary/ACT teams, they could not financially support and potentially divert resources from other services. The extent of this additional cost will depend upon the degree to which families and providers choose to file petitions for district court-ordered AOT, the extent to which judges grant such a request, and the degree to which hospitalizations occur as a result of the respondent's substantial failure to comply with court-ordered AOT. The cost of this treatment will either be borne by Managed Care Organizations (MCOs), since the persons affected by this will most likely be Medicaid eligible, or the CMHCs providing the multi-disciplinary team, which is to be available 24 hours a day. How much of the total cost would be covered by Medicaid or health insurance is indeterminable. Private insurance and Medicaid can only pay for services determined to be medically necessary, which is consistent with the language in Section 1, Subsection 10 that requires services to be subject to the same medical necessity criteria by the Department for Medicaid Services and its contractors.

Department of Public Advocacy

Section 1

The legislation allows the patient agreed order to be extended for up to two additional periods of up to 120 days each, rather than the present one additional period of up to 60 days, and adds reporting requirements regarding the respondent's compliance with the patient agreed order, which could result in compliance hearings at the court's discretion. While this wouldn't increase caseloads, the additional time involved in developing the terms of the patient agreed order, compliance hearings, and the added hearing for the other extension period would result in an increased workload. Even if extension hearings replace involuntary commitment hearings, that could be offset by compliance hearings. DPA states that their caseloads already exceed standards set by the National Advisory Commission on Criminal Justice and Goals by 55%. The cost for each additional full-time attorney is $72,900 (salary and benefits).

Sections 4 to 14
The increased time involved in developing the terms of the district court-ordered AOT, compliance hearings, and modification hearings would be in addition to the current procedures for involuntary commitment cases/community-based outpatient treatment agreed orders (respondent as well as treating qualified mental health professional may move the district court to change the terms of the court-ordered AOT at any time). DPA states 329 clients were involuntarily hospitalized two times or more in calendar year 2016. This, while not a rolling count, gives an estimate of the potential number of court-ordered AOT cases that could be handled by DPA per year. DPA also affirmed that, since 25 offices do not presently manage these types of cases, there would be training costs for attorneys, alternative sentencing workers, and investigators, as well as potential travel time and expenses to staff the smaller offices in the interim. Specific expenses would be dependent upon the volume and geographic distribution of district court-ordered AOT cases.

Protection and Advocacy (independent division within DPA)
Depending upon the extent of the increased AOT orders, additional personnel may be needed to provide information and rights training to individuals with mental illness and their families. One staff attorney, $74,800 (salary and benefits), and one disability rights advocate, $59,200 (salary and benefits) was cited in the event that 2,300 people met the criteria for district court-ordered AOT although it appears from AOC data above that the number of individuals may be significantly less.

Unified Prosecutorial System (County Attorneys)

Section 1
The compliance hearings and the added hearing for the other extension period would result in an increased workload. Even if extension hearings replace involuntary commitment hearings, that could be offset by compliance hearings. The cost for each additional full-time attorney is $79,116 (salary and benefits).

Sections 4 to 14
The compliance and modification hearings would be in addition to the current procedures for involuntary commitment cases/community-based outpatient treatment agreed orders (respondent as well as treating qualified mental health professional may move the district court to change the terms of the court-ordered AOT at any time). If an additional full-time attorney were needed at

the 30 largest offices, then that would equate to $2.4 million per year. If part-time attorneys were needed at the remaining 90 offices, then that would be an additional $5 million for a total of $7.4 million per year. Specific expenses would be dependent upon the volume and geographic distribution of district court-ordered AOT cases.

Education and Workforce Development Cabinet

EPBs may include supported employment services. Current funding for the Education and Workforce Development Cabinet's Supported Employment services program is not sufficient for all applicants. Therefore, according to federal funding guidelines, Kentucky operates under an Order of Selection whereby individuals who have the most significant disabilities are given first priority. In addition, there are not currently enough providers statewide to serve consumers needing supported employment services. Many counties in Kentucky do not have providers for Supported Employment services or they are limited in what they can offer. General Fund moneys are currently not sufficient to fully leverage federal matching funds, as well. It is unknown how many of the people affected by this bill would actually qualify for Category One, the population with the most significant disabilities. In essence, this bill would simply add new consumers to the unserved and underserved populations unless additional funding is provided.

DATA SOURCE(S): **Unified Prosecutorial System; Cabinet for Health and Family Services; Department of Public Advocacy; Department of Public Advocacy - Protection and Advocacy; Education and Workforce Development Cabinet; Administrative Office of the Courts**
PREPARER: **Katherine L. Halloran, Chuck Truesdell, Zach Ireland, Seth Dawson** **NOTE NUMBER**: **25** **REVIEW**: **JRS** **DATE**: **2/22/2017**